School of Allied Health / Department of Athletic Training

Patient Perceptions in Receiving LGBTQIA Culturally Competent Health Care

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INTRODUCTION

Health-care providers are caring for more than just the majority populations in the present time. Minorities are expanding rapidly. This warrants a level of cultural competence (CC) when making health care decisions.[1,2] Traditionally, race and ethnicity have been the focus in CC.[1,2] However, criteria such as sexual orientation and gender identity and expression (SOGIE) are often forgotten, or left-out completely.[1,2,3] Because of this, patients whose sexual orientation or are non cisgender, may often receive inadequate treatment. This is in-part due to the lack of knowledge in this type of CC, or present sexual prejudices by health care providers.[4] Because of this lack of familiarity, more research is needed to investigate the perceptions of patients that identify as lesbian, gay, bisexual, transgender, queer/questioning, intersex, ally and/or asexual, (LGBTQIA) when receiving health care. Brief definitions of sexual orientations are depicted in Figure 1.

OBJECTIVES

Our research intends to investigate the level of health care received by LGBTQIA patients and if they feel their health care provider presents an awareness and/or greater knowledge of CC in this area.

METHODS

Design: Cross-sectional quantitative design
Population: Patients seeking health care
Recruitment: snowball sampling method via email and list-serves
Instrumentation: Survey via Qualtrics. Included: demographics section (gender and sexual orientation) and a modified version of the Gay Affirmative Practice (mGAP) survey to measure need of LGBTQIA cultural competent treatment by health care providers.
Analysis: Means and standard deviations were calculated for each independent variable (gender, sexual orientation), as well as an overall mGAP score (out of 150). Two, single, one-way ANOVAs (gender and sexual orientation) were performed with mGAP score as the dependent variable to determine significance in CC.

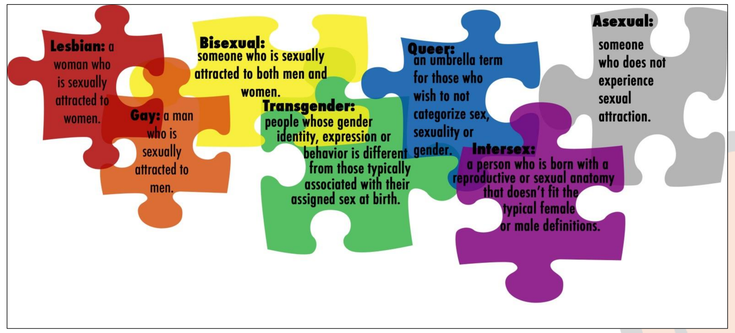

Figure 1. Definitions of sexual orientation

RESULTS

The total overall mean mGAP score is 128.82 ± 18.48. Gender demonstrated scores as follows: male=128.49 ± 15.60, female=130.35 ± 17.10, transgender=129.80 ± 9.31, other=143. 57. Sexual orientation scores: heterosexual=129.33 ± 17.12, gay or lesbian=128.25 ± 15.85, bisexual/omni/pansexual/queer/non-monosexual=132.79 ± 14.99, other=131.38 ± 20.37. ANOVA results were modified with Kruskal-Wallis adjustments due to violation of normality and homogeneity of variance, and now are represented by Chi Squares. Gender was the single significant outcome, ($X^2(3) = 8.01$, $p < 0.05$). Post hoc testing of gender demonstrated statistical significance in comparing males and other. (Figure 2)

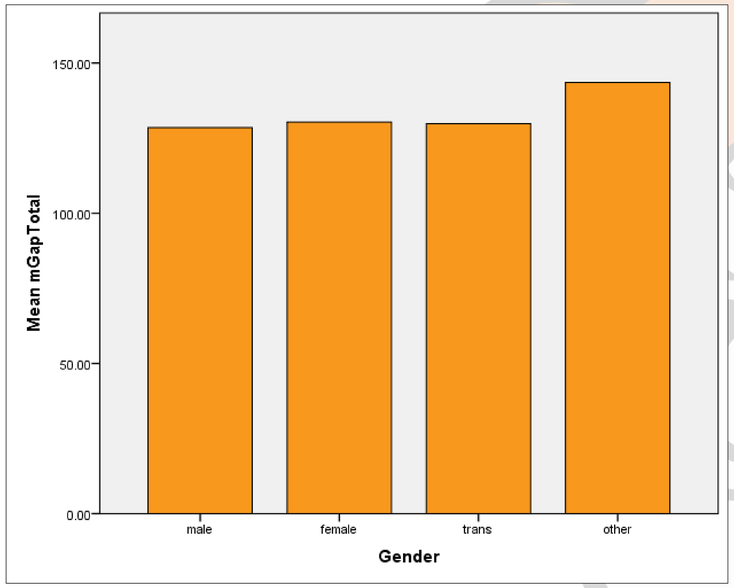

Figure 2. Mean mGAP totals for Gender

CONCLUSION

Our research concludes that patients do find it necessary for health care providers to have specific training and/or knowledge in LGBTQIA cultural competence. A majority of our results demonstrate patients "strongly agree" in the need for better CC in LGBTQIA by health care providers. Additionally, in comparison of mGAP scores in regard to gender, the category "other" demonstrates a great need for CC in LGBTQIA in health care providers. Furthermore, males demonstrate a significantly lower mGAP score, indicating a low priority for LGBTQIA CC in health care. With an increasing LGBTQIA patient population, a need is demonstrated for health care providers to provide knowledgeable, competent, and fair treatment and care.

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