



Supporting sexual and gender minority health-care workers

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Sexual and/or gender minority health-care workers are subject to the heteronormativity and cisnormativity of society and often face open discrimination. Empowering these individuals to bring their full, authentic selves to work so that they can serve their patients and institutions with the totality of their strengths requires institutes and cisgender or straight allies to support LGBTQ+ communities by creating a culture of inclusivity and enacting progressive policies.

Lesbian, gay, bisexual, transgender and queer (LGBTQ+) individuals — or, more broadly, sexual and/or gender minority (SGM) individuals — disproportionately experience discrimination in health-care settings¹; however, little is known about the experiences of SGM health-care workers (HCWs). In the past decade, the proportion of individuals in the USA who identify as LGBTQ+ has increased. One survey from 2021 reported that 7.1% of American individuals considered themselves to have an LGBT identity, compared to 3.5% in 2012 (REF.²). Despite this increase in the US general population, in the 2017–2021 Association of American Medical Colleges Graduation Questionnaire (a survey that is given to fourth-year medical students in doctor of medicine programmes in the USA and Canada), ≤5% of responders identified as gay or lesbian or as bisexual, and <1% identified as transgender. To our knowledge, no data have been routinely collected for nursing, mental health or other health-care workforces.

An analysis from 2018 found that up to 38% of SGM HCWs had not disclosed their identity in the workplace, owing to fears of job loss, potential harassment or discrimination³. Specific concerns included discomfort, heteronormative and cisnormative attitudes, use of inappropriate pronouns, delay of academic promotion, refusal of tenure and loss of patients⁴. Institution-mediated discrimination and professional isolation have been identified as reasons for SGM HCWs to leave practice environments or relocate⁵. Even with rampant burnout caused by high workloads and the COVID-19 pandemic, the extra stress of these concerns may accelerate burnout in SGM HCWs.

The diversity of experiences of SGM individuals is incredibly vast. For example, the experience of a white, gay, cisgender man will be different from that of a Black, asexual, transgender woman⁶. Intersectionality recognizes the multiple, interlocked social identities — for instance, race, ethnicity, culture, religion, age, ability, immigration status and socioeconomic status — of an individual that interact with systems of privilege and power to produce systemic inequities⁷. Intersectionality

underlies the compounded marginalization of some SGM HCWs in the health-care space. To mitigate these negative experiences and actively support SGM HCWs, interventions should be framed through institutional, interpersonal and patient-centred lenses.

Institutional support

Institutions — and the straight and cisgender allies who work within them — have the power to create a welcoming, safe environment for SGM HCWs. Nondiscrimination policies that explicitly include sexual orientation, gender identity and gender expression are essential to achieving this aim. Valuing diversity in hiring, academic promotion and tenure decisions, and achievement awards will help institutions to recruit and retain top talent from SGM communities. SGM HCWs should be offered appropriate leadership positions beyond roles in diversity, equity and inclusion and social justice committees. Outside of leadership roles, the contributions of SGM HCWs to LGBTQ+ educational content and overall structural changes must be consistently and appropriately compensated. Such compensation is particularly important for early trainees and faculty who often forfeit their skills and time to uncompensated opportunities for hopes of upward mobility. In the past few years, some academic institutions have developed LGBTQ+-specific resources for patients, which simultaneously signal safety to prospective trainees, employees and staff. For example, the [University of California San Francisco's OUTlist Directory and Visibility Project](#) aims to promote visibility and awareness for LGBTQ+ students, trainees and staff to foster allyship and education about SGM communities within the university. The provision of benefits that cover adoption costs and health-care plans that cover assisted reproductive technology support SGM HCWs who want to grow their families.

Institutions must educate their employees regarding LGBTQ+ issues. Training modules promote sensitivity and humility, while creating a culture of inclusion. LGBTQ+-themed grand rounds in academic centres should be actively solicited by the leadership team rather

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than by SGM HCWs delegated with this task, and attendance should be widely encouraged. Against a backdrop of a culture of SGM inclusion, small gestures can make a big impact in creating a safe and welcoming space. Displaying LGBTQ+ symbols (for example, the progress pride flag) in medical offices and other public spaces, and providing similar symbols for employees to optionally display on ID badges, can help SGM HCWs to feel included.

Interpersonal interactions

The cognitive burden and dissonance that comes from working in a system of traditional, heteronormative standards can actively discourage SGM HCWs from feeling comfortable with identity disclosure (that is, ‘being out’). The degree to which SGM HCWs feel safe to be their full, authentic selves often lies in their interactions with those around them. Straight and cisgender allies of all positions in the organization can individually support their SGM HCW colleagues. A 2011 study of the experiences of SGM HCWs in the workplace reported that 10% of SGM physicians were denied referrals from heterosexual colleagues; 15% experienced harassment by a colleague; 27% witnessed discriminatory treatment of an SGM coworker; and 65% witnessed derogatory comments about SGM individuals⁸. Straight and cisgender allies must educate themselves on sources of their unconscious bias and openly challenge others when they observe discrimination. Educators should evaluate without bias their SGM trainees who do not conform to majority-accepted speech patterns, appearance, mannerisms and other ways of interacting, to avoid reinforcing a form of ‘professionalism’ that is exclusionary to SGM HCWs⁹. Colleagues should allow SGM HCWs to take the lead in language, such as in the pronouns they use to refer to themselves and in the labels they give to their relationships (for example, partner, husband, wife or other terminology). As with other interactions with people different from oneself, an open attitude with a desire to learn more goes a long way. SGM HCWs should not bear the burden of educating those around them, contributing to the ‘minority tax’, in which further burden is placed on those who are already disadvantaged: rather, straight and cisgender allies should actively seek out resources with which to educate themselves.

Patient relationships

Beyond institutional and interpersonal discrimination towards SGM HCWs, attention must be given to the experiences of SGM HCWs with their patients. Zero-tolerance policies for overt discrimination and hate speech should be instituted and publicly displayed to protect SGM HCWs and other underrepresented groups. However, SGM HCWs may risk losing patients if they come out. A 2008 survey of 502 adults living in the USA found that 30.4% of patients would change clinicians from a gay or lesbian clinician, and 35.4% would change practices if a gay or lesbian clinician was employed there¹⁰. Patients may also choose not to recognize the gender expression or identity of their clinician. Such discriminatory and invalidating experiences contribute to burnout, mental-health exacerbations and the overall degradation of psychological safety in the workspace of SGM HCWs.

The potential for negative reactions weighs heavily on SGM HCWs, who often withhold their identities to preserve a therapeutic alliance or avoid discrimination from patients⁴. Alternatively, correcting a patient’s assumptions about a SGM HCW’s spouse or family structure can feel damaging to the therapeutic relationship, as the SGM HCW may feel they are causing an awkward interaction with a patient who is coming to them for help. Organizations should refrain from tying HCW compensation to patient satisfaction scores to enable SGM HCWs to safely come out to patients without fear of financial repercussions.

In nephrology and other specialties with long-term patient relationships that can sometimes last for decades, hiding one’s identity or not correcting false assumptions can feel progressively more dishonest as the relationship deepens. Navigating whether to come out to patients is deeply personal; straight, cisgender allies have a role in affirming those choices. Providing referrals and promoting SGM HCW colleagues where appropriate can help to mitigate discrimination from patients and support the patient–clinician relationship.

Conclusions

Institutions have a key role in creating a culture of inclusivity and enacting policies that emotionally and financially support SGM communities. Straight, cisgender allies can help to implement policies and create a supportive culture, both at leadership levels and in daily interpersonal interactions. Finally, SGM HCWs may face a unique burden in navigating their relationships with patients in the context of their authentic selves. Moving towards a truly equitable society is the ultimate solution for this struggle.

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Competing interests

The authors declare no competing interests.

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University of California San Francisco's OUTlist Directory and Visibility Project: <https://lgbt.ucsf.edu/outlist>