Objectives

Upon completion of this activity, the learner will be able to:

1. Describe what cultural humility is and how it can be applied in the provision of health care to people who are lesbian, gay, bisexual, transgender, or queer (LGBTQ).
2. Define pertinent terms related to care of LGBTQ populations.
3. Apply knowledge of how clinicians' biases or assumptions can hinder the provision of optimum health care to develop strategies for providing inclusive, respectful care.

Continuing Nursing Education (CNE) Credit

A total of 1.1 contact hours may be earned as CNE credit for reading "Cultural Humility in the Care of Individuals Who Are Lesbian, Gay, Bisexual, Transgender, or Queer" and for completing an online posttest and participant feedback form.

To take the test and complete the participant feedback form, please visit **http://learning.awhonn.org**. Certificates of completion will be issued on receipt of the completed participant feedback form and any processing fees.

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Cultural Humility in the Care of Individuals Who Are Lesbian, Gay, Bisexual, Transgender, or Queer CNE

Maria Ruud

ABSTRACT: Health care providers' knowledge about the health issues of individuals who are lesbian, gay, bisexual, transgender, or queer (LGBTQ) has increased in the past few years, but significant gaps still exist. Nurses and other clinicians may be unfamiliar with current concepts of sexual orientation and gender identity, as well as with current language and terminology. Health care settings that lack informed staff or have environments that are not inclusive can influence the quality of care delivered or whether care is pursued at all. This article describes the application of cultural humility in the care of people who are LGBTQ, reviews key concepts of sexual orientation and gender identity, and provides definitions of common terms. Two brief case examples are provided, as are suggestions for creating welcoming and inclusive settings and providing person-centered care.

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KEYWORDS: cultural competence, cultural humility, gender identity, LGBTQ, person-centered care, sexual orientation

Introduction

Nursing professionals are continually challenged in their daily practice to meet the needs of an increasingly diverse population. Clients may be from another town, state, or part of the world. They may speak a different language, have a different family structure, or be from a different socioeconomic background than their nurse. They may identify as male, female, transfemale, transmale, or other. They may share that they are lesbian, gay, bisexual, transgender, or queer (LGBTQ).

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CLINICAL IMPLICATIONS

- Many health care providers lack knowledge about the needs of individuals who are LGBTQ, and fear of discrimination in health care settings is a barrier to these individuals accessing health care.
- For nurses and other clinicians seeking to advance their knowledge and skills in providing person-centered care to members of a population that may be unfamiliar, the focus of learning has increasingly shifted from one of *cultural competence* to one of *cultural humility*.
- Cultural humility includes ongoing self-reflection and education in which health care professionals seek to gain an awareness of their own assumptions and biases that may contribute to health disparities.
- Organizations and resources exist to help clinicians advance their knowledge and provide optimum care to members of LGBTQ populations.
- Nurses are well positioned to create a safe environment and provide care that is informed, respectful, and inclusive.

Cultural Humility

For nurses and other clinicians seeking to advance their knowledge and skills in providing person-centered care to members of a population that may be unfamiliar, the focus of learning has increasingly shifted from one of *cultural competence* to one of *cultural humility*. Cultural competence implies "I am the expert," whereas cultural humility implies "You are the expert." Cultural humility includes ongoing self-reflection and education in which health care professionals seek to gain an awareness of their own assumptions and biases that contribute to health disparities (Tervalon & Murray-Garcia, 1998; Yeager & Bauer-Wu, 2013).

Organizations and Resources for Fostering Cultural Humility

The engagement of health care providers and systems with the populations they serve is an essential element of cultural humility. Educational, professional, and community organizations provide opportunities to enhance alliances and address disparities. The Gay, Lesbian, and Straight Education Network (n.d.) is a national organization that focuses on ensuring safe and inclusive schools for LGBTQ students from kindergarten through 12th grade. Fostering a safe and supportive school environment is critical for the well-being of LGBTQ youth (Sadowski, 2016). At the collegiate level, the website *Campus Pride Index* (Campus Pride, 2018) provides a national listing of LGBTQ-friendly colleges and universities. Some factors that are considered in the listing include LGBTQ student and academic life, support and institutional commitment for these students, and efforts to recruit and retain LGBTQ students. Institutions of higher learning need to provide resources for students and staff, because faculty serve a diverse student population and seek to educate a workforce that is more inclusive.

The Gay Lesbian Medical Association has a nursing section and is a professional organization serving LGBTQ and all nurses, as well as advanced practice nurses, midwives, and nursing students. The organization seeks to reduce disparities in LGBTQ health care through advocacy and education (Gay Lesbian Medical Association, n.d.). Other organizations such as the Center of Excellence for Transgender Health at the University of California at San Francisco and the National LGBT Health Education Center based at the Fenway Institute in Boston provide current resources for health care professionals and consumers. Other organizations exist that seek to advocate for LGBTQ populations. Resources available in each community may vary, but virtual connections are available on the Web. Health care professionals can seek out resources; build alliances with the populations served; and help educate themselves, their students, and their coworkers.

Sexual Orientation and Gender Identity

Everyone has a gender identity and a sexual orientation. Sexual orientation cannot be assumed based on gender identity. The culture in the United States is binary with regard to gender: an individual is male or female. Medical forms and surveys usually leave no options for a person who identifies as transmale, transfemale, genderqueer, or other. In 2011, the Institute of Medicine recommended routine collection of data about sexual orientation and gender identity (SOGI) in federally funded surveys and in electronic health records. In 2015, the U.S. Department of Health and Human Services issued a rule that requires electronic health records certified for Stage 3 of Meaningful Use to include fields to collect SOGI data (Cahill, Baker, Deutsch, Keatley, & Makadon, 2016). Collecting more accurate data will serve to refine research and direct care.

SOGI data intersect with other characteristics, such as race/ethnicity and class, and affect the health and health care of an individual (Kates, Ranji, Beamesderfer, Salganicoff, & Dawson, 2017). Collecting data on SOGI is necessary to direct the research and ultimately inform the care that is provided. Health care professionals need a basic understanding of the definitions, history, and disparities that exist with regard to the health of people who are LGBTQ. Acquiring this knowledge is the first step in reducing health disparities.

LGBTQ Health

Over the past 20 years, research in the area of LGBTQ health has increased. However, knowledge gaps still exist that affect

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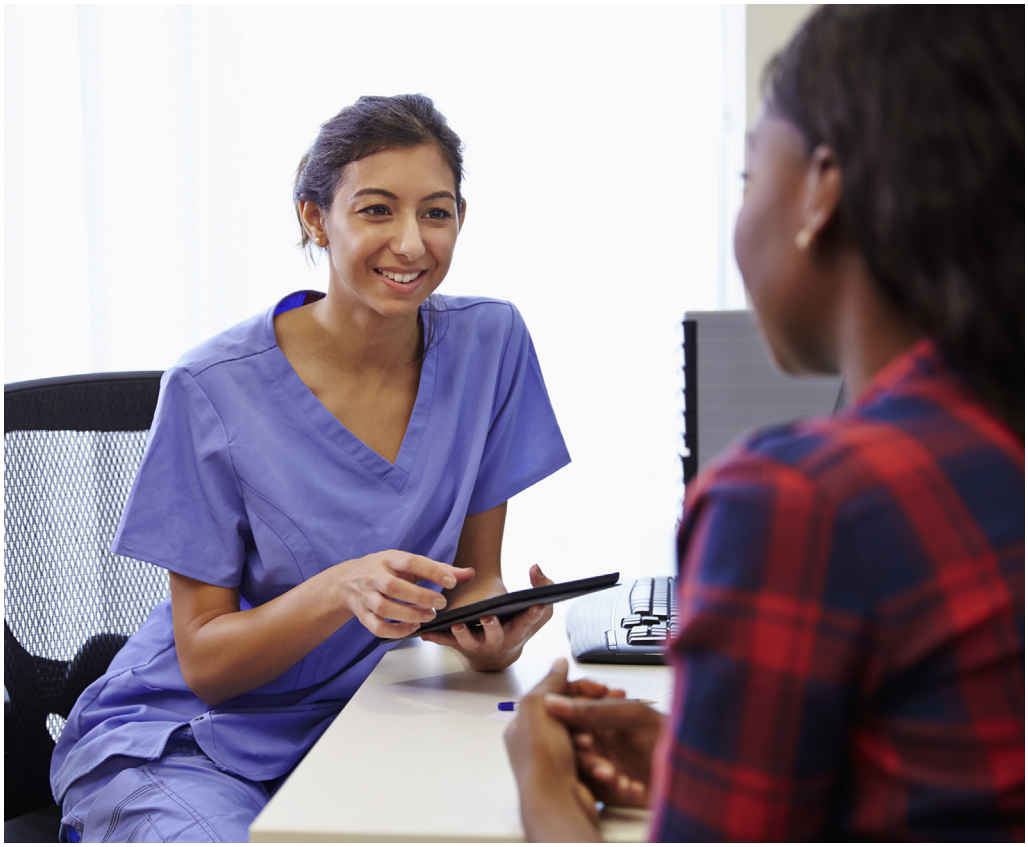
the health care that is provided and the outcomes that are achieved. In 2011, the Institute of Medicine released the landmark report *The Health of Lesbian, Gay, Bisexual, and Transgender People*. The authors of the report—members of the Institute of Medicine's Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities—sought to identify the state of knowledge of the health status of LGBT populations and the gaps and opportunities in research. The authors noted that studies focused on bisexual and transgender individuals were limited, LGBT youth experienced an elevated risk for depression and suicide, and elders who identified as LGBT were more apt to rely on friends for caregiving than on family members (Institute of Medicine, 2011). Of note, there is a lack of health care providers who are knowledgeable about the needs of individuals who are LGBT, and fear of discrimination in health care settings served as a barrier to these individuals accessing health care (Institute of Medicine, 2011).



> Cultural competence implies "I am the expert," whereas cultural humility implies "You are the expert"

Terms and Definitions

In the area of LGBTQ health, the language is ever evolving. The terms and definitions can be unfamiliar and confusing. Although it may be a challenge to keep up with changing terminology, the onus should not be on individuals to educate their care providers. The terms *lesbian, gay, bisexual, transgender,* and *queer* may be represented by the initials LGBTQ. A glossary of some common terms can be found in Box 1. It is important to note that the glossary is not comprehensive, items listed may appear in a different order in different settings, and the glossary may not be accepted by everyone whom it is meant to encompass. The acceptance of terms varies and changes. The National LGBT Health Education Center (2018) has published a convenient online glossary of LGBT terms for health care providers that is updated regularly. Terms that are outdated or offensive are also included in the glossary to guide health care professionals in avoiding their use. For example, the word *homosexual* is considered outdated. It is not a preferred term because of the history of the word, which implied that being gay was a pathologic condition (Drescher, 2015). The limitations of the glossary are noted, such as the variation of definitions across cultures, the difficulty in providing a comprehensive list, and the dynamic nature of language. Contemporary suggestions for the glossary may be sent to the e-mail address that is included with the glossary.

Case Examples

To illustrate the complexity of issues related to LGBTQ health care, consider the following two examples. Kade is a 22-year-old who identifies as a transmale. He presented to the clinic for an injection of depot medroxyprogesterone acetate, a long-acting reversible contraceptive that often has the side effect of amenorrhea, which Kade perceives as a benefit. The injection must be given every 12 weeks to be effective against pregnancy. Kade presented outside the recommended time frame for his injection. Guidelines set by the Centers for Disease Control and Prevention recommend

BOX 1 GLOSSARY OF TERMS

Agender (adjective): Describes a person who identifies as having no gender.
Ally (noun): A person who supports and stands up for the rights of LGBT people.
Asexual (adjective): Describes a person who experiences little or no sexual attraction to others. Asexuality is not the same as celibacy.
Binding (noun): The process of tightly wrapping one's chest to minimize the appearance of having breasts. This is achieved through use of constrictive materials such as cloth strips, elastic or no-elastic bandages, or specially designed undergarments.
Bisexual (adjective): Describes a sexual orientation in which a person is emotionally and sexually attracted to people of their own gender and to people of other genders.
Bottom surgery (noun): Colloquial way of describing gender-affirming genital surgery.
Cisgender (adjective): Describes a person whose gender identity and assigned sex at birth correspond (i.e., a person who is not transgender).
Gay (adjective): Describes the sexual orientation of a person who is emotionally and sexually attracted to people of their own gender. It can be used regardless of gender identity, but it is more commonly used to describe men.
Gender binary structure (noun): The idea that there are only two genders—boy/man/male and girl/woman/female—and that a person must strictly fit into one category or the other.
Gender dysphoria (noun): Distress experienced by some individuals whose gender identity does not correspond with their assigned sex at birth. Manifests itself as clinically significant distress or impairment in social, occupational, or other important areas of functioning. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) includes gender dysphoria as a diagnosis.
Gender fluid (adjective): Describes a person whose gender identity is not fixed. A person who is gender fluid may always feel like a mix of the two traditional genders but may feel more one gender some of the time and another gender at other times.
Gender identity (noun): A person's inner sense of being a boy/man/male, girl/woman/female, another gender, or no gender.
Gender nonconforming (adjective): Describes a gender expression that differs from a given society's norms for males and females.
Genderqueer (adjective): Describes a person whose gender identity falls outside of the traditional gender binary structure. Other terms for people whose gender identity falls outside the traditional gender binary include gender variant, gender expansive, etc. Sometimes written as two words: gender queer.
Heteronormativity (noun): The assumption that everyone is heterosexual and that heterosexuality is superior to all other sexualities.
Heterosexual ("straight") (adjective): Describes a sexual orientation of women who are emotionally and sexually attracted to men and men who are emotionally and sexually attracted to women.
Intersex (noun): Group of rare conditions in which the reproductive organs and genitals do not develop as expected. Some prefer to use the term *disorders* (or *differences*) *of sex development*. Also used as an identity term by some individuals and advocacy groups.
Lesbian (adjective, noun): Describes a sexual orientation of women who are emotionally and sexually attracted to other women.
Nonbinary (adjective): Describes a person whose gender identity falls outside of the traditional gender binary structure. Sometimes abbreviated as *NB* or *enby*. See more at **gender binary structure**.
Pangender (adjective): Describes a person whose gender identity comprises many genders.
Queer (adjective): An umbrella term used by some to describe people who think of their sexual orientation or gender identity as outside of societal norms. Some people view the term *queer* as more fluid and inclusive than traditional categories for sexual orientation and gender identity. Because of its history as a derogatory term, *queer* is not embraced or used by all people who identify as lesbian, gay, bisexual, or transgender.
Sexual orientation (noun): How a person characterizes their emotional and sexual attraction to others.
Top surgery (noun): Colloquial way of describing gender-affirming surgery on the chest.
Transgender (adjective): Describes a person whose gender identity and assigned sex at birth do not correspond. Also used as an umbrella term to include gender identities outside of male and female. Sometimes abbreviated *trans*.
Trans man/transgender man/female-to-male (FTM) (noun): A transgender person whose gender identity is male may use these terms to describe themselves. Some will just use the term *man*.
Trans woman/transgender woman/male-to-female (MTF) (noun): A transgender person whose gender identity is female may use these terms to describe themselves. Some will just use the term *woman*.

Source: National LGBT Health Education Center (2018).

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that pregnancy must be reasonably ruled out before giving an injection if a person presents more than 15 weeks from the last injection (Curtis et al., 2016). A detailed history of a person's recent sexual activity is an accurate approach to assess for risk of pregnancy. Because Kade identified as male, the nursing staff assumed that Kade was sexually active with females and therefore was not at risk for pregnancy. By failing to obtain an accurate sexual history, the standard of being reasonably certain that a person is not pregnant was not met.

> Sexual orientation and gender identity are complex and not explained by a simple binary system of male and female

Staff members were reluctant to obtain a thorough sexual health history because they were unfamiliar with what it meant to be transmale. A straightforward sexual health history would have indicated that Kade was having vagina–penis sexual intercourse without the protection of a condom, so pregnancy was a possibility. A more accurate picture of Kade's risks would have been identified by a sexual health history that did not assume heteronormative behaviors and that included questions regarding Kade's sexual partners, what body parts were involved in sexual activity, and if they were having oral, vaginal, or anal intercourse. A helpful resource for taking an inclusive sexual history was created by the Sexuality Information and Education Council of the United States and is available for free on its website. The guide specifically suggests asking if partners are men, women, both, or transgender, in addition to asking questions about sexual practices, protection from sexually transmitted infections and pregnancy, and risk for HIV and hepatitis (Sexuality Information and Education Council of the United States, n.d.).

The second example involves a 32-year-old named Jo who presented to the clinic to establish care and identified as gender nonconforming. Jo preferred use of the pronoun *they*. Jo was not interested in hormone therapy or surgery to alter their appearance but bound their breasts to give the chest a more neutral contour. When the practitioner was reviewing Jo's chart, she noted Jo's stated gender and pronoun, along with a history of a previous breast biopsy and infrequent periods. The choice of words used to obtain a history and perform an examination can convey an attitude of respect or one of disregard for an individual's stated gender identity. To affirm Jo's gender identity, the practitioner asked Jo what words they would prefer when referencing their anatomy. Jo stated they preferred "chest" (for breasts) and "front hole" (for vagina). It is important for health professionals to address the anatomy that is before

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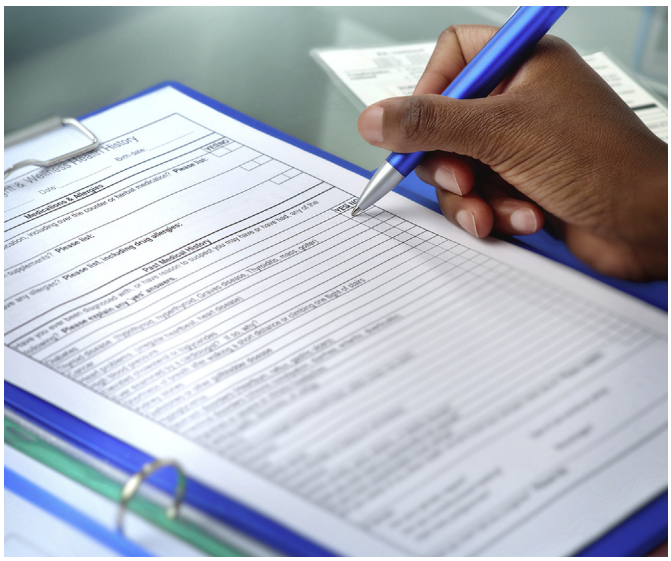
them and provide the recommended screenings. Failure to do so may lead to inadequate preventive screening for breast and cervical cancer. Using language that affirmed Jo's gender identity, the practitioner was able to perform a clinical breast examination and a pelvic examination to obtain a Pap test. Because Jo had a lifetime of infrequent periods, they were at risk for developing endometrial hyperplasia, a precancerous condition of the uterine lining. Treatment options were reviewed with Jo, including oral contraceptives or periodic cycling with medroxyprogesterone. Jo stated that they were sexually active with a cisfemale, did not need or want to take oral contraceptives, and liked having infrequent periods. Taking the time to review risk factors with an individual and negotiate an approach that is affirming will be more acceptable and thus more effective. In this case, Jo did not want a monthly menstrual cycle; however, after the health care provider explained the risks associated with a lifetime of infrequent menstrual cycles, Jo was open to periodic cycling with medroxyprogesterone.

Health Disparities and Data Collection

According to a recent Gallup poll (Gallup, 2017), there are an estimated 10 million individuals (4.1%) in the United States who identify as LGBT, although the poll did not include a designation for queer. It is difficult to obtain an accurate assessment, because questions about SOGI are not routinely included on most national or state surveys (Institute of Medicine, 2011). Emerging evidence suggests that people who are LGBTQ experience some health conditions at a greater rate than the general population. Rates of smoking and alcohol consumption are greater among lesbian and bisexual women (Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014; Medley et al., 2016). The rate of suicide attempts is 4 times greater for LGBT youth than their straight counterparts (Kann et al., 2016). Persons who identify as lesbian or



> Registration and history forms should include questions about sexual orientation and gender identity

bisexual are less likely to get routine screenings for colon, breast, and cervical cancer (Blosnich, Farmer, Lee, Silenzio, & Bowen, 2014). More information is needed to identify health disparities that exist and the reasons underlying them and to use their identification to help guide policies, education, and, ultimately, improve health care.

A two-step process to allow for the collection of SOGI data has been adopted by the Centers for Disease Control and Prevention and is recommended by various organizations, including the Center of Excellence in Transgender Health at the University of California, San Francisco and the Fenway Institute (National LGBT Health Education Center, n.d.; Sausa, Sevelius, Keatley, Iñiguez, & Reyes, 2009). This approach allows for more than a binary choice of gender identity and is gender affirming. Recommendations for how to ask questions about SOGI are found in Box 2. In addition, gender pronouns may not match others' assumptions. Including the question *What are your gender pronouns?* on medical intake forms removes assumptions and allows others to honor and respect an individual's stated pronouns. See Box 3 for a list of gender pronouns.

Practical Implications for Nurses and Other Clinicians

Policies will continue to evolve and influence the life and well-being of LGBTQ individuals at the local, state, and federal levels. In health care, steps can be taken to create a more welcoming and inclusive environment. Artwork and periodicals can reflect different and diverse family structures. Registration and history forms should include questions about SOGI. Individuals who express concerns about confidentiality should be reassured that this information is protected and is intended to enhance care and services (Baker, 2017; National LGBT Health Education Center, n.d.). All staff can be educated regarding the use of inclusive language. Unfounded assumptions and the use of heteronormative language may inadvertently exclude an individual's family in important decision making and care. For example, clinicians might assume that a laboring woman is partnered with a male and thereby fail to include her partner in pertinent discussions. Barriers to health care

BOX 2 SEXUAL ORIENTATION AND GENDER IDENTITY QUESTIONS

1. What is your current gender identity? Check one:
   - _ Male
   - _ Female
   - _ Transgender male/trans man/female-to-male (FTM)
   - _ Transgender female/trans woman/male-to-female (MTF)
   - _ Genderqueer, neither exclusively male nor female
   - _ Additional category (please specify): _____
   - _ Choose not to disclose
2. What sex were you assigned at birth or on your original birth certificate? Check one:
   - _ Male
   - _ Female
   - _ Choose not to disclose
3. Do you think of yourself as:
   - _ Lesbian, gay, bisexual, or queer
   - _ Straight or heterosexual
   - _ Something else
   - _ Don't know

Source: Grasso and Makadon (2016).

BOX 3 GENDER PRONOUNS

He, him, his, himself
She, her, hers, herself
They, them, theirs, themselves
Ze, hir/zir, hirs/zirs, hirself/zirself (may be used by gender nonconforming or nonbinary individuals)

Source: Lesbian, Gay, Bisexual, Transgender Resource Center (2017).

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BOX 4 SELECTED ONLINE RESOURCES

Centers for Disease Control and Prevention
Lesbian, Gay, Bisexual, and Transgender Health
www.cdc.gov/lgbthealth
Fenway Health
www.fenwayhealth.org
National LGBT Health Education Center
A Program of the Fenway Institute
www.lgbthealtheducation.org
The Center of Excellence for Transgender Health
at University of California, San Francisco
www.transhealth.ucsf.edu
The Fenway Institute
fenwayhealth.org/the-fenway-institute
U.S. Department of Health and Human Services
Health & Well-being for Lesbian, Gay, Bisexual and Transgender Americans
www.hhs.gov/programs/topic-sites/lgbt/index.html

and gaps in coverage may require the need for more social and financial services. A resource list (see Box 4) for LGBTQ health issues can be created for use by individuals, their families, and health care providers. In addition, steps can be taken to educate a health care workforce that is reflective of diverse populations. All of these factors taken together will communicate an attitude of care and concern and will allow us to better serve our patients.

Conclusion

People who are lesbian, gay, bisexual, transgender, or queer face unique challenges and disparities in health care. Health care providers who adopt an attitude of cultural humility, in which they are open to learning about concepts of sexual orientation and gender identity that may be new to them, will be better able to provide optimal, person-centered health care to members of LGBTQ populations. Sexual orientation and gender identity are complex and are not explained by a simple binary system of male or female. Health care providers and especially nurses are well positioned to create a safe environment and provide care that is informed, respectful, and inclusive. **NWH**

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Posttest Questions

Instructions: To access this CNE activity online, visit **http://learning.awhonn.org**.
CNE for this activity is available online only; written tests submitted to AWHONN will not be accepted.

1. Which of the following statements is true with regard to cultural competence and cultural humility?
   a. Cultural competence is no longer required.
   b. Cultural competence includes ongoing self-reflection and education in which health care professionals seek to gain an awareness of their own assumptions and biases that contribute to health disparities.
   c. Cultural humility includes ongoing self-reflection and education in which health care professionals seek to gain an awareness of their own assumptions and biases that contribute to health disparities.

2. Which of the following is listed as a recommendation of the Institute of Medicine to address health disparities for LGBTQ individuals?
   a. Cultural humility training for all health care professionals in areas with large LGBTQ populations
   b. Individualized patient satisfaction surveys for LGBTQ clients
   c. Routine collection of data about sexual orientation and gender identity (SOGI) in federally funded surveys and in electronic health records.

3. What does the term *cisgender* describe?
   a. A person who identifies with more than one gender
   b. A person whose gender identity and assigned sex at birth correspond
   c. A person whose gender identity and assigned sex at birth do not correspond

4. What is heteronormativity?
   a. A sexual orientation that describes women who are emotionally and sexually attracted to men and men who are emotionally and sexually attracted to women
   b. The assumption that everyone is heterosexual and that heterosexuality is superior to all other sexualities
   c. The assumption that some people are heterosexual and some people are homosexual and that this is normal

5. What is the definition of sexual orientation?
   a. How a person characterizes their emotional and sexual attraction to others
   b. How a person currently identifies their sex
   c. The sex a person was assigned at birth

6. Which of the following is an appropriate question to include on intake/history forms?
   a. What is your gender?
   b. What is your sexual orientation?
   c. What sex were you assigned at birth or on your original birth certificate?

7. Which of the following does the author list as a way to create environments that are welcoming to members of the LGBTQ population?
   a. Open facilities in communities with large LGBTQ populations
   b. Provide artwork and periodicals that reflect different and diverse family structures
   c. Train health care staff in cultural competence

8. In the case examples, which of the following is an illustration of how clinicians' assumptions can impede the provision of optimal care?
   a. Assuming that a person who identifies as asexual cannot contract a sexually transmitted infection
   b. Assuming that a person who identifies as male cannot be pregnant
   c. Assuming that a person who looks female identifies as female

9. In the case example of Jo, what was the result of the clinician using the pronoun *they*?
   a. It confused the client.
   b. It conveyed an attitude of disregard for the client.
   c. It conveyed an attitude of respect for the client.

10. What is one strategy the author recommends for improving the provision of health care to members of the LGBTQ population?
    a. Develop a resource list for LGBTQ health issues for use by individuals, their families, and staff.
    b. Plan activities for LGBTQ awareness month.
    c. Provide separate examination rooms that serve only members of the LGBTQ population.