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Culturally Competent Care of LGBT Patients: The NP Experience

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Abstract

Nurse practitioners (NPs) who are culturally competent can enrich patient care, reduce health disparities, and improve health outcomes. Research that examines NP practice as it relates to the culturally competent care of lesbian, gay, bisexual, and transgender (LGBT) patients has been lacking in the literature. To address this gap, an exploratory qualitative descriptive design was used to explore NP experiences with LGBT patients. Data were collected via semi-structured interviews with 22 NPs. Inductive analysis was used to identify, analyze, and report themes within the data. Key findings were that LGBT patients were generally not seen as a distinct cultural group with specific health needs and that NP participants were unclear about the definition or principles of cultural competence as it relates to LGBT persons. Most NPs were not using a model of cultural competence to guide their practice. Instead, they utilized strategies that primarily revolved around the development and maintenance of the therapeutic nurse - patient relationship. These findings have implications for patient outcomes, as well as education, practice, and research.

Keywords: *Nurse practitioner, Lesbian, Gay, Bisexual, Transgender, LGBT, Cultural competence*

1. Introduction

1.1. Necessity of study

Increasing numbers of individuals, families and communities in Canada are receiving health care services provided by nurse practitioners (NPs). There are currently 4,967 NPs licensed across Canada, 312 of whom are practicing in the Maritime provinces of New Brunswick, Nova Scotia, and Prince Edward Island [1]. As registered nurses who have completed an approved NP program, typically at the graduate level, NPs are educated in both nursing theory and medical skills, and must successfully pass an entry-to-practice examination approved by the nursing regulatory body prior to licensure [2]. NPs provide care across the lifespan, ordering and interpreting diagnostic tests; diagnosing acute and chronic conditions; prescribing pharmaceuticals; and performing specific procedures within their legislated scope of practice. Current NP core competencies include health promotion and prevention of illness

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and injury; health assessment and diagnosis; therapeutic management; and professional role, responsibility and accountability [2].

NPs are employed in a variety of practice settings, including community health centers and collaborative family practice; urgent care and emergency departments; mental health and addiction services; correctional services; long-term care; and non-government agencies [3]. An individual's first point of contact or primary provider of health care may be an NP. The hallmark of NP practice is holistic, patient-centered care that assists persons of diverse cultures, races, religions, genders and ethnicities in achieving, maintaining, and enhancing their health and wellbeing [2]. Holism in nursing is grounded in caring. It is foundational to the development of the nurse-patient relationship, and a fundamental component of the Canadian Code of Ethics for Registered Nurses which outlines standards for the safe, competent, and ethical care of patients. Originally adopted in 1984, the code was revised in 2017 to reflect, among other things, the increasing diversity among Canadians accessing the health care system, and the impact of social inequities on health inequities[4].

NPs have a long history of providing care to diverse populations who live within vastly different social contexts, and the impact of determinants of health are routinely incorporated into NP practice. Patients experience a variety of acute and chronic health needs over their lifespan, and possess varying levels of health management and coping abilities. However, all patients should expect to receive ethical, competent, and compassionate care from their health care provider, that acknowledges and recognizes the circumstances which influence a person's health and well-being. A key component of the NP role is advocacy, particularly for underserved, marginalized or minority populations [2][5]. One such group is LGBT persons. The widely-adopted acronym LGBT refers collectively to those who identify as lesbian, gay, bisexual, or transgender. Additional letters have been added to the acronym to reflect more inclusively the diversity of the community, including Q (queer, questioning), I (intersex) A (asexual) and others. Individuals whose biological sex at birth and throughout life corresponds to the culturally accepted male and female gender identity, behaviour, and roles are referred to as cisgender [6]. Considering the diversity within the LGBT community, it is beyond the scope of this work to provide a detailed analysis of all permutations of sexual orientation or gender identity. Rather, we intended to highlight the working knowledge that NPs should possess in order to provide competent, culturally sensitive care to LGBT patients.

2. LGBT health

It is important to note that while there are some commonalities among populations incorporated under this umbrella term, there also are some fundamental differences. Therefore, each group should be considered as distinct, with their own health and psychosocial needs and concerns [7]. LGBT or questioning youth represent an especially vulnerable population who experience higher rates of social and psychological challenges, including family rejection, homelessness, bullying, physical violence, depression, and suicide. They are more likely to start using tobacco, alcohol or other substances at an early age [8]. The overall goal for all youth is to achieve physical, social, and psychological well-being. For this to occur, health care providers must be attentive and vigilant in both recognizing and addressing the physical, psychological, and psychosocial issues that contribute to negative health outcomes. LGBT or questioning youth may be reluctant to disclose sensitive information out of concern for privacy or from fear of prejudice or discrimination. Disclosure is much more likely to occur when health care providers are comfortable and competent in having an open dialogue with youth regarding topics related to sexuality and gender in

general [9]. Like their heterosexual counterparts, lesbian and bisexual women have healthcare needs related to health promotion, sexual health, and reproductive health. A prominent feature in LGB research is that lesbian and bisexual women's health-seeking behaviors may be affected negatively by a provider's attitudes and behaviors, in particular the assumption of heterosexuality [10][11]. Gay and bisexual men's health has focused primarily on prevention and treatment of sexually transmitted infection such as HIV as a result of the AIDS epidemic of the 1980s and early 1990s. However, gay, bisexual, or men who have sex with men (MSM) are at increased risk of other preventable conditions that have not received the same attention, including a higher incidence of smoking, which leads to an increased risk of cardiovascular disease, as well as lung and other cancers [12]. They also are more likely to experience mental health disorders, such as eating disorders, substance abuse, anxiety, depression, and suicidal ideation than their heterosexual counterparts [7]. Intimate partner violence, most often perceived as only occurring to women, is also a concern for gay, bisexual, and MSM [13]. Older gay men and women experience the traditional challenges associated with aging, including changes in physical and cognitive functioning, loss of autonomy, retirement, isolation, and decrease in financial status. However, they also face unique health and social challenges, particularly with regard to substitute decision-making in the case of illness, and discriminatory healthcare and institutional practices that exist within some hospital and nursing home settings [14]. Individuals who are questioning their gender identity or who identify as transgender may fear the repercussions of disclosing or discussing this, including concerns for their personal safety. Transgender individuals are more likely to face discrimination and interpersonal violence as a result of transphobia [15]. Although Statistics Canada does not maintain information on the number of transgender Canadians who are victims of violence or murder, a cross-Canadian study published in 2014 found that transgender persons, particularly transgender women, experience violence at much higher rates than the general population [15].

3. Culture and cultural competence

Culture can be described as the interactions that occur between individuals, groups, communities, and society that impart meaning and significance. It is the most comprehensive, universal, and holistic feature of human beings [16]. Along with race, religion, and ethnicity, gender and/or sexual orientation are components of an individual's culture. Cultural competence is a set of attitudes, behaviors, and policies that enables nurses (and others) to work effectively in cross-cultural situations. It acknowledges diversity in society, helps to ensure the most appropriate care is provided to each person, and holds the health care provider accountable for recognizing and meeting the needs of individuals and communities . In the context of the nurse-patient relationship, a simple yet powerful definition of cultural competence is "knowing another as I would want another to know me" (p. 6) [17]. Nurses are expected to integrate cultural competence into their practice; it is considered an entry-level ability for registered nurses. In all domains of nursing practice, nurses are professionally and ethically responsible for acquiring cultural competencies, and incorporating these into their therapeutic relationships with patients [3].

3.1. Theoretical frameworks

In nursing, the metaparadigm or central concepts related to the discipline are the person, the environment, health, and nursing [18]. Theoretical or conceptual frameworks provide a 'world view' or lens through which concepts derived from the metaparadigm of nursing can

be viewed, understood, and interpreted [19]. In practice, theoretical frameworks or models help define and explain the principles that guide nurses in professional practice. They provide a paradigm through which to view the nursing process of assessing, planning, implementing, and evaluating care, and can facilitate a systematic, knowledgeable and practical approach to patient interactions [18]. Using a holistic, culturally-centered lens through which to view and develop understanding about the human experience can result in improvements in patient care [20]. Several well-known frameworks or models of cultural competence have been adopted within the nursing profession, including Campinha-Bacote's Process of Cultural Competence[21][22]; Leininger's Theory of Culture Care, Diversity and Universality [16][23], and the Purnell Model of Transcultural Health Care [20].

An individual's cultural experiences may influence perceptions and expectations related to health and psychosocial needs. LGBT persons, as well as members of other minority groups, have described feeling unwelcome, uncomfortable, and at times unsafe due to discriminatory attitudes and practices in health care [24][25]. Homophobia, transphobia and heterosexism feature prominently in LGBT research, and can contribute to misinformation, stereotyping, discrimination, and violence [26][27]. The experience of homophobia, stigmatization, and social isolation, manifested as minority stress, can heighten the health risks associated with sexual or gender minority status, negatively impact health, and result in adverse health outcomes across the life cycle for LGBT people[7][25]. As a component of a quality nursing practice environment, cultural competence can contribute to the reduction or elimination of health disparities, leading to improved health outcomes for patients, families, and communities [3][7][28].

4. Statement of the problem

The ability to provide care that is culturally appropriate is recognized as an integral component of nursing practice. A culturally competent health care workforce that can adequately meet the needs of varied populations is essential in Canada's diverse cultural climate. NPs are providing health services to increasing numbers of Canadians, and therefore are well positioned to enrich patient care, reduce health disparities, and improve health outcomes through the provision of culturally competent care. Adequate preparation of nursing professionals at both the baccalaureate and graduate levels is critical for ensuring that the nursing workforce is competent to meet the needs of diverse populations[3].

5. Research purpose and questions

The purpose of this research study was to explore and describe the experiences of NPs in providing health care to LGBT patients, and to examine how NPs demonstrate cultural competence in providing care to members of the LGBT community. Specific research questions included: 1) How do you feel you demonstrate cultural competent when caring for LGBT patients? and 2) Is there a cultural competence framework that you use to guide your NP practice?

6. Method

A qualitative descriptive design was used for this study to develop a more complete understanding of the experiences of the participants [29]. Relevant ethics board approval for this study was obtained prior to participant recruitment and data collection. Eligibility criteria for participation were: (1) Family/All Ages or Adult NP; (2) Current license to practice in the

provinces of NB, NS, or PEI; (3) had provided primary care to at least one LGBT patient(s) in their practice setting in the past three years; and (4) understood and spoke English. A purposive convenience sampling technique, supplemented by snowball sampling, was used to facilitate locating potential information-rich participants.

Data were collected via one-on-one qualitative interviews conducted either in person or over the phone between July 2016 and June 2017. Interviews ranged in length from 40-100 minutes. Demographic data including age, gender, years of NP practice, educational background and educational institution, practice setting and place of employment were collected on all participants. Questions related to sexual orientation are not permitted by the research ethics board. The interview guide consisted of semi-structured, open-ended questions derived from a literature review and designed to elicit detailed descriptions regarding participant's experiences. It was reviewed for face validity with pre-identified key informants, and piloted with one person prior to being used formally in the research project. Minor modifications to the initial interview guide were made based on feedback received. Additional questions related to key concepts, themes, and ideas or topics that emerged were incorporated as interviews progressed in keeping with the iterative process of qualitative research. Data collection was concluded when data saturation was achieved. This occurred after 19 interviews; three additional interviews were conducted to increase confidence in the findings. The PI completed verbatim transcription of all interviews with the assistance of an experienced research transcriptionist, who signed a confidentiality agreement. All participants were given pseudonyms to ensure their privacy and confidentiality.

The qualitative data were analyzed using Braun and Clarke's six phases of thematic analysis [30]. NVivo® Version 9, a data management software tool, was used to assist with data management. Criteria for ascertaining the trustworthiness of a qualitative study as established by Lincoln and Guba were used [31]. Participants included NPs from the three Maritime Provinces, who worked in a variety of practice settings in both urban and rural areas. This sampling allowed the individual contributions and viewpoints of a range of people to be verified against each other. Respondent validation or member checks were undertaken both during and at the conclusion of the research study to further bolster the study's credibility. To ensure both dependability and confirmability, an audit trail and field notes were maintained. Relevant direct quotes from participants were used to facilitate the possible transferability of findings for the reader.

7. Results

As previously noted, demographic data pertaining to the sample were collected. All participants identified as cisgender female; none self-identified as LGB to the researcher. The NPs were aged 30-49 years (14%), 40-59 years (73%) and older than 60 years (14%). Most participants (91%) identified their ethnicity as Caucasian. All had at least a Master degree in nursing or nursing science; three had a doctoral degree (PhD or DNP) completed or in progress. The majority of participants (82%) had completed a Canadian-based NP program, whereas three (18%) were educated in countries outside of Canada. Most participants (82%) had five years or more of experience as a NP.

All but one participant was licensed as a Family/All Ages NPs; the other was licensed as an adult NP. The NPs were employed in a wide variety of practice settings in both hospital and community settings. While the majority worked in organizations governed by provincial Health Authorities, there were several participants employed in either not for profit or other governmental or non-governmental organizations. The NP participants provided care to

patients of all ages; none were currently employed in either exclusively pediatric or long-term care settings. Participants varied greatly in the estimated or reported percentage of their practice that was comprised of members of the LGBT community (between 1-50%). The majority acknowledged that they had no formal mechanism for identifying LGBT patients; instead, they relied on assumptions based on patient appearance or behaviour, or patient disclosure.

Most NPs (91%) did not recall receiving any LGBT-specific content in their NP education program. Of those participants who reported that their NP program did contain LGBT-specific material (9%), the contact was described as only minutes to a few hours, primarily focused on sexual or psychosocial health. This resulted in lack of knowledge regarding concepts related to LGBT health, such as appropriate terminology (what do all those letters mean? How do I ask about 'that'?) or an understanding of what it meant to be cisgender or transgender. These factors can be a potential barrier to therapeutic communication and the development of the nurse-patient relationship. Continuing education or training related specifically to LGBT health was also lacking. Only two participants (9%) reported participating in or receiving LGBT-specific continuing education since the completion of their NP program.

7.1. Cultural competence

One of the objectives of this research was to examine how NPs demonstrate cultural competence in providing care to members of the LGBT community. Participants were asked "can you tell me how you feel you demonstrate cultural competence when caring for LGBT patients?" This discussion frequently started with asking NPs whether they thought that LGBT patients belonged to a distinct cultural group.

Heather: Yes, I would say they have their own culture. I think they'd agree, they have their own. It's a very tight knit community and yes, I would say they do, for sure.

Olive: Definitely, yes absolutely. I think it's so fascinating.

Some NPs shared that they did not consider LGBT people as belonging to a distinct cultural group, For these participants, describing how they provided culturally competent care assumed a different meaning in which they defaulted to the principle of not treating LGBT patients differently than heterosexual or cisgender patients. This was viewed as a way of providing culturally competent care, a finding that emerged in numerous interviews.

Monica: I don't really think it changes the care I provide…I would treat them just like I would any other patient…I don't treat them any different than anybody else.

Danielle: That's a tough one. With regards to cultural (competence), and I guess I don't want to, you know, my whole idea is that if you are gay or if you are lesbian if you come in with something, I'm going to treat you exactly the same way as I would treat somebody that wasn't. Why do I have to pick them apart? And that's why I try to, I'm not going to change my treatment plan, the way I'm going to talk to you, because you're a lesbian.

Interestingly, many NPs interviewed seemed to be unfamiliar with specific principles of cultural competence, or appeared at a loss for words when asked this question. Several NPs directly stated that they were not clear what the term cultural competence meant. When this occurred, they were provided with the CNA's definition of cultural competence to facilitate the discussion. Others appeared to confuse cultural competence with the development and

maintenance of a therapeutic relationship, or mainly articulated very general components of culture such as language or religious beliefs in the context of immigrant populations.

Beth: I don't know what to say to that one. I feel that, cultural competence? I'm at a loss, I don't know, I'm at a loss for that one.

Melanie: I mean, I've read about that before, but it would just be, trying to be empathic, and respectful and trying not to judge anybody else's position. Yes, I guess that's kind of how I go about it.

7.2. Cultural competence models

Another important finding of this study was the fact that most participants were not familiar with any models of cultural competence, or how they were applicable to clinical practice. The majority (91%) of NPs interviewed stated that they did not use a conceptual or theoretical model of cultural competence to guide their practice.

Joan: No, I'm afraid not

Beverly: I'm embarrassed to say so, but no

Heather: I think probably when we were learning about cultural competence, it would have been helpful.

Despite this, NPs reported that they felt they were culturally competent in the care that they delivered to LGBT patients.

Beth: I think I am culturally competent.

Monica: But also just looking at like, you know the basics that we are taught in nursing school as far as being non-judgmental and the holism that we use, I think those things have allowed me to be culturally competent to the patients.

When NPs were asked how they demonstrated cultural competence with LGBT patients without the use of a particular model, they highlighted principles of equity, justice, and inclusivity. In particular, NPs discussed concrete and practical strategies that they associated with being culturally competent, including providing a safe and welcoming environment, not treating LGBT patients differently, being respectful, and being careful with language so as not to offend.

Kathy: So inclusivity - making people feel that, you know everyone is welcome here, so it's not just for full-time or part-time or heterosexual (patients), this is a safe space for all, which I guess would also fall into the category of equity. Respect, I feel that as a Nurse Practitioner, I do respect patients' rights every day. I think that we, it's a fundamental core of kind of what I do. So I feel like I demonstrate that every day by whether it's calling him, him when he's biologically a she, by not recognizing, calling and addressing him as such, would be offensive and disrespectful to him. I would never do that. So that would be an example of perhaps of how I've done that (demonstrated cultural competence). I do value differences in my practice.

Beth: That's a good question, I have to think about that, like cultural competence and that means, like how does that, I haven't even looked at that competence for a long time. But to me it doesn't matter what gender, what culture or ethnical group or religion that they're from, that really means nothing to me. Like I would, and I shouldn't say it means nothing to me, like I respect them for whatever of those that, you know, if they are within the LGBT group or if they are, you know, whatever.

8. Discussion

In addition to developing a better understanding of how NPs demonstrate cultural competence in providing care to LGBT patients, this study also was intended to identify potential gaps in NP knowledge or practice, as well as any barriers that impact care delivery. If we examine the construct of cultural competence as identified by 3 prominent theorists, LGBT people meet the criteria of a distinct cultural group. Cultural competence is conceptualized by Purnell as a non-linear transition through four stages, from unconscious incompetence where the provider lacks insight into the needs of diverse cultures, to unconscious competence where culturally-congruent care is provided automatically [20]. Campinha-Bacote's Process of Cultural Competence envisions cultural competence as a process encompassing five constructs, including cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire [21][22]. Leininger's Theory of Culture Care, Diversity and Universality depicts culturally competent care as the knowledge, acts, and decisions used sensitively and appropriately to meaningfully fit the cultural values and beliefs of the individuals being cared for [16][23]. However, the majority of the NP participants in this study did not think of or recognize LGBT people in terms of a distinct cultural group. In fact, a theme that emerged in this study was 'not treating LGBT patients differently', which further perpetuates a heteronormative world-view. For the most part, NPs were not using frameworks or models of cultural competence to guide their practice. Instead, they were more comfortable using more practical strategies primarily involving acceptance and the development and maintenance of therapeutic NP-patient relationships.

The research findings have implications for patient outcomes, as well as for NP education, practice, and research. Although NPs are well positioned to advocate for change within the health care system, they appear to lack specific knowledge related to the LGBT population and associated health and social concerns, all components of cultural competence. There is growing recognition of the gap that exists with provider knowledge about the health concerns experienced by LGBT people, and the implications on the health and well-being of LGBT people. Numerous organizations at the national and international level have begun to address this. The AMA; the Canadian and American Pediatric Societies; the College of Family Physicians of Canada; GLMA: Health Professionals Advancing LGBT Equality; the Society of Obstetricians and Gynecologists of Canada; the World Professional Association for Transgender Health (WPATH); and the World Health Association (WHO) have all provided recommendations or created guidelines for the care of LGBT people [26][32][33][34][35][36][37][38].

Other groups have spoken out or issued official statements calling for more progressive training and approaches to ensuring that the health and social needs of LGBT people are recognized and addressed by health care and social service providers. The Canadian Nursing Students' Association released a position statement in 2013 stressing the importance of incorporating LGBT education into nursing curriculum. In part, their statement highlights that the lack of LGBT specific training makes it difficult for nursing students (and future registered nurses and NPs) to provide holistic, patient-centered care to the LGBT community [39]. Similarly, the Canadian Federation of Medical Students issued a statement on improving healthcare for LGBTQ populations [40]. The American Nurses Association (ANA) recently committed to promoting strategies that educate nurses on patient care and cultural sensitivity specific to the LGBT community, with the goal of achieving culturally competent and non-discriminatory care of LGBT persons[41]. This includes the development and implementation of a nursing curriculum and toolkit that allows students to develop competence through

empirically-derived understanding of the complex societal and cultural causes of health disparities [42]. The Canadian Nurses Association has published a position statement on cultural competence and respecting diversity [3], and the Canadian Association of Schools of Nursing state that they are committed to "developing inclusive policies and statements that challenge discrimination and cisnormative behaviour". A recently published competency framework on nursing care of the childbearing family includes the importance of promoting "sensitivity, inclusion, and respect for all people including but not limited to transgender, non-binary, intersex, and for all marginalised communities" [43]. However, neither major nursing organization has a formal position statement or guidelines available on their website that relates specifically to the integration of LGBT specific education or competencies in nursing curricula.

Researchers have examined LGBT-specific curriculum content in medical and nursing education to assess the degree to which new health professionals are acquiring information and skills relevant to treating LGBT patients To date, inclusion of LGBT health in both medical and nursing curricula has typically been lacking [44][45][46]. LGBT-related curricula content at 176 allopathic and osteopathic medical schools in both Canada and the US was evaluated. Findings determined that the median time dedicated to LGBT-related content was five hours over the entire curriculum. One-third of schools reported no LGBT content whatsoever during students' clinical years, and 78% of schools did not offer LGBT-specific clinical experiences. Many of the survey respondents expressed dissatisfaction with the coverage of LGBT-related content in their institution, and identified the availability of faculty willing and able to teach it as a strategy for potentially increasing LGBT-related content in the curricula[44]. A national survey of baccalaureate nursing programs in the U.S assessed faculty knowledge, experience, and readiness for teaching lesbian, gay, bisexual, and transgender health. Findings demonstrated that faculty knowledge was limited, and that the estimated median time devoted to LGBT health throughout the baccalaureate program was 2.12 hours [47]. Another study published in 2015 stated that 79% of nurse informants reported having received no LGBT patient-centered care education or training [48]. When nurse educator attitudes toward homosexuality were examined, it was found that most participants had positive attitudes toward LGBT people, and the importance of teaching LGBT-related content to nursing students was acknowledged. However, most faculty considered themselves unprepared with regard to knowledge, skill, and tools to deliver this material [49]. These research studies highlights the circular nature of this issue that is applicable to all health care professions. The lack of meaningful, comprehensive, and progressive LGBT specific content in health care curricula has significant and inter-related consequences. If health educators lack sufficient knowledge and understanding regarding the specific health needs of LGBT persons, they are unable to impart this knowledge to the future generations of healthcare providers.

As noted above, research supports that healthcare providers are often ill-prepared educationally to address the healthcare needs of members of the LGBT community across the lifespan. Lack of familiarity with the concepts of sexual orientation, gender identity, and LGBT-specific terminology have been identified as a barrier between health care providers and LGBT patients [50][51][52]. Recent studies have examined strategies to address this deficit. Clinical training on physiological and psychosocial components of LGBT health, experiential learning, and communication skills have been identified as essential provider qualities for improving the sexual health of LGBT people [45]. The baseline knowledge and understanding of LGBT health exhibited by upper-year nursing students, as well as their knowledge and skill after an educational assignment intervention aimed at increasing

knowledge of LGBT health issues, was assessed. Results demonstrated that 40% of nursing students felt unprepared to care for LGBT patients pre-intervention, with 85% stating that they had not been prepared by their nursing education program. Post-intervention, 74% of students stated they were more aware of LGBT issues, although they recognized that they still had a lot to learn [48]. Lack of knowledge regarding sexual and gender minority groups can be an obstacle to open communication, and can leave health care providers feeling ill-equipped to care for LGBT patients. Other educational and student support strategies have been suggested, including use of high-fidelity simulation, case studies in which the client is LGBT, and independent study and elective courses. However, adoption of these strategies has been slow [53]. As a component of examining culturally competent LGBT care, an educational program was developed and delivered from current evidence-based practice guidelines for the care of LGBT individuals. Post implementation evaluation demonstrated positive results in improving health care providers' level of cultural competence [54].

It has been suggested that clinical nursing instructors and nurse preceptors assume a lead role in identifying learning opportunities for students related to LGBT health, and that nurses have a professional obligation to intentionally strive to improve health-related encounters for LGBT people [46] Using a student-faculty partnership model, transgender health content was developed and successfully incorporated into five required nursing courses in a baccalaureate nursing program. Feedback on this approach was positive from faculty and students [56]. Recent works have described the implementation of a model of preparing NPs for competence in providing sexual health care, including with LGBT people, and how students have enthusiastically received this [57][58]. These research studies serve to emphasize the existing lack of LGBT-specific content in nursing curricula, the potential for didactic and experiential learning opportunities related to LGBT health, as well as the barriers that may require further consideration and investigation.

We know that LGBT people continue to fear discrimination in health care environments, and may experience challenges in accessing care where they are understood, accepted, and well cared for [59]. A lack of sufficiently educated and culturally sensitive nursing professionals is a factor in the continued marginalization of this patient population. Health care providers such as NPs have a key role to play in improving the health and well-being of LGBT people; however, this can only be achieved if they receive the education and training necessary to recognize and address the health and social needs of members of the LGBT community in a culturally sensitive way. Including up-to-date, accurate, evidence-based information regarding sexual orientation and gender identity in nursing education curricula is essential to developing a nursing workforce that is culturally competent in caring for LGBT patients. Additional teaching and learning strategies including case studies and simulation with a LGBT focus, inviting LGBT individuals as guest speakers, panel discussions, and information on available supports and resources can all facilitate this process.

9. Potential limitations of the study

While qualitative description can provide rich, detailed description, assisting in the understanding of human experiences, a potential limitation is that it does not stray far from the data to assign meaning or develop theory [29]. For the purposes of this research this was not a barrier, as the goal was to explore and describe the experiences of individual NPs. However, it is always possible that the researcher's own perspectives and perceptions may have exerted an influence on the interpretation of the findings. To minimize this, reflexivity and field notes were used during all phases of the research process. They allowed the

researcher to capture and document personal thoughts and impressions, questions, and concerns, which were subsequently used as part of an ongoing internal reflexive dialogue.To further explore the themes and concepts that emerged from a theoretical perspective, additional investigation may be warranted.

Several of the research participants had past professional working relationships with the PI. While this facilitated the building of rapport, it also is possible that this could have influenced some NPs' decision to participate in the study, or to respond in a way that they perceived the researcher would want to hear. Being an NP did provide the PI with insider knowledge and insight into how NPs practice. Particular attention was given to ensuring that the pre-existing assumptions of the researcher did not interfere with, or overshadow, the experiences of the participants. However, it does remain that the PI is an NP with an interest in LGBT health. Therefore, it is possible that this did exert influence during data analysis, despite these deliberate efforts to mitigate this possibility.

This study highlights the experiences of a group of NPs in a particular geographic area in Canada, and may not reflect the perspectives of NPs working in other geographic locations. The sample was relatively homogenous, consisting predominantly of Caucasian women, age 30-50 years, with a Master degree in nursing. This is not generally a concern with qualitative research, where the goal is to provide rich description of a phenomenon among a known group and generate insights that can be explored further [60]. Additional studies examining the practice experiences of a broader group of NPs could provide further illumination. Finally, there was the potential for volunteer bias. It may be that the NPs who volunteered to participate had more positive attitudes with regard to LGBT people, or wished to share positive encounters they experienced with LGBT patients.

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