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Tasmanian Healthcare Professionals' & Students' Capacity for LGBTI+ Inclusive Care: A Qualitative Inquiry

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Abstract

The health disparities and care needs of lesbian, gay, bisexual, transgender and intersex (LGBTI+) patients are becoming well known. However, healthcare practitioners and medical students across the Global North report limited understanding of this population and express concern about their capacity to meet the needs of LGBTI+ patients. To address these gaps in literature and practice, this study draws on qualitative interviews with 12 clinicians and 5 health professional students exploring their understandings and approaches to LGBTI+ inclusive practice in Tasmania, Australia. Through a reflexive thematic analysis we identified that both practicing clinicians and students did not believe that their training adequately prepared them to treat LGBTI+ patients. Other key *barriers* included reduced awareness of LGBTI+ community needs due to lack of exposure to LGBTI+ patients and unfamiliarity with appropriate referral pathways in the regional Tasmanian context. Conversely, factors *enabling* provision of LGBTI+ inclusive care included prior experience working with LGBTI+ patients and establishing a network of supportive colleagues and local services. Participants who identified as LGBT+ themselves saw their personal experiences as a strength in supporting LGBTI+ patients. While awareness of LGBTI+ inclusive health practice is increasing, Tasmanian practitioners report insufficient training and practical difficulties with referral as key challenges.

Key words: Australia, gender, LGBTI health, inclusive practice, sexuality*What is known about this topic:*

- Lesbian, gay, bisexual, transgender and intersex (LGBTI+) people experience a range of health disparities and barriers to quality health and community care.
- Health care practitioners frequently report limited knowledge and awareness of LGBTI+ health and care needs.
- LGBTI+ health and inclusive practice are often poorly integrated into medical curricula and training.

What this paper adds:

- Rich insight into healthcare practitioners' and students' understandings and attitudes to LGBTI+ inclusion in Tasmania, Australia.
- A qualitative consideration of the barriers and enablers for LGBTI+ inclusive care among Tasmanian healthcare practitioners and students.
- An improved understanding of these issues, which may assist service providers, medical educators, and the development of interventions to more effectively support and meet the needs of this population.

Tasmanian Healthcare Professionals' & Students' Capacity for LGBTI+ Inclusive Care: A Qualitative Inquiry

Introduction

As the rights of lesbian, gay, bisexual, transgender and intersex (LGBTI+) people have variously improved in the Global North, albeit with many disparities and with differences across spaces, research has increasingly focused on the capacity of healthcare practitioners (HCPs) to provide healthcare that is either culturally competent or inclusive. We use the term 'LGBTI+ inclusive healthcare' in this article, although cultural competence is frequently used in US and Canadian literature. Numerous studies have concluded that LGBTI+ inclusive healthcare is important in delivering optimised healthcare , including in alcohol treatment and mental health (McNair et al., 2018), HIV prevention, including pre-exposure prophylaxis (Maloney et al., 2017; Smith et al., 2019), sexual and reproductive health (Grant & Nash, 2019; Logie et al. 2019; Malmquist & Nelson, 2013), cancer treatment (Quinn et al., 2015), dementia care (Price 2010), and aged care (Waling et al., 2019). Access to and provision of high quality healthcare, free from

discrimination, pertaining to diverse sexual orientation, gender identity, gender expression, and sex characteristics, is an explicit right in the Yogyakarta Principles plus 10, the highest level international human rights instrument pertaining to LGBTI+ people (Yogyakarta Principles plus 10, 2017; Zeeman et al., 2019).

Qualitative research on LGBTI+ inclusive healthcare presents numerous issues regarding the interactions between HCPs and LGBTI+ patients. Lesbian, bisexual and queer women in multiple Canadian studies held low expectations of their HCPs' capacity to provide culturally competent care, and instead hoped that, at the very least, HCPs would not be discriminatory (Baker & Beagan, 2014; Heyes, Dean, & Goldberg, 2016). Although HCPs may feel that it is medically appropriate to approach every patient in an equal way, this frequently translated to a neutralising stance that ignored the diverse needs of LGBTI+ patients by maintaining cisgender heterosexuality as the assumed norm (Baker & Beagan, 2014). It is common for HCPs to assume that patients are not diverse in their sexuality and/or gender unless otherwise disclosed by the patient (McGlynn et al., 2019). However, young LGBTI+ Australians have reported feeling uncomfortable disclosing their identity to HCPs due to fears of experiencing homophobia or transphobia (Robinson et al., 2014). LGBTI+ people often look for cues or signs from their HCP that disclosing is safe and will be met positively, such as their HCPs' use of gender-neutral terms such as 'partner' rather than assuming 'boy/girlfriend', and the presence of LGBTI-friendly posters, badges, stickers, and declarations in waiting rooms that diversity is welcome (Grant, Nash & Hansen, 2019; Wilkerson et al., 2011). LGBTI+ inclusive healthcare therefore involves not just an openness to the LGBTI+ patient who discloses their identity and experience, but also facilitating a clinical encounter in which LGBTI+ people know that they are safe to bring their whole identity into the space (Utamsingh et al., 2015).

Despite the well-documented need for LGBTI+ inclusive healthcare internationally, clinicians report various difficulties treating LGBTI+ patients including personal discomfort, unconscious bias, or insufficient education and training (Hinchilff, Gott, & Galena, 2005; McNair, Hegarty, & Taft 2015; Moe & Sparkman, 2015). A comprehensive understanding of LGBTI+ medical curricula in Australia and New Zealand is lacking. One survey in Australia and New Zealand found an average of 0-5 teaching hours throughout an average medical course, which typically only addressed sexuality or sexual health, and usually focused on men who have sex with men (Sanchez, Southgate, Rogers, & Duvivier, 2017). Evidence suggests that inadequate curriculum development and learning activities shape medical students' attitudes towards LGBTI+ patients.

For example, Burke et al.'s (2015) study of US medical undergraduates shows that nearly half of those surveyed held explicit bias against LGBTI+ people, while the majority held some implicit or unconscious bias. Stroumsa et al. (2019) importantly noted that medical students may hold homophobic or transphobic views that must be challenged through medical education in order for key information about LGBTI+ health and care provision to be learned. Although most HCPs are required to engage in continuous professional development as part of their ongoing professional registration, it is not clear what proportion of ongoing training addresses LGBTI+ inclusive healthcare or LGBTI+ topics. Furthermore, when this training exists, it is optional.

In the Australian TransPathways study – the largest survey of young Australian trans and gender diverse people – participants reported significant negative experiences with HCPs, including invalidation of identity, misgendering, and refusal of services (Strauss et al., 2017). Although there were some positive stories in TransPathways, even stories of respectful HCPs reflected a lack of training and expertise, in which many trans people needed to educate their clinician about the kind of specialist care they needed. Australian trans people experience difficulties finding trans-inclusive services and HCPs, and this is amplified outside of major cities and in rural and remote areas (Heng et al., 2019; Kerry, 2017).

It should be noted that in many parts of the world, movements championing intersex rights exist separately to LGBT movements. In Australia, intersex people are included as part of many LGBTI+ organisations. However, the violations of the human rights of intersex people occurring through healthcare in Australia (Australian Senate, 2013) are not always well understood or effectively advocated for outside of specific intersex organisations (Carpenter, 2016; Jones, 2018). Australian peer-based intersex organisations have compared historic and ongoing non-consensual surgery performed on intersex infants and children as analogous to female genital mutilation, which is legally prohibited as a human rights violation (Senate, 2013). Intersex-inclusive healthcare involves understanding that intersex people variously identify as cisgender, heterosexual, trans, and/or non-heterosexual (Jones et al., 2016), but also that intersex people may have specific healthcare needs related to their intersex variation, and/or as a result of the non-consensual healthcare abuses enacted upon some intersex people in infancy or childhood (Carpenter, 2018).

Understanding and practice of LGBTI+ inclusive healthcare is increasing in Australia. For example, the Royal Australian College of General Practitioners (RACGP) has produced

guidelines for sensitive care for lesbian, gay, and bisexual patients (see McNair 2012). However, previous research highlights the need for further consideration of LGBTI+ health in regional and rural areas (Staunton Smith & Haigh, 2019). The Australian state of Tasmania falls behind the nation on many key health indicators. For instance, compared with national averages Tasmanians exhibit higher rates of obesity, smoking, disability, chronic illness and increased difficulty accessing health services (Australian Bureau of Statistics (ABS), 2014a, 2014b). In addition to this unique health profile, as the last Australian state to decriminalise homosexuality in 1997, Tasmania has a particular LGBTI+ social history that arguably shapes contemporary LGBTI+ health and wellbeing. While there is limited research examining LGBTI+ health in the state of Tasmania, previous studies highlight barriers to inclusive services (Grant & Nash, 2019; Grant, Nash, & Hansen, 2019). For this reason, Tasmania is a compelling site to examine healthcare students' and clinicians' understandings and approaches to LGBTI+ inclusive practice.

Methods

This article reports on interpretive qualitative interview data that were collected as a part of a broader mixed-methods study investigating healthcare practitioners and students' understandings of LGBTI+ inclusive practices in Tasmania, Australia from May-September 2019. Key research questions were: 1) How do Tasmanian HCPs and students understand and approach LGBTI+ health? and 2) What are the challenges Tasmanian HCPs and students face in providing optimum care to LGBTI+ patients? In addressing these questions the project aimed to explore the knowledge and practices of both clinicians and students with a view to informing health policy, training, and curriculum development.

The first phase of the broader study included an exploratory online survey using a validated questionaire based in Sanchez et al.'s (2017) model, garnering 219 individual responses (207 valid at 75% complete). Inclusion criteria for both the study were: >18 years of age, currently studying or working in a health-related field (e.g. medicine, nursing, paramedics, psychology) in Tasmania. Survey respondents were recruited via social media advertisements, a University staff newsletter, and medical professional association newsletters and listservs Following completion of the survey, respondents were then invited to express interest in being interviewed. This study only reports the data gathered from the qualitative interview stage of this study.

Seventeen participants were purposively selected from a larger pool of expressions of interest (n=42). These specific participants were chosen to represent a range of professions and areas of study and to ensure representation of men and participants from diverse cultural backgrounds. Although this is a small sample, it meets the criteria for sample size outlined in Malterud et al. (2015) and Morse (2000) in relation to aims and scope of the study, study design, analysis strategy and quality of the data.

On obtaining participants' informed consent, semi-structured interviews were conducted by Author 3. The interviews lasted up to 1 hour and were conducted via telephone, Skype, or in person at a University or participants' workplace. All interviews were conducted using an interview guide (see figure 1) developed by authors 1 and 4 building on the initial survey model and its emerging findings. This guide included a range of open-ended questions about participants' health professional training, professional development opportunities, clinical experiences, and understandings of LGBTI+ inclusive practice. Participants were also encouraged to reflect on any challenges they had faced (or anticipated) in providing LGBTI+ inclusive care in their professional contexts in Tasmania. Some improvised follow up questions were also deployed during interviews to build rapport and expand on individual participants' particular experiences. Interviews were audio-recorded with consent and transcribed verbatim. No compensation or reimbursement was provided as part of this study. The study received ethical approval from the University of Tasmania Social Science Human Research Ethics Committee (Ref: H0018092). In line with the committee's recommendations data has been deidentified to ensure participant anonymity and confidentiality. Participants have been assigned numerical pseudonyms and some general descriptors of their role are used to provide context in the reporting of data.

[figure 1 here]

Interview transcripts were analysed using reflexive thematic analysis, with a focus on developing inductive codes that are identified during analysis, but also deductive codes that reflected our research questions (Braun & Clarke, 2006). QSR NVivo (v.11.2.2 Mac) was used as a software to organise data and codes. Author 2 immersed himself with the data, generated initial codes, and then developed draft themes to collate patterns of meaning across the data (Braun & Clarke, 2006). Author 2 conferred twice with Author 1 to critically discuss coding and

to workshop and refine themes. In developing the analysis and linking to broader literature, Author 2 went back to the data to ensure that the patterns of meaning described in this article reflected the data. All authors contributed to writing the manuscript.

Findings

This section explores qualitative data from the interview stage of the broader mixed-methods study. As outlined above, data have been analysed thematically using an interpretive qualitative methodology. Through this process, key themes relating to barriers and enablers for LGBTI+ inclusive practice were developed. Specifically, key barriers included: insufficient training, lack of exposure to LGBTI+ communities, and difficulties referring LGBTI+ patients. Conversely, common enablers were identifying as LGBTI+, experience with LGBTI+ patients, and building inclusive practitioner networks.

Participants

[Table 1 here]

While information about age, gender, language spoken at home, and professional role were gathered during interviews, 11 participants identified themselves as members of the LGBTI+ community without prompting from the interviewer (although none of these participants identified as intersex).

Barriers to LGBTI+ Inclusive Practice

Insufficient Training

The most common barrier reported by health students and clinicians was a lack of knowledge about LGBTI+ health issues and inclusive practices resulting from insufficient training on the topic. When participants were asked if they had received any training regarding LGBTI+ inclusive healthcare in their education, they explained:

> Not as of yet, no. Like, I don't know if there's going to be more content in the future, but as of now, no. [P19 – student – medicine]

> I don't think I learnt anything about LGB - like treating LGBTI+ people in my university at all. [P14 – clinician – naturopath]

> Not at all, not in the slightest. I mean I graduated quite a long time ago and we weren't even encouraged to ask about gender preferences and orientation and we were completely ignorant. [P11 – clinician – GP]

Echoing previous US research (see Burke et al. 2015), both clinicians and students reported little formal training on these topics. While older clinicians like P11 saw this as characteristic of the era when they were studying, current students also report limited coverage of LGBTI+ health in their degrees. In line with Sanchez et al.'s similar findings in Australia and New Zealand (2017), this is concerning as it suggests that little has changed despite the growing awareness of the need for LGBTI+ inclusive practice.

When LGBTI+ health was included in medical curricula it was described as brief and with little detail or practical application:

> Well, the only time they've ever mentioned it is when we were looking at special patient groups, so elderly, babies, international people and they just mentioned that people in the LGBT community are special patient groups which you have to treat differently and be careful, but it was never anything specific … It was just like one dot point on a slide. [P5 – student – pharmacy]

> Each week we have to practice history taking, because that is a skill we have to develop, so you get a hypothetical case with a hypothetical patient, and once we got a hypothetical patient that had - he was a male and he had a male partner and that kind of thing. So, they're kind of exposing us to that, but I wouldn't say we've had any overt education about it. [P19 – student – medicine]

These students highlight that while some progress has perhaps been made, LGBTI+ health remains a peripheral issue in their broader medical training and is not taught in depth or as a focused topic. Further, as previous studies have identified, when LGBTI+ issues are taught these tend to focus on the sexual health of men who have sex with men (Sanchez et al., 2017).

Lack of Exposure

In addition to experiencing limited formal education or training about LGBTI+ health, participants believed that a lack of social and professional exposure to LGBTI+ individuals and communities was another barrier to providing LGBTI+ inclusive care:

> A lot of people just don't think they've ever met someone [in the LGBTI+ community], and the ignorance comes from just lack of exposure. [P9 – clinician – emergency medicine specialist]

> I guess I face LGBTI+ issues so rarely that I think the biggest challenge is just not experiencing it or having that ongoing practice, if that makes any sense. [P14 – clinician – naturopath]

For these participants, limited social experience, such as having never met someone who publicly identifies as LGBTI+, compounded with a lack of formal education on LGBTI+ health led to a feeling of unpreparedness to work with LGBTI+ patients. While awareness of LGBTI+ population needs was low in general, our participants highlighted transgender and intersex patients as groups that were especially misunderstood:

> Transgender; I think this one is quite tricky because I haven't experienced anyone or have any experience working with them. And so, I can't say, whether I have, or I haven't had any sort of challenges because I haven't experienced them. [P3 – clinician – psychology]

> … intersex people, because I feel like my knowledge is lacking in that area and they're a minority - from my understanding, intersex people are a minority even within the LGBTI community. So, yeah. [P19 – student – medicine]

Here, in line with Grant, Nash and Hansen's (2019) findings, LGBTI+ inclusive practice is seen as a niche issue requiring specific expertise that can only be gained through familiarity with the community and experience treating this population group regularly. Like P3, several participants identified transgender and intersex people as particular patient groups within the broader

LGBTI+ community that pose challenges, as many were unfamiliar with their specific health needs. P19 importantly identifies intersex people as a minority within the LGBTI+ community, echoing the limited scholarly literature on the topic of intersex inclusive care. In addition to a lack of exposure to LGBTI+ patients in a professional context, P9 also highlights that many healthcare practitioners and students do not have social exposure to LGBTI+ individuals or communities. Following Stroumsa et al.'s (2019) recommendations for more reflective and community-based learning opportunities in medical school, our findings also suggest the need for greater awareness and engagement with local LGBTI+ communities.

Difficulty Referring LGBTI+ Patients

Perhaps as a result of their limited training and reduced awareness of LGBTI+ communities, participants were not aware of relevant referral pathways for LGBTI+ patients:

> But in terms of resources about where do I refer somebody I wouldn't even know. And I'm a leader, I should know this stuff but if I don't know… it makes me think that other people wouldn't have a clue. [P9 – clinician – emergency specialist doctor]

> I think that if I was caring for somebody that was transgender or anything really and I didn't know how to get them the support that they needed I'd think I'd find that quite stressful. [P6 – clinician – nurse]

Participants' lack of awareness of existing referral pathways was also compounded by the scarcity of such services available in Tasmania, especially in rural areas:

> Particularly one of the hardest things in Tasmania is there's only one service. [P16 – clinician – counsellor]

> … there's not many services at all. There's a couple of sexual health services but I'm not really aware of any that are particularly LGBTI focused. So I think that makes it really hard. And Tassie's [Tasmania] such a small place that it's – again harder just to have all the services around that they might have on the mainland. [P13 – student – medicine]

In rural areas with limited health services, greater pressure is placed on primary care to address

a range of complex concerns. For this reason, it is important that LGBTI+ inclusive principles are incorporated in generalist health settings, and that rural clinicians are familiar with referral pathways, including other local services and community resources. As the quotes above suggest, a dearth of services and unfamiliarity with appropriate referral pathways reduces clinicians' capacity to provide inclusive whole-patient care.

Enablers for LGBTI+ Inclusive Care

While participants noted several barriers or challenges they faced in providing LGBTI+ inclusive care in Tasmania, in this section we explore positive factors that enabled inclusive practices.

LGBT+ Identifying Practitioners

As nearly 65% of the sample identified as LGBT+ themselves, sharing an LGBT+ identity with patients was a common strength noted by these participants:

> I feel like a lot of the stuff I know about LGBTI+ health I know from being a member of the community, not from medical school. [P9 – clinician – emergency medicine specialist]

> I am a queer person myself and that's probably one of the biggest factors [helping understand LGBTI+ inclusive practice]. General media coverage and friends who are also queer have all helped as well. [P7 – student – medicine]

> Just being gay myself, I know - I've educated myself a lot about transgender issues and things like that, so I feel like I would have some knowledge, something to go off whereas others may have no basic knowledge at all. [P5 – student – pharmacy]

> I would say [I'm] well informed but there are still areas where I am learning and one of those things is in supporting people who identify as trans, which is kind of strange because that's a fairly recent thing for me that I identify as non-binary. The reason it's recent is there weren't words for that when I grew up. [P15 - clinician - counsellor]

Here, participants suggest that being members of LGBTI+ communities themselves, they are

more aware of issues facing this patient group. In contrast to participants who felt they had not been exposed to LGBTI+ individuals, LGBT+ identifying participants note that community membership had been a key source of knowledge about LGBTI+ health issues, contributing to their professional practice. However, P5 notes that identifying as gay did not automatically result in understanding all issues related to LGBTI+ health, with transgender issues being something they had to learn about. Furthermore, as P15 demonstrates, LGBTI+ identifying HCPs may also be in an ongoing process of learning about their own identities and how these relate to the broader LGBTI+ community. Thus, while sharing an identity with a patient group is not a prerequisite for quality care, these participants felt it made them more empathetic towards minority patients and willing to self-educate on aspects of inclusive practice they were not familiar with.

Experience working with LGBTI+ Patients

For participants who did not identify as LGBT+ themselves, approaches to LGBTI+ inclusion developed with time and experience. Just as lack of exposure to LGBTI+ individuals and communities was seen as a barrier to inclusive care, having clinical experience working with LGBTI+ patients was a key factor contributing to confidence in this area:

> Initially the first few [transgender patients] had to inform me. I asked lots of questions and learnt from what they had to say, so I think over the years I've - again, nothing formal, but acquired a bit of knowledge just from the people I've looked after and the first few times, 'well I know nothing, tell me,' and they were kind enough to help me. [P11 – clinician – GP]

Participants who did identify as LGBT+ still stressed the importance of learning from their patients:

> I actually work with transparency in so far as my clients are concerned so I encourage open communications whereby we regularly check in: where I'm going wrong, where I'm going right, ways they think I should improve. So taking it from the people themselves. [P15 - clinician - counsellor]

Baker and Beagan (2014, p. 594) emphasise how health practitioners can promote inclusive

clinical encounters by “learning with” patients rather than “learning about” them. In the present study, clinicians similarly note that their understandings and abilities to provide inclusive care developed through actively learning with LGBTI+ patients rather than adopting the stance of an ‘expert.’ Participants also routinely drew upon the notions of patient/person-centered care and holistic care as important to approaching all of their patients.

Building and Accessing LGBTI+ Inclusive Practitioner Networks

In rural and regional Tasmanian contexts where participants noted limited awareness of LGBTI+ community needs and fewer services, strength in LGBTI+ inclusive practice was gained by making use of knowledgeable colleagues, referral networks, and LGBTI+ organisations:

> Yeah, we’ve got a really good relationship with the local sexual health people, so I’d - for instance, when I first had to break the news of HIV diagnosis, I just rang up the sexual health nurse who knows everything there is to know and said, “I don’t know how to do this, I don’t know what to say, what should I do?” And she was fantastic, sent me resources, told me what to say and how to say it and what to do next, and all that sort of stuff. Not only referring but helping me to deal with my issues with communicating that sort of news and treatment and all that sort of stuff and if I didn’t know quite where to send people, I’d ask her as well. [P11 – clinician – GP].

> I just have a disposition to try to keep myself up to date with [LGBTI knowledge]. If I think that I don’t understand something, I’ll go and ask. So, I’ll go and ask TasCAHRD in Hobart if I need to understand the changes to things like PrEP or something like that. That sort of thing. [P12 - clinician - nurse].

As participant accounts reveal, knowing where to refer patients or who to ask for advice or assistance empowered clinicians to support LGBTI+ patients. However, while some participants highlighted networks that were important to maintaining LGBTI+ inclusive practice, expertise was typically located in one or two organisations and participants worried about where else they could find locally relevant information, similar to the difficulties reported earlier in referring LGBTI+ patients. In rural areas LGBTI+ inclusion is often left to singular “change champions” in health services, making the delivery of holistic LGBTI-inclusive care fragile and conditional on individual clinicians (see Barrett & Stephens, 2012). As Barrett and Stephens (2012) note, this is

an unsustainable model for rural communities, and more whole-clinic approaches to LGBTI+ inclusion are needed. Although participants in this study emphasised the limited number of services available in Tasmania, they highlighted the importance of accessing or building networks with colleagues, services and local organisations.

Furthermore, while geographical location and limited available services were barriers both for LGBTI+ health and for clinicians' to provide inclusive care in rural areas, participants identified telehealth initiatives as helping to overcome these challenges. For example, one general practitioner described how teleconferencing had improved their ability to refer patients in isolated areas to specialist mental health services:

> Good access to things like telehealth, telemedicine, telepsych; in fact since we've been using telepsych, like Psych2U, that's made this process an awful lot easier because before we would have to try and find a psychiatrist who had some sort of experience or a psychologist. They're pretty thin on the ground, they're usually in Hobart, travel's an issue and people don't have great incomes so there's lots of barriers and removing as many barriers including distance and cost, those sorts of resources would be good. [P11 – clinician – GP].

This participant highlights how initiatives like telehealth make specialist care more accessible for rural patients and enable practitioners to establish referral networks beyond their local area, where these services may not be available. However, practitioners were not always sure if these services would be LGBTI+ inclusive, and identified the need for further resources to assist these services in providing LGBTI+ inclusive care.

Discussion

Our study provides a unique and timely opportunity to identify key issues shaping clinicians' and students' approaches to LGBTI+ inclusive healthcare provision in rural Australia, focusing on Tasmania. Based on the data, we identified various barriers and enablers for LGBTI+ inclusion. In line with the existing literature, we found that HCPs were unlikely to learn about LGBTI+ health and inclusive practice principles during their medical education. Current students also reported receiving limited information about LGBTI+ health in their degrees so far. However, the students reported higher levels of confidence and awareness of LGBTI+ issues compared to

HCPs. Students highlighted that specific areas of LGBTI+ inclusion were especially lacking, particularly transgender and intersex health. Therefore, more understanding of what is currently taught in Australian medical schools is required to inform future development in this area.

A lack of formal training combined with limited social awareness of LGBTI+ people can result in "inappropriate curiosity" among HCPs, especially regarding trans and gender diverse patients (see also Shepherd, Hacknel, & Guise, 2019; Stroumsa et al. 2019), detracting from the quality of care these patients receive. In contrast, participants who identified as LGBT+ themselves believed they had a greater understanding of LGBTI+ inclusion and were more likely than cisgender/heterosexual colleagues to self-educate on LGBTI+ health issues. However, given that there are important differences between various LGBTI+ identities and people, belonging to one aspect of the LGBTI+ spectrum does not necessarily translate to interest and expertise with others, and this was reflected by some cisgender gay participants who were not familiar or confident with transgender or intersex topics.

Although reduced awareness due to limited training and exposure were seen as barriers to inclusive care, clinicians emphasised that gaining experience treating LGBTI+ patients helped to address their gaps in knowledge. Echoing previous research, practitioners reported being educated on LGBTI+ inclusion by patients themselves, which they saw as a positive experience. Although some scholars argue this approach places undue burden on marginalised groups to educate their HCPs, some empirical studies suggest that patients prefer clinicians who are willing to educate themselves with an open mind (Heng et al., 2019; Heyes et al., 2016; Strauss et al., 2017). In light of this, Baker and Beagan (2014) stress the difference between "learning about" minority patient groups and "learning with" patients themselves. We argue that healthcare providers and medical students require additional support in building foundational skills to learn *with* LGBTI+ patients, both through formal education and workplace training.

Clinicians and students reported a lack of awareness of referral pathways for LGBTI+ patients. This was noted as an issue specific to their context, given the statewide socio-economic and health service disparities experienced in comparison to more populous cities in mainland Australian states. To address this, participants stressed the importance of building local networks with other LGBTI+ inclusive colleagues, services, and organisations to draw on the strength of their collective expertise and networks. Some participants also mentioned that telehealth and other flexible healthcare services and support were especially important but were

unsure if these were LGBTI+ inclusive. We suggest that information about such networks, or how to establish them, be further incorporated in formal education and workplace training, particularly in rural and regional areas.

Given the study's small sample size and the self-selected method, this research can only provide a 'snapshot' into a particular group of clinicians and students. Although this study aimed to investigate the understandings and experiences of a specific group, and therefore did not aim to be generalisable, it is notable that the self-selected sampling method produced a sample biased towards younger women, many of whom were nurses or medical students. While it was useful to explore the understandings and experiences of professionals from different healthcare disciplines, the small sample means that participant accounts should not necessarily be interpreted as generalisable to their fields more broadly. The self-selected sampling approach was also unlikely to capture those with anti-LGBTI+ views or those with less interest or experience with LGBTI+ patient groups, suggesting that the higher levels of confidence/comfort treating these populations reported in this study may be biased. These results are also somewhat limited by their focus on clinicians' and students' self-assessed competence in providing LGBTI+ inclusive care rather than more objective measures of knowledge and practice.

Despite these limitations, we argue that our results make an important empirical contribution to literature and practice, with the key findings being conceptually transferable in a range of contexts (see Kitto, Chesters & Grbich 2008). Although awareness of LGBTI+ health issues is arguably increasing in Australian healthcare, few Australian studies have qualitatively examined clinicians' and students' lived experiences and challenges in providing LGBTI+ inclusive care. In doing so, this article contributes new insight into the barriers and enablers students and HCPs face in LGBTI+ inclusive healthcare provision. By focusing on Tasmania specifically, this research also contributes to further understanding of LGBTI+ healthcare provision in regional and rural areas. Unlike previous Australian research, the high proportion of clinician and student participants identifying as LGBT+ themselves provides a new perspective on inclusive healthcare that warrants further exploration in future research.

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Figures

Figure 1. Example interview guide for HCPs

Opening Discussion

1. Tell me about the work that you do.
2. When did you complete your medical training and how long have you been practicing?
3. What interested you about this study?
4. How informed would you say you were on LGBTI issues?

Inclusive Practice

5. Do you feel your medical training adequately prepared you to treat LGBTI people? (What was covered/what was excluded?)
6. Have you ever had any additional training or professional development around LGBTI health? (Who delivered this training/what was covered? How useful was it?)
7. Would you describe your current workplace as LGBTI-inclusive? (if so, how does it promote this?)

8. Have you faced any challenges in providing LGBTI-inclusive care in Tasmania? (how did you overcome these?)
9. What kinds of resources would assist you in supporting LGBTI patients?

Consultations with LGBTI patients

10. How would you describe your overall approach to LGBTI-inclusive practice?
11. Can you give me an example of some of the things you do to provide culturally competent care for LGBTI patients?
12. Would you say you feel comfortable discussing sexuality and sexual health LGBTI patients? (Why/Why not? Has this always been the case?)
13. If you were unsure about a particular aspect of LGBTI health, are you confident that you could refer the patient to relevant services or resources?
14. Are there areas of LGBTI health that you would like to know more about?
15. Would you like to add anything that we haven't discussed?

Tables

Table 1. Participant Demographics (n=17)

Demographic Characteristics	N
Age	
18-24	6
25-34	3
35-44	2
45-54	3
55+	3
Gender	
Women	10
Men	5
Non-Binary	2
Identifies as member of the LGBTI+ Community	**11**
Language spoken at home	

English	14
Mandarin	1
Cantonese	1
Arabic	1
Health Care Practitioners	**12**
Medical doctor/GP	4
Nurse	4
Psychologist/counsellor	3
Naturopath	1
Students	**5**
Medicine	2
Nursing	2
Pharmacy	1

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