Inhospitable Healthcare Spaces: Why Training on LGBTQIA Issues Is Not Enough
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Definitions/Terminology.1
(LGB) Lesbian  Gay  Bisexual: Sexual orientation/partner attraction
(T) Transgender: Gender of person does not match that which corresponds with sex assigned at birth
(I) Intersex: Anatomy does not fit with typical definitions of male/female
(A) Asexual: Sexual orientation/partner attraction often (inappropriately) treated as a mental disorder
  ❖ Distinct health needs but grouped together because all deviate from gender norms and sexuality norms bundled into heteronormativity.

Heteronormativity: belief that people fall into distinct and complementary gender roles (man/woman), and that heterosexuality is the only sexual orientation upon which to base sexual/marital relationships.

Structural Heteronormativity: rules/regulations that favor heterosexual persons and relationships

Micromessages: persistent, nuanced, often unconscious, behaviors that underlie verbal and nonverbal communication.
  ❖ improper gendered pronouns
  ❖ heterosexist words for partners
  ❖ insistent questions about birth control
  ❖ intake forms with no space for preferred name, gender, or queer relationships
  ❖ heterosexist brochures, posters, reading materials
  ❖ provider discomfort around and avoidance of LGBTQIA patients

Barriers to Standards of Care
  ▪ LGBTQIA patients may be reluctant to disclose to providers
  ▪ When LGBTQIA patients do disclose, micromessages undermine trust
    ❖ Erasure of identity
    ❖ Explicit or implicit pathologized gender or sexual orientation and/or body presentation
  ▪ Lack of disclosure and lack of trust make a strong therapeutic relationship difficult
    ❖ Different health risks/needs not recognized or met
    ❖ Avoidance of healthcare system

Cycle of Perpetuation

Double bind: “situations in which options are reduced to a very few and all of them expose one to penalty, censure or deprivation,” (Frye, 1983, 2).
  ❖ Disclosure risks prejudice, discrimination, and improper care
  ❖ Lack of disclosure risks improper care, exclusion of partners in care, and inadvertent outing

Why Training is not Enough
  ▪ Backlash
  ▪ Micromessages are habitual, and often unintentional and unconscious
  ▪ Policy cannot easily address habits or unconscious actions

Suggestions
  ▪ Individual: engage in positive activities with members of an out-group to form new associations.
  ▪ Institutional Culture: In addition to procedural changes (e.g., intake form modification, ensure diverse representation in posters), clinics/hospitals provide scripts to structure all patient encounters to draw attention to behavioral cues, such as voice, body language, eye contact.
  ▪ Education: Change narratives in bioethics to expand clinician education and knowledge.

1We are indebted to Alison Reiheld for the LGBT definitions here.
Resources & Feedback Website:
http://lgbtqia-healthcare-spaces.weebly.com/

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Selected References


