

# Experiences of family and community doctors in the health care of lesbian, gay, bisexual and transgender patients

Experiências de médicos de família e comunidade no cuidado com a saúde de pacientes lésbicas, gays, bissexuais, travestis e transexuais

*Experiencias de médicos de familia y comunitarios en el cuidado de la salud de los pacientes lesbianas, gays, bisexuales y personas transexuales*

Joao Antonio Smania Gomes<sup>1</sup> , Zeno Carlos Tesser Junior<sup>2</sup> 

<sup>1</sup>School of Public Health of Florianópolis – Florianópolis (SC), Brazil.

<sup>2</sup>Universidade Federal de Santa Catarina – Florianópolis (SC), Brazil.

## Abstract

**Introduction:** The lesbian, gay, bisexual, transvestite and transsexual community and its health-related particularities were ignored for many years. Although homosexuality and transsexuality are no longer considered diseases, the marginalization of many lesbians, gays, bisexuals, transvestites and transsexuals at the socioeconomic-cultural level and with regard to access to health services still prevails. As to access to health care, the first contact of lesbian, gay, bisexual, transvestite and transsexual patients within the health care system can be through the family doctor. **Objective:** To analyze the experiences of family and community doctors with lesbian, gay, bisexual, and transgender people in the primary care scenario of the public health network in a city in southern Brazil. **Methods:** In July 2019, two focus groups were arranged (13 professionals in total), one of which consisted of 6 self-declared heterosexual and cisgender family doctors and another group consisting of 7 self-declared lesbian, gay, bisexual and transgender family doctors. **Results:** Participants considered the issue of lesbian, gay, bisexual, and transgender health in primary care important, but added that it was very little studied in their undergraduate/graduate training. They reported that the main demands of lesbian, gay, bisexual and transgender patients are mental health, violence and sexually transmitted infections. They pointed out that they have difficulties in addressing issues involving sexuality and gender identity during their office visits. **Conclusions:** The results reinforce the need for family and community doctors to understand better specifics of the lesbian, gay, bisexual, and transgender population. It is suggested that the health issues of the lesbian, gay, bisexual, and transgender population be more taught in undergraduate and graduate medical courses.

**Keywords:** Sexual and gender minorities; Family practice; Primary health care.

### Corresponding author:

Joao Antonio Smania Gomes  
E-mail: joaosmania@gmail.com

### Funding source:

Not applicable.

### CEP approval:

CAAE 16080619.4.0000.5360.

### Origin:

Not requested.

### Peer review:

External.

Received on: 21/02/2020.

Accepted on: 07/11/2021.

**How to cite:** Gomes JAS, Tesser Junior ZC. Experiences of family and community doctors in the health care of lesbian, gay, bisexual and transgender patients. Rev Bras Med Fam Comunidade. 2022;17(44):2407. [https://doi.org/10.5712/rbmfc17\(44\)2407](https://doi.org/10.5712/rbmfc17(44)2407)



## Resumo

**Introdução:** A comunidade lésbicas, gays, bissexuais, travestis e transexuais e suas particularidades associadas à saúde foram ignoradas por muitos anos. Embora a homossexualidade e a transexualidade não sejam mais consideradas doenças, ainda prevalece marginalização de muitas pessoas lésbicas, gays, bissexuais, travestis e transexuais a nível sócio-econômico-cultural e de acesso aos serviços de saúde. No que tange ao acesso à saúde, o primeiro contato do paciente Lésbicas, Gays, Bissexuais, Travestis e Transexuais dentro do sistema de saúde pode ser através do médico de família e comunidade. **Objetivo:** Analisar as experiências dos médicos de família e comunidade no atendimento às pessoas lésbicas, gays, bissexuais, travestis e transexuais na atenção básica da rede municipal de saúde em uma cidade no Sul do Brasil. **Métodos:** Desenvolveram-se dois grupos focais (13 profissionais no total), um deles constituído de seis médicos de família e comunidade autodeclarados heterossexuais e cisgêneros e outro grupo constituído de sete médicos de família e comunidade autodeclarados lésbicas, gays, bissexuais, travestis e transexuais, em julho de 2019. **Resultados:** Os participantes consideraram importante a temática da saúde lésbicas, gays, bissexuais, travestis e transexuais na atenção primária, embora ela tenha sido pouco explorada nos seus cursos de graduação. Relataram que as principais demandas dos pacientes lésbicas, gays, bissexuais, travestis e transexuais são as de saúde mental, violência e infecções sexualmente transmissíveis. Apontaram que possuem dificuldades em abordar questões que envolvem sexualidade e identidade de gênero em suas consultas. **Conclusões:** Os resultados reforçam a necessidade de os médicos de família e comunidade conhecerem especificidades da população lésbicas, gays, bissexuais, travestis e transexuais. Sugere-se que a temática da saúde da população lésbicas, gays, bissexuais, travestis e transexuais seja mais ensinada nos cursos de graduação em Medicina.

**Palavras-chave:** Minorias sexuais e de gênero; Medicina de família e comunidade; Atenção primária à saúde.

## Resumen

**Introducción:** Introducción: La comunidad lesbiana, gays, bissexuales, travestis y transexuales y sus particularidades relacionadas con la salud fueron ignoradas durante muchos años. Si bien la homosexualidad y la transexualidad ya no se consideran enfermedades, aún prevalece la marginación de muchas personas lesbianas, gays, bissexuales, travestis y transexuales en términos socio-económico-culturales y de acceso a los servicios de salud. En cuanto al acceso a la asistencia sanitaria, el primer contacto de las pacientes lesbianas, gays, bissexuales, travestis y transexuales dentro del sistema sanitario puede ser a través del médico de familia y comunidad. **Objetivo:** Analizar las experiencias de los Médicos de Familia y Comunidad en el cuidado de las personas lesbianas, gays, bissexuales y personas transexuales en la atención primaria de la red de salud municipal en una ciudad del sur de Brasil. **Métodos:** Se desarrollaron dos grupos focales (13 profesionales en total), uno de los cuales consistió en 6 Médicos de Familia y Comunidad autodeclarados heterossexuales y cisgénero y otro grupo compuesto por 7 Médicos de Familia y Comunidad lesbianas, gays, bissexuales y personas transexuales autodeclarados en julio de 2019. **Resultados:** Los participantes consideraron que el tema de la salud lesbianas, gays, bissexuales y personas transexuales era importante en la atención primaria, aunque fue poco explorado en sus cursos de formación. Informaron que las principales demandas de las pacientes lesbianas, gays, bissexuales y personas transexuales son la salud mental, la violencia y las infecciones de transmisión sexual. Señalaron que en sus consultas tienen dificultades para abordar cuestiones relacionadas con la sexualidad y la identidad de género. **Conclusiones:** Los resultados refuerzan la necesidad de que los Médicos de Familia y Comunidad conozcan las especificidades de la comunidad lesbianas, gays, bissexuales y personas transexuales. Se sugiere que el tema de salud lesbianas, gays, bissexuales y personas transexuales sea más enseñado en la formación médica.

**Palabras clave:** Minorías sexuales y de género; Medicina familiar y comunitaria; Atención primaria de salud.

## INTRODUCTION

The lesbian, gay, bisexual, transvestite and transgender (LGBT) community and its health-related particularities were ignored for many years.<sup>1</sup> The simple fact of identifying as a gay man or a lesbian woman was considered a disease until the beginning of the years 1970 by the American Psychiatric Association (AAP)<sup>2</sup> and until the early 1990s by the World Health Organization (WHO).<sup>3</sup> Furthermore, trans people were classified by the WHO as having a gender identity disorder until 2018. It was then that this characteristic was no longer classified as part of the scope of mental illness and was treated as a “condition related to sexual health” in the update of the International Code of Diseases (ICD-11).<sup>4</sup>

Although homosexuality and transsexuality are no longer considered diseases by the health sciences, a culture of misinformation on the subject still prevails, built over the years and that generates prejudice and determines the marginalization of many LGBT people at a socioeconomic-cultural level and with regard to access to health services.<sup>5</sup>

As important social determinants of health, it is essential to differentiate between sexual orientation and gender identity.<sup>5</sup> Sexual orientation “(..) is the ability to have, feel or develop attraction and/or emotional, affective or sexual relationships with other people”,<sup>6</sup> where it can be classified (in a binary gender system — male and female) as homosexual (people of the same gender being attracted), heterosexual (opposite genders being attracted) and bisexual (attraction to both genders).

On the other hand, gender identity “(..) is the expression of an identity constructed from how the person recognizes and/or presents themselves, which may or may not correspond to their biological body”,<sup>6</sup> regardless of body modifications, which may or may not exist. There are numerous identities described, including trans men and women, transvestites, queers, non-binary people, etc. It is noteworthy that there is no direct association between sexual orientation and gender identity; for example, trans people can be straight, gay or bisexual.<sup>5</sup>

We refer to transgender people in this article as those who identify with a different gender than that determined at birth; for example, a trans woman, at birth, was determined to be male by typical male genitalia, but identifies as female, so she is a trans woman. Another example is a trans man, at birth determined as a woman by the typical female genitalia, but he identifies himself as a man is therefore a trans man. Cisgenders (the term “cis” comes from Latin and means “on the same side as”) are people who recognize their own gender identity according to their biological sex. So cisgenders are men so designated by typical male genitalia at birth who identify with the male gender; or women so designated by their genitalia at birth who identify with the female gender.<sup>7</sup> We also emphasize that heteronormativity will be referred to as a system in which romantic relationships and sexual conduct are constituted between cisgender men and women, in a heterosexual way, and which is understood as the culturally accepted “natural” order.<sup>8</sup>

Gender identity and sexual orientation were included in the analysis as social determinants of the health of the LGBT population at the 13th National Health Conference, in 2007. This conference resulted in a series of recommendations to health professionals regarding care for the LGBT population. In subsequent years, the National Comprehensive LGBT Health Policy (PNSILGBT) was approved, which further strengthened the theme and care guidelines for this population.<sup>9</sup>

Regarding access to health care, the first medical contact of the LGBT patient in the health system may be through one of the specialties that most routinely deals with social minorities in health: the family and community doctor (FCD). Among the attributes associated with this specialty of medicine, the FCD must promote broad and unlimited access to users, dealing with all types of health problems regardless of age, gender or any other patient characteristic.

The FCD, with such specialty, must also, by definition, promote patient empowerment, develop the continuity of care in a longitudinal way, as well as dealing with health problems in their physical, psychological, social, cultural and existential dimensions.<sup>10</sup>

Considering the numerous health disparities experienced by the LGBT population,<sup>11</sup> the aim of the present study was to analyze the experiences of FCD with LGBT people in relation to medical care provided in primary care, that is, in the Basic Health Units (UBS) of the municipal network.

Accordingly, we relied on experiences of FCD who self-declared belonging to the LGBT group and of FCD who self-declared being heterosexual and cisgender, comparing them to observe the issues/experiences with the LGBT population in everyday life. The objectives of this research also included establishing what contact the participants had with the LGBT issue in formal medical education and to know the main challenges and advances that the FCD highlight in the care of this population.

The scientific literature has focused more on the experiences of prejudice and stigmatization that LGBT people suffer in health services and less on the experiences that medical professionals have in caring for these people. Therefore, knowing the experiences of FCD in the care of LGBT patients contributes to the possibility of thinking about different angles and perspectives on the health of the LGBT population. After all, FCD are also interested in giving visibility to the demands and health situations that occur in their daily professional activities.

## METHODS

A qualitative study was carried out with two focus groups. According to Minayo,<sup>12</sup> the focus group is “(...) a type of interview or conversation in small and homogeneous groups”, and it can complement participant observation and semi-structured interviews and is useful for the formation of collective opinion and the formation of consensus. According to Barbour,<sup>13</sup> more than a group interview, it is a way of analyzing the interaction between the participants, which must be at least six per group.

The research subjects were 13 FCDs working in the municipal health network of a city in the southern part of Brazil. One group was composed of seven FCDs who self-identified as LGBT, and the other comprised six FCD who self-identified as cisgender heterosexuals. No participant declared being transgender. The characteristics of the participants, identified by codes to preserve the confidentiality of their identities, are described in Table 1.

**Table 1.** Characterization of family and community doctor participants of focal group.

Identification of participant	Group	Age	Gender identity	Sexual orientation	Marital status	Time as FCD
P1	LGBT FCD	29	Woman	Lesbian	Single	2
P2	LGBT FCD	52	Woman	Lesbian	Married	20
P3	LGBT FCD	32	Woman	Bisexual	Married	6
P4	LGBT FCD	32	Woman	Bisexual	Single	2
P5	LGBT FCD	40	Man	Gay	Single	12
P6	LGBT FCD	35	Man	Gay	Married	6
P7	LGBT FCD	28	Man	Gay	Single	2
P8	N-LGBT FCD	45	Woman	Heterosexual	Divorced	18
P9	N-LGBT FCD	32	Woman	Heterosexual	Married	4
P10	N-LGBT FCD	32	Woman	Heterosexual	Married	5
P11	N-LGBT FCD	43	Man	Heterosexual	Married	10
P12	N-LGBT FCD	44	Man	Heterosexual	Married	9
P13	N-LGBT FCD	42	Man	Heterosexual	Married	10

FCD: family and community doctor; LGBT: lesbian, gay, bisexual, transvestite and transsexual.

The focus groups were created by contacting those responsible for the FCD in the municipality, who kindly disclosed the invitation to participate in the research to the other FCD members of the municipal network. The inclusion criteria were: being a doctor with a degree in Family and Community Medicine working in the primary care network, having voluntarily declared themselves as LGBT or heterosexual and not having conflicts of interest with the study theme.

FCD who showed an interest in participating and who self-declared being LGBT were placed in the “LGBT FCD” group, while those who self-declared as heterosexual were placed in the “N-LGBT FCD” group. Participants were separated in this way to give both groups a voice among their peers, so that there was no risk of suppression of opinions or speech by either party. In this way, the homogeneity of the groups was privileged, which according to Westphal<sup>14</sup> results in the deepening of the discussions as the participants talk about their specific place in society.

In the initial part of this study, the semi-structured script used in the focus groups was planned. This script was identical for both groups and composed of five topic guides, which are shown below.

1. How do LGBT issues appear in your daily life as a FCD in primary care?
2. When and how do you address patients' sexual orientation and gender identity in office visits?
3. What challenges do you perceive in relation to the LGBT issue as an FCD in primary care?
4. What advances do you perceive in relation to the LGBT issue as an FCD in primary care?
5. Do you have any suggestions for improving service to the LGBT population in primary care?

Each group participated in a meeting for the fulfillment of the focus groups, which took place on separate dates, at night, in July 2019. The location of the two meetings, one for each group, was a UBS in the city where the study was carried out. The duration of each meeting was approximately 90 min. Before starting the focus groups, the participants answered questions that aimed to determine their sociodemographic profiles.

The focus groups were carried out by two researchers. One of them was responsible for moderation; thus, when necessary, he encouraged the participation of all, limited the predominance of some participant and restricted the conversation to the scope of the study. Meanwhile, the other researcher, without interacting with the group, had the role of reporter, writing down the opinions, experiences, observations and other questions raised by the participants. It is noteworthy that both researchers did not show any kind of judgments during the meetings.

The participants' speeches were captured on audio using a digital recorder. The following day, all of them were transcribed in full by the groups' reporter. After conducting the focus groups, the researchers met for a discussion about the data collected.

For data analysis, thematic analysis was used, as suggested by Minayo,<sup>12</sup> carried out in three stages. In the first stage, the pre-analysis, after exhaustive reading of the collected material, keywords and important phrases were selected that would be used as context units, based on which the clippings, categorization and coding of the data would be made, as well as the selection of theoretical concepts.

In the second stage, the exploration stage, the material was categorized, where the text was reduced to speeches or expressions considered significant, which were classified and grouped into eight thematic categories, shown in the results. In the third stage, the processing and interpretation of data, the meanings of the raw results were worked out, from which inferences and interpretations were made. It is noteworthy that we opted for the variant of the technique that does not subject the data to statistical operations, as suggested by Minayo.<sup>12</sup>

The present study was approved by the relevant Ethics Committee for Research with Humans according to the Certificate of Presentation for Ethical Assessment (CAAE) 16080619.4.0000.5360 and by the Commission for Monitoring Health Research Projects of the Municipal Department of the city where the study took place. All participants signed an informed consent form.

## RESULTS AND DISCUSSION

On the basis of thematic analysis, the following thematic categories emerged from the participants statements:

1. importance of the LGBT issue in primary care;
2. mental health of LGBT people;
3. domestic violence against the LGBT population;
4. sexually transmitted infections (STIs);
5. FCD's difficulty in addressing issues involving sexuality and gender identity;
6. teaching LGBT issues and hidden curriculum in medicine courses;
7. advances and challenges in health care for the LGBT population; and
8. suggestions for improving service to the LGBT people.

We emphasize that methodological limitations are common in research carried out on LGBT subject around the world, either due to the lack of interest in participating in the research, or the fear that people have of being victims of prejudice when participating in them. Another limitation is that FCD were self-selected for this study through an invitation, so our sample may not represent the experience of all FCD but of those who are already more familiar with and attentive to the health demands of LGBT people.

### **1. Importance of lesbian, gay, bisexual, transvestite and transsexual issues in primary care**

All participants, from both groups, considered the issue of LGBT health to be important. In the group of cisgender heterosexuals, it was highlighted that in the city where the study was conducted, there is an outpatient clinic that serves the transgender/transvestite population in primary care. The aforementioned outpatient clinic was established voluntarily by FCD residents who experienced a similar practice in an internship in Uruguay, having been taken over and expanded by other FCD.<sup>14</sup>

### **2. Mental health of lesbian, gay, bisexual, transvestite and transsexual people**

Regarding the main ways in which they observe the demands related to sexual orientation and gender identity, both groups reported the association with complaints related to patients' mental health, either as suffering from non-acceptance in the family from difficulties in their own acceptance and substance abuse.

Such data are in agreement with the world literature, which shows that lesbians, bisexuals and gay men are 1.5 times more likely to develop anxiety and depression than heterosexuals, with the chance of suicide attempts being four times greater in gay and bisexual men when compared to heterosexuals.<sup>15</sup> The risk of suicide in the transgender population is even greater. A national survey found that 41% of transgender respondents had attempted suicide, with even higher rates in younger individuals.<sup>16</sup>

Another form of mental distress can appear in substance abuse, which is also more common among LGBT people: lesbian and bisexual women have higher rates of tobacco use and passive exposure to tobacco, in addition to alcohol and chemical dependence.<sup>17</sup> An American study showed that, compared



to heterosexuals, the odds of lifetime substance abuse were three times higher in lesbian women and 1.6 times higher in gay men.<sup>18</sup> In the trans population, the abuse data are even higher and the chemical substances used even more varied and dangerous.<sup>16</sup>

### **3. Violence against the lesbian, gay, bisexual, transvestite and transsexual population**

The issue of violence against LGBT people also appeared as a demand of LGBT people in primary care, according to the FCD participants in the study. It is worth noting that domestic violence — physical, psychological or sexual — is as prevalent as in heterosexual relationships, with US studies showing a significant percentage of same-gender couples who reported this type of violence.<sup>19,20</sup> However, in relation to external violence, the Trans Murder Monitoring.<sup>21</sup> project documented more than 2,000 murders in 66 countries between 2008 and 2016, the equivalent of one murder every two days.

In Brazil, the Gay Group of Bahia (GGB)<sup>22</sup> produces annual reports on LGBT people killed as victims of homophobia. In the data released by them, since the 2000s, an increase in this accounting can be seen. In 2018, there were 420 deaths, with a predominance of gays, followed by trans/transvestites and lesbians. By the method of collecting data from the GGB, which is given by news about homophobic violence, it is therefore understood that there is an underestimation of these data.

When analyzing the data available from the Ministry of Health (MS), available in TabNet Win32 3.0, it is observed that between 2012 and 2016 the rise in the number of homicides against LGBT increased in Brazil. When compared to the general population, in the same period, the number of homicides against LGBT people was 13 times higher. These crimes are a public health problem that most often victimizes young people, especially transgender people.<sup>23</sup>

### **4. Sexually transmitted infections**

Another important point highlighted by the two groups of participants was the high number of gay patients with human immunodeficiency virus (HIV). A participant from the LGBT FCD group reported that in the area assigned to his team, most homosexual male patients with open sexuality to the community attended the Health Center for the treatment of chronic HIV infection. Regarding STIs of the HIV virus, there was an increase in detection in Brazil between the years 2007 and 2017, mostly among males in homosexual and bisexual relationships, with an increase in detection in the age group of 13–39 years. Female infection, on the other hand, was concentrated in heterosexual relationships (>95%).<sup>24</sup> It is important to note that many times, homosexual cisgender men are protagonists of scientific studies with this focus alone. A review of research projects funded by the US National Institute of Health (NIH) in 2014, which evaluated 628 studies between 1998 and 2011 related to LGBT health, showed that nearly 80% of these studies focused on HIV/AIDS. The study concluded that the NIH's lack of LGBT health-related research contributes to the perpetuation of health inequities.<sup>25</sup>

### **5. Difficulty of FCD in approaching issues that involve sexuality and gender identity**

When asked how they approach sexual orientation and gender identity, both groups differed in their responses and experiences. In both groups, members reported that they were not in the habit of routinely asking their patients about their sexuality or gender identity, while others reported asking all of their patients

at relevant appointments, such as “routine office visits”. A participant from the LGBT group spoke about his difficulty:

“I was going to talk about this issue of heteronormativity, I think that even though I’m a gay man, I often think I slip a little in the approach. We even discussed with the residents recently about the time of the office visit, how to approach it in a way that is calm, because of the hurry it sometimes gets rushed” (P6).

The LGBT focus group agreed with this attitude, and participants added that they believed that the power of empathy of LGBT doctors is greater because they also feel prejudice in their skin, but they have difficulties because they are not trained. One of the participants reported that he felt that he was invading the patient’s privacy. Another reported:

“It’s something projected over time, now aware of it, the movement I make is to try to deconstruct it and approach it as naturally as possible ‘do you have a person?’, ‘do you have sex with men? And with women?’ It’s natural” (P3).

Participants in both groups reported experience with lesbian and bisexual women in which they assumed heteronormativity and offered contraceptive methods to these patients. Brazilian data also show the difficulty in accessing health services by lesbian and bisexual women. About 40% of them did not reveal their sexual orientation. Among those who did, 28% reported faster medical care<sup>26</sup>

## **5. Teaching lesbian, gay, bisexual, transvestite and transsexual issues and hidden curriculum in medicine courses**

Participants in both groups were unanimous in recognizing the lack of content on the health of LGBT people in formal teaching in medicine, both in undergraduate and specialization courses. However, only in the LGBT FCD group were issues of the LGBT theme identified as part of a hidden curriculum that took place after homophobic demonstrations by teachers.

Hidden curriculum is understood as the learning experiences about norms, values and tendencies that take place in the routines and social relations that surround the institutional teaching spaces, without being manifest in the formal curricula of the courses.<sup>27</sup> An example was the expression “this is the fruit”, said by one of the participants’ teachers when a gay patient left the office.

Participants in the LGBT FCD group also pointed out that the discussions about the specialties they would do after graduating were loaded with prejudice. When, for example, a male student declared an interest in pediatrics, he would hear comments such as: “He is not a man, because he chose a specialty that is for women” (P5).

Another participant cited the teaching of approaching the homosexual patient as a risk group: “(...) when the patient identified themselves as homosexual, we should approach STIs and serology; now if he was heterosexual and married, there would be no need to” (P7).

Such attitudes perceived and highlighted by the LGBT FCD group during their graduation perpetuate prejudices that, in turn, contribute to inferior health care for these minorities, in addition to maintaining misconceptions for teaching future generations of health care workers.<sup>28</sup>



In this sense, it is important to pay attention to the fact that medical students have high rates of prejudice against LGBT people. In 2017, a study with 391 undergraduates from the first to the eighth semester of Medicine at a public university in the southern region of Brazil showed, for example, that 74.9% of students agreed that sex between two men is wrong and that 83.9 % stated that masculine girls should receive treatment.<sup>29</sup>

## **6. Advances and challenges in health care for the lesbian, gay, bisexual, transvestite and transsexual population**

In both groups, participants cited the difficulty of accessing health services as the main challenge in health care for LGBT people. They emphasized that prejudice can start at the reception, even before the person arrives at the doctor's office, when, for example, the gender identity and social name of a trans person are not respected by security guards and receptionists.

A survey of different health workers such as dentists, nurses and community agents from a municipal health network showed that they have social representations of LGBT people established in religious and heteronormative morals, relating them to stereotypes, STIs and promiscuity.<sup>30</sup>

The groups expanded the notion of difficult access to the prejudice present in society. A participant in the N-LGBT FCD group reported:

“(...) I consider myself a slightly more enlightened person and this maybe makes it difficult for me to recognize it, but even so I have prejudice, I think we are always looking, “why did you do that, why did you act like that, and didn't act like that? how do you usually act?”, I think we have to be careful, the prejudice of the team, the prejudice of society, this brings a lot of difficulty, there are reports of many people who did not seek the health center in the neighborhood because they are ashamed to be in the middle of the close people, but because of previous experiences” (P11).

The notes made by professionals are in agreement with several other world experiences that indicate that LGBT patients experience disparities in health care when compared to the general population,<sup>31</sup> in addition to having less confidence in health services.<sup>32</sup>

When the participants were asked about the advances they perceived in relation to the health issue of the LGBT population, both groups agree that there are advances in society in general, greater discussion of the theme mainly among young adults, greater media exposure dedicated to the subject (such as characters in novels). More specifically in the city of the study, a participant from the N-LGBT FCD group emphasizes that the trans clinic provided training for the professionals who were involved. Such professionals disseminate the LGBT theme more through the health network. Another participant emphasized that having the space to put the social name in the electronic medical record is already an advance.

## **7. Suggestions for improving health service to LGBT people**

Regarding the suggestions that the participating professionals would have for improvements in relation to the LGBT issue, the groups were unanimous in reinforcing the importance of institutionalizing

and formalizing teaching about LGBT health in medical graduation, as well as offering training for all health professionals, whether in the municipal network of health services, or in online courses. They highlighted the importance of valuing the professional who has this knowledge and demanding that they have an ethical posture towards the LGBT patient, as highlighted by a participant of the N-LGBT FCD group:

“I think that, in addition to offering training, demanding that the person be updated with that, but demanding that the person has that attitude, it is no use offering only the certificate (...) that the probationary evaluation would work, even in contemplating this question of ethics and professionalism, this is actually even professionalism, as you are professional, regardless of what life is like” (P9).

The suggestions presented dialogue directly with other studies on the subject found in the world literature, which also suggest as resources for education: the inclusion of LGBT patients in simulated cases to be studied as part of the population variety, the improvement of sexuality studies in the curricula residency and medical graduation, support groups sponsored by educational institutions, institutional guidelines that condemn discrimination widely publicized by health institutions and measures to be taken against individuals who practice LGBTphobia in these environments.<sup>33</sup>

## **FINAL CONSIDERATIONS**

The importance of recognizing sexual orientation and gender identity as social determinants of health explains some of the disparities associated with the health of LGBT people. The different forms of discrimination, including lesbophobia, gayphobia, biphobia, travestiphobia and transphobia, have a profoundly negative impact on the health of those who suffer them, creating difficulties that range from access to the health system to maintaining care. of yourself.<sup>5</sup>

The focus groups with cisgender heterosexual FCD and LGBT FCD participants both presented difficulties with the LGBT issue, ranging from how to approach LGBT health to how to provide quality access to this population, which indicates the fallibility of approaching the subject in institutions teaching health and society's prejudice on the subject, in general.

As future perspectives, further studies on the health of LGBT people are extremely necessary to increase the visibility of the topic, to reduce health inequities for this population, in addition to promoting discussion on the subject in search of the inclusion of their studies in a systematic way in health education.

## **AUTHORS' CONTRIBUTIONS**

JASG: conceptualization, data curation, formal analysis, writing – first draft and writing – review and editing. ZCTJ: conceptualization, data curation, formal analysis, writing – writing – review and editing.

## **CONFLICT OF INTERESTS**

None to declare.

## REFERENCES

1. United Nations. Born free and equal: sexual orientation and gender identity in international human rights law. United Nations: New York and Geneva, 2012.
2. Drescher J. Out of DSM: depathologizing homosexuality. *Behav Sci* 2015;5(4):565-75. <https://doi.org/10.3390/bs5040565>
3. World Health Organization. The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research. Geneva: World Health Organization; 1993.
4. The Lancet. ICD-11: a brave attempt at classifying a new world. *Lancet* 2018;391(10139):2476. [https://doi.org/10.1016/S0140-6736\(18\)31370-9](https://doi.org/10.1016/S0140-6736(18)31370-9)
5. Brasil. Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais. Brasília: Ministério da Saúde; 2013.
6. Brasil. Atenção Integral à Saúde da População Trans. Brasília: Ministério da Saúde; 2014.
7. Aultman B. Cisgender. *TSQ* 2014;1(1-2):61-2. <https://doi.org/10.1215/23289252-2399614>
8. Wieringa SE. Symbolic subversion. *TSQ* 2014;1(1-2):210-2. <https://doi.org/10.1215/23289252-2400046>
9. Brasil. Relatório Final da 13ª Conferência Nacional de Saúde. Brasília: Conselho Nacional de Saúde; 1998.
10. Allen J, Gay B, Crebolder H, Heyrman J, Svab I, Ram P. The European definition of general practice/family medicine. Ljubljana: EURACT; 2005.
11. Tesser-Junior ZC, Kovaleski DF. A invisibilidade das pessoas LGBT na atenção a saúde. In: Figueiredo GLA, Martins CHG, Akerman M, org. Vulnerabilidades e Saúde: grupos em cena por visibilidade no espaço urbano. São Paulo: HUCITEC; 2018. p. 123-31.
12. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 12ª ed. São Paulo: HUCITEC; 2010. 269 p.
13. Barbour R. Doing focus groups. 2007. <https://doi.org/10.4135/9781849208956>
14. Westphal MF. Uso de métodos qualitativos no estudo de movimentos sociais por saúde. In: Spínola AWP, Sá ENC, Westphal MF, Adorno RCF, Zioni F, org. Pesquisa social em saúde. 1ª ed. São Paulo: Cortez Editora; 1992.
15. King M, Semlyen J, Tai SS, Killaspy H, Osborn D, Popelyuk D, et al. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry* 2008;8:70. <https://doi.org/10.1186/1471-244X-8-70>
16. Grant JM, Mottet LA, Tanis J, Herman JL, Harrison J, Keisling M. National transgender discrimination survey report on health and health care. National Transgender Discrimination Survey Report on Health and Health Care; 2010.
17. Cochran SD, Bandiera FC, Mays VM. Sexual orientation-related differences in tobacco use and secondhand smoke exposure among US adults aged 20 to 59 years: 2003-2010 National Health and Nutrition Examination Surveys. *Am J Public Health* 2013;103(10):1837-44. <https://doi.org/10.2105/AJPH.2013.301423>
18. McCabe SE, West BT, Hughes TL, Boyd CJ. Sexual orientation and substance abuse treatment utilization in the United States: results from a national survey. *J Subst Abuse Treat* 2013;44(1):4-12. <https://doi.org/10.1016/j.jsat.2012.01.007>
19. Tjaden P, Thoennes N. Extent, nature, and consequences of intimate partner violence. Atlanta: Centers for disease control and prevention; 2000.
20. Stephenson R, Khosropour C, Sullivan P. Reporting of intimate partner violence among men who have sex with men in an online survey. *Vest J Emerg Med*. 2010;11(3):242-6. PMID: 20882143
21. Transrespect versus Transphobia Worldwide [internet]. 2018 [acessado em 11 jan. 2020]. Disponível em: <https://transrespect.org/en/trans-murder-monitoring/>
22. Michels E, Mott L. Mortes violentas de LGBT no Brasil: relatório 2017. Salvador: Grupo Gay da Bahia; 2018.
23. Mendes WG, Silva CMFP. Homicídios da população de lésbicas, gays, bissexuais, travestis, transexuais ou transgêneros (LGBT) no Brasil: uma análise espacial. *Cien Saude Colet* 2020;25(5):1709-22. <https://doi.org/10.1590/1413-81232020255.33672019>
24. Brasil. Boletim Epidemiológico HIV Aids 2017. Brasília: Ministério da Saúde; 2018.
25. Deschamps D, Singer B, Boylan JF. LGBTQ Stats: Lesbian, Gay, Bisexual, Transgender, and Queer People by the Numbers. New York: The New Press; 2017. 340 p.
26. Facchini R, Barbosa RM. Dossiê saúde das mulheres lésbicas: promoção da equidade e da integralidade. Belo Horizonte: Rede Feminista de Saúde; 2006.
27. Apple MW. Ideologia e currículo. [Internet]. 3ª ed. Porto Alegre: Artmed; 2006.
28. Fallin-Bennett K. Implicit bias against sexual minorities in medicine: cycles of professional influence and the role of the hidden curriculum. *Acad Med* 2015;90(5):549-52. <https://doi.org/10.1097/ACM.0000000000000662>
29. Moretti-Pires RO, Guadagnin LI, Tesser-Júnior ZC, Campos DA, Turatti BO. Preconceito contra diversidade sexual e de gênero entre estudantes de medicina de 1º ao 8º semestre de um curso da região sul do Brasil. *Rev Bras Educ Med* 2019;43(Suppl 1):557-67. <https://doi.org/10.1590/1981-5271v43suplemento1-20190076>
30. Silva ALR, Finkle M, Moretti-Pires RO. Representações sociais de trabalhadores da atenção básica à saúde sobre pessoas LGBT. *Trab Educ e Saúde* 2019;17(2). <https://doi.org/10.1590/1981-7746-sol00197>

31. Makadon HJ. Ending LGBT invisibility in health care: the first step in ensuring equitable care. *Cleve Clin J Med* 2011;78(4):220-4. <https://doi.org/10.3949/ccjm.78gr.10006>
32. Fadus M. Mental Health Disparities and Medical Student Education: Teaching in Psychiatry for LGBTQ Care, Communication, and Advocacy. *Acad Psychiatry* 2019;43(3):306-10. <https://doi.org/10.1007/s40596-019-01024-y>
33. Risdon C, Cook D, Willms D. Gay and lesbian physicians in training: a qualitative study. *CMAJ* 2000;162(3):331-4. PMID: 10693588