Past, Present, and Future of LGBTQ Health Care

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EDITORIAL

Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+) individuals have largely faced bias, stigma, and victimization in health care settings.[1] Factors such as lack of knowledgeable providers and access to inclusive facilities have led to reduced utilization of the healthcare system, and therefore, negative long term health outcomes.[1] Although the LGBTQIA+ community is most often tied together as one population, each letter may represent an individual of diverse socioeconomic status, race, ethnicity, abilities, and identities. In recent years, the athletic training profession has largely focused on how to create inclusive spaces for LGBTQIA+ patients and have worked towards a more culturally competent membership. Now that athletic trainers (ATs) have a foundational level of knowledge, we must move to considering how intersectionality, or an approach which considers the interaction of different factors or social categories, rather than each in isolation,[2] impacts patient outcomes.

The concept of intersectionality was first introduced to highlight the connections between race and gender and has gained interest by healthcare providers looking to better serve patients. Intersectionality recognizes the multidimensionality of each individual and argues the social oppression they may experience is caused from the intersection of different social inequalities, rather than one marginalized identity.[3] ATs must recognize the patients we treat are comprised of multiple identities, have varying values and beliefs, and should not be categorized into one group. Although we are bound by the Board of Certification's Standards of Professional Practice, and specifically to render quality patient care regardless of the patient's race, religion, age, sex, ethnic or national origin, disability, health status, socioeconomic status, sexual orientation, or gender identity,[4] now is the time to begin considering how each of these demographics connect to one another.

Patterns of discrimination and substandard care have been well documented across health care settings, particularly for those who identify as LGBT.[1] Healthcare providers' refusal of care, refusing to touch patients or use additional precautions, the use of harsh or abusive language, or being rough or abusive was reported by more than half of respondents in one of the largest studies on LGBT health care.[5] Staggeringly, respondents of color experience even higher rates of discrimination and substandard care, and were twice as likely as White people to report experiencing physically rough or abusive treatment by medical providers.[5] In a 2020 study, researchers found gender minority blacks were more likely to report experiencing severe mental distress, longer periods of being physically or mentally unwell, longer periods of activity limitations due to poor health, than cisgender blacks, as well as cisgender Whites.[6]

Additionally, the US Transgender Survey, a 2015 nationwide survey with 27,715 transgender respondents, revealed that Black transgender women reported higher HIV prevalence rates

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compared with the overall transgender sample, and that transgender people of color reported higher rates of attempted suicide and lack of health insurance.[7] In an effort to reduce these poor health outcomes, ATs must not only continue to seek out educational resources to become more culturally agile, but also go beyond seeing our patients through single identifiers.

A valuable step in bridging the knowledge gap of intersectionality is to incorporate not only LGBTQIA+ related themes into AT curricula, but also to integrate how additional racial and ethnic identities impact the patients ATs care for. A recent study appearing in the *Athletic Training Education Journal* outlined that 45% of AT educators who responded have had athletic training-specific diversity or cultural competency training. Further, 21% reported being taught cultural competence concepts during their professional education.[8] Formal educational training which focuses on best practices for treating marginalized patient populations should be implemented not only for AT educators, but for practicing clinicians as well. The Commission on Accreditation of Athletic Training Education (CAATE) has proposed accreditation standards for diversity, equity, inclusion, and social justice. As new cultural competence standards are implemented into AT education programs, ATs should look to incorporate intersectionality into the standard educational content.

In this issue, the authors address several action steps for ATs looking to better serve patients of diverse identities. As we continue to provide patient-centered care and work towards a more culturally competent profession, ATs should seek out ways to bridge the knowledge gap, demonstrate empathy and understanding, and practice patient advocacy.

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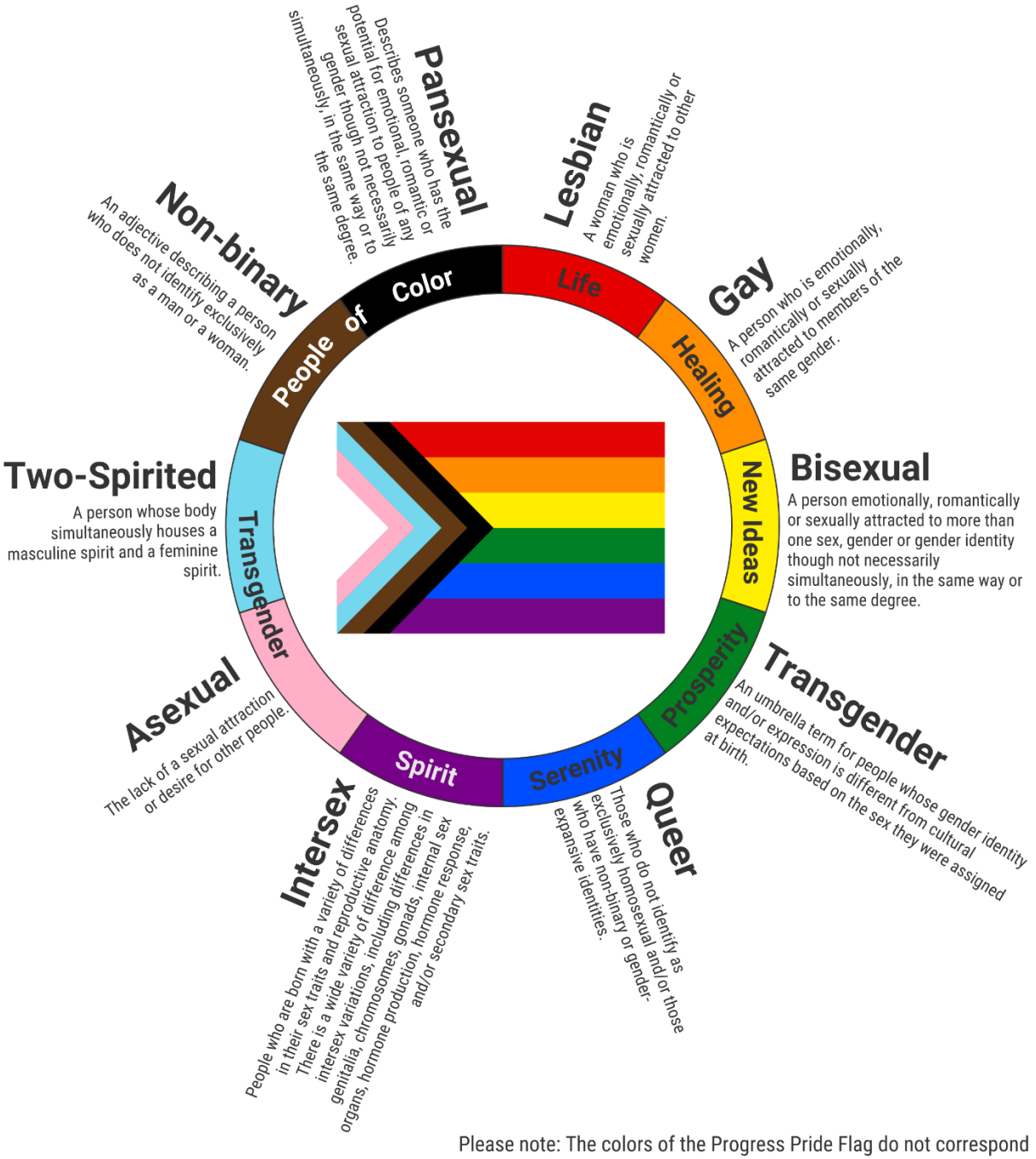
Figure 1
Identities and Definitions



Please note: The colors of the Progress Pride Flag do not correspond to groups listed, but rather themes important to the LGBTQIA2S+ community. These themes are listed within the colors on the wheel.