

Review article / Pregledni znanstveni članek

Experiences of individuals with various sexual orientations with healthcare professionals: integrative literature review

Izkušnje posameznikov različne spolne usmerjenosti z zdravstvenimi delavci: integrativni pregled literature

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Key words: heteronormativity; gender identity; homosexuality; homophobia; discrimination; bisexuality; transgender persons

Ključne besede:

heteronormativnost; spolna identiteta; homoseksualnost; homofobija; diskriminacija; biseksualnost; transspolne osebe

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ABSTRACT

Introduction: Individuals may belong to different sexual minorities. Such a personal circumstance should not influence the quality of healthcare. Yet, many face discrimination due to their sexual orientation, while the healthcare system is typically heteronormative. The objective of this integrative review was to provide a synthesis of research evidence on the experiences of lesbian, gay, bisexual and transgender (LGBT) individuals with healthcare professionals.

Methods: An integrative literature review was employed, and codes and categories were identified. A literature search was performed in the databases Springer Link, SAGE, CINAHL, Academic Search Elite and MEDLINE. The key words used were: "experiences", "healthcare", "gay patient experiences", "gay", "lesbian", "homosexual", "bisexual" and "transgender". Primary sources were selected according to inclusion and exclusion criteria. Thematic analysis was conducted with an open coding of the results of selected sources.

Results: A total of 6,839 studies were screened from June to August 2018 and 14 (published between 2009 and 2017) were selected for the final analysis. The results yielded 41 codes, combined into two categories termed: 'Positive experiences of LGBT individuals with healthcare professionals' and 'Negative experiences of LGBT individuals with healthcare professionals'.

Discussion and conclusion: The experiences of LGBT individuals with healthcare professionals are ambivalent. Although positive experiences prevail, negative ones should not be overlooked as they are derived from heteronormativity and sometimes even prejudice and homophobia. Healthcare professionals need cultural competences which reflect the developments in a society and the needs of its individuals.

IZVLEČEK

Uvod: Posamezniki lahko pripadajo različnim spolnim manjšinam. Ta osebna okoliščina ne sme vplivati na kakovost zdravstvene obravnave. Kljub temu številni doživljajo diskriminacijo zaradi svoje spolne usmerjenosti, zdravstveni sistem pa je prežet z normo heteronormativnosti. Namen integrativnega pregleda je bil sinteza dokazov glede izkušenj lezbijk, gejev, biseksualnih in transspolnih (LGBT) oseb z zdravstvenimi strokovnjaki.

Metode: Uporabljena je bila metoda integrativnega pregleda literature s tematsko analizo rezultatov izbranih virov na način oblikovanja kod in kategorij. Literaturo smo iskali po elektronskih podatkovnih bazah Springer Link, SAGE, CINAHL, Academic Search Elite in MEDLINE. Iskali smo s pomočjo angleških ključnih besed: »experiences«, »healthcare«, »gay«, »lesbian«, »homosexual«, »bisexual« in »transgender«. Izbor primarnih virov smo opravili glede na vključitvene in izključitvene kriterije. Tematska analiza je potekala na način odprtega kodiranja rezultatov izbranih virov.

Rezultati: Skupno smo v obdobju od junija do avgusta 2018 presejali 6.839 virov; v končno analizo smo jih uvrstili 14 (objavljenih med letoma 2009 in 2017). Oblikovali smo 41 kod, ki smo jih združili v 2 kategoriji: »Pozitivne izkušnje LGBT-posameznikov z zdravstvenimi delavci« ter »Negativne izkušnje LGBT-posameznikov z zdravstvenimi delavci«.

Diskusija in zaključek: Izkušnje LGBT-posameznikov z zdravstvenimi delavci so ambivalentne. Čeprav prevladujejo pozitivne izkušnje, negativnih ne smemo zanemariti, saj izvirajo iz heteronormativnosti, včasih pa celo predsodkov in homofobije. Zdravstveni delavci potrebujejo kulturne kompetence, ki so odraz razvoja družbe in potreb posameznikov v njej.



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Introduction

Sexual orientation denotes who a person is attracted to physically and sexually, as well as romantically and emotionally (Kersey-Matusiak, 2013). Sexual orientation can be heterosexual: attraction towards a different biological sex; homosexual: attraction towards the same biological sex; or bisexual: attraction towards both biological sexes (Giddens & Sutton, 2013). The revised International Council of Nurses (ICN) Code of Ethics for Nurses explicitly states in its preamble that "nursing care is respectful of and unrestricted by considerations of" gender and sexual orientation (ICN, 2012). This means that gender identity and sexual orientation is a personal circumstance which cannot influence the quality of provided nursing care in any way. However, the fact that discriminatory practices are not allowed does not mean that they do not exist (Edwards, 2012). Up to now, more attention has been given to individuals with various sexual orientations compared to those with various gender identities. Gender identity refers to how an individual identifies themselves: as a man, a woman or other (Kersey-Matusiak, 2013). After the year 2000, research evidence on attitudes towards individuals with various sexual orientations in healthcare has revealed less standard homophobia, an increase in tolerance and acceptance, and less judging, but still a certain degree of distance (Rondahl, et al., 2004).

Sociologists have termed this phenomenon 'new homophobia' and claim that it is much more furtive and subtle (Kuhar, et al., 2011): the term homophobia denotes "different forms of general, political, social, moral and personal disagreement with homosexuality per se; it includes judging, aversion, disagreement and violence, as well as depreciation, criticism and discrimination of individuals with same-sex sexual orientation". 'New homophobia' can be characterised as stigmatisation, a concept which is also commonly experienced by other marginalised social groups. However, stigmatisation should not be examined only from the perspective of those stigmatising, but also (or primarily) from the perspective of those being stigmatised. Research evidence thus shows that individuals with various sexual orientation or gender identities are bothered mainly by the high degree of heteronormativity in today's society (Rondahl, 2009). The term heteronormativity is defined as "the sum of social norms that developed around heterosexuality throughout history and are based on the binary opposition male-female" (Bibič, et al., 2011). Individuals with a different sexual orientation are a specific group, a minority with certain characteristics and needs; healthcare professionals are often not aware of these characteristics and needs and therefore cannot provide the most appropriate care (Dunjić-Kostić, 2012).

Aims and objectives

The aim of this integrative literature review is to present a synthesis of evidence on the experiences of individuals with various sexual orientations with healthcare professionals. The goal of the review is to contribute to a better understanding of patients with various sexual orientations to facilitate the provision of ethical and culturally competent healthcare.

The following research questions were posed:

- What are the experiences of individuals with various sexual orientations and / or gender identities with healthcare professionals?
- Do individuals with various sexual orientations and / or gender identities feel stigmatized or face discrimination in the healthcare system?

Methods

Review methods

An integrative literature review was conducted according to the guidelines set by Whitemore and Knafl (2005). The search for literature was conducted in electronic databases between June 2018 and August 2018. The databases Springer Link, SAGE, CINAHL, Academic Search Elite and MEDLINE were searched. The following key words together with Boolean operators were used: *experiences* AND *healthcare* AND *gay* OR *lesbian* OR *homosexual* OR *bisexual* OR *transgender*. Sources were selected according to the inclusion and exclusion criteria which are presented in Table 1 below.

Results of the review

We obtained 11,347 hits in the Springer Link database; after applying inclusion and exclusion criteria, 13 articles were selected for further analysis (Figure 1). The search in SAGE database yielded 3,391 hits, six of which were selected for further analysis after inclusion and exclusion criteria were applied. The search in other databases (CINAHL, Academic Search Elite and MEDLINE) at first yielded 4,749 hits; after applying the criterion of qualitative research, 97 articles remained. Of these, five were selected for further analysis. In total, 24 articles were thus selected for further analysis. Based on a full-text screen, we further eliminated 10 articles: two systematic literature reviews, two sources with the oldest date of publication and six articles that failed to provide the answers the research questions. Thus, 14 primary sources were retrieved for final analysis (mostly qualitative and mixed methods research designs and one quantitative research study). They were published from 2010 onwards, with the exception of one article published in 2009 (Figure 1).

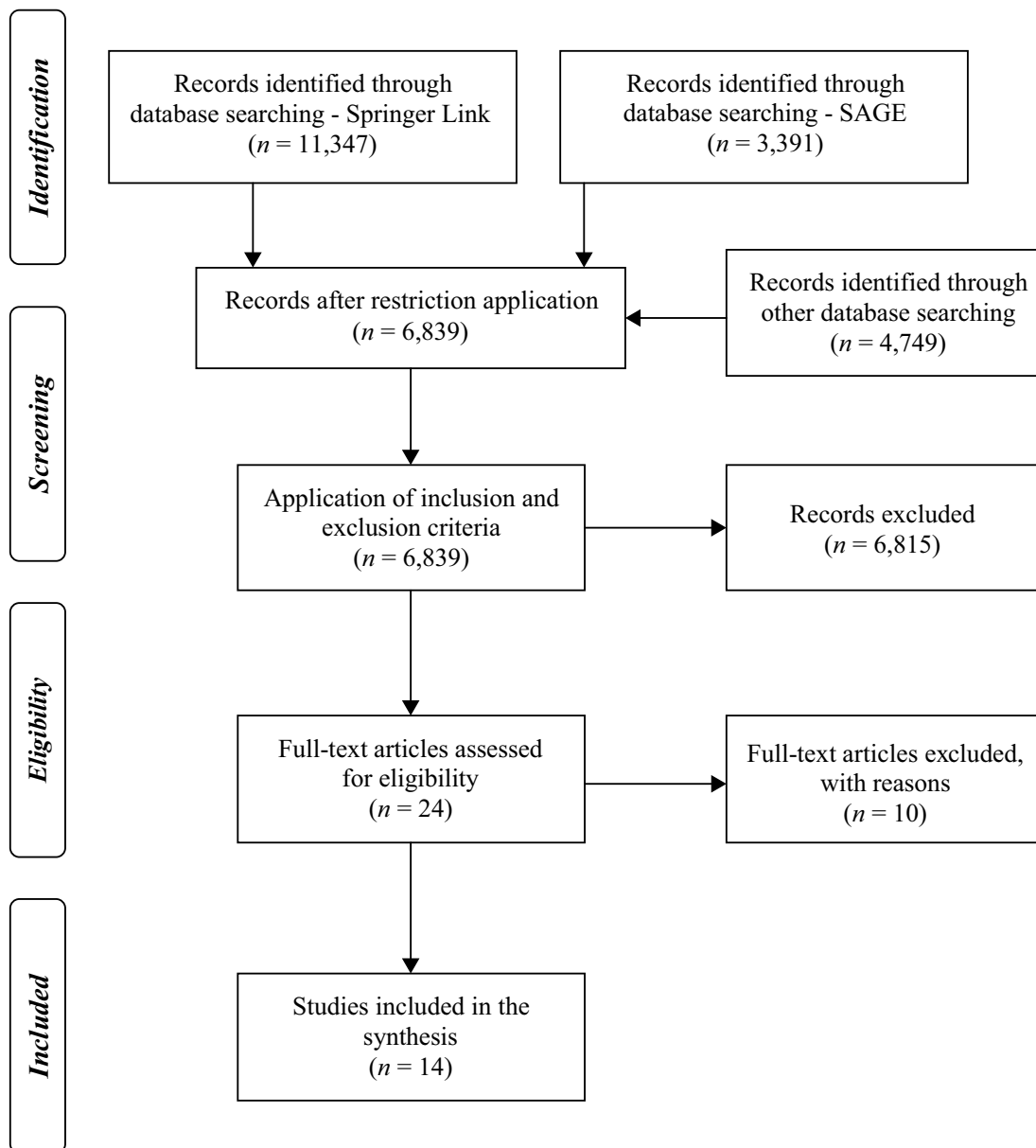


Figure 1: Review process flowchart

Slika 1: Shema procesa pregleda

The quality assessment of the review and the description of data processing

All sources are reviewed research papers from international scientific journals with an impact factor, available either in printed or electronic form online. The quality of selected articles were assessed separately based on utilised research designs. Qualitative papers were assessed based on the guidelines described by Streubert and Carpenter (2011), quantitative papers were assessed based on the guidelines set by Long (2002), and mix-methods papers were assessed based on the guidelines described by Pluye and colleagues (2009). The assessed quality of articles varies: we evaluated most of them

to be good or very good, while one article was rated as sufficient. All the selected articles were considered as appropriate, especially in terms of diversity of the described experiences with healthcare professionals.

Sources included in the final analysis were processed using the method of thematic text analysis, in which codes and categories were identified according to the guidelines described by Vogrinc (2008). The so-called open / inductive coding was employed. Coding units included key findings that were categorised into codes. Thus, a thematic text analysis was conducted for the Results section of each source included in the final analysis. Codes with similar content were merged to form broader categories, presented in Results.

Table 1: Inclusion and exclusion criteria**Tabela 1: Vključitveni in izključitveni kriteriji**

<i>Inclusion criteria / Vključitveni kriteriji</i>	<i>Exclusion criteria / Izključitveni kriteriji</i>
Publications in scientific journals	Sources related to sexually transmitted diseases, HIV-infection, AIDS, STD testing
Published between 2009 and 2018	Sources related to health or illness in general
Scientific articles in English	Epidemiological data, prevention, screening
Full-text articles	Sources related to patient knowledge
Qualitative, quantitative or mix-methods research designs	Sources related to pathology, treatment of diseases, dependence illnesses
Examination of the experiences of LGBT individuals with healthcare professionals	Sexual practices or sexual violence
/	Sources related to quality of life, social issues or violence in general
/	Attitudes of different social groups to individuals with various sexual orientations
/	Parenting and LGBT families
/	Research methodology

Table 2: Analysed sources**Tabela 2: Analizirani viri**

<i>Author (country) / Avtor (država)</i>	<i>Research method / Raziskovalna metoda</i>	<i>Research purpose / Namen raziskave</i>	<i>Sample / Vzorec</i>	<i>Key findings / Ključne ugotovitve</i>
Katz, 2009 (Canada)	semi-structured in-depth interview	to describe the experiences of gay and lesbian cancer patients in Canadian healthcare system	7 gays and lesbians	experiences with disclosure of sexual orientation to healthcare professionals were positive, neutral or the disclosure was ignored; oncology care is governed by heteronormativity
Duffy, 2011 (Ireland)	unstructured interview	to examine the experiences of lesbians as users of the Irish healthcare system	12 lesbians	lesbians' experiences included prejudice, heteronormativity, discrimination and a lack of genuine communication
Eady, et al., 2011 (Canada)	focus groups; semi-structured questionnaire	to understand the experiences of bisexual individuals with the mental healthcare system and to determine their perception of healthcare professionals' attitude towards bisexuality	55 bisexual men and women	most experiences could be categorized as negative, including judgment, heteronormativity and pathologisation; some had a positive experience, characterised by openness, non-judgment, acceptance, support and self-education
Vanden-Langenberg, et al., 2012 (USA)	semi-structured interview	to investigate the experiences of lesbian, gay and bisexual individuals with genetic counselling	12 gays, lesbians, and bisexual men and women	positive experiences included well-being, equality, consideration, enabling a choice, and security
Riggs, et al., 2014 (Australia)	mixed methods design: survey and open questions	to investigate the experiences of transgender individuals with the Australian healthcare system	188 transgender men and women	positive experiences were connected to professionalism, willingness to help, knowledge, respect, caring and compassion; negative experiences were connected to hurtful questions

Continues / Se nadaljuje

<i>Author (country) / Avtor (država)</i>	<i>Research method / Raziskovalna metoda</i>	<i>Research purpose / Namen raziskave</i>	<i>Sample / Vzorec</i>	<i>Key findings / Ključne ugotovitve</i>
Lyons, et al., 2015 (Canada)	semi-structured in- depth interview	to investigate the experiences of transgender individuals with drug addiction treatment	34 transgender men and women	negative experiences included discrimination, social exclusion, violence, abuse, and stigmatization; positive experiences were connected to acceptance and respect
Marques, et al., 2015 (Portugal)	semi-structured interview	to describe the positive and negative experiences lesbians have when seeing physicians, especially about their sexual and reproductive health	30 lesbians	negative experiences included fear, shame, discrimination and heteronormativity; positive experiences were connected to being accepted, the absence of direct disapproval and protection of confidentiality
Rasberry, et al., 2015 (USA)	mixed methods research—cross- sectional study and interview	to help inform the development of school strategies aimed at connecting teenage men having sexual intercourse with men with preventive services	415 + 32 teenage men having sexual intercourse with men	in the school setting, teenage men would prefer to discuss sexual health with a school counsellor or a school nurse; teenagers appreciate openness, the desire to help, non-judgment, stating facts and providing details
Hirsch, et al., 2016 (Germany)	questionnaire	to investigate lesbians' access to healthcare services and explain the role of general physicians in the process	766 lesbians	experiences of lesbians included fear, discrimination, concealing of one's identity, heteronormativity
Victor & Nel, 2016 (South Africa)	semi-structured in- depth interview	to examine the experiences of LGB individuals with psychotherapy and counselling	15 gays, lesbians, and bisexual men and women	positive experiences included acceptance, non-judgment, honesty, warmth, professionalism, calmness, kindness, listening, caring, sensitivity, compassion; negative experiences included non-acceptance, prejudice, dichotomy, non-understanding, sexualisation
Hoffkling, et al., 2017 (USA)	semi-structured interview	to identify the needs of transgender men in regard to family planning and around pregnancy	10 trans-gender males	transgender individuals faced a high level of heteronormativity, a lack of evidence-based information, discrimination, fear, a lack of cultural competences, transphobia, and avoidance; positive experiences included protection of privacy, absence of irritating questions, acceptance and self-education
Hoyt, et al., 2017 (USA)	focus groups	to describe the experiences of gay men with prostate cancer	11 gay men	experiences of gay men included stigmatisation, prejudice, discrimination, fear, lack of caring, non- understanding, and heteronormativity
Müller, 2017 (South Africa)	interview; focus groups	to examine the experiences of LGBT individuals with healthcare in South Africa	44 gays, lesbians, bisexual and transgender males and females	experiences were connected to heteronormativity, geographic conditioning, lack of public funding, discrimination, homophobia, violation of rights, abuse, prejudice, lack of knowledge, fear, avoidance, and hiding
Westerbotn, et al., 2017 (Sweden)	semi-structured interview	to describe the experiences of transgender individuals with healthcare professionals	14 trans-gender males and females	most respondents reported neutral experiences; however, they did notice a lack of knowledge and they all reported having had a negative experience at some stage; experiences included heteronormativity, fear and, consequently, avoidance of healthcare services

Table 3: *Codes combined in categories***Tabela 3:** *Kode, oblikovane v kategorije*

<i>Category</i>	<i>Codes</i>	<i>Authors</i>
Positive experiences of LGBT individuals with healthcare professionals	openness, non-judgment, acceptance, awareness of lack of knowledge, appropriate provision of healthcare services, LGBT-friendly physician, protection of privacy / confidentiality, respect, inclusion of partner, support, consideration, absence of direct disapproval, honesty, warmth, caring, professionalism, compassion, equality, confirmation of identity, absence of irritating questions, calmness, kindness, listening, sensitivity, empathy	Katz, 2009; Duffy, 2011; Eady, et al., 2011; Vanden-Langenberg, et al., 2012; Riggs, et al., 2014; Lyons, et al., 2015; Marques, et al., 2015; Rasberry, et al., 2015; Hirsch, et al., 2016; Victor & Nel, 2016; Hoffkling, et al., 2017; Westerbotn, et al., 2017;
Negative experiences of LGBT individuals with healthcare professionals	disrespectful healthcare, provision, non-acceptance, impatience, disrespect, offensive questions, non-understanding, lack of empathy, sexualisation, fear of negative experiences, violation of rights, lack of knowledge, ridiculing, insolence, lack of time, failure to care, judging, heteronormativity	Katz, 2009; Duffy, 2011; Eady, et al., 2011; Riggs, et al., 2014; Lyons, et al., 2015; Rasberry, et al., 2015; Victor & Nel, 2016; Hoffkling, et al., 2017; Hoyt, et al., 2017; Müller, 2017; Westerbotn, et al., 2017

Results

Analysed scientific sources are presented in Table 2 and discussed below.

A thematic analysis of the Results section of the selected sources ($n = 14$) yielded results that were translated into 41 codes. In the next step of the analysis, codes with a similar theme were combined to form two categories; these were termed: 'Positive experiences of LGBT individuals with healthcare professionals' and 'Negative experiences of LGBT individuals with healthcare professionals', and are shown in Table 3.

Positive experiences of LGBT individuals with healthcare professionals

In general, LGBT individuals have positive experiences with healthcare professionals (Katz, 2009; Riggs, et al., 2014; Marques, et al., 2015; Westerbotn, et al., 2017), but this could also be because some do not come out with their sexual orientation or gender identity, or even purposefully conceal it. In one study 60.6 % of respondents had not informed their primary care provider about their sexual orientation (Hirsch, et al., 2016). Nevertheless, most respondents reported receiving the same healthcare provision as others and said their gender identity was not unnecessarily emphasised (Westerbotn, et al., 2017), they also mainly had positive experiences with general practitioners (Riggs, et al., 2014) and characterised school nurses as being open and caring (Rasberry, et al., 2015). Moreover, respondents reported having mainly positive experiences with gender reassignment surgery and postoperative support received (Riggs, et al., 2014). Positive experiences are connected to openness, non-judgment, acceptance and support (Eady, et al., 2011); to acceptance, consideration and respect of sexual orientation or gender identity (Lyons, et al., 2015); to privacy protection, confirmation of sexual orientation or gender identity, and absence of irritating questions

(Hoffkling, et al., 2017); they also included acceptance, non-judgment, honesty, warmth, care, professionalism, calmness, kindness, listening, sensitivity, and empathy (Victor & Nel, 2016); and they refer to professionalism, a willingness to help, knowledge, care, respect, and compassion (Riggs, et al., 2014). Acceptance, absence of direct disapproval, and protection of confidentiality contribute to a positive attitude (Marques, et al., 2015). Respondents highly regard staff members who are aware of their own lack of knowledge and express a desire to self-educate (Hoffkling, et al., 2017), and feel that school staff should be open, express a desire to help, and should not be judgmental (Rasberry, et al., 2015). An important element of best practice examples is including the partner in healthcare provision (VandenLangenberg, et al., 2012), as partners play a crucial supportive role for (cancer) patients (Katz, 2009). In a private hospital, the experience was exemplary (Duffy, 2011).

Negative experiences of LGBT individuals with healthcare professionals

Despite a prevalence of positive or appropriate experiences, negative experiences were nevertheless present, significant and, most of all, persistent. All respondents reported having had a negative experience at some point (Westerbotn, et al., 2017). Many met with negative judgment (Eady, et al., 2011) or disrespectful healthcare provision due to their sexual orientation or gender identity (Müller, 2017), while in one study most of the experiences described could be categorised as negative (Eady, et al., 2011). Participants experienced stigma, prejudice, and discrimination (Lyons, et al., 2015; Hoyt, et al., 2017). Other examples of negative experiences include non-acceptance, prejudice, dichotomy, non-understanding, sexualisation (Duffy, 2011; Victor & Nel, 2016), and sometimes they were connected to offensive questions (Riggs, et al., 2014), respondents also described a lack of caring and understanding (Hoyt, et al., 2017). There was evidence of transphobia experienced by some

respondents which ranged from mocking to rudeness and dismissal (Hoffkling, et al., 2017). Some reported that school nurses were unkind, overworked and impatient (Rasberry, et al., 2015), a lack of empathy coming from nurses was common (Duffy, 2011). Disrespect was conveyed both through verbal abuse and non-verbally (Müller, 2017). Sometimes therapists wanted to discuss sexuality, although respondents wanted to discuss other issues (Eady, et al., 2011). The majority of respondents experienced that healthcare professionals lacked knowledge (Westerbotn, et al., 2017); there is, for example, a lack of biomedical research addressing the specific issues of (transgender) individuals (Hoffkling, et al., 2017), and healthcare professionals' lack of knowledge was worryingly high (Müller, 2017). Fear of negative experiences may prevail over the possibility of positive acceptance (Duffy, 2011), and many fail to disclose their sexual orientation due to past negative experiences (Eady, et al., 2011). There were also reports of sexual violence (Lyons, et al., 2015). LGBT individuals do not file complaints about violations of their rights—either because they do not know how to or because they believe that this would not help solve anything (Müller, 2017).

Discussion

We have found that experiences of individuals with various sexual orientations with healthcare professionals are ambivalent. Most experiences are positive or at least neutral. Negative responses, including disrespect, neglect or judgment, reveal a lack of empathy and a lack of cultural competences. To neglect the information that a patient is, for example, a homosexual, as we explain, can be positive in the sense that they receive the same treatment as everybody else – the ethic principle of equity – and that healthcare professionals do not allow stereotypes or prejudice to influence the provision of healthcare. However, neglecting such information can in some cases also result in overlooking an important dimension of the patient's life, which may in turn affect the health / illness status.

Sexual orientation has many characteristics of a social health determinant. Sexual minority group members more often report a poorer overall health status: they report experiencing long-term psychological or emotional states 2-3 times more often compared to heterosexuals; they are also more likely to live in underprivileged areas (Elliott, et al., 2014). In addition to a higher incidence of psychological distress, sexual minority group members are more likely to have a mental disorder (substance abuse, depression, anxiety, eating disorders) or somatic disease (cancer, cardiovascular disorders) and are more likely to commit suicide (Stewart & O'Reilly, 2017). Considering the above, the neglect of sexual orientation can result in a lower quality of healthcare provision which is not completely patient-oriented, or, as explained by Klančar and colleagues (2013),

healthcare professionals may disregard the specific factors of a health risk. Although in general, negative experiences of LGBT individuals with healthcare professionals are rare, the fact that they are 1.5 times more common compared to the general population is disconcerting (Elliott, et al., 2014), while positive experiences could also be influenced by the geographic area or privileged identity (Jowett & Peel, 2009).

The noted deliberate absence of the LGBT population from the healthcare system is problematic from the perspectives of public health, politics, and from the biopsychosocial perspective. Some research evidence shows that fear of discrimination can lead individuals to avoid the healthcare system (Hoffkling, et al., 2017); similarly, other research results reveal that some respondents failed to seek needed healthcare provision due to fear (Westerbotn, et al., 2017), or that many even decided to stop their treatment early due to stigmatisation or a sense of endangerment (Lyons, et al., 2015). Homophobia represents an obstacle to accessing healthcare services (Dente, 2013). Many LGBT individuals report avoiding healthcare services due to fear of discrimination and homophobia (Müller, 2017), which is not the case with the majority population. Just under one in ten respondents say that they decided not to receive the necessary check-ups or treatment due to fear of discrimination (Hirsch, et al., 2016).

The two most problematic issues related to the LGBT community and healthcare are heteronormativity and discrimination. Heteronormativity is a phenomenon generally pervasive in the society, representing a norm and stigmatising all those who deviate from it. Healthcare professionals usually assume that their patients are heterosexuals (Marques, et al., 2015; Hoyt, et al., 2017). Discrimination represents a violation of basic human rights and is prohibited by law. Homophobia, however, is the issue that continues to exist and persist in all its forms, both in the society in general, and in the healthcare system. The phenomenon is nowadays known as 'new homophobia' a much more veiled version, appearing in different, more subtle forms than before (Kuhar, et al., 2011). In healthcare, it can be explained as the general ethical stance of healthcare professionals (physicians and nurses alike must adhere to the Code of Ethics), but without the comprehensive understanding and empathy towards individuals with various sexual orientations (Krnel, et al., 2015). Because being influenced by stereotypes and prejudice, as well as religion, healthcare professionals sometimes do not approve of the behaviour of LGBT individuals and do not want to be in contact with them (Krnel, et al., 2015). Healthcare professionals may also wrongly interpret their behaviour as a choice, a transitional period, immaturity, or even a danger or pathology, instead of embracing it as an individual's legitimate identity. Of course, heteronormativity greatly contributes to this. In Slovenian healthcare system for example, heteronormativity is reflected

in the correction of statements made by LGBT individuals by some healthcare professionals or in the form of stereotypical questions and / or statements made by healthcare professionals (Krnel & Skela-Savič, 2017). It is definitely crucial that LGBT individuals are treated as people and not as patients (Victor & Nel, 2016).

Young people prefer to talk to staff members who state facts and provide details (Rasberry, et al., 2015). In general, the LGBT community values knowledge and has noted that healthcare professionals lack knowledge on specific needs and issues connected to the LGBT identity (Victor & Nel, 2016; Hoffkling, et al., 2017; Müller, 2017; Westerbotn, et al., 2017). This is also a result of heteronormativity, stigmatisation, and marginalisation. A lack of knowledge can lead to a failure to address specific needs, something that has already been noted (Marques, et al., 2015), but even more importantly, it hinders healthcare professionals from obtaining the information which could be crucial for diagnostics and treatment. Thus, healthcare professionals should have enough cultural competencies to address specific issues related to the LGBT health. Just over one in five respondents assessed their physician's knowledge of specific topics positively (Hirsch, et al., 2016). Lack of information hinders educated decision-making (Hoffkling, et al., 2017), which in turn may compromise the quality of healthcare provision. Furthermore, lack of knowledge may lead to excessive questions being asked, making some individuals uncomfortable, to the execution of unnecessary diagnostic procedures, or, conversely, to phasing out or denying the necessary diagnostic procedures or treatment. Lack of knowledge also leads to sexualisation, and perhaps takes the most problematic form when expressed as pathologisation. Respondents have experienced the pathologisation of their transgender identity (Hoffkling, et al., 2017), but we should also mention the pathologisation of bisexuality. The former is still defined as a mental disorder, compared to homosexuality which has officially not been classified as a mental disorder since 1973 (Erić, 2011), while the latter has faced a lack of understanding and non-acceptance even within the LGBT community, known as biphobia. Lack of knowledge was emphasised as an important issue also in a recent review by Nhamo-Murire and Macleod (2017).

Even though homosexuality was removed from the International Classification of Diseases in 1989, there are still some known cases of treating homosexual orientation (Erić, 2011). Such is the example of a high-profile case in Croatia, where a teenage woman was involuntarily hospitalised and treated for being a lesbian in a psychiatric hospital for many years on the initiative of her parents (Tratnik, 2009). This has launched much ethical dilemmas and debates. There are no such cases known in Slovenia. In terms of experiences

of individuals with various sexual orientations with healthcare professionals in Slovenia one pilot study is available (Krnel & Skela-Savič, 2017) that has found that most respondents have good experiences with healthcare professionals; none of them mentioned experiences of homophobia, discrimination or violence.

Conclusion

The experiences of LGBT individuals with healthcare professionals are ambivalent and conditioned by heteronormativity. Although positive experiences prevail, negative experiences cannot be overlooked because they draw from stereotypes, prejudice, and homophobia. Lack of knowledge significantly contributes to them. Despite stigmatisation and discrimination being ethically unacceptable and legally prohibited, LGBT individuals still experience them in their many forms, while remaining marginalised and quite invisible themselves. Sexual minority group members have more negative experiences with the healthcare system compared to the general population. Nowadays, the so-called "new homophobia" is present in the healthcare system. In order to provide the LGBT population with high-quality healthcare services, healthcare professionals need to have the necessary cultural competences and an ethical attitude towards patients.

Conflict of interest / Nasprotje interesov

The authors declare that no conflicts of interest exists. / Avtorja izjavljata, da ni nasprotja interesov.

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Ethical approval / Etika raziskovanja

The study need no ethical approval, and was conducted in accordance with the Code of Ethics for Nurses and Nurse Assistants of Slovenia (Kodeks etike v zdravstveni negi in oskrbi Slovenije in Kodeks etike za babice Slovenije, 2014). / Raziskava ni potrebovala odobritve etične komisije. Članek je pripravljen v skladu s Kodeksom etike v zdravstveni negi in oskrbi Slovenije (2014).

Authors contribution / Prispevek avtorjev

The first author carried out all the phases of research and writing the article. The second author mentored the first author and directed the research and writing of the article. / Prvi avtor je izvedel vse faze raziskave in pisanja članka. Druga avtorica je mentorica prvemu avtorju in je usmerjala raziskavo in pisanje članka.

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