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A Systematic Review of the Discrimination Against Sexual and Gender Minority in Health Care Settings

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Abstract

The present systematic review aimed to determine discrimination experiences of sexual and gender minority (SGM) individuals and attitudes toward SGM among health care staff in health care settings. Following PRISMA guidelines, the review was conducted in 3 databases (PubMed, Cochrane Library, Science Direct) using keywords of sexual and gender minority, including "gay," "lesbian," "bisexual," "transgender," "LGB," "LGBT," "health care discrimination," "stigma," "homophobia," "transphobia," and "attitudes of healthcare professionals" from May to September 2016. Predetermined inclusion criteria were selected. Thirty quantitative studies were eligible for inclusion in this review. Discriminative behaviors experienced by SGM individuals were stigma, denial or refusal of health care, and verbal or physical abuse. Knowledge and educational levels, beliefs, and religion of health care providers affected their attitudes toward SGM patients and their homophobia level. These findings revealed that health care providers needed more education about SGM issues, and SGM-friendly policies should be created for improving health care for SGM individuals.

Keywords

health care discrimination, barriers to care, access to care, health inequalities, LGBT, homophobia, transphobia

The umbrella term "lesbian, gay, bisexual, and transgender (LGBT)" is widely used to denote sexual and gender minority (SGM) individuals. In the past 5 years, the National Institutes of Health[1] has suggested that SGM be used instead of LGBT, because it is inclusive of all populations and individuals "whose sexual orientation . . . is not exclusively heterosexual, [or] whose gender identity differs from the sex assigned to them at birth; [or] who vary from or reject traditional cultural conceptualizations of gender in terms of male-female dichotomy." Thus, throughout this article on discrimination against LGBT individuals in health care settings, the term "SGM" will be used to acknowledge and include a variety of subpopulations. While the studies in this review differ in terms of the sexual identities of the participants, the term "sexual minority" was widely used to refer to individuals who experience same-sex attraction, engage in same-sex sexual behaviors, or identify as lesbian, gay, bisexual, and queer.

The term "gender minority" has also been used to refer to transgender individuals and gender nonconforming individuals, whose gender identity or expression does not conform to gender roles assigned at birth but who do not self-identify as transgender. To identify significant differences between the subpopulations investigated in the reviewed studies (e.g., individuals who are defined as men having sex with men [MSM]), if necessary, specific terms will be used when discussing specific studies.

Attitudes toward SGM individuals vary depending on the societies in which those individuals live.[2] While in some societies and communities non-heterosexual sexual orientations have been met with some degree of

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tolerance, in many societies SGM individuals have been perceived as discredited and unhealthy compared to other individuals.[2,3] Significant changes have taken place in the social sphere with the beginning of the gay and lesbian movement in the United States and Western Europe in the 1970s and the removal of homosexuality from the Diagnostic and Statistical Manual (DSM) classification of mental disorders in 1973. However, negative attitudes toward these individuals resulting from cultural and social norms are still evident, although they are declining.[4] SGM individuals are exposed to negative attitudes, discrimination, and stigma, including fear, hatred, verbal or physical violence, economic abuse, and threats.[4,5] Moreover, they may experience discrimination in many areas of their lives, such as health care services, employment, education, hate speech, and military service.[3–7] The Institute of Medicine's (IOM)[8] report on the health of LGBT individuals stated that the risk of suicide attempts in LGBT youth is 2 to 3 times higher than it is in other populations, and the rate of tobacco and alcohol use and substance abuse is also high in this population.[8] That report stated that gay men are at high risk for contracting HIV and venereal diseases, while lesbians are less apt to use preventive cancer-care services. In the report, HIV, venereal diseases, and mental health problems – such as depression, anxiety, and suicide – are stated to be common in transgender individuals. Transgender individuals are exposed to more discrimination than gay men and lesbians due to their gender identity without taking into account their choices about disclosing their transgender identity.[9] The negative consequences of coming out include the high risk of physical and verbal violence and loss of employment, which occur more frequently for transgender individuals than LGB people.[9] Hence, transgender individuals have less health assurance compared to heterosexual, lesbian, gay, and bisexual individuals.[8] Moreover, they have also health care needs as much as the general population based on gender reassignment processes, sexually transmitted diseases, and mental health problems.[8]

In the literature, studies have reported that SGM individuals experience inequality when receiving health care services. Stress, stigmatization, homophobia, transphobia, and a lack of social support are thought to be the reasons why they do not always receive equal treatment from health care providers.[10] It has been determined that SGM individuals experience dissatisfaction in health care settings, are less likely to seek health care services than heterosexuals, receive less benefit from health care services, and experience negative communication with health care professionals.[11–15] Moreover, SGM individuals benefit less from preventive health services (HIV testing, cancer screenings, Pap smears, mammography, etc.) due to the fear of stigmatization.[8] SGM individuals are also neglected for their primary health care needs, other than HIV and sexually transmitted diseases. Thus, the lack of awareness of health care professionals has led them to overlook the health needs of SGM individuals; consequently, SGM individuals become ill and do not benefit from health care services.[16,17] Within this context, this review aimed to systematically examine the discrimination experiences of SGM individuals in health care. Based on previous research findings, this article helps identify what is already known about discrimination against SGM individuals in health care settings; it also aims to reveal health professionals' attitudes toward these people and provide guidelines for future studies. As such, it sought to answer the following main question: What experiences of discrimination do SGM individuals encounter in health care? Toward that end, it investigated whether or not SGM individuals experience discrimination in health care settings, and if so, which types of discrimination they encounter. It also aimed to identify the causes, risk factors, and consequences of experiencing discrimination.

Method

Search Strategy

The search strategy included electronic databases and a manual search from citation lists in relevant journals. PubMed, Cochrane Library, and Science Direct electronic databases were searched from May to September 2016 for peer-reviewed papers written in English. These databases were preferred because they contain a significant amount of evidence-based literature in the field of biomedical sciences and psychology. A date restriction was not set because all previous work in this field was considered relevant. The last search was done on September 30, 2016.

The search terms included pairs of words that defined SGM (including "gay," "lesbian," "bisexual," "transgender," "LGB," "LGBT" AND "health care discrimination," "SGM" AND "attitudes of health care professionals," "SGM" AND "stigma," "SGM" AND "homophobia," and "transphobia."

Study Selection and Data Extraction

Multiple strategies were used to determine which articles were relevant for inclusion in this review. Therefore, the titles from each database were initially screened for their relevance to the parameters of the study and the search terms. After completing the screening process, all the selected articles were examined, and the full texts were found for the articles that met the selection criteria. The relevant articles where then reviewed for inclusion in this study based on the abstract or full text; duplicates were

removed from each list when identified. The selected articles met the following inclusion criteria: (1) contained the full text of the research articles; (2) published in a peer-reviewed journal; (3) written in English; (4) consisted of original, quantitative data, and the level of evidence of the publication was not limited; and (5) discussed discrimination, inequalities, potential barriers to care, and attitudes toward SGM individuals in health care settings for one or more SGM populations. Articles that were review papers, not open access, or not relevant to the topic were excluded.

Following the screening, 31 qualitative studies focusing on the SGM population's experiences in health care settings, which contained a significant amount of useful information, were obtained; however, those articles were excluded because they addressed topics that were beyond the scope of this current study.

Articles that met the inclusion criteria were subjected to quality assessments by evaluating their commitment to the Joanna Briggs Institute (JBI) Checklist. This focused on selection bias, research method, data collection methods, comparators, confounders, withdrawals and dropouts, integrity, and analyses. No articles were excluded based on the JBI scores.[18] Figure 1 presents a flow diagram of the systematic review and article selection process used in this study, which is Preferred

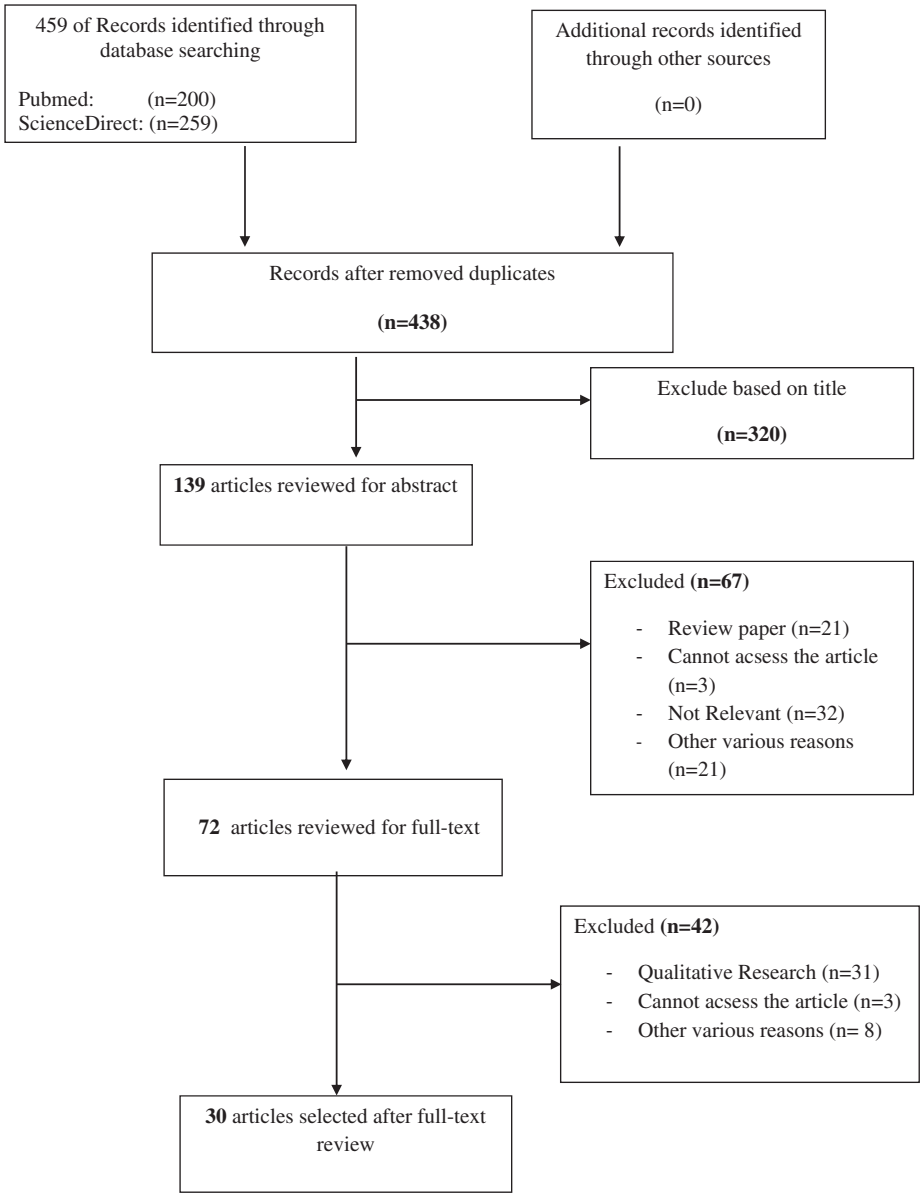

Figure 1. Flow diagram of the systematic review and article selection process PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses).

Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA).

Assessment

After obtaining the full texts, the articles were examined. The articles were categorized by their authors, origin, year, sample features, data collection method, and results. Based on the criterion that the articles should address health care discrimination toward SGM individuals, the results of the research were examined in detail.

Results

Study Selection

The preliminary electronic search in the databases resulted in a total of 459 references. The articles were evaluated according to their relation to the theme and to determine if they should be removed, due to duplicates. This resulted in a preliminary exclusion of 387 articles. The remaining 72 articles were compared against the other inclusion and exclusion criteria. A total of 30 articles (Table 1) met the inclusion criteria and were appropriate for data extraction.[14,16,19–48] The studies described in these articles were published between 1985 and 2017; 18 of the studies had been published in the last decade.

Characteristics of the Included Studies

Twenty studies were conducted in North and South America, and the other studies were conducted in Europe, Asia, Australia, and Africa. The majority of the included articles used a descriptive design. Only 2 studies used a cross-sectional design, and one used a descriptive-comparative design. Sixteen of the 30 selected articles were conducted with SGM individuals, and 14 of these were conducted with health care workers. The majority of the studies in which the sample consisted of SGM (56.25%) individuals used convenience samples, the remaining studies (12.5%) used snowball sampling methods or were subsamples from larger studies (31.25%). The majority of the studies in which the sample consisted of health care staff contained convenience samples; only one study used random/probability-based sampling methods. The sample sizes of the SGM studies ranged from 102[19] to 6,451 [34]; the sample size of the studies including health care staff ranged from 46 [24] to 21,134.[42]

Studies varied in terms of the SGM subgroups included. Four studies[22,34,39,44] included transgender people (2 of those studies included female-to-male transgender individuals, and 2 included female-to-male and male-to-female transgender individuals). Three studies[19,32,48] included LGBT people, and 3 studies[20,46,47] only included lesbians and/or bisexual women. Two studies[28,40] included only self-identified MSM individuals. Four studies[16,33,37,38] contained subgroups in the SGM group, such as gay and bisexual men, LGB individuals, sexual minority women (SMW), and queer women. In most of the studies conducted with health care staff, the sample often consisted of nurses.[14,21,25,31,35,41]

Analysis of the Findings

The analysis identified 3 main findings related to the health care experiences of SGM individuals: (1) discrimination against SGM individuals in health care settings; (2) the importance of disclosure to health care staff; and (3) awareness of homophobia and transphobia among health care professionals.

Discrimination Experiences of SGM People

This section summarizes the findings that included factual information about discriminatory behaviors, the subgroups of SGM people experiencing more discrimination, and the consequences of experiencing discrimination.

In 9 of the 16 studies,[22,28,32–34,37,39,40,44] the rate of discrimination was reported to range between 2%[33] and 41.8%.[34] The types of discriminatory behavior encountered by SGM individuals were often the refusal of needed medication due to sexual orientation and gender identity[22,28,32–34,37,39,40,47] and discriminatory attitudes.[22,28,32–34,37,39] Belonging to an ethnic minority group led to double stigmatization among sexual and gender minorities.[34,37] However, little is known about how ethnic differences may affect the discrimination experiences of SGM individuals in health care services; that issue has only been addressed in a small number of studies. Sexual minority men had more negative experiences of discrimination than the other SGM subgroups because of risk of HIV transmission.[28,33,40] However, SMW were less exposed to discrimination due to sexual orientation because health care providers assumed they were heterosexual; thus, they had positive experiences in health care settings if they did not disclose their identity to their health care providers.[38,46,47]

Differences in sexual minority status were only addressed in one study.[38] That study examined any differences in health care experiences among SMW who identify as lesbian and other queer-identified women (those who identify as bisexual, queer, etc.).[38] In the study's presentation of findings, queer women were categorized as non-lesbian SMW, and it was shown that there were no differences in health care experiences between the 2 groups. Therefore, it is not possible to provide a full account of these analyses here.[38]

Table 1. Characteristics of Included Studies.

Reference/ Country	Research Type	Population/Sample Size	Instrument	Aim	Results
Allen et al.,[19] USA	Quantitative descriptive	LGB 18–23 aged (102)	Survey (consisted of a confidential self-report, theory-driven, 32-item, written questionnaire)	Describe the experience of gay adolescents with their health care providers; Subjects' experiences of discussion of sexual orientation issues and medical confidentiality; Elicit subjects' opinions on how care may have been improved; Identify barriers to effective health care for gay adolescents.	Most of them (78%) not discussed their sexual orientation with their health care provider when they were younger (14–18 years old). The most reason of not to disclose their own sexual orientations: -They were afraid of the heath care provider would tell their parents, sending to a psychiatric hospital by provider, or the care provider would think they were mentally ill. -They thought that the health care provider would be homophobic or against the homosexuality.
Austin,[20] USA	Descriptive	Lesbians (934) 19 age and older Self-identifying as lesbian	The Lubben Social Support Scale The Pearlin Mastery Scale Lesbian Internalized Homophobia Scale Discrimination index	Correlates of sexual orientation disclosure to health care providers among 934 lesbian women living in urban and non-urban areas of the South.	Internalized homophobia and stigma were both negatively associated with disclosure. Psychosocial resources were all independently associated with a greater likelihood of having disclosed sexual orientation status to one's health care provider. Each of the scales was related with disclosure of sexual orientation to a health care provider. Psychosocial resources and fewer negative experiences associated with lesbian identity. The sole exception (sub of discrimination scale) was not significant with disclosure status.
Bradford et al.,[22] USA	Descriptive	Transgender (350; n = 229 Male to Female, n = 121 Female to Male)	Survey (consisted of demographic characteristics, gender transition, health care, violence, HIV serostatus, substance use health behaviors, interpersonal factors, discrimination)	Examine relationships between social determinants of health and experiences of transgender-related discrimination reported by transgender people in Virginia.	Forty-one percent of participants (n = 143) reported experiences of transgender related discrimination. %27 of them reported experiences of transgender-related discrimination from health care providers. Of participants who had a regular primer care provider (60%); 15% of them reported being very uncomfortable or uncomfortable discussing transgender-specific health care needs with their provider, and 20% reported they had to educate their primary care provider about their health care needs.

(continued)

Table 1. Continued

Reference/ Country	Research Type	Population/Sample Size	Instrument	Aim	Results
Fay et al.,[28] Africa	Descriptive	MSM (537)	Survey (consisted of demographics, sexuality, HIV knowledge, perceived and experienced stigma, access to health care, experienced discrimination, and human rights)	Assess cross-sectional relationships between discrimination, access to and use of health care services, and HIV knowledge among MSM.	Half of participations were homosexual, and 38 % of them bisexual; 17% reported ever disclosing same sex practices to a health professional and19% reported ever being afraid to seek health care; 5% reported ever been denied health care services cause of their past discrimination experience. Strong associations were observed between experiences of discrimination and fear of seeking health care services.
Johnson et al.,[32] USA	Descriptive	LGBT (127; 56 gay males, 60 lesbians, 9 bisexual, 2 transgender)	Questionnaire (consisted of information about LGBT perceptions of discrimination and sources of discrimination, and suggestions for how discrimination might be eliminated in retirement care settings, demographic data, openness to others regarding sexual orientation, attitudes towards retirement care facility, discrimination, sources of suspected discrimination)	Exploratory study on perceptions of discrimination and bias in retirement care facilities.	Seventy-three participation had an experience of discrimination in care facilities, % 74 of them believed that facilities didn't include sexual orientation in their anti-discrimination policies; 60% of them believed that they hadn't equal access to social and health services; 34% of them believed that they would have to hide their orientation if they moved to a retirement facility; 62 individuals believed that administrative staff, 73 individuals believed that care staff and 64 individuals believed that residents were potential sources of discrimination.
Kass et al.,[33] USA	Descriptive	Gay and bisexual (Sample 1: 857, Sample 2: 708, Sample 3: 59)	Survey (consisted of demographic characteristics; HIV antibody status; AIDS diagnosis;CD4 count; and self-reported weight loss, fevers, fatigue, and diarrhea)	Document the extent to which homosexual and bisexual men believe they have been refused services by a doctor or dentist because of their sexual orientation or because of a known or suspected HIV-related condition.	Two percent of seronegative participation men cause of their condition, 4% of seronegative participation cause of their sexual orientation refused the treatment. Participation reported refuse dental treatment cause of their HIV + conditions.

(continued)

Table 1. Continued

Reference/ Country	Research Type	Population/Sample Size	Instrument	Aim	Results
Kattari et al.,[34] USA	Descriptive	Transgender (6,451)	Questionnaire (consisted of discrimination experience)	Examine the prevalence of discrimination faced by transgender/GNC people and compares by race/ethnicity those rates of discrimination when accessing medical services such as emergency rooms, doctors/hospitals, and ambulances/EMTs.	20.4% of all transgender/GNC individuals reported having experienced discrimination when attempting to access doctors/hospitals; 11.9%, when attempting to access emergency room services; and 4.6%, when attempting to access services of ambulances/EMTs. Transgender/GNC people of color (26.1%) reported statistically significant higher rates of having experienced discrimination than their White counterparts.
Li et al.,[37] USA	Cross-sectional descriptive	SMW (226)	Andersen's Behavioral Model of Health Services Utilization, Health care quality Negative interactions with a health care provider Reduced health care utilization.	Examined the associations between negative experience in a health care setting and subsequent reductions in health care utilization among African American SMW.	More than one-third of the sample reported a negative health care experience in the past 5-years. One fourth of those reporting a negative experience attributed it to discrimination including race/ethnicity (70.4%), gender (58.2%), and sexual orientation (46.2%). Reduction in health care utilization following the negative experience was common (34%).
Mosack et al.,[38] USA	Quantitative descriptive	324 women including lesbian, gay, bisexual, or other "queer" identified women 66 heterosexual women	Survey (consisted of demographic characteristics, Time since last primary health care visit, Quality of health care experiences, Preventive health care recommendations and receipt, health care providers knowledge of participant sexual orientation	Explore how SMW's health care experiences compared with those of their heterosexually identified counterparts.	Contrary to our expectations, we found that SMW's were as likely to have had a recent health care appointment, to have been recommended and to have received similar diagnostic and preventive care, and to feel comfortable discussing their sexual health with their health care providers. No differences between lesbian SMW and non-lesbian SMW with respect to these indicators. We found important differences with respect to sexual orientation disclosure and health care satisfaction, however.
Neville and Henrickson,[16] New Zealand	Descriptive	LGB (2,269)	Survey (consisted of health and well-being situation, health providers attitudes)	Explore people's perceptions of disclosure about lesbian, gay and bisexual identity to their primary health care providers.	More women than men identified that the practitioner's attitude toward their non-heterosexual identity was important when choosing a primary health care provider.

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Table 1. Continued

Reference/ Country	Research Type	Population/Sample Size	Instrument	Aim	Results
					Statistically significantly more women than men reported that their health care provider usually or always presumed that they were heterosexual and in addition more women had disclosed their sexual identity to their health care provider.
Reisner et al.,[39] USA	Cross-sectional descriptive	Transgender (FTM) (2,578)	Survey (consisted of health indicator, enacted and anticipated stigma in health care)	Examine the effects of these forms of stigma on the substance use behaviors of FTM trans masculine people.	Overall, 14.1% of the sample reported having been refused care by a provider (enacted stigma), 32.8% reported delaying needed medical care when sick/injured, and 39.1% delayed routine preventive care (anticipated stigma). Having been refused care was significantly associated with avoidance of health care, including delaying needed medical care when sick/injured and delaying routine preventive medical care. Substance use to cope with mistreatment was self-reported by 27.6% of the sample. Enacted stigma by providers was associated with self-reported substance use to cope. Delays in both needed and preventive care (anticipated stigma) were highly associated with substance use, and attenuated the effect of enacted stigma.
Risher et al.,[40] Switzerland	Descriptive	MSM (323)	Survey (consisted of socio-demographics, sexual orientation, behavioral HIV-related risk factors, stigma and discrimination, and social cohesion, perceived stigma and enacted stigma)	Assess the relationship of fear of seeking health care and disclosure of same-sex practices among a sample of men MSM in Switzerland with demographic, socio-economic and behavioral determinants	It was found that stigma was common in this sample. 61.7% of them reported fear of seeking health care, 44.1% of them any enacted stigma and 73.9% of them any perceived social stigma (family, friends). Disclosing sexual practices with other men to health care providers was low. Fear of seeking health care was significantly associated with: having experienced legal discrimination as a result of sexual orientation or practice.
Shires and Jaffe,[44] UK	Descriptive	FTM (1,711)	Survey (consisted of health care discrimination, demographic and socio-economic variables)	Document of health care discrimination against transgender people.	Overall, 41.8% of FTM participants reported verbal harassment, physical assault, or denial of equal treatment in a doctor's office or hospital.

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Table 1. Continued

Reference/ Country	Research Type	Population/Sample Size	Instrument	Aim	Results
					The participations that were using hormones or surgery for medical transition were associated with increased reporting of health care discrimination experiences.
Smith et al.,[46] USA and Canada	Descriptive	Lesbian (1,921) and bisexual (424) women	Questionnaire	Obtain information from women who defined themselves as bisexual or lesbian; and focus on gynecologic care since knowledge of sexual orientation is particularly important.	About 40 per cent of each group believed that physician knowledge about their sexual preference would hinder the quality of medical care and about as many believed that it would have no effect. Only 20% of them thought that if they disclose to their doctor their health would be provided. About one-third in each group had not disclosed their sexual behavior although they desired to do so; 30% the participation who disclose to their physician, they had experience negative attitudes. Most of these physicians were male gender.
Steele et al.,[47] Canada	Descriptive	Lesbian (489)	Survey Self-administered survey	Test the influence of provider inquiry about sexual orientation, perceived provider gay-positivity and patient disclosure of sexual orientation on regular health care use in a sample of Canadian lesbians.	Seventy-eight percent of participations reported regular health service use; 75.8% of women had disclosed their sexual orientation to their provider. Provider-related factors including perceived gay-positivity and inquiry about sexual orientation are strongly associated with disclosure of sexual orientation. Disclosure is associated with regular health care use.
Whitehead et al.,[48] USA	Descriptive	LGBT (1,014) Cisgender men (477) Cisgender women (368) Transgender (169)	CES-D 11-item Iowa form, Questionnaire	Determine whether higher levels of stigma and/or lower levels of outness correlate with less primary health care access for rural LGBT populations.	Higher scores on stigma scales were associated with lower utilization of health services for the transgender and nonbinary group, while higher levels of disclosure of sexual orientation were associated with greater utilization of health services for cisgender men. They reported that they feared of seeking health care cause of experience stigma.
Blackwell,[21] USA	Descriptive	Nurses (165)	Attitudes Toward Lesbian Gay Scale	Examine registered nurses' overall levels of homophobia and attitudes toward a	Seventy-three percent of participants have at least one friend or family member who is a gay man or lesbian, and 62% indicated that they would support a

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Table 1. Continued

Reference/ Country	Research Type	Population/Sample Size	Instrument	Aim	Results
				workplace policy protective of gays and lesbians.	nondiscrimination policy in their workplace that protects gay men and lesbians. The nurses who were had high scores from homophobia wouldn't support a nondiscrimination policy in their workplace. On the other who has less scores from homophobia support the policy in their workplaces.
Chapman et al.,[23] Australia	Descriptive, comparative	Health Professionals (86; n = 18 doctors and n = 68 nurses)	Questionnaire (socio-demographic data, including the presence of religious beliefs) Attitude Toward Lesbians and Gay Men Scale Knowledge About Homosexuality Scale Gay Affirmative Practice Scale	Assess health professionals' knowledge, attitudes and beliefs regarding lesbian, gay, bisexual and transgender parents accessing health care for their children.	Both of nurses and doctors (particularly among religious and non-Caucasian staff) in this study has poor knowledge regarding LGBT individuals. Nurses had more positively attitudes than doctors. There was a negative correlation between the beliefs and attitudes.
Cochran et al.,[24] USA	Descriptive	Substance abuse treatment counselors (46)	Survey (consisted of demographic characteristics) *Index of Homophobia* IHP Modern homophobia scale Implicit Association Test	Asses the substance abuse treatment counselors' attitudes toward LGBT individual.	46% of the counselors in the study scored primarily in the high-grade non-homophobic range; 10.9% of them scored in the low-grade homophobic range. Participants identifying as sexual minorities in the present study would have less homophobic attitudes than heterosexuals; 15.2% of counselors believed that substance abuse treatment was more effective for heterosexuals, 26.1% found it difficult to relate to the specific problems that LGBT individuals present in treatment, 26.1% of counselors had seen or witnessed discrimination based on LGBT status at their agencies, and 19.6% of counselors did not feel adequately trained to work with LGBT clients.
Dickey,[25] USA	Descriptive	Nurses (116)	Survey (consisted of demographic questionnaire and discrimination questions) Homophobic Scale	Examine attitudes of sexual orientation among a sample of certified nurse assistants who work in long-term care.	Low levels of homophobia among the certified nurse assistants who participated. Participation who reported an acquaintance had a significantly lower HS scores than who had not.

(continued)

Table 1. Continued

Reference/ Country	Research Type	Population/Sample Size	Instrument	Aim	Results
					Participations who were acquainted with gay, lesbian person expressed more positive attitudes toward gay, lesbian elders.
Eliason,[26] USA	Quantitative descriptive	Addiction counselors (242)	Questionnaire (consisted of experience/knowledge/ familiarity, demographic data, open-ended items) Attitude Toward Lesbians and Gay Men Scale	Examine the attitudes and knowledge of substance abuse counselors regarding LGBT clients.	Nearly half of the addiction counselors had negative or ambivalent attitudes. They had more negative attitudes especially to transgender than the others. They had very little formal education about LGBT. Most of them lacked knowledge about legal issues of LGBT clients, the concepts of domestic partnership and internalized homophobia, and family issues. Most of them believed that LGBT people were sinful and immoral.
Eliason and Hughes,[27] USA	Descriptive	Addiction counselors (109 in Iowa; 242 in Chicago)	Questioner (consisted of experience/knowledge/ familiarity, demographic data, open-ended items) Attitudes Toward Lesbians and Gays	Explore differences in urban and rural treatment counselors' knowledge and attitudes regarding lesbian, gay, bisexual, and transgendered clients.	Chicago (17%) than Iowa (10%) counselors agreed that LGBT clients were less likely to benefit from treatment than their heterosexual counterparts. Chicago providers reported significantly more education about LGBT issues than Iowa providers. No statistical differences were found between the Chicago and Iowa providers from negative attitudes. Chicago providers work with LGBT more than Iowa providers. Both providers had more negative attitudes towards bisexuals and transgender.
Fisher et al.,[29] Italy	Descriptive	General population (135) Heath care professionals (53) Gender dysphoric (122; 63 trans-women and 59 trans-men)	Survey Modern Homophobia Scale and the Attitude Toward Transgendered Individuals Scale The Discrimination and Stigma Scale The Religious Fundamentalism Scale Liebowitz Social Phobia Scale	Compare attitudes toward homosexual and transgender individuals between gender dysphoric individuals, general population controls (C) and HCP.	Heterosexual men and men who were health providers had high levels of homophobia. Men in general population and men who were health providers had more negative attitudes towards to lesbians and gays. Men had higher scores from homophobia and trans phobia. Religious fundamentalism was associated with both homophobia and trans phobia. Perceived discrimination was higher in lesbian women compared to gay men and in trans women compared to trans men.

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Table 1. Continued

Reference/ Country	Research Type	Population/Sample Size	Instrument	Aim	Results
Hou et al.,[31] Taiwan	Quantitative descriptive	Psychiatric Nurses (133)	Attitudes Toward Homosexuality Questionnaire (Beere) Questionnaire on Knowledge about Homosexuality	Examine the association between psychiatric nurses' attitudes toward homosexual individuals and their intention to provide care, and demographic and occupational factors, sexual orientation, knowledge about homosexuality, and experiences of contact with homosexual people.	The results revealed that psychiatric nurses who had a high education degree, higher level of knowledge about homosexuality, and friends or relatives with a homosexual orientation had a more positive attitude toward homosexuality; 53% of them had negative attitudes towards homosexuality.
Klotzbough and Spencer,[35] USA	Quantitative descriptive	Chief nurses (115)	The Modern Homonegativity Scale	Explore the chief nursing officers' attitudes toward gays and lesbians and the impact that these attitudes have on providing advocacy for LGBT patients and staff.	The religionist chief nursing officers has high level of homophobia. The participations had moderate level of homonegativity.
Rondahl et al.,[41] Sweden	Descriptive	Nurses and assistant nurse (48 nurses; 37 assistant nurses)	Affect Adjective Checklist Nursing Behaviour Questionnaire	Investigate the emotions of nursing staff and nursing students, and possible relations to cultural background and gender, towards homosexual patients; and Investigate whether nursing staff and nursing students would choose to refrain from nursing homosexual patients, if the option existed; and look at how they express their wish to refrain from nursing this group of patients.	Of the nursing staff, 36% stated that, given the option, they would refrain from nursing homosexual patients. Several of the respondents [nurses/assistant nurses (n = 7), nursing students/assistant nursing students (n = 112) used the space provided to add comments to this question. 47% of them thought that every person had rights to take equal care, 34% of them had positive attitude, and 11% of them had condemning attitudes. The assistant nursing students expressed more homophobic anger and homophobic guilt than the other groups.
Sabin et al.,[42] USA	Descriptive	Medical doctors (2,338), Nurses (5,379), Mental health providers (8,531), Other treatment providers (2,735), Nonproviders (214,110)	The Implicit Association Test. Explicit measure	Examine providers' implicit and explicit attitudes toward lesbian and gay people by provider gender, sexual identity, and race/ethnicity.	Among heterosexual providers, implicit preferences always favored heterosexual people over lesbian and gay people. Implicit preferences for heterosexual women were weaker than implicit preferences for heterosexual men. Heterosexual nurses held the strongest implicit preference for heterosexual men over gay men. Among all groups, explicit preferences for heterosexual versus lesbian and gay people were weaker than implicit preferences.

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Table 1. Continued

Reference/ Country	Research Type	Population/Sample Size	Instrument	Aim	Results
Shetty et al.,[43] USA	Descriptive	Oncology Providers (108)	Survey (Consisted of knowledge, attitudes, practice behaviors)	Assess knowledge, attitudes, and practice behaviors of oncology providers regarding LGBT health.	Half of the participation responded knowledge questions correctly; 94% stated they were comfortable treating this population; 26% actively inquired about a patient's sexual orientation when taking a history; 36% felt the need for mandatory education on LGBT cultural competency at the institution. Results from the open comments section identified multiple misconceptions.
Smith and Mathews,[45] USA	Descriptive	Physicians (736)	HIV-phobia Scale Medical homophobia Scale	Determine the physicians' attitudes toward homosexuality.	The least homophobic specialties in ranked order were psychiatry, internal medicine, and pediatrics, while the most homophobic specialties in ranked order were surgery (excluding orthopedics), family medicine, and orthopedics. Gay and bisexual participations supported that same sex marriage and entry of healthy HIV-positive students to medical school, but there was no difference by sexual orientation on entry of a gay student.
Yen et al.,[14] Taiwan	Descriptive	Nurse (1,540)	Attitudes Toward Homosexuality Questionnaire Questionnaire on knowledge about homosexuality	Explore different dimensions of the attitudes toward gay men and lesbians among nurses in southern Taiwan and to examine the association between attitudes and intention to provide care to homosexual individuals.	Participants had the most negative attitude toward homosexuality in the 'contact' and 'stereotypes' dimensions. Nurses who had friends or relatives with a homosexual Orientation and, had a higher educational degree were more likely to have positive attitudes toward homosexuality.

Abbreviations: CES-D, Center for Epidemiologic Studies-Depression Scale; EMT, emergency medical technician; FTM, female-to-male; GNC, gender nonconforming; HCP: health care provider; MSM, men who have sex with men; SMW, sexual minority women.

Moreover, studies that only included transgender men reported that they delayed their medication[42] and were exposed to verbal and physical violence during the health care physical examination.[44] Transgender individuals (men and women) who use hormones or who undergo gender reassignment surgery experienced more discrimination than transgender individuals who did not pursue those options.[44] In a study conducted with a transgender population, it was found that they were exposed to discrimination mostly while obtaining health care services in hospitals and from doctors.[34]

In all the examined studies, the outcomes of negative health care experiences for SGM individuals were to postpone their health care needs and avoid obtaining health care services due to their fears of stigmatization.[14,27–48] Furthermore, delay in addressing health care needs was the behavior most frequently used to minimize and cope with the effect of stigmatization in transgender individuals.[48] A relationship was found between the discrimination experiences and fear of seeking health care services in MSM.[28,40] Among SMW, decreased health care utilization due to health care discrimination was common.[37] Reisner et al.[39] found that there was a link between substance use and coping with stigmatization in transgender men (n = 2,578).

Disclosure to Health Care Staff

This section describes the findings concerning the effect of disclosure to health care staff on health determinants, such as access to health care. Only 6 studies[16,19,20,38,47,48] examined the impact of disclosure status to health care staff and related factors. Most of the studies were conducted with sexual minority groups. The prevalence of disclosure to health care staff in SGM individuals varied from 17%[28] to 75%.[47]

In a study of LGB individuals, the reasons for not disclosing sexual orientation were that the participants feared that the health care providers would tell their families about their sexual orientation and that they would be referred to a mental health care provider due to their sexual orientation.[19] Fear of stigmatization and being aware of its negative effects on health care were the other reasons why transgender and cisgender sexual minority individuals (i.e., those who define their current gender as their biological gender and their sexual orientation as different from straight or heterosexual) did not disclose to health care staff.[48] An important difference for not disclosing was found in the study conducted by Mosack et al.[38] on lesbian or bisexual women. While the participants did not suffer from disclosing their sexual orientation to the health care staff in that study, it was found that there was a negative link between disclosure and being satisfied with health care services.[38]

It was also found that the level of internalized homophobia and stigma of self-identified lesbians was linked to not disclosing their sexual orientation to health care providers. Psychosocial resources were associated with disclosing to health care providers.[20] It has also been examined whether disclosure is associated with regular health care use among lesbians.[47] One study[47] found that the positive attitude of health care staff and questions about sexual orientation were linked to the disclosure of lesbians. A study conducted with LGB individuals found that health care practitioners' attitudes toward their sexual orientation were important in choosing health care providers.[16]

Attitudes Toward SGM Individuals Among Health Care Personnel

This section discusses how the demographic characteristics and knowledge level of health care staff had an effect on their attitudes toward SGM individuals. Several studies examined attitudes against homosexuality and transgender individuals and related factors. Many studies used standardized scales, such as the Attitudes Toward Lesbian and Gay Men (ATLG) Scale,[21,23,26,27] the Attitudes Toward Homosexuality Questionnaire (ATHQ),[14,31] the Index of Homophobia,[24] the Homophobic Scale,[25] the Modern Homophobic Scale,[29] the Modern Homonegativity Scale,[35] and the Affect Adjective Checklist.[41]

The most frequently examined correlations between demographic variables and attitudes across all studies were gender,[25,29,42] religion,[23,26,29,35] occupation,[23,45] knowledge level,[26,27,31,43] sexual orientation,[26,42,45] and education level.[14,31] These demographic variables were associated with negative attitudes about SGM people. Having an SGM relative[14,21,25,31] was also linked to positive attitudes about this group of people.

In studies that examined the attitudes of nurses,[14,21,25,31,35,41] positive attitudes were detected. However, in a study that compared the attitudes of doctors and nurses,[23] nurses had a more positive attitude than doctors. Another study[45] found that psychiatrists, medical doctors, and podiatrists had positive attitudes, but surgeons and orthopedists had negative attitudes. Moreover, health care providers had more negative attitudes toward transgender individuals than individuals who are members of sexual minority groups.[26]

Discussion

The present study aimed to investigate the discrimination experiences of SGM individuals in health care settings. It is important to examine discrimination in health care settings on a bilateral basis by addressing SGM individuals (as victims) and health care professionals

(as perpetrators). Thirty studies were reviewed, incorporating quantitative evidence.

The clear evidence obtained from this systematic review demonstrated that SGM individuals are subjected to discrimination in health care settings, despite the use of the various survey measures on discrimination and the diverse populations recruited using various sampling methodologies. The stigmatization and discrimination experiences were similar in all the reviewed studies.

Only 4 studies[22,34,39,44] included gender minority groups. In 10 studies, the sample included a sexual minority group, and 2 studies included a mixed LGBT group. The lack of clarity between the subgroups in the examined studies, the difficulty of recruiting SGM individuals for the study, and the wide variety of terminology used to identify and define SGM communities made it challenging to systematically review the discrimination experiences of SGM individuals in health care settings. Moreover, because the inclusion criteria of the examining studies were based on how an individual defines oneself, and a wide variety terms are used by SGM individuals, generally the researchers preferred to use the umbrella term SGM when presenting the findings, even though sharp distinctions were made while explaining the sample characteristics.

Prospective studies should focus on clarifying the differences between the subgroups in the samples and approach sexual minority individuals and gender minority individuals separately to effectively compare the findings. In the future, comprehensive and scholarly published articles are needed to identify how to prevent stigmatization of and discrimination against SGM individuals in health care settings.

Access to health care services is difficult for both sexual and gender minority individuals because of discriminatory behaviors. Discrimination in health care settings, particularly stigma, influenced the health care utilization and health care behaviors of SGM individuals. Consequently, SGM people are afraid of disclosing their sexual orientation and gender identity in health care settings, estimating the negative effect that such an attitude will have on the quality of care they receive.

The existence of internalized stigma in SGM individuals restrains them from disclosing their orientation to health care staff and receiving the necessary care. This review also determined the relative importance of the attitudes of health care staff and patient-related factors in the determination of appropriate health care services used by SGM individuals. When SGM people delay their health care needs, due to the fear of disclosure to health care staff or their concern about encountering negative attitudes, the attitudes of health care staff and related factors are important. Some variables, such as beliefs, gender, knowledge level, and having a relative or friend who is SGM, have an influence on the attitudes that health care staff have about SGM people. It has been reported that providers who encourage SGM individuals to disclose their sexual orientation or gender identity improve the quality of the health services that are used.[47]

The right to equal access to quality health care is fundamental for all people; unfortunately, SGM people are too often denied their rights due to discriminatory behaviors. Furthermore, the attitudes of health care personnel should be changed, and resistance to changing needs to be addressed.

From this review of the literature, it is evident that it is necessary to identify specific interventions to meet the health care needs of SGM individuals and prevent health discrimination. The attitudes of health care professionals are one of the primary problems that SGM individuals experience in health services when considering the behaviorally based nature of discrimination. Health care staffs' level of education and knowledge influence their attitudes toward SGM individuals. It is useful to provide an opportunity for practitioners to undertake training and education in the health care needs of SGM individuals, thus developing an understanding of how their knowledge and skills can enable them to better support the health needs of SGM individuals. Information on issues, such as sexual orientation, gender identity, being SGM, health care, access to health care, and support, should be provided in an accessible format.

Limitations

This review has several limitations. All the searched studies were written in English. Most of the articles that met the search criteria provide low-level qualitative evidence. The majority of studies used the convenience sample method. Thus, it is not possible to generalize the results that are presented. The lack of a validated scale to determine the discrimination experienced by SGM people and the use of various scales to determine the health care staffs' attitudes about SGM people are 2 other limitations.

Conclusion and Recommendations

The results of the various studies about discrimination and attitudes toward SGM individuals indicate that health care providers need to be more sensitive to SGM individuals. Although the professional code of ethics for health care professionals necessitates that professionals recognize and respect the uniqueness of each patient and provide high standards of care, the evidence suggests that this is not always true for SGM individuals. Health care service administrators must increase health care providers' awareness about negative

attitudes toward SGM individuals and avoid negative behaviors. The providers must receive training to increase their knowledge about SGM individuals. The negative attitudes can be affected by health care professionals' beliefs and religion; therefore, they must be reminded about the nondiscriminatory nature of the health care profession. The prevalence of discrimination has increased over the years. Precautions must be taken to prevent discrimination among health care providers. Providers must be more competent when communicating with SGM individuals during the examination process, and a comfortable environment should be provided in which patients can feel free to disclose their situation. This would enable SGM individuals to be more open to discussing their health problems with their providers.

Finally, rights-based policies that address anti-discrimination, inclusivity, and empowerment issues should be established based on a multidisciplinary approach. Innovative approaches are needed to improve the quality of care in this population, and they should become the main theme of future research.

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