

## Review Article

# Primary Care Providers' Attitudes Related to LGBTQ People: A Narrative Literature Review

Mollie E. Aleshire, DNP, MSN, FNP-BC, PPCNP-BC<sup>1</sup>   
 Kristin Ashford, PhD, WHNP-BC<sup>1</sup>  
 Amanda Fallin-Bennett, PhD, RN<sup>1</sup>  
 Jennifer Hatcher, PhD, MPH, RN<sup>1</sup>

*The purpose of this article is to review the current literature describing primary care providers' (PCPs) attitudes related to lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) people. LGBTQ individuals experience significant health disparities, and these inequities may be better understood via an ecological systems framework. PCPs' actual or perceived discriminatory attitudes can lead to suboptimal treatment or health outcomes for LGBTQ people. A review of the literature from 2005 through January 2017 was completed using the Cumulative Index for Nursing and Allied Health Literature and PubMed (Medline) databases. The purpose, sample, measure(s), design, findings, strengths, and weaknesses of each study were examined; and findings were synthesized, summarized, and critically appraised. Eight articles were eligible for review. There was significant heterogeneity in the studies' purposes, research questions, LGBTQ population(s) of focus, and findings. Many PCPs' attitudes toward LGBTQ people were positive, but a minority of each studies' participants had negative attitudes toward LGBTQ people. Stigma and health care barriers negatively affect LGBTQ health. Interventions must address LGBTQ health disparities at the individual, mesosystem, exosystem, and macrosystem levels. Research, education, and practice strategies all must be integrated across socioecological levels as components of a population-based approach to eliminate health disparities for LGBTQ persons.*

**Keywords:** LGBTQ; health disparities; medical care

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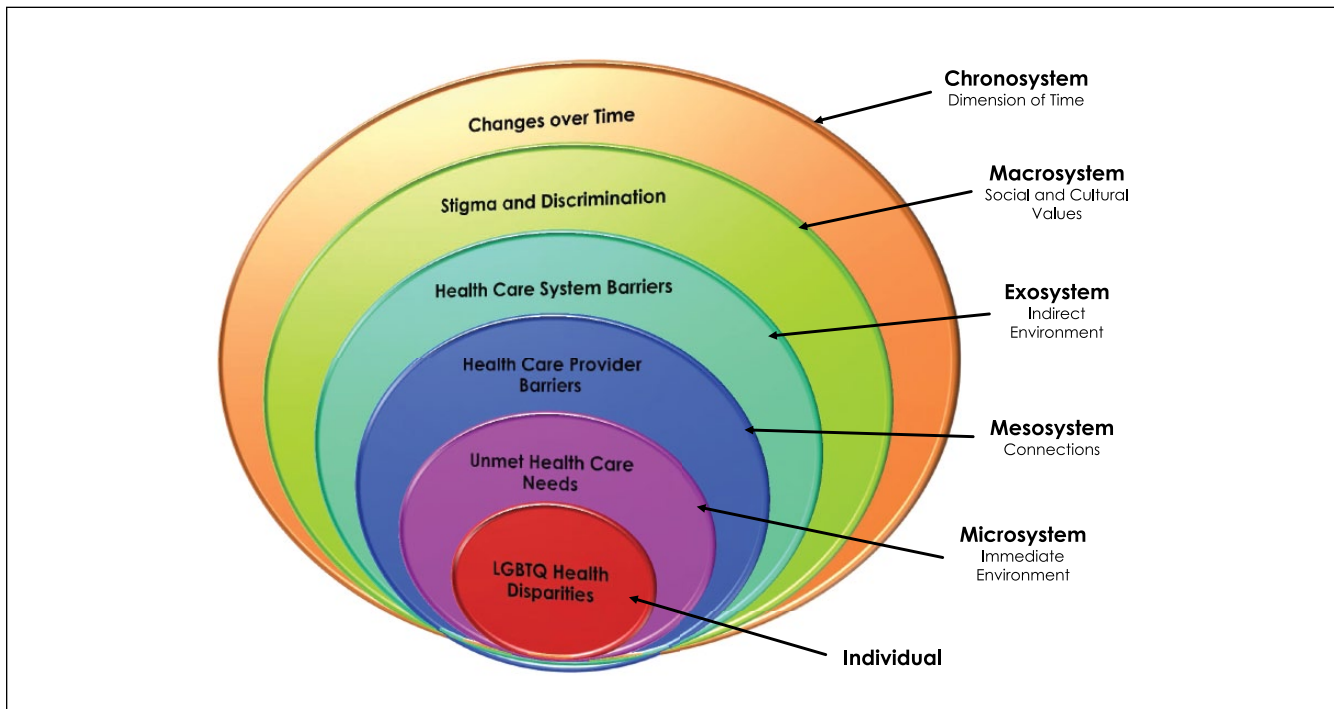
## ► INTRODUCTION

Lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) individuals experience health disparities when compared to their heterosexual and cisgender counterparts (Agency for Healthcare Research and Quality, 2014; Institute of Medicine [IOM], 2011). Although LGBTQ persons have health concerns similar to those of the general population, they face disproportionate challenges related to health care access, quality, and outcomes. Health disparities for LGBTQ people persist even when other factors such as race, ethnicity, religion, geographical location, age, and socioeconomic status are considered (Daniel & Butkus, 2015).

A nested model based on ecological systems theory (Bronfenbrenner & Ceci, 1994) depicts multiple factors that affect LGBTQ health disparities (Figure 1). Bronfenbrenner and Ceci's (1994) model describes five environmental levels. The central microsystem is encompassed by the mesosystem, which in a health context includes relationships with health care providers (HCPs). The next level is the exosystem, in which individuals are affected by forces outside their direct control, such as health care system policies or decisions made between HCPs and health insurances. The

<sup>1</sup>University of Kentucky College of Nursing, Lexington, KY, USA

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**FIGURE 1 Factors Affecting LGBTQ Health Disparities Based on Bronfenbrenner's Ecological Systems Theory**

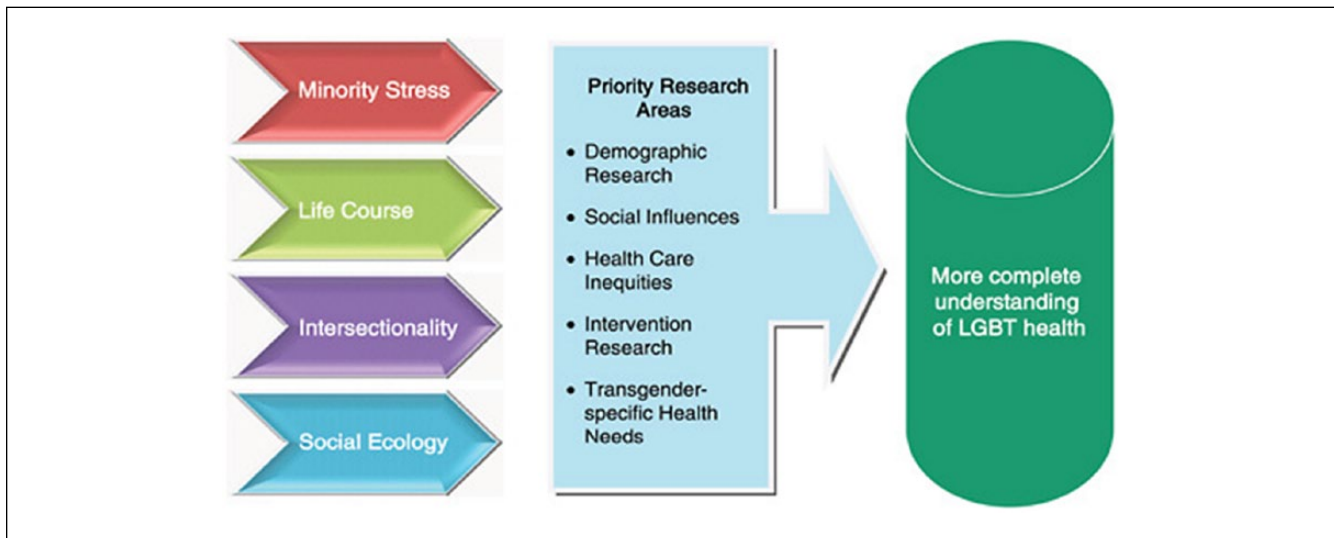
NOTE: LGBTQ = lesbian, gay, bisexual, transgender, and queer/questioning. Adapted from Santrock (1988). Reproduced with permission of Wm. C. Brown in the format: Republish in a journal/magazine via Copyright Clearance Center.

macrosystem is the cultural environment, including policies, politics, cultural beliefs, and the economy. Finally, the chronosystem, encompasses how place in time affects an individual and cultural development.

Despite changes over time, LGBTQ health disparities are linked to societal stigma, discrimination, and denial of human and civil rights (IOM, 2011). These environmental and social factors often affect the quality of life, mental and physical health, and health care of LGBTQ persons (Daniel & Butkus, 2015; Fredriksen-Goldsen et al., 2014; IOM, 2011). LGBT individuals are more likely to be homeless (IOM, 2011), to report barriers to health care access and have unmet health care needs (Agency for Healthcare Research and Quality, 2014; IOM, 2011), to describe their health as poor (Baker & Beagan, 2014; Daniel & Butkus, 2015; Fredriksen-Goldsen et al., 2014; Johnson & Nemeth, 2014), and to be disabled at a younger age (Daniel & Butkus, 2015; Fredriksen-Goldsen et al., 2014). Lesbian, gay, bisexual, and transgender (LGBT) persons also have higher rates of psychiatric disorders (Daniel & Butkus, 2015; IOM, 2011; Johnson & Nemeth, 2014), tobacco use (Daniel & Butkus, 2015; Johnson & Nemeth, 2014), suicidal ideation and attempts (Daniel & Butkus, 2015; IOM, 2011), and substance abuse (Daniel & Butkus, 2015; Johnson &

Nemeth, 2014). Gay and bisexual men account for more than half of all individuals in the United States living with HIV (Daniel & Butkus, 2015; Fredriksen-Goldsen et al., 2014; IOM, 2011). Lesbian and bisexual women are more likely to be overweight or obese (Fredriksen-Goldsen et al., 2014; IOM, 2011; Johnson & Nemeth, 2014) and are less likely to have had screening for breast cancer, cervical cancer, or sexually transmitted infections (Daniel & Butkus, 2015; Fredriksen-Goldsen et al., 2014; IOM, 2011; Johnson & Nemeth, 2014). Transgender persons have a high prevalence of victimization (Fredriksen-Goldsen et al., 2014) and are less likely to have health insurance (Agency for Healthcare Research and Quality, 2014; Daniel & Butkus, 2015; IOM, 2011; Johnson & Nemeth, 2014).

LGBTQ individuals' health care is often compromised by their invisibility within the health care system, deficiencies in LGBTQ culturally competent care, and stigmatization and discrimination within the health care environment (Baker & Beagan, 2014; IOM, 2011). Many LGBTQ patients report reluctance to disclose their gender identity or sexual orientation to HCPs (Baker & Beagan, 2014), and lack of disclosure has been associated with poor health outcomes (Ard & Makadon, 2013). Alarming, one in five transgender



**FIGURE 2 Research Agenda: Different Conceptual Perspectives That Can Be Applied to Priority Areas of Research to Further the Evidence Base for LGBT Health Issues**

NOTE: LGBT = lesbian, gay, bisexual, transgender. Republished with permission of National Academies Press (Institute of Medicine, 2011). Permission conveyed through Copyright Clearance Center, Inc.

people has been denied services by an HCP because of their gender identity, and one in three has delayed needed health care due to fear of discrimination (Agency for Healthcare Research and Quality, 2014).

The IOM (2011) has recommended the implementation of research that will advance the understanding of LGBTQ health (Figure 2). Knowledge regarding HCPs' attitudes related to LGBTQ people is foundational information necessary to guide future interventions to address inequalities in LGBTQ health care and health outcomes (Daniel & Butkus, 2015). Primary care providers (PCPs) may be physicians, nurse practitioners, clinical nurse specialists, or physician assistants, and PCPs often serve as a health care system entry portal. Actual or perceived discriminatory attitudes by PCPs may cause LGBTQ patients to not disclose their sexual orientation or gender identity, to postpone care, or to avoid care, potentially leading to suboptimal treatment or health outcomes (Agency for Healthcare Research and Quality, 2014; Baker & Beagan, 2014; Johnson & Nemeth, 2014; Stott, 2013). To date, scant research has examined PCPs' attitudes related to sexual and gender minorities. The purpose of this article is to review the current literature describing PCPs' attitudes related to LGBTQ people.

## ► EXTENSIVE LITERATURE REVIEW

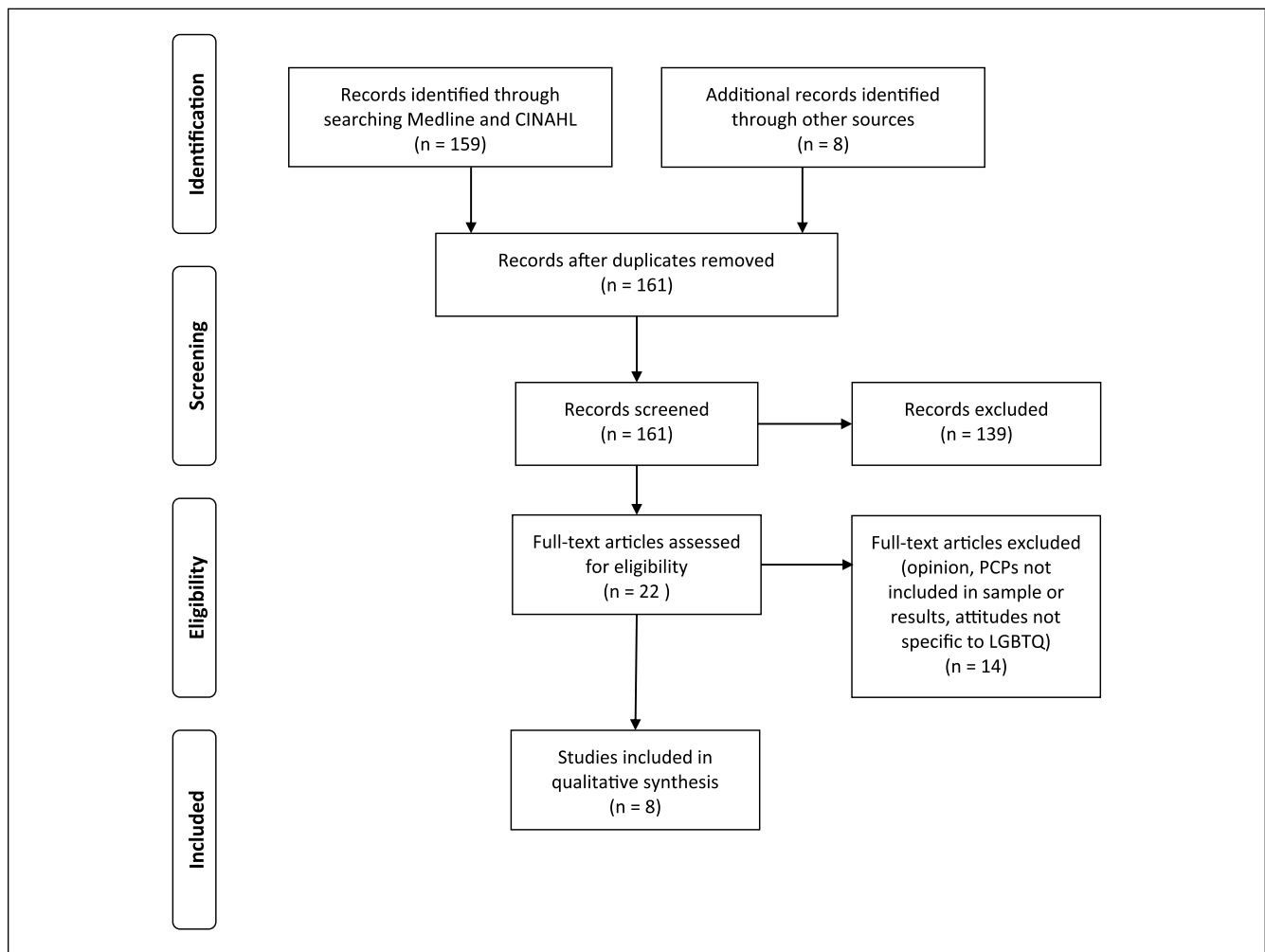
### **Method**

A review of the literature was completed in January 2017 using Cumulative Index for Nursing and Allied

Health Literature (CINAHL) and PubMed (Medline) databases. LGBTQ was defined as any sexual or gender minorities and PCP was defined as any HCPs providing primary care services. Inclusion criteria were peer-reviewed research articles, research including PCPs, articles published in English, and articles published from 2005 to January 2017. All fields were searched; the key search terms used were *LGBT*, *attitude*, and *primary care provider*. Alternate terms were added such as *lesbian*, *gay*, *bisexual*, *transgender*, *questioning*, *homosexual*, *queer*, *physician*, *nurse practitioner*, *physician assistant*, *health care provider*, *doctor*, and *PCP*. Searches were completed using standard terms, using Medical Subject Headings (attitude, attitude to health, and attitude of health personnel), and using the "explode" function. Studies were excluded if they were opinion articles, if PCPs were not included in the results, and if attitudes studied were not specific to sexual or gender minorities.

Figure 3 summarizes the article selection process. Database searches yielded 159 articles, and 8 additional articles were identified by hand-searching of the articles' reference lists. After duplicates were removed, 161 articles were screened by title and abstract, and 139 articles were excluded as not meeting inclusion criteria. The 22 remaining full-text articles were assessed for eligibility and 8 articles were identified meeting review criteria.

To facilitate data analysis, data from each study were compiled in a table format, and the purpose, sample, measure(s), design, findings, strengths, and weaknesses of each study were examined (Table 1). Subsequently, find-



**FIGURE 3 Flow Diagram of Article Selection Process**

NOTE: From Liberati et al. (2009).

ings from the literature were synthesized, summarized, and critically appraised; gaps in the literature were identified; and implications for research, education, and practice were delineated.

### Results

**Study Characteristics.** Eight studies were included in the review. All of the studies reviewed were descriptive and cross-sectional; however, Smith and Mathews (2007) also compared their findings to those of a previous study that used a similar instrument. Each study included PCPs, but not all studies provided PCP data separately from HCP aggregate data. None of the studies operationalized the definition of the specific LGBTQ population(s) of focus in their research. There was significant variability in the studies' countries of origin. There was one international

sample, while the remaining studies' samples were limited to one country of origin. The most frequent countries of origin were Canada (2 studies) and the United States (3 studies) and there was one study each from Serbia and the United Kingdom.

**Research Questions/Purposes.** All studies assessed attitudes of PCPs related to LGBTQ people, but there was significant heterogeneity in the studies' purposes, research questions, and the specific LGBTQ population(s) of focus. Four studies included PCPs' knowledge as a variable, and two studies also included PCPs' practices as a variable. Sabin, Riskind, and Nosek (2015) examined both implicit and explicit attitudes of PCPs, and Smith and Mathews (2007) assessed PCPs' attitudes toward individuals with HIV. The two qualitative studies had broad research purposes that yielded data

**TABLE 1**  
**Articles Reviewed**

<i>Author(s), Year; Title</i>	<i>Purpose</i>	<i>Sample</i>	<i>Measure(s)</i>	<i>Design</i>	<i>Findings</i>	<i>Strengths (1) and Weaknesses (2)</i>
Abdessamad, Yudin, Tarasoff, Radford, and Ross (2013); "Attitudes and Knowledge Among Obstetrician-Gynecologists Regarding Lesbian Patients and Their Health"	Assess the attitudes and knowledge of obstetrician-gynecologists working in Ontario, Canada, and to determine if a correlation existed between medical knowledge and attitudes toward sexual minority patients	Convenience sample; N = 260 obstetrician-gynecologists; PCP n = 177 (68%); Canada	Homosexuality Attitude Scale (HAS) Knowledge survey (author-developed) Sociodemographic survey	Descriptive, correlational, cross-sectional design; self-report	HAS scores (Mdn 96, range 40-105) indicative of overall positive attitudes toward sexual minorities.	1. HAS has been shown to be valid with high internal consistency ( $\alpha = .93$ ) and reliability ( $r = .71$ ). Study was conducted anonymously. 2. HAS may not reflect contemporary attitudinal biases. The term <i>lesbian</i> was not defined for study participants. Convenience sample, small sample, and potential response bias.
Baker and Beagan (2014); "Making Assumptions, Making Space: An Anthropological Critique of Cultural Competency and Its Relevance to Queer Patients"	Explore how routine practices in health care can perpetuate or challenge the marginalization of LGBTQ women	Convenience and snowball sample; N = 62; 24 primary care physicians, 38 women; PCP n = 24; Canada	In-depth, semistructured, face-to-face interview Sociodemographic survey	Qualitative, exploratory, descriptive design; face-to-face interview	To avoid making assumptions and appearing judgmental, many physicians attempted to retreat into professional neutrality. Physicians tried to mitigate judgment and discomfort by attempting to suspend personal beliefs and biases. Physicians felt that expectations of professionalism require them to appear as experts and not disclose uncertainty.	1. Physicians were asked how they experienced and understood primary health care practice with LGBTQ women. 2. Study is cross-sectional and evolution of attitudes was not obtained. Face-to-face interviews may have led participants to not discuss homophobic attitudes. Convenience sample, small sample, and possible sample bias.

(continued)

**TABLE 1 (CONTINUED)**

<i>Author(s), Year; Title</i>	<i>Purpose</i>	<i>Sample</i>	<i>Measure(s)</i>	<i>Design</i>	<i>Findings</i>	<i>Strengths (1) and Weaknesses (2)</i>
Dunjic-Kostic et al. (2012); "Knowledge: A Possible Tool in Shaping Medical Professionals' Attitudes Toward Homosexuality"	Evaluate knowledge about homosexuality and attitudes of second-and sixth-year medical students and physicians toward homosexual men and women	Convenience sample; N = 177; 79 physicians, 98 students; Serbia	Attitudes Towards Homosexuals Questionnaire Sex Education and Knowledge About Homosexuality Questionnaire Sociodemographic survey	Descriptive, correlational, cross-sectional design; self-report	Only a small number of participants held extremely negative attitudes toward homosexuality. The strongest negative predictor of attitudes toward homosexuals was knowledge about homosexuality, while religiosity and male gender were positive predictors.	1. Study was conducted anonymously. Survey instruments showed internal consistency reliability. 2. Convenience sample, small sample, and potential response bias. Existing questionnaires were not used, and there was no assessment of psychometric properties of instruments.
Hinchliff, Gott, and Galena (2005); "I Daresay I Might Find It Embarrassing: General Practitioners' Perspectives on Discussing Sexual Health Issues With Lesbian and Gay Patients"	Explore general practitioners' perspectives on the difficulties they experience when dealing with the sexual health care of lesbian and gay patients	Convenience sample; N = 22 general practitioners; United Kingdom	"Guided in-depth face-to-face interviews Sociodemographic survey	Qualitative, exploratory, descriptive design; face-to-face interview	Nonheterosexual identity perceived as a barrier to discussing sexual health. Lack of knowledge of sexual practices of lesbians and gay men created a barrier to asking about sexual matters. Personal feelings about homosexuality formed a set of difficulties for some participants when interacting with homosexual patients. A minority of participants held negative conceptualizations of homosexual relationships.	1. Thematic data analysis with data analysis themes evaluated for cohesiveness by two researchers. 2. Participants' sexual identity was not asked. Face-to-face interviews may have led participants to not discuss homophobic attitudes. Convenience sample and possible sample bias.

(continued)

**TABLE 1 (CONTINUED)**

<i>Author(s), Year; Title</i>	<i>Purpose</i>	<i>Sample</i>	<i>Measure(s)</i>	<i>Design</i>	<i>Findings</i>	<i>Strengths (1) and Weaknesses (2)</i>
Jabson, Mitchell, and Doty (2016); "Associations Between Non-Discrimination and Training Policies and Physicians' Attitudes and Knowledge About Sexual and Gender Minority Patients: A Comparison of Physicians From Two Hospitals"	Assess the relationship between the Human Rights Campaign Healthcare Equality Index (HEI) Leader designation and physicians' attitudes and knowledge about sexual and gender minority patients	Random sample; N = 180 physicians; PCP n = 72 (40%); Tennessee, United States	Attitudes Toward Lesbians, Gay Men, Bisexuals, and Transgender Individuals Physicians' Attitudes About Treating Lesbian, Gay, Bisexual, and Transgender Patients Knowledge of Lesbian, Gay, Bisexual, and Transgender Patients Gender and Sexual Minority Affirmative Practice Scale Sociodemographic survey	Descriptive, correlational, cross-sectional design; self-report	Physicians' knowledge and attitudes about LGBT patients and LGBT affirmative practice did not vary based on hospital HEI status. Physicians at the non-HEI leader hospital had more negative attitudes toward LGBT people (nonpatients).	1. Study was conducted anonymously. Survey instruments showed internal consistency reliability. 2. Study is cross-sectional and evolution of attitudes was not obtained. Low response rate, small sample, and possible sample bias.
Kitts (2010); "Barriers to Optimal Care Between Physicians and Lesbian, Gay, Bisexual, Transgender, and Questioning Adolescent Patients"	Identify barriers to optimal care between physicians and LGBTQ adolescents, particularly looking at elements of physicians' practice, knowledge, and attitudes	Convenience sample; N = 184 physicians; PCP n = 136 (74%); United States	Author-developed survey Sociodemographic survey	Descriptive, correlational, cross-sectional design; self-report	23% of the physicians reported that same-sex relationships were always or almost always wrong. Attitudes were not found to affect their practice.	1. Study was conducted anonymously. Survey response rate of 43%. 2. Survey instrument developed by author, and internal reliability and validity not established. Limited sample size, selection bias, convenience sample, and limited LGBT and African American responses.

*(continued)*

TABLE 1 (CONTINUED)

<i>Author(s), Year; Title</i>	<i>Purpose</i>	<i>Sample</i>	<i>Measure(s)</i>	<i>Design</i>	<i>Findings</i>	<i>Strengths (1) and Weaknesses (2)</i>
Sabin, Riskind, and Nosek (2015); "Health Care Providers' Implicit And Explicit Attitudes Toward Lesbian Women And Gay Men"	Examine providers' implicit and explicit attitudes toward lesbian and gay people by provider gender, sexual identity, and race/ethnicity	Convenience sample; N = 247,030 physicians, nurses, mental health providers, other diagnostic providers, nonproviders; International	Sexuality Implicit Association Test Explicit measure (1-item) Sociodemographic survey	Descriptive, correlational, cross-sectional design; self-report	Heterosexual providers' implicit preference was heterosexual people. Lesbian and gay providers held implicit and explicit preferences for lesbian and gay people. Among all groups, explicit preferences for heterosexual versus lesbian and gay people were weaker than implicit preferences. Heterosexual, lesbian, and gay people in almost all provider groups reported moderate to strong explicit preferences for people who shared their sexual identity.	3. Large, international sample of health providers. Study was conducted anonymously. Implicit Association Test demonstrated to be reliable and valid across a variety of topics. 4. Sample is a convenience sample and is not representative of a definable population. Sample bias likely. Providers' attitudes toward bisexual and transgender people not assessed.
Smith and Mathews (2007); "Physicians' Attitudes Toward Homosexuality and HIV"	Assess current physicians' attitudes toward homosexuality and persons with HIV infection	Convenience sample; N = 736 physicians; PCP n = 302 (41%); United States	Physicians' Attitudes Toward Homosexuality and HIV Sociodemographic survey	Descriptive, correlational, cross-sectional design and ex post facto design; self-survey	Considerable decrease in homophobic attitudes since 1982, although 33% disagreed or strongly disagreed with homosexual marriage. More contemporary graduates consistently more accepting of homosexuality than their predecessors. Gay specialists still face discrimination by losing colleague referrals.	1. Anonymous, self-administered survey. The measure Physicians' Attitudes Toward Homosexuality and HIV included items with established consistency and reliability. The HIV-Phobia scale and Medical Homophobia scale were reliable ( $\alpha = .72, \alpha = .78$ ) 2. Limited sample size, selection bias, convenience sample, and low response rate.

NOTE: PCP = primary care provider; LGBTQ = lesbian, gay, bisexual, transgender.



regarding PCPs' attitudes (Baker & Beagan, 2014; Hinchliff, Gott, & Galena, 2005). LGBTQ population(s) of focus were homosexuals (2 studies), lesbians (1 study), lesbian or gay individuals (2 studies), LGBTQ women (1 study), and LGBTQ (2 studies). Three studies investigated participants' attitudes related to LGBTQ people (nonpatients) while four studies researched participants' attitudes specific to LGBTQ patients. Jabson, Mitchell, and Doty (2016) examined attitudes toward sexual and gender minority patients and nonpatients.

*Study Samples.* Seven studies used convenience samples, with one also employing snowball sampling. Only Jabson et al.'s (2016) study used random sampling. Most samples were small in size (range = 22-247,030; *Mdn* = 182). Four studies reported response rates, and these rates ranged from 13% to 40%. In each of the quantitative studies, participants responded anonymously. All samples included physician participants, but the specialties of the physicians were varied.

Percentages of male and female respondents were nearly equal in a majority of studies; however, respondents in Smith and Mathews's (2007) study were 78% male, in Jabson et al.'s (2016) study were 66% male, and in Baker and Beagan's (2014) study were predominantly female. Hinchliff et al. (2005) did not assess participant's sexual orientation, while the remaining reviewed studies had samples composed primarily of participants who identified as non-LGBTQ. In studies where race/ethnicity was reported, most participants were White/Caucasian. Six studies reported participants' ages, and across these studies, ages ranged from 18 to 65+ years.

*Study Measures.* Measures used to determine PCPs' attitudes toward LGBTQ people varied widely across quantitative studies, with no two studies using the same instrumentation. Abdessamad, Yudin, Tarasoff, Radford, and Ross (2013) used the Homosexuality Attitude Scale to measure PCPs' attitudes toward lesbian patients. This scale was developed in 1986 and has shown internal consistency ( $\alpha = .93$ ) and test-retest reliability ( $r = .71$ ). Dunjic-Kostic et al. (2012) created the Attitudes Towards Homosexuals Questionnaire ( $\alpha = .92$ ) by combining parts of three questionnaires that were created in 1988, 2002, and 2007. Jabson et al. (2016) and Smith and Mathews (2007) modified existing tools to measure PCPs' attitudes. Kitts (2010) developed their own survey to assess attitudes, and internal consistency was not reported. Sabin et al. (2015) measured implicit and explicit attitudes toward gay people using the Sexuality Implicit Association Test and an explicit measure. Both qualitative studies in the review used in-depth interviews for data collection.

*Study Findings.* Several recurrent themes were identified in the literature pertaining to PCPs' attitudes related to LGBTQ people. The percentage of respondents whose attitudes toward LGBTQ people were considered negative varied significantly by study. In Hinchliff et al.'s (2005) study, nearly half of the PCPs felt that it was a barrier to their ability to deliver health care when a patient identified as nonheterosexual. Abdessamad et al. (2013) reported that less than 2% of their Canadian obstetrician-gynecologist participants had attitudes regarding lesbian patients that were considered homophobic. Dunjic-Kostic et al. (2012) found only a small number of Serbian participants held extremely negative attitudes toward homosexuality; however, average scores (possible 0-100) on the Attitudes Towards Homosexuals Questionnaire were wide-ranging ( $M = 62.91$ ,  $SD = 16.34$ ). Twenty-three percent of physicians in Kitts's (2010) research categorized same-sex relationships as always or almost always wrong. Jabson et al. (2016) compared physicians' attitudes toward sexual and gender minority patients at a hospital with Human Rights Campaign Healthcare Equality Index (HEI) status and at a hospital without HEI status. Attitudes toward LGBT patients did not differ between the hospitals; however, physicians at the HEI hospital had more positive attitudes toward LGBT nonpatients than the physicians at the hospital without HEI status. The only study that compared attitudes cross-sectionally suggested a substantial reduction in negative attitudes toward homosexuality with the passage of time. In 1982, 58% of physicians surveyed had strongly homophobic attitudes, but that number decreased to 19% in 1999 (Smith & Mathews, 2007).

Some studies found associations between PCPs' attitudes toward LGBTQ people and PCPs' gender or race. Three studies indicated that female PCPs were more likely to have positive attitudes toward LGBTQ people than their male counterparts, while two studies found that gender was not predictive of attitudes related to LGBTQ people. Of the articles that reported provider race as a study variable, two found a positive correlation between white race and affirmative attitudes related to LGBTQ people, one found no relationship between race and attitudes, and one did not make any conclusions regarding this relationship.

Age was not consistently a predictor of attitudes related to LGBTQ people. Although younger age was associated with more positive attitudes toward LGBTQ people in Abdessamad et al.'s (2013) study, age was not strongly associated with implicit or explicit attitudes in Sabin et al.'s (2015) research, and age did not affect attitudes related to LGBTQ people in Dunjic-Kostic et al.'s (2012) study.

A PCP not identifying as heterosexual was associated with more favorable attitudes toward LGBTQ people

in all studies where this relationship was reported. Two studies could not assess for relationships between sexual or gender identity and attitudes toward LGBTQ people due to the small number of sexual or gender minority participants. Of the remaining three studies, one did not establish participants' sexual orientation, and the others did not report any conclusions regarding sexual or gender identification and attitudes related to LGBTQ people.

Data regarding knowledge of LGBTQ people or LGBTQ health were included in five studies. Dunjic-Kostic et al. (2012) found that higher knowledge levels had a significant negative predictive effect on attitudes of PCPs toward homosexuality. Abdessamad et al. (2013) found no correlation between knowledge of lesbian health and PCPs' attitudes regarding lesbian patients. Although Kitts's (2010), Hinchliff et al.'s (2005), and Jabson et al.'s (2016) studies included knowledge as a variable, they did not report analysis for a relationship between knowledge related to LGBTQ health and attitudes toward LGBTQ people.

The two qualitative articles included in the review add to the knowledge regarding PCPs' attitudes related to LGBTQ people by providing descriptive data based on PCPs' experiences. Two primary themes emerged: (1) PCPs had more difficulty providing care to LGBTQ patients because of the PCPs' attitudes related to these patients and (2) PCPs often dismissed sexual and gender identity as irrelevant to care in an effort to avoid seeming discriminatory.

PCPs felt it was a barrier to their ability to deliver health care when a patient identified as nonheterosexual:

"I have relatively few [barriers] over heterosexual relationships; homosexual relationships I find a bit more difficult, prescribing Viagra for homosexual men I think is a bit dubious. . . . I think it's a slightly inappropriate use of resources really, but it's probably my prejudices, I'm prepared to admit that . . . particularly if they are not in a stable relationship, I don't see it's appropriate." (Hinchliff et al., 2005, p. 349)

PCPs retreated into professional neutrality in an attempt to avoid making assumptions and appearing judgmental:

"I'm doing many of the same things with everybody regardless of orientation or gender. I understand it's important to that patient. But to me, I guess it doesn't impact the way I practice, because I wouldn't do anything different. I'd feel that I would be treating everybody equally." (Baker & Beagan, 2014, p. 585)

## ► DISCUSSION

This literature review reveals findings to inform future research, education, policy development, and practice across ecological levels. Some PCPs hold negative perceptions related to LGBTQ populations, thus the need for further inquiry concerning how attitudes toward LGBTQ people may affect their health care and outcomes (Sabin et al., 2015; Smith & Mathews, 2007). Interventions must be developed and evaluated that address not only the LGBTQ individual but also the mesosystem, exosystem, and macrosystem (Sabin et al., 2015; Smith & Mathews, 2007).

Increased knowledge related to LGBTQ people, LGBTQ health, and LGBTQ health care has been shown in other studies to be predictive of more positive attitudes toward LGBTQ people (Herek, 2002; Herek & Gonzalez-Rivera, 2006; Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006) but was not a finding in this review. Some HCPs indicate knowledge deficits create a barrier to asking about patients' sexual orientation, gender identity, and sexual health (Abdessamad et al., 2013; Hinchliff et al., 2005; Stott, 2013). Providing HCPs opportunities to increase knowledge related to sexual and gender minorities, LGBTQ health, and LGBTQ health care is likely a prerequisite to improve health care for LGBTQ individuals (Abdessamad et al., 2013; Dunjic-Kostic et al., 2012; Hinchliff et al., 2005; Kitts, 2010; Sawning et al., 2017; Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly, 2017; Stott, 2013).

Younger age has been correlated with more positive attitudes toward LGBTQ people in some studies (Herek, 2002; Herek & Gonzalez-Rivera, 2006; Sanchez et al., 2006) but was not consistently a predictor of attitudes toward LGBTQ people in this review. Stott (2013) found that medical students who indicated comfort with LGBT people still rarely routinely asked about sexual orientation, gender identity, or sexual health during their clinical encounters. Thus, HCPs younger age or reported comfort with LGBTQ people may not translate into provision of culturally concordant care.

In an attempt to avoid assumptions about sexual orientation and gender identity, HCPs report retreating into professional neutrality, and LGBTQ patients indicate such neutrality reinforces heterosexism (Baker & Beagan, 2014; Hinchliff et al., 2005). To avoid such scenarios, all health care forms and the electronic health records must contain inclusive, gender-neutral language that allows for self-identification (The Joint Commission, 2011).

## **Limitations**

Limitations of this review include the number and types of studies that were reviewed and the time span of publication. The study designs varied, with six studies using a quantitative design and two studies employing a qualitative approach. Since all studies but one employed cross-sectional designs, these studies were not able to indicate the potential evolution of attitudes over time. Since no reviewed studies used the same study instruments, data across studies could not be reliably compared statistically.

All studies used unique research purposes or questions, different types of research participants, dissimilar research measures, multiple variables, and widely varied LGBTQ population foci. Many of the studies' instruments were created more than a decade ago, which may affect the measures' ability to reflect current attitudes. Nonphysician PCPs were not part of any of the studies' samples. Additionally, there was little rigor in the sample selections for the reviewed research studies, none of the reviewed studies defined LGBTQ for study participants, and most had small sample sizes.

Sampling bias and voluntary response bias are a limitation across all of the reviewed studies due to the sampling techniques. Also, assessment of attitudes increases the likelihood of response bias, since social desirability response bias has been identified as a phenomenon most likely to occur in responses to socially sensitive questions (van de Mortel, 2008).

The search methodology may have limited the number of studies identified for inclusion. The nursing, medical, and allied health literature were searched using CINAHL and PUBMED as well as hand-searching. Searches of additional databases and grey literature may have led to the identification of additional studies meeting inclusion criteria.

The diversity of the research reviewed limits the ability to generalize the review findings. Attitudes related to LGBTQ people are evolutionary phenomena likely influenced by factors such as geographical region, religion, legislation, sociopolitical factors, sociocultural norms, and a myriad of other factors. Data classification and thematic identification and classification were based on subjective inferences; consequently, this is a limitation affecting the results.

## **Implications**

*Implications for Research.* Studies using different conceptual perspectives should be applied to the priority areas of research identified by the IOM (2011) to increase the evidence base related to LGBTQ health

(Figure 2). Investigating how multiple factors interact to foster or impede quality health care for LGBTQ people is essential. Much current research has focused on the experiences and outcomes of LGBTQ individuals. While such inquiry is indispensable, to fully address LGBTQ health disparities, we must seek to affect LGBTQ health barriers that exist at the mesosystem, exosystem, and macrosystem levels (Figure 1). At the mesosystem level, qualitative studies exploring HCPs' attitudes could highlight sources of unconscious bias and guide the development of interventions that could reduce these dangerous attitudes and improve the care of this and other vulnerable populations. In addition, more reliable, contemporary instruments to measure HCP attitudes regarding LGBTQ people must be developed and validated. Considering evolution in the macrosystem and chronosystem, such instruments should use more current language and be reflective of contemporary policy changes.

To develop targeted interventions to improve LGBTQ health, baseline information must be accurate and based on behavior change theory, guiding the development of appropriate and theoretically grounded interventions. Larger sample sizes and use of more rigorous sampling techniques are also critical components to addressing the gaps in this research area. Future studies must operationalize LGBTQ definitions. While HCPs may hold common attitudes and beliefs about each of these subgroups, there may be important and distinct attitudes toward each population that may directly affect their care and should be elucidated. A necessary and important addition to the body of evidence is focus within the mesosystem on comparison of LGBTQ patients' and HCPs' perspectives regarding the same clinical encounters. This will allow interventions to be tailored to fit the needs of both the HCPs and the priority LGBTQ population and thus will determine best practices to decrease LGBTQ health disparities.

Few longitudinal or interventional studies exist in the LGBTQ research, and such designs are necessary to understand trajectories related to LGBTQ health and to improve LGBTQ health care and health outcomes (Fredriksen-Goldsen et al., 2014). Implementing research studies with an increased emphasis on each unique LGBTQ population will help guide practice by providing recommendations that are holistic, yet individualized and patient-centered (Davy & Siriwardena, 2012).

*Implications for Education.* Implementing HCP-targeted educational interventions that can affect the mesosystem, exosystem, and macrosystem barriers to care of LGBTQ individuals is a necessary step (Abdessamad

et al., 2013; Dunjic-Kostic et al., 2012; Hinchliff et al., 2005; Kitts, 2010; Stott, 2013). Many HCPs report brief or nonexistent LGBTQ curricula in their professional training (Carabez et al., 2015; Honigberg et al., 2017; Parameshwaran, Cockbain, Hillyard, & Price, 2017; Sekoni et al., 2017) and indicate a lack of knowledge and comfort regarding assessment of sexual health and sexual or gender identity (Abdessamad et al., 2013; Hinchliff et al., 2005; Stott, 2013).

All HCPs should be required to complete education that addresses sexual orientation, gender identity, gender expression, sexual and gender minority health, LGBTQ health needs, and LGBTQ health disparities (Abdessamad et al., 2013; Stott, 2013). Furthermore, curricula for all HCPs must include training in unconscious bias, communication, sexual health, and LGBTQ health and social issues (Bellack, 2015; Blair, Steiner, & Havranek, 2011). This content must be an integral part of HCP curricula, continuing education programs, and health care system competencies that is normalized and required. This content must be woven throughout learning opportunities and taught when health assessment, health promotion, and disease prevention are discussed (Cornelius, Enweana, Alston, & Baldwin, 2017).

Education on these topics should not only be didactic but also include multimodal learning strategies, clinical experiential learning, and reflective practice to better prepare HCPs to meet LGBTQ patients' health care needs (Daniel & Butkus, 2015; Gay and Lesbian Medical Association, 2006; The Joint Commission, 2011; Society for Adolescent Health Medicine, 2013; Stott, 2013). Example strategies that may be implemented within HCPs' professional programs include the following: (1) assessment of the program's inclusivity of LGBTQ issues using the HEI benchmark (Carabez et al., 2015; The Human Rights Campaign, 2017), (2) unconscious bias training (Phelan et al., 2017; Sabin et al., 2015), (3) training focused on cultural competence and patient-centered care (Carabez et al., 2015), (4) use of existing education resources from evidence-based sources such as the Gay and Lesbian Medical Association and Fenway Institute (Carabez et al., 2015), (5) inclusion of LGBTQ patients' perspectives and health care experiences (Carabez et al., 2015; Honigberg et al., 2017), (6) active and interactive simulation and clinical experiences in providing LGBTQ-competent care (Carabez et al., 2015; Honigberg et al., 2017), and (7) opportunities for a LGBTQ-specific certification or minor (Carabez et al., 2015; Sawning et al., 2017). Since many HCPs have not had appropriate or adequate LGBTQ content in their professional training, health care systems should include LGBTQ health and diversity training in new employee orientation requirements

as well as mandate annual updates and training on LGBTQ care for all HCPs (Carabez et al., 2015).

*Implications for Practice.* Health care interaction components of disclosure of sexual orientation or gender identity and provider attributes (knowledge, communication, and attitudes) have been identified by LGBTQ people as key points in the health care experience that directly affect subsequent behaviors and therefore can affect health outcomes (Johnson & Nemeth, 2014). These key components must be addressed in HCP-patient interactions and care (mesosystem), within health care systems (exosystem), and within the larger community (macrosystem). "Making space for LGBTQ identities and experiences to be acknowledged and reflected in all levels of the healthcare system" (Baker & Beagan, 2014, p. 589) must become a priority. HCPs must have sensitivity, knowledge, and awareness related to the health and social needs of LGBTQ people to facilitate a trusting HCP-patient relationship (Daniel & Butkus, 2015; Gay and Lesbian Medical Association, 2006; The Joint Commission, 2011; Lim, Brown, & Justin Kim, 2014; Society for Adolescent Health Medicine, 2013; Stott, 2013). Evidence-based strategies to promote culturally sensitive care for LGBTQ people include creating a welcoming, supportive, safe, inclusive environment; facilitating disclosure of sexual orientation and gender identity; advancing effective communication; and advocating for LGBTQ people in the health care system and community (The Joint Commission, 2011).

To create an environment that is inclusive of LGBTQ patients, HCPs must evaluate their own belief system, cultural norms, and bias to increase their cultural sensitivity, develop better collaborative relationships with patients, and gain trust from LGBTQ patients (Coren, Coren, Pagliaro, & Weiss, 2011; The Joint Commission, 2011). Waiting rooms, common areas, and patient care areas should reflect inclusivity and support of LGBTQ patients and families via a posted nondiscrimination policy/bill of rights; LGBTQ-friendly symbols; LGBTQ magazines, posters, and information; and decor/images that depict same-sex partners, same-sex families, and LGBTQ families (Gay and Lesbian Medical Association, 2006; The Joint Commission, 2011; Lim et al., 2014). Gender neutral restrooms should be available; however, individuals should be permitted to use restrooms that conform with their gender identity (The Joint Commission, 2011; Lim et al., 2014).

Disclosure of sexual orientation and gender identity can be facilitated by allowing individuals to self-identify and by refraining from making assumptions regarding gender identity or sexual orientation based on behaviors or appearance (Gay and Lesbian Medical

Association, 2006; The Joint Commission, 2011; Lim et al., 2014; National LGBT Health Education Center, 2015). Inclusive processes, language, forms, and electronic health records allow self-identification and should include preferred name and pronouns, gender identity, sex assigned at birth, and sexual orientation (Gay and Lesbian Medical Association, 2006; IOM, 2011; The Joint Commission, 2011; Lim et al., 2014; National LGBT Health Education Center, 2015).

HCPs must ensure that patient-provider communication is protected in accordance with privacy and confidentiality laws (Gay and Lesbian Medical Association, 2006; The Joint Commission, 2011). Neutral and inclusive language should be used with all patients, and language or questions that imply assumption of sexual orientation or gender identity must be avoided. HCPs should listen to and reflect the language used by patients when they describe themselves, their relationships, and their families (The Joint Commission, 2011; Lim et al., 2014).


Finally, advocacy for sexual and gender minorities within health care systems and communities is an integral part of inclusive, patient-centered care (Daniel & Butkus, 2015; The Joint Commission, 2011). Advocacy for LGBTQ populations must occur throughout all levels of the ecological system, and unique LGBTQ health disparities and health care needs must be considered at all levels of health policy development (Daniel & Butkus, 2015; The Joint Commission, 2011). Every health care organization should espouse patient, employee, and visitation nondiscrimination policies that include sexual orientation and gender identity (The Human Rights Campaign, 2017). Health care organizations should strive to achieve benchmarking status as an HEI Leader in LGBTQ Healthcare Equality, which is indicative of the “healthcare facilities’ policies and practices related to the equity and inclusion of LGBTQ patients, visitors, and employees” (The Human Rights Campaign, 2017). Furthermore, LGBTQ\*-affirming and -inclusive media campaigns and social media marketing are strategies that can be used to influence exosystems and macrosystems (The Joint Commission, 2011).

## ► CONCLUSION

LGBTQ people experience health disparities at significantly higher rates than the general population, and HCPs’ attitudes related to these populations as well as other health care barriers have often affected LGBTQ populations and contributed to their health disparities (Abdessamad et al., 2013; Hutchinson, Thompson, & Cederbaum, 2006; Jabson et al., 2016). The infancy of

the science regarding LGBTQ people and the health of sexual and gender minorities makes it critical to explore demographic and social characteristics, the influence of contextual factors on health status, the impact of barriers to care, and the extent to which stigma influences LGBTQ health (IOM, 2011). Improving the health, safety, and well-being of LGBTQ persons is an essential component of improving population health (“Healthy People 2020,” 2010). To achieve this goal, development and evaluation of interventions need to expand beyond the LGBTQ individual and also address the mesosystem, exosystem, and macrosystem. Research, education, and practice strategies all must be integrated as components of a population-based approach across socioecological levels that will eliminate health care disparities for LGBTQ individuals.

## ORCID ID

Mollie E. Aleshire  <https://orcid.org/0000-0002-1701-0980>

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