

Bachelor Thesis

Raising the rainbow coloured flag in palliative care –
challenges and misconceptions while providing care
for the members of the LGBTQ+ community: a
literature review

Submitted by Julia Theresia Berger

To obtain the academic title of
Bachelor of Nursing Science (BScN)

Medical University of Graz

Institute of Nursing Science

Under the supervision of
Gerhilde Schüttengruber, BSc, MSc

Graz, März 2020

„Ich erkläre ehrenwörtlich, dass ich die vorliegende Arbeit selbstständig und ohne fremde Hilfe verfasst habe, andere als die angegebenen Quellen nicht verwendet und die den benutzten Quellen wörtliche oder inhaltlich entnommene Stellen als solche kenntlich gemacht habe.

Graz, am 26.03.2020

Julia Theresia Berger, eh”

Table of Contents

Table of Figures	IV
Abstract	V
Zusammenfassung	VI
1. Introduction	1
1.1 Relevance to Nursing	9
1.2 Gap in Knowledge and Objective	9
2. Methods	11
2.1 Literature search	11
2.2 Study selection	13
2.3 Mixed Methods Appraisal Tool (MMAT)	15
3. Results	17
3.1 Characteristics	17
3.2 Heteronormativity	21
3.3 Discrimination and Disclosure	23
3.3.1 Discrimination	23
3.3.2 Avoiding the health care setting	24
3.3.3 Disclosure	25
3.4 Family and Next-of-kin	26
3.4.1 Bereavement	27
3.4.2 Last wishes	28
4. Discussion	30
5. Recommendations for Research and Practice	37
6. Conclusion	39
References	40
Attachments	45

Table of Figures

Table 1: Common Stereotypes about the LGBTQ+ community (Lopez 2018; Malia 2016; Moor 2019; Robinson 2018; Stossel & Binkley 2006; Vancouver Island University 2020).....	4
Table 2: Search terms and synonyms.....	12
Table 3: Search strategy	12
Table 4: Google operators (Southern Adventist University 2019).....	13
Table 5: Characteristics of the studies.....	18
Figure 1: Flow diagram portraying the search for literature and process using the PRISMA Statement (Moher et al. 2009).....	16

Abstract

Background: The number of people who identify as members of the LGBTQ+ community, in the United States of America, has risen from 3.5% to 4.1% between 2012 and 2016. These numbers align with statistics published by the European Union and the United Kingdom. Due to the fear of anticipated discrimination, stereotypization and negative encounters within the health care setting, the members of the LGBTQ+ community avoid the health care setting and present late with advanced or life-limiting diseases. This means they are more likely to seek care within the palliative care setting.

Aim: The aim of this thesis is to describe the experience of the members of the LGBTQ+ community in the palliative care setting and to determine how stereotypes and bias, nurses have against them, influence the quality of nursing care.

Method: The search for literature has been conducted in October 2019. The relevant databases PubMed and CINAHL have been used for the search, using keywords. The search has been supplemented by an Internet search and a manual search. 213 studies have been identified as relevant, and after screening, fourteen have been included in the results after being critically appraised.

Results: The results can be categorized in three categories: heteronormativity, discrimination and disclosure, and family and next-of-kin. Heteronormativity includes nurses' assumptions of heterosexuality and not presenting the patients treatment and care options, tailored to their specific health care needs. Discrimination and disclosure include LGBTQ+ patients not disclosing their sexual or gender identification, in order to avoid discrimination and anticipated breaches in confidentiality. Family and next-of-kin include the family of choice not being supported in the bereavement process by nurses, and the patients' last wishes not being respected by the family of origin.

Conclusion: The palliative care for the members of the LGBTQ+ community is neither person-centred, nor equitable. This is due to stereotypization and discriminatory beliefs by nurses against LGBTQ+ patients, which negatively influences the care they provide for the community members.

Keywords: stereotypes, bias, quality of care, palliative care, LGBTQ+

Zusammenfassung

Hintergrund: Die Anzahl der Menschen, die sich zu den Mitglieder der LGBTQ+ Community zählen, ist in den USA zwischen 2012 und 2016 von 3.5% auf 4.1% gestiegen. Aufgrund der Angst vor der zu erwartenden Diskriminierung, Stereotypisierung und den negativen Erfahrungen, die im Gesundheitsbereich bereits gemacht wurden, versuchen die Mitglieder der LGBTQ+ Community den Kontakt mit dem Gesundheitssystem so weit wie möglich zu vermeiden. Dies führt dazu, dass PatientInnen, die sich als LGBTQ+ identifizieren, erst später das Health Care Setting aufsuchen und mit fortgeschrittenen, lebensbedrohlichen Krankheiten in die Pflegebedürftigkeit eintreten. Das bedeutet, dass diese PatientInnen meist bereits Pflege im Palliativsetting in Anspruch nehmen.

Ziel: Ziel dieser Arbeit ist es die erlebten Erfahrungen der LGBTQ+ PatientInnen im Palliativsetting zu beschreiben und zu klären inwiefern Stereotypen und Vorurteile des diplomierten Gesundheits- und Pflegepersonal gegenüber dieser Patientengruppe die Qualität der Pflege beeinflussen.

Methode: Die Literatursuche wurde im Oktober 2019 durchgeführt. Die Datenbanken PubMed und CINAHL wurden dafür herangezogen. Die Suche wurde durch eine Handsuche und eine Suche im Google Scholar supplementiert. 213 Studien wurden als relevant identifiziert, wobei 14 der Studien in den Ergebnissen inkludiert wurden, nachdem sie kritisch bewertet wurden.

Ergebnisse: Die Resultate wurden in drei Kategorien gegliedert: Heteronormativität, Diskrimination/Outing und Familie/nächste Angehörige. Heteronormativität inkludiert Annahmen von Heterosexualität und im Zusammenhang dazu, eine nicht patientenorientierte Pflege und Behandlung. Diskriminierung/Outing inkludiert, dass sich LGBTQ+ PatientInnen nicht im Gesundheitssetting outen, um Diskriminierung zu vermeiden. Familie/nächste Angehörige inkludiert, dass die Angehörigen der gewählten Familie nicht in ihren Trauerprozessen unterstützt werden und die letzten Wünsche der PatientInnen von der biologischen Familie nicht berücksichtigt werden.

Schlussfolgerung: Die Stereotypisierung und Diskriminierung der LGBTQ+ PatientInnen von diplomierten Gesundheits- und Krankenpflegepersonen wirkt sich negativ auf die Qualität der Pflege dieser PatientInnen-Gruppe aus.

Keywords: stereotypes, bias, quality of care, palliative care, LGBTQ+

1. Introduction

Statistics show that the number of people, who openly identify as members of the LGBTQ+ community has risen over the last decade. The community members mention, amongst other things, stereotypization and discrimination as barriers to accessing care. But before further describing the different stereotypes and bias the members of this marginalized community are facing within society and their maltreatment in the health care setting, the term LGBTQ+ shall be introduced and defined. (Bridges 2017; Bristowe et al. 2018)

LGBTQ+ or LGBTQIA is an acronym, which stands for lesbian, gay, bisexual, transgender, queer or questioning, intersexual, and asexual or ally. This abbreviation has changed over the years from only representing the lesbian, gay and bisexual community (LGB) to be more inclusive and open to people, with sexual or gender orientation outside the lesbian, gay and bisexual spectrum, who have since joined the community. Lesbian and gay are the most commonly known sexual orientations, other than heterosexuality, within society and refer to a same-sex attraction between two women or two men. Bisexuality is the attraction to people, who identify as either male or female. Bisexuals are oftentimes the most affected by stereotypes, since being bisexual is commonly seen as a transitional stage to being either gay or lesbian within society. In correlation to bisexuality, pansexuals are attracted to all genders and gender identities, meaning they are more drawn to a person's personality, rather than their gender or biological sex. Within the LGBTQ+ spectrum, the term asexual refers to someone who experiences little to none sexual attraction towards another person, yet an asexual individual might still be romantically interested in another person. The A in LGBTQIA might also stand for ally, which refers to a person, who is friends with a member of the community or supports the members of the LGBTQ+ community in their way possible. Intersexuality is a term, which is not commonly known within society, since it does not refer to a sexual orientation or a gender identity. Intersexual individuals are born with the bodily characteristics that are not traditionally associated with being a woman or a man, due to genetic mutations or hormone imbalances. As for gender identities, the most common identifications used are transgender, transsexual, gender nonconforming, non-binary and cisgender. The term transgender is used to describe people, whose gender differs from the sex, which they were assigned at birth. Being transsexual is a more specific term within the transgender spectrum. It refers to the process of changing one's sex, using for example hormone therapy or surgical measures, in order to align a person's chosen gender identity with their sex. A person, who identifies themselves as gender nonconforming, is someone

who expresses their gender outside of the norms of society, which are traditionally associated with masculinity or femininity. Being nonbinary, means, that a person does not identify themselves as either male or female. They see themselves outside of the available gender spectrum. Cisgender refers to a person, who's gender identity matches their biological sex. The '+' at the end of the LGBTQ+ is a denotation. It was introduced in order to include every gender identity and sexual orientation within the rainbow spectrum. Even those who cannot yet be described by using letters or words. (Abrams 2019; Gold 2018; OK2BME 2019)

As mentioned above the number of people who identify as members of the LGBTQ+ community has been growing. Between 2012 and 2016 the percentage of people who openly identify as part of this community has risen from 3.5% to 4.1% in the United States of America. This means that in 2016 around 10 million U.S. citizens identified themselves as members of the LGBTQ+ community. According to The Williams Institute (2019), in the year 2019 4.5 % of the population of the United States of America defined themselves as being a part of this community. This number aligns with data from Europe collected in 2016, which showed that 5.9% of European citizens identified as LGBTQ+. Yet the specific statistics vary throughout Europe, ranging from a percentage of 7.4% in Germany to 1.5% in Hungary. As for Austria, 6.2% of the Austrian population openly identify as members of the LGBTQ+ community. These percentages might not be entirely accurate, due to many LGBTQ+ individuals not openly disclosing their gender identity or sexual orientation. (Bridges 2017; Lam 2016; The Williams Institute 2019)

As any other marginalized group, the members of the LGBTQ+ community also face stereotypization, discrimination and, specifically for their community, homophobia on a daily basis. Discrimination is defined as treating a group of people or a singular person differently, mostly worse, due to their colour of skin, sexual or gender identity, age, or for any other underlying reason. Accounts of discrimination against the members of the LGBTQ+ community have been reported over decades and from all over the globe. Examples range from being denied job opportunities, being bullied on the street by colleagues or members of other communities, being denied appropriate, person-centred health care services to being beaten up and killed due to sexual orientation or gender identity. Between October 2017 and September 2018 369 transgender individuals lost their lives because of violence based on discrimination and homophobia worldwide, according to Transgender Europe and Carsten (2020). In over 70 countries in the world, being in a same-

sex relationship is still considered a crime, and in nine of those countries, including Saudi Arabia, Sudan and Yemen, the death penalty is seen as a legitimate sentencing for identifying as a member of the LGBTQ+ community. (Amnesty International 2020; Cambridge Dictionary 2014b)

Another obstacle the members of the LGBTQ+ community face are stereotypes, bias and prejudice. Stereotypes are defined as pre-set ideas that people have about a person, a group or anything else. These fabricated ideas are not based on fact and often wrong. Bias is an action of either supporting or opposing a person or thing in an unjust way. Bias are the result of letting one's personal opinion and values influence their judgement. Prejudice are defined as unfair and sometimes unreasonable opinions or feelings, which are formed without seeking background knowledge or thinking thoroughly about a situation.(Cambridge Dictionary 2014a, 2014c, 2014d)

Being judged due to sexuality or gender identity by someone else is a common occurrence for the members of the LGBTQ+ community. Common stereotypes about the lesbian, gay, bisexual and transgender population of the LGBTQ+ community can be seen in Table 1. Only these four groups of the community were used to identify stereotypes, since these groups are the most visible within the LGBTQ+ community and therefore there are more prone to being stereotyped. (Moor 2019)

Table 1: Common Stereotypes about the LGBTQ+ community (Lopez 2018; Malia 2016; Moor 2019; Robinson 2018; Stossel & Binkley 2006; Vancouver Island University 2020)

Gender/Sexual Identity	Stereotype
Lesbian	<ul style="list-style-type: none"> - Molested by men during childhood – turned them into lesbians - Hate men - Not been with the right guy yet - one has to “be the man” - Dress like men - hate make-up, shaving, bras and dresses - “It is just a phase.”
Gay	<ul style="list-style-type: none"> - Are paedophiles - Obsessed with fashion, tan and coloured hair - Speak differently than straight men - More promiscuous - Effeminate and flamboyant
Bisexual	<ul style="list-style-type: none"> - Inability to have a stable relationship - Indecision to whether one is gay or straight
Transgender	<ul style="list-style-type: none"> - trying to confuse or trick other people - sexual orientation and gender identity are linked to another - letting them use bathrooms and locker room, that match gender identity is dangerous for heterosexual people in the room - Transitioning is only one surgery - All transgender people transition medically - Transgender-inclusive health care is way too expensive - Children cannot know their gender identity - All transgender women are drag queens - Mental illness

The stereotypes mentioned in Table 1, influence the way people who identify as heterosexual and cisgender see the members of the LGBTQ+ community. A term, which is used to describe the way sexual orientation and gender identity are seen within the greater social community is heteronormativity. Heteronormativity describes the strict norms society has about sexuality and how they try to reinforce gender roles within the public setting. This includes being gender binary, which means that an individual could only either be male or female, according to their sex assigned at birth. Heteronormativity is described as the only normal and natural expression of sexuality and gender identity.(Merriam-Webster 2020a; Study.com 2015)

A term also linked to the discrimination of the members of the LGBTQ+ community is heterosexism. This term is based on the believes that heterosexuality is the only natural and normal expression of sexuality. Heterosexism and homophobia are often used as interchangeable term, however homophobia is the irrational aversion or fear of homosexual individuals, their culture and their lifestyle. Homophobia refers to an individual's believes or feelings, whereas heterosexism is a system of oppression. (Herek 2012; Merriam-Webster 2020b; The Pennsylvania State University 2007)

In order to summarize stereotypes, discrimination, heterosexism and homophobia another term was introduced. Sexual prejudice refers to an all negative attitude towards people, who have a different sexual orientation. The target of sexual prejudice can either be homosexual or bisexual, yet also heterosexual individuals might be affected by sexual prejudice. Due to the current social organization of sexuality, sexual prejudices are almost exclusively directed towards the members of the LGBTQ+ community, who define their sexuality as gay, lesbian or bisexual. (Herek 2012)

Discriminatory believes, stereotypes and bias against the members of the LGBTQ+ community, as mentioned before, do not only arise within the greater society, but also effect patients, who identify as LGBTQ+, within the health care setting. The members of the LGBTQ+ community are at an increased risk to be diagnosed with certain illnesses and have a reported heightened risk behaviour. People, who identify as LGBTQ+, are more likely to abuse nicotine and alcohol, and are more prone to using drugs. This heightened risk behaviour can be attributed to the stress felt by the LGBTQ+ community members in view of discrimination and homophobia. The members of the community are statistically more likely to be diagnosed with sexually transmitted diseases, such as syphilis, HPV, the human

papillomavirus, and hepatitis, because of the lack of safe sex practices. Especially men, who have sex with men have been affected by sexually transmitted diseases. As for their increased risk of being diagnosed with certain illnesses, lesbian and bisexual women are statistically more likely to be diagnosed with breast, ovarian and endometrial cancer, because of fewer full term pregnancies, mammograms and a higher prevalence of obesity. Gay and bisexual men are more likely to be diagnosed with Hodgkin's disease, Non-Hodgkin lymphoma and anal cancer, than their heterosexual counterparts. The transgender population of the LGBTQ+ community are more susceptible to diabetes mellitus, as well as, liver and cardiovascular diseases. The members of the LGBTQ+ community are also less likely to attend routine health care screenings and are more likely to present themselves with a more advanced state of illness, than their cisgendered, heterosexual counterparts. (Bristowe et al. 2018; Cartwright et al. 2012; Hafeez et al. 2017)

When faced with an advanced illness, the need for an individualized, person-centred care is higher than ever, so that a patient's last wishes are ensured and palliative care needs are being met. A patient facing an advanced illness is defined as having one or more conditions, which result in a decline of general health, and a deterioration of mental and bodily functions that will continue till the end of the patient's life. Palliative care is defined as a way to improve a patient's quality of life and in relation to support the patient and their family, while facing this life-limiting illness and the eventual death of the patient. This special field of nursing includes the prevention of diseases, relieving any sort of suffering, relying on diagnosing an illness early on and the treatment of pain. Palliative care is also concerned with other aspects at the end of life, such as physical, psychosocial and spiritual questions or problems a patient and their family might face. The purpose of the palliative care setting is to relieve the patient from pain, educate them about their awaiting death and seeing it as a natural part of life. Palliative care does neither hasten nor postpone a patient's death and tries to integrate spiritual and psychological aspects of death into a patient's care. In the palliative care setting, the patient is offered support systems in order for them to deal with their own mortality and furthermore with their eventual death. The sole focus in the palliative care setting, does not lie on the patient, since the family members of the patient are also offered guidance and support systems in order for them to cope with the life-limiting illness and the anticipated bereavement. In order to address a patient's and their family's needs, a team approach is used, meaning different professions within the palliative care system come together trying to enhance the patient's quality of life and support their family. This approach

to palliative care might also positively influence the course of a patient's illness. Palliative care should start early in the course of an illness using a holistic approach, since the care should intertwine with other treatments, such as chemotherapy or radiation treatment, in order to delay the course of a life-limiting illness. (Bristowe et al. 2018; World Health Organization 2019b)

In regard to palliative care, end-of-life care supports patients within their last months to years of their life. Its purpose is to help the patient maintain as much of their independence and their quality of life as possible, as well as, to ensure a death with dignity. In order to appropriately care for a patient, a nurse or any other health care provider should be informed about a patient's wishes and preferences about the end of their life, so they can arrange for the patient's optimal care. End-of-life care should also include a patient's family, their personal carers and other important people in their lives. This specific care can be received at home, in the long-term care setting, in hospices, as well as, in hospital, again depending on a patient's needs and wishes. End-of-life care is tailored at patients dying within 12 months. (The National Health Service England 2018)

Since the members of the LGBTQ+ community present late with life-limiting illnesses, they often receive care within the palliative care setting. As for the members of the LGBTQ+ community, their family structures might vary from those of their cisgendered heterosexual counterparts. The family structures known within the LGBTQ+ community are family of origin and family of choice. Family of origin is known as the family a person gets adopted or born into. It describes the family structures in which a person has been raised in. These bonds include biological parents, siblings, grandparents and other relatives. The family structures of the family of origin impact the development of a person. These bonds shape a person's worldviews, interactions with others and effect one's health and coping mechanisms. The way somebody is raised, affects them in every aspect of their life and their future, especially in the context of interpersonal relationships and self-perception. (Currin 2015; Horne 2019)

Within the family of choice the members of the family get chosen, oftentimes including friends, neighbours and work colleagues. As for the members of the LGBTQ+ community, the family of choice include people from within the community; people with similar life experience and interests, someone who understands a person's life choices. Oftentimes the members of the LGBTQ+ community have been banished from their family of origin, due to

their coming out or them wanting to hide their sexual and gender identity. A person's family of choice might also include members of their family of origin, in other words, blood relatives, with whom the person has reconnected at some point in their life. The members of the family of choice have the same responsibilities within the system, as the members of the family of origin, such as being loyal towards other family members, showing empathy and an underlying willingness to help each other. A person's family of choice might change over time, since the member of the LGBTQ+ community might grow apart from some family members, as interpersonal relationships deteriorate over time. People, who identify as LGBTQ+, generally include people of roughly the same age in their family of choice. This means, as the natural course of life progresses, the members of the family of choice are faced with frailty, progressing diseases and disabilities at the same time. As a logical conclusion, the family of choice can no longer support each other and their members cannot care for other family members facing different illnesses. (Bomba 2011; Currin 2015)

According to Hafeez et al. (2017), 68% of the LGBTQ+ youth report not discussing their sexual orientation with their physicians and 90% have reported reservations concerning the disclosure of their sexual or gender orientation. Their disclosure experience, as well as, a physician's attitude towards their disclosure, negatively influence the LGBTQ+ patients' experience within the health care system. A lack of training about LGBTQ+ related issues can strain the relationship between a LGBTQ+ patient and their health care provider. It, furthermore, influences the delivery of care and the quality of care they receive. (Hafeez et al. 2017)

Quality of care, as defined by the World Health Organization (2019a), is solely focuses on improving a patient's desired health outcome. In order to provide a high-quality care for patients, care needs to be effective, efficient, equitable, safe, timely and people-centred. Summarized, high quality care has to be based on scientific knowledge and evidence-based guidelines, it needs to maximize a patient's resources and avoid waste. Nurses or other health care professionals have to deliver health care that does not differ in quality in relation to personal characteristics, such as gender, race, ethnicity, geographical location or socioeconomic status. In order for care to be safe, health care needs to minimize the risk and the harm to the patient, which means that it needs to prevent injuries and reduce medical errors. High quality care needs to reduce delays in providing and receiving health care. Care needs to take the preferences and aspirations of a patient into account, as well as, the culture of their community. The nursing profession is responsible for achieving a high quality care

for its patients, since it coordinates and integrates multiple aspects of quality in to nursing care. A higher quality in nursing care is associated with fewer medical complications and a lower mortality rate. Nurses monitor and survey the patient, identify hazards and patient deterioration, before they become irreversible events. The Donabedian model is used as a framework to evaluate the quality of care in health care services. The quality of care is categorized in three dimensions: structure, process and outcome. Structure describes the context in which care is being delivered, such as hospitals or other facilities, the staff of a hospital or facility, and the equipment used to treat the patient. The process describes the interaction between a health care provider and a patient, throughout the delivery of care. The outcome refers to the effect health care has on the health of a patient or population. (Donabedian 1988; Mitchell 2008; World Health Organization 2019a)

1.1 Relevance to Nursing

Due to homophobic encounters previously experienced within society and the anticipated stereotypization associated with these negative experiences, the members of the LGBTQ+ community are less likely to regularly visit their physician or local hospital for health care check-ups. In correlation to this, the growing population of sexually diverse people will present late with chronic and life-limiting illnesses. This also means that the members of the LGBTQ+ community will seek care within the palliative care setting. Due to the members of the community oftentimes not disclosing their sexual or gender identity, nurses and other health care professionals do not know about the specific health care needs and wishes of the LGBTQ+ patients. The lack of awareness about this marginalized minority group, leads to undiagnosed conditions, and health care providers not being able to appropriately educate the members of the LGBTQ+ community about anticipated outcomes of risk behaviour. Due to a lack of data about the health care needs of the LGBTQ+ community, little to no education about this minority group is included within nursing and medical curricula. This lack of awareness about this community, especially among nurses, indicates that patients, who identify as members of the LGBTQ+ community, receive suboptimal care. (Bristowe et al. 2018; Krehely 2009)

1.2 Gap in Knowledge and Objective

To date, there are no literature reviews or studies available concerning the quality of nursing care regarding the influence of stereotypes and bias against the members of the LGBTQ+ community. Additionally, only a very limited amount of studies about LGBTQ+ patients in the palliative care setting have been published. This thesis aims to describe the experience

of the members of this marginalized group in the palliative care setting and to determine how stereotypes and bias that nurses have against this group influence the quality of nursing care. Therefore, the research question of this thesis is: “How do stereotypes and bias influence the quality of nursing care, while providing palliative care for the members of the LGBTQ+ community?”

2. Methods

In order to answer the research question a literature review was conducted. The purpose of a literature review is to give an overview on the evidence of the studied topic. They are often used as a basis for new studies and to illuminate the significance of a new study. A literature review also helps researchers interpret their findings. (Polit & Beck 2018)

2.1 Literature search

The literature search was conducted in October 2019. The literature searches included health care relevant databases and were supplemented by an Internet and manual search. The databases CINAHL (The Cumulative Index to Nursing and Allied Health Literature) and PubMed (U.S. National Library of Medicine) were used for the search using keywords and synonyms. Different combinations and strategies of these keywords and synonyms were attempted until the optimal results were received. (Table 2)

The keywords were combined with the Boolean operators “AND” and “OR”. (Table 3) The keywords ‘stigma’, ‘homophob’, ‘homonegativ’, ‘trans’, ‘non-heterosexual’ and ‘hospic’ had a truncation symbol, in order to expand the search. The term “quality of care” and the related synonyms listed in Table 2, were excluded from the search, because of a lack of results.

MeSH-Terms (Medical Subject Headings) were not used. MeSH-Terms are used to describe articles by experts for MEDLINE records. (U.S. National Library of Medicine 2019) Filters in the relevant databases limited the language of the full text of the studies to English and German. In order to obtain the largest possible number of relevant studies, there was no filter added to exclude studies before 2009.

The search in the databases was supplemented by an Internet search in Google Scholar. The search terms used in Google Scholar were LGBT, palliative care, stereotype and homophobia. Additional to the Boolean operators “AND” and “OR”, specific operators for Google Scholar were used. (Table 4)

In order to identify primary literature a manual search was also conducted, using the reference lists provided in the literature reviews found through the search strategies on CINAHL and PubMed.

Table 2: Search terms and synonyms

Stereotypes, bias	Stereotype, prejudice, stigma*, homophob*, homonegative*, misconception, discrimination, antigay, sexual prejudice
Quality of care	Care quality, health care quality, quality of health care
Palliative care	Hospice care, end of life care, terminal care, end of life, hospice nursing, dying, supportive care, palliative nursing, palliative supportive care
LGBTQ+	Lesbian, gay, bisexual, transgender, transsexual, queer, asexual, intersexual, pansexual, trans*, homosexual, sexual minority, GLBT, LGBTI, LSBTTIQ, LGBTQIA, LGB, LGBT, non-heterosexual*, lesbigay, gender-nonconforming

Table 3: Search strategy

PubMed	((((((((((((stereotyp*) OR bias) OR prejudice) OR stigm*) OR homophob*) OR homonegativ*) OR misconception) OR discrimination) OR "antigay prejudice") OR antigay) OR "sexual prejudice") AND (((((((((((palliative care) OR hospic*) OR hospice care) OR "end of life") OR dying) OR "supportive care") OR "palliative supportive care") OR terminal care) OR "terminal care") OR "hospice nursing") OR palliative)) AND (((((((((((((((LGBTQ+) OR lesbian) OR gay) OR bisexual) OR
--------	---

	transgender) OR queer) OR asexual) OR intersexual) OR pansexual) OR homosexual*) OR "sexual minority") OR non-heterosexual*) OR LGB) OR LGBT)))
CINAHL	(((((LGBTQIA OR LGB OR LGBT OR non-heterosexual OR lesbigay OR gender non-conforming)) OR (LGBTQ+ OR lesbian OR gay OR (transgender or transsexual) OR queer OR asexual OR intersexual OR pansexual OR homosexual OR sexual minority OR GLBT OR LGBTI)) AND (stereotypes OR prejudice OR (stigma or stigmatization or stigmatisation) OR sexual prejudice OR antigay prejudice OR homophobia OR homonegativity OR misconception OR discrimination) AND (palliative care OR hospice care OR end of life care OR terminal care OR end of life OR hospice nursing OR dying OR supportive care OR palliative nursing OR palliative supportive care OR palliative OR hospice)

Table 4: Google operators (Southern Adventist University 2019)

-	Excludes a term or phrase from the search
“ “	Searches the exact phrase
~	Includes synonyms of the term in the search
+doi/ +issn	Searches for scientific studies

2.2 Study selection

Inclusion and exclusion criteria

Studies that concentrated on palliative or end-of life care, including oncological care, and LGBTQ+ patients were included in the study selection. The content of the studies had to

focus to some extent on stereotypes and bias experienced by the members of the LGBTQ+ community in the palliative care setting. Studies that concentrated on the diagnosing process of HIV (human immunodeficiency virus) or AIDS (acquired immunodeficiency syndrome) and did not concern the patient's experience in the palliative care setting were excluded from the study selection, as well as, studies on LGBTQ+ patients, who survived their respectable cancers. Studies that focused on teenagers, who identified as transgender, and the history of the LGBTQ+ community, as well as, a National U.S. health report were eliminated from the full text screening. These studies were excluded due to them not discussing the experience of the LGBTQ+ community in the palliative care setting. Literature reviews were omitted due to the fact that they simply display information from primary sources and might be a source of errors. However, those literature reviews were used to identify primary literature that was mentioned in the reviews. This was based on the assumption that primary literature has a higher research evidence and possible sources of error can be eliminated by using them. The setting of the studies selected included home care, palliative care facilities and out-patient care.

In the majority of the studies, the interaction within the palliative care setting between the LGBTQ+ patients and health care professionals was not limited to nurses, due to the aforementioned team process. Encounters with other health care professionals, which influenced the quality of palliative care the LGBTQ+ patients received, were also taken into account and mentioned as 'other health care professionals' in this thesis.

Selection process

After the optimal search strategy was chosen, the results from CINAHL, PubMed, as well as, the results from the Internet and hand search were imported into the reference management software Endnote X9. In this software the duplicates were removed to unveil the total numbers of studies. A title and abstract screening followed in order to eliminate studies that did not meet the criteria to answer the research question. The screening removed several studies, which left 25 viable studies for further evaluation. A full-text screening of the studies revealed fourteen relevant studies to be included in the review. The excluded full-text articles were excluded as they did not include data on stereotyping and bias in the palliative care or oncological care setting. The elimination process is portrayed in a flow diagram. (Figure 1)

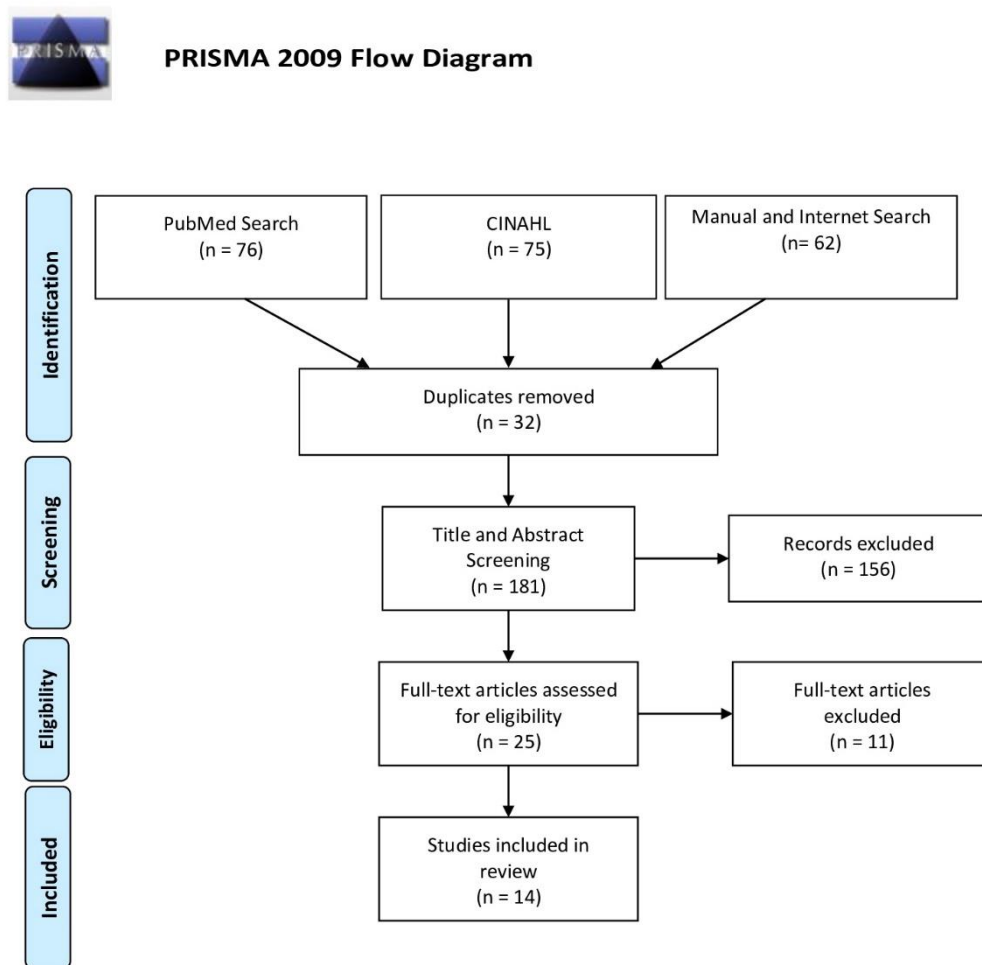
The relevant studies were then evaluated using a critical appraisal tool.

2.3 Mixed Methods Appraisal Tool (MMAT)

The final fourteen studies were assessed using a critical appraisal tool by Hong et al. (2018) in order to discover the strengths and weaknesses of each study selected. The Mixed Methods Appraisal Tool is designed for the appraisal stage of reviews in order to appraise the methodological quality of a study. This tool can be used for qualitative research, randomized controlled trials, non-randomized studies, quantitative descriptive studies and mixed methods studies. This critical appraisal tool consists of two parts, a checklist and an explanation of the criteria. The Mixed Methods Appraisal Tool has two screening questions, which have to be answered before moving on to the subsection of the particular study design. These questions concentrate on the research question and if the data collected in the study answers it. In order to indicate that a paper might not be an empirical study, it cannot be appraised by using this tool. After answering these questions, one moves on to the specific design of the studies selected. For each design there are five questions. All of the questions asked in the Mixed Methods Appraisal Tool can be answered with 'Yes', 'No' or 'Can't tell'. In order to assess the quality of a study, it is advised to provide a more detailed presentation of the ratings of each criterion. (Hong et al. 2018)

The results of the studies will be exemplified in the following chapter.

Figure 1: Flow diagram portraying the search for literature and process using the PRISMA Statement (Moher et al. 2009)



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

3. Results

After being critically appraised for their quality and compared to each other, the studies were categorized based on their findings: heteronormativity, discrimination and disclosure, and family and next-of-kin.

3.1 Characteristics

Eleven of the studies included in this literature review were qualitative studies, two were mixed methods and one study was of quantitative nature. The number of participants ranged from 7 to 793, who took part in an U.S. nationwide survey concerning the needs of LGBTQ+ people. The studies were conducted in the United States of America, the United Kingdom, Canada, Australia, Zimbabwe and Kenya.

A summary of the characteristics of the used studies can be found in Table 5.

Table 5: Characteristics of the studies

Author, Country	Study Aim	Design	Sample	Method	Main Findings
Hudson S.P. 2015 U.S.A.	To trail an 'EOL needs' interview guide	Qualitative study	9 participants, age between 31 and 59, recruited through a discreet, confidential verbal invitation at the HIV/AIDS Centre of Excellence	In-depth, semi-structured interview	Stigma surrounding HIV and sexual orientation, Religious values contribute to differences in health care, Death with dignity
Cartwright C. et al. 2012 Australia	To highlight the challenge of LGBT patients towards end of life	Qualitative study	25 participants (19 service providers, 6 members of the LGBTQ+ community) via newspaper advertisements, flyers and mailing lists of EOL care providers	Semi-structured questionnaires	Lack of recognition of sexual or gender identity, Fear of discrimination as a barrier to advance care planning
Fish J. et al. 2016 United Kingdom	To describe LGB people's information needs and help-seeking experience in the UK	Qualitative study	15 participants , recruited though flyer distributed by community-based organisations and social media	Semi-structured interviews	Not enough opportunities for disclosure, Heteronormativity and homophobia in the cancer care setting
Bristowe K. et al. 2017 United Kingdom	To explore health-care experiences of LGBT people facing life-limiting illnesses	Qualitative study	40 participants, recruited through six UK palliative care teams, media and the community	Semi-structured interview	Last wishes, Family ties and bereavement, Lack of recognition, Heteronormative assumptions, Homophobic behaviour, Presenting late for illnesses
Kortes-Miller K. et al.	Examine the fears and hopes of	Qualitative study	23 participants, age 57 to 78 (mean age of	Questionnaire and focus group	Fear of stigmatization and discrimination, Homophobia,

2018 Canada	LGBTQ+ patients at EOL		67.39), recruited through LGBTQ+ organizations, support groups, referral from other participants		Heterosexism, Family ties and isolation, Need to be self-sufficient and independent
Hunt J. et al. 2019 Zimbabwe	Identify experiences of sexual minorities and health/palliative care providers regarding palliative care	Qualitative study	72 participants, recruited through non-governmental, sexual minority supporting organisations	In-depth interview and focus group	Discrimination by health care providers, Limited experience of nurses, Heterosexual assumptions, Presenting late with life-limiting illnesses, Last wishes not respected
DeVries B. et al. 2019 Canada	Highlight challenges in EOL preparation in the LGBT community	Qualitative study	93 participants, aged 55 to 89, recruited through community agencies, social media, news reports and promotional materials in LGBT-identified venues	Focus groups	Gender identity not respected, Non-disclosure in care settings, Estrangement from biological family, Social isolation based on negative interactions, Fear of stigmatization
Graham S.M. et al. 2018 Kenya	Identify barriers of HIV care engagement and ART adherence	Qualitative study	30 participants, recruited through peer outreach and referrals from health care providers	In-depth interviews	Heteronormative assumptions, Fear of homophobia and stigmatization
Hunt J. et al. 2017 Zimbabwe	Describe health care experience for key population	Qualitative study	60 participants, recruited through thorough organisations working with this population	Focus group and in-depth interview	Presenting-late with illnesses, Heteronormative assumptions, Lack of knowledge of health care providers, Discrimination and personal attitudes by health care providers, Non-disclosure
Witten T. 2014 U.S.A.	Collecting information on later-life, EOL	Mixed-methods study	Between one and five participants in 24	Online survey	Western religion's rejection of trans-identities and last wishes, Isolation and lack of social support,

	needs and the perception of these topics in transgender people		countries, recruited via Internet		Lack of knowledge about trans-identities, Fear of discrimination by caregivers
Boehmer U. 2004 U.S.A.	Investigate the process of disclosure/ nondisclosure of lesbian and bisexual patients	Qualitative study	39 participants, recruited by referral from other participants	Semi-structured interview	Fear of homophobia, Lack of inquiry into sexual orientation, Non-recognition of relationships, Heterosexual assumptions, Health care professionals' negative attitudes
Higgins A. et al. 2009 Ireland	Explore the grief experience of same-sex couples	Qualitative study	7 participants	Unstructured in-depth interview	Breaking bad news, Health care professionals' negative attitudes, Lack of understanding the relationships Ineffective communication
De Vries B. et al. 2009 U.S.A.	Explore if state recognition of same-sex relationships has an impact on preparations for future	Quantitative study	793 survey respondents, recruited via invitation of online panel	Online questionnaire	Legal/ funeral preparations, Fears about discrimination
Almack K. et al. 2015 United Kingdom	Identify needs and preferences related to EOL care for LGBT older people	Mixed-methods study	237 survey respondents, 60 interview participants	Online survey and in-depth interview	Family/ next of kin, Heteronormative assumptions, Last wishes, Religious support, Choice of disclosure

3.2 Heteronormativity

The members of the LGBTQ+ community describe experiences of heteronormative assumptions in the palliative care setting as a common occurrence. Hospital questionnaires are used routinely, without adapting them for the members of the LGBTQ+ community and without including their sexual behaviours. Nurses are described as being closed-minded, automatically assuming heterosexuality, even if cues about identifying as LGBTQ+ are provided by the patients. In instances, where sexual behaviour has been discussed with patients, it has only been in the sense of heterosexuality. In correlation to those findings, nurses and other health care providers oftentimes did not recognize same-sex partners as a vital part in the patients' lives. (Bristowe et al. 2018; Fish & Williamson 2018; Hunt et al. 2019; Kortess-Miller et al. 2018)

A finding, unique to the lesbian population of the LGBTQ+ community, is that treatments regarding cancer care only meet the needs of heterosexual women. While receiving chemotherapy, some lesbian women mentioned only being presented long hairstyles, which they considered as being too feminine for their liking. They felt like their gender and sexual identity had not been considered by the health care professionals advising them in their post-therapy treatment. (Boehmer & Case 2004; Fish et al. 2018; Graham et al. 2018)

An overt form of heteronormativity encountered by the transgender LGBTQ+ community members has been the misuse of the correct gender pronouns, when referring to a transsexual patient. Nurses and doctors outright refuse to address the patients correctly in some instances, when referring to them. As an example, Bristowe et al. (2018) mention a transgender woman being referred to as 'Mister' by a doctor in front of her. These encounters create uncomfortable situations for the transsexual patients, who have to correct and educate the health care professionals about their gender identities. (Bristowe et al. 2018; deVries et al. 2019)

In order to avoid any form of direct or indirect disapproval about their sexual or gender identity, and in correlation to that heteronormative assumptions, the members of the LGBTQ+ community reported to having observed the body language of a health care professional and the way they acted around other patients, before disclosing their sexuality or gender identification. After disclosing their sexuality or gender identification, the LGBTQ+ patients stated that they oftentimes second guessed the health care professionals' motives and actions towards them as a member of the LGBTQ+ community. (Fish et al. 2018)

People, who identify as LGBTQ+, often mention that they are met with heteronormative assumptions and heterosexism, because of a lack of knowledge about the care needs of the members of this sexual minority group. They describe nurses having limited experience in

providing palliative and end-of-life care for the members of the LGBTQ+ community. This lack of knowledge extends to nurses not being able to inform the LGBTQ+ patient about the legal actions they have to take, in order to appoint a health care proxy or claim their same-sex partners as next-of-kin. These findings are not limited to the Western World, but also align with the results of a study conducted in Zimbabwe, Africa. (Bristowe et al. 2018; Cartwright et al. 2012; Graham et al. 2018; Hunt et al. 2019)

The reported encounters of heteronormativity and heterosexism created a distance in the relationships between the interviewed LGBTQ+ patients and their nurses or caretakers. Experiences of overt heterosexism and homophobia in the palliative care setting were associated with LGBTQ+ members receiving a poorer quality of palliative care than their cisgendered, heterosexual counterparts by the members of the community. This lack in care quality was felt by the LGBTQ+ patients during medical consultations, when a same-sex partner was not included in the conversation, the health care professionals did not recognize their beloved ones as next-of-kin and did not offer the bereaved adequate support after a LGBTQ+ patient's death. A poorer quality of care is also strongly felt by the transgender population of the LGBTQ+ community. Reports mention transgender patients being bullied into reverting back to their birth gender by their nurses or not having their chosen identity recognized by their care takers. These findings were especially significant in the religious long-term care settings. (Bristowe et al. 2018; Cartwright et al. 2012; Fish et al. 2018; Higgins & Glacken 2009)

Fish et al. (2018) mentions that the members of the LGBTQ+ community oftentimes do not know if a health care professional's attitude towards them and their significant others varies between them and their heterosexual, cisgender counterparts. The authors mention the possibility of the LGBTQ+ patients' obliviousness to the fact that a health care professional might treat all their patients, heterosexual and homosexual, transgender and cisgender, with disrespect. (Fish et al. 2018)

The needs, preferences and wishes towards the end-of-life of the LGBTQ+ community need to be addressed by nurses, in order for them to appropriately care for a LGBTQ+ patient. A person-centred care, which addresses sexuality and gender identity has been deemed important for the members of the community. Adapting a person-centred care is a subsequent art of optimizing nursing care for the members of the LGBTQ+ community. It is implied that nurses have to start thinking outside of assumed sexuality and gender standards, in order to appropriately care for the members of this marginalized group. (Bristowe et al. 2018)

3.3 Discrimination and Disclosure

Discriminatory beliefs by nurses and other health care providers have been strongly felt by the members of the LGBTQ+ community in the palliative and the general health care setting. These beliefs negatively influence the decision of the community members to disclose their sexual orientation and gender identity to nurses or lets them avoid the health care setting completely. (Hunt et al. 2017; Hutson 2016)

3.3.1 Discrimination

Members of the LGBTQ+ community describe encounters of homophobia and discrimination by nurses and other health care providers as a common occurrence in the palliative care setting. An overlying topic, which was addressed in the studies reviewed for this thesis, is the members of the community's fear of being mistreated by nurses due to their sexual orientation or gender identity. (Kortes-Miller et al. 2018; Witten 2014)

LGBTQ+ patients mention fearing an inappropriate nursing care and treatment, which they might receive at the end of their lives, because of their identity. LGBTQ+ community members fear abuse from nurses, such as being denied treatments and physical abuse. Especially the transgender population of the LGBTQ+ community has little to no confidence, of being treated with dignity and respect in the palliative care setting. Their expectation is that they will not receive a culturally competent and respectful nursing care at the end of their lives. These expectations influence their willingness to engage in palliative care preparations. (Witten 2014)

The transgender members of the LGBTQ+ community, mention the possible necessity of reverting back to their birth gender, in order to protect themselves against harassment and discrimination from health care providers. The studies suggest that transgender patients are also often met with insensitivity by nurses before and after receiving gender reassignment surgery. A fear unique to transgender palliative patients is having to explain their particular gender situation, in order to receive appropriate care and care products. In correlation to this, a big concern for the transgender population is receiving intimate care, before they have not had their gender reassignment surgery. Not knowing who would be providing their care, in the home care setting, and the possibility of the nurses not knowing about their gender identity has been mentioned as a stressor regarding palliative care and care preparations for the transgender members of the LGBTQ+ community. (Bristowe et al. 2018; Cartwright et al. 2012; deVries et al. 2019; Kortes-Miller et al. 2018)

Discrimination has also been strongly felt by LGBTQ+ patients living with HIV, due to nurses assuming they were promiscuous. In Zimbabwe, nurses oftentimes blamed the patients'

homosexuality to be the cause for their HIV status. Members of the LGBTQ+ community mention not being seen as humans, but as animals and feeling like they were being treated as such. For members of the LGBTQ+ community breaches in confidentiality especially by nurses are also a big concern, since the nurses live in the same local communities as the LGBTQ+ patient does. Reports of members of the LGBTQ+ community, who are suffering from HIV, depict instances where nurses told their acquaintances, who had come to the HIV clinic including the reasons for their visits. Gay patients with a negative HIV status are also seen as a source of infection, because of the automatic assumption of nurses that every man, who has sex with men, suffers from HIV. (Higgins et al. 2009; Hunt et al. 2017, 2019; Hutson 2016)

Nurses' attitudes influence the kind of care the members of the LGBTQ+ community receive. The religious values of a nurse heavily influence the nursing care, they provide for the community members. Patients, who identify as LGBTQ+, actively decide against receiving treatment at catholic hospitals, because they fear their gender identity and sexual orientation, as well as, their wishes would not be respected in this setting. LGBTQ+ community members, receiving palliative care, have been called 'dirty' and a 'sinner' by nurses on the grounds of them being homosexual or transgender. LGBTQ+ patients describe feeling like a lesser human, because of their sexual or gender identity, while receiving care. A common occurrence has also been nurses lecturing the LGBTQ+ community members about the bible and how homosexuality was against Christian values. Nurses' attitudes are perceived as more negative towards gay men than towards lesbian women, however, these findings are limited to Zimbabwe, Kenya and Tennessee. Therefore, it has been concluded that these religious beliefs negatively impact the palliative care patients receive. (Boehmer et al. 2004; Hunt et al. 2017; Hutson 2016)

3.3.2 Avoiding the health care setting

The members of the LGBTQ+ community might avoid the palliative and health care setting completely, because of the fear of anticipated discrimination and stereotypization. Being judged by nurses, due to a different gender and sexual orientations, and an inconsistent nursing care increases the odds of patients, who identify as LGBTQ+, to avoid care settings completely. In correlation to that, the probability of patients defaulting on treatments and failing to attend hospitals for diagnosis is also heightened. (Bristowe et al. 2018; Hunt et al. 2017, 2019)

The stigma and discrimination surrounding the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS) leads to situations in which patients, suffering from this infection or later disease, do not seek treatment. The absence of exploring patients'

risk behaviours leads to untreated symptoms, increased rates of transmission and an earlier mortality. Without monitoring a patient's health and the progression of an illness, a LGBTQ+ patient might suffer a painful and undignified death. (Hunt et al. 2019; Hutson 2016)

As a result of their encounters with discrimination and homophobia, the elderly members of the LGBTQ+ community isolate themselves in the health care and the social context. They describe a lack of trust and honesty, which is primarily felt by gay men and the transgender LGBTQ+ population. (deVries et al. 2019)

3.3.3 Disclosure

Fears of anticipated homophobia and a lack of inquiry into sexual orientation and gender identity leads to members of the LGBTQ+ community keeping nurses and other health care professionals on a 'need-to-know' basis. They only disclose information, which they deem as important to their treatment and care. Before disclosing their sexuality in the palliative or health care setting, patients report assessing the level of anticipated bias from the nurses' body language and the language they are using. This assessment often discourages patients from disclosing their sexual orientation and gender identity with their health care providers. (Boehmer et al. 2004; Fish et al. 2018; Hunt et al. 2017; Hutson 2016)

Disclosure has been met with insensitivity, with health care professionals not minding being out of earshot from other patients, before addressing a patient's disclosure and therefore treating the information about their sexuality and gender identity insensitively and disrespectfully. Members of the LGBTQ+ community report feeling afraid of exposing themselves to harassment and discrimination, if they choose to disclose their identity. LGBTQ+ patients have pretended to be heterosexual in order to receive appropriate nursing care, feeling pressured into concealing their identity in order to access health and palliative care services. (Bristowe et al. 2018; Graham et al. 2018)

Disclosing their sexual orientation or gender identity has been especially difficult for the African LGBTQ+ community members. Within the African cultural context, nurses have responded to disclosure by humiliating LGBTQ+ patients. This included asking inappropriate questions about a patient's sex life and providing inadequate care for the member of the LGBTQ+ community, such as being unwilling to examine and treat the patient, who identifies as part of the community. (Hunt et al. 2017)

LGBTQ+ patients feel that the long-term care setting would not be a safe space to disclose their sexual orientation or gender identity. Fears about being forced into silencing this part of their

identity or having to ‘go back into the closet’ are frequent fears, that have been felt by the members of the LGBTQ+ community. Concerns about needing to compromise their identity in order to receive appropriate care from the nursing staff have also arisen. In order to receive appropriate care, for example for incontinence, transgender patients feel like they might need to educate nurses about their specific gender situation. A concern limited to the transgender population of the LGBTQ+ community, is not being able to conceal their birth gender, due to them not having gender reassignment surgery or not being able to conceal previous medical records. Living with a part of their identity hidden could also negatively impact a LGBTQ+ patient’s quality of life. (Cartwright et al. 2012; deVries et al. 2019; Hutson 2016; Kortess-Miller et al. 2018)

One of the main reasons the transgender members of the LGBTQ+ community decide against disclosing their gender or sexual identity, is nurses and other health care professionals not recognising their chosen identities. Reports of other transgender men and women who were forced to resume to their birth gender by religious organisations also influence their decision to disclose their identity. (Cartwright et al. 2012)

Terminally ill transgender patients have been refused gender confirmation surgery, due to their underlying illnesses. They have had to choose between treatments, to preserve their health, and their gender identity. A unique desire for the transgender population of the LGBTQ+ community is to be buried as their chosen gender. (Bristowe et al. 2018)

3.4 Family and Next-of-kin

A wide-spread phenomenon in the LGBTQ+ community is the lack of family presence and strong ties to the family of origin. Gay and transgender community members use the word ‘distant’ to describe their relationships with their families of origin. A main resource for the members of the LGBTQ+ community is family of choice. LGBTQ+ patients oftentimes do not know who to appoint, and if they do, how to appoint a health care proxy or next-of-kin, who would be responsible to reinforce their wishes at the end of their lives. Next-of-kin often reflects heteronormative norms, which means, the decision-making responsibilities oftentimes revision to the family of origin. This might mean that the family of origin excludes the partner and friends of the dying patients from their care. A patient’s last wishes might get overwritten by their biological family, because of the aforementioned distance between the patient and their family of origin, and them not seeing the need of having end-of-life-discussions with the members of the family of origin. (Almack et al. 2015; Cartwright et al. 2012; deVries et al. 2019; Hutson 2016)

The legitimacy of same-sex relationships is oftentimes not recognized within the health care system, which describes an inability to recognize different family structures. This failure to acknowledge the appropriate health care proxy in the palliative care setting leads to additional grief for the bereaved family members and a loss of dignity for the patient. In order for the LGBTQ+ patients to receive an appropriate end-of-life care and a death with dignity, the nature and depth of a same-sex relationship and relationships within the LGBTQ+ community need to be recognized by nurses. Due to the LGBTQ+ patients' estrangement from their biological families, LGBTQ+ patients often rely heavily on the support of other LGBTQ+ community members and other friends, known as the family of choice. Not being legally recognized as a civil partner or being married, can lead to concerns regarding the acknowledgement of same-sex partners as next-of-kin. In order to get authority in the decision-making process without them being challenged by the family of origin, LGBTQ+ members feel like they have to bring their legal documents appointing members of the family of choice as the patient's health care proxy to the hospital at all times. Nurses not being able to recognise the nature, depth and duration of these relationships, leads to them being emotionally unavailable for the bereaved partners after the death of a LGBTQ+ patient. (Boehmer et al. 2004; Bristowe et al. 2018; Cartwright et al. 2012; Higgins et al. 2009; Hunt et al. 2017)

As a result of the biological family not being present, the members of the LGBTQ+ community have a strong need for self-reliance, which is often mentioned as a survival strategy. As the LGBTQ+ community members age, their large social networks change and get smaller, due to them being acquainted with members roughly the same age as themselves, which means all their acquaintances and/or family members face disabilities and diseases around the same time. These changes in a patient's support systems and networks lead to isolation. Isolation is seen as a barrier to end-of-life care and, in relation to that, advanced care planning. Because of their lack of social networks, members of the LGBTQ+ community fear that their quality of life might spiral downwards, since they have no one who could take care of them. The members of the LGBTQ+ community describe an absence of who they could appoint as a health care proxy as they age. (Cartwright et al. 2012; deVries et al. 2019; Hutson 2016; Kortess-Miller et al. 2018)

3.4.1 Bereavement

The offered support during the bereavement process influences the quality of palliative and end-of-life care patients and their families receive. The failure of nurses to recognize and acknowledge same-sex relationships adds additional grief to the bereaved. Due to a lack of knowledge about LGBTQ+ friendly support groups, nurses cannot inform the bereaved

LGBTQ+ community members about how and where to access them. Bereaved partners of LGBTQ+ patients oftentimes have to go through the process of finding these support groups alone, adding yet another layer of stress to the grieving process. Another aspect, which influences the bereavement process, is the family of origin excluding friends and members of the family of choice from the funeral of a deceased LGBTQ+ community members. Not being able to share their grief in the social context, leads to a heightened suicide rate among the bereaved LGBTQ+ members. (Almack et al. 2015; Bristowe et al. 2018; Cartwright et al. 2012; Higgins et al. 2009)

3.4.2 Last wishes

The most prominent last wishes of the members of the LGBTQ+ community are that they do not want to suffer at the end of their lives and die with dignity. Living in an environment that is free from harassment and being accepted by the people surrounding them is also often mentioned as a desire by the LGBTQ+ patients. Members of the LGBTQ+ community suffering from the human immunodeficiency virus (HIV) share concerns that they might be forced to suffer and beg for an appropriate nursing care at the end of their lives, due to their illness and the stigma surrounding the infection. A fear unique to the transgender population of the LGBTQ+ community is not acquiring a gender recognition certificate before their death. This certificate legally recognizes their chosen gender and is necessary for the gender to be correctly identified on their death certificate. (Bristowe et al. 2018; Hutson 2016; Kortés-Miller et al. 2018)

In the palliative care setting the communication about end-of-life wishes with partners, different family structures, nurses and other health care professionals plays an important role. As mentioned above older LGBTQ+ patients might isolate themselves from the greater community and might be forced to die alone. This empathizes the importance of nurses acting as health care advocates for the members of the LGBTQ+ community. (Cartwright et al. 2012)

At the end of life spirituality and religious beliefs are substantial. Spiritual and religious support might be compromised due to discriminatory beliefs of religious leaders. A dominating theme in the end-of-life discussions with the members of the LGBTQ+ community are concerns regarding burials and the question of what will happen to their bodies after death. Fears about not being allowed to be buried in a church graveyard and not having their gender identity recognized on the tombstone have arisen during the end of life discussions. (deVries et al. 2019; Hunt et al. 2019; Witten 2014)

The members of the LGBTQ+ community fear that their last wishes will not be respected by their family of origin and health care professionals. A question surrounding the end-of-life discussion of LGBTQ+ patients is, if they will be allowed to live out the last moments of their lives with grace and dignity. (Hunt et al. 2019; Witten 2014)

4. Discussion

The aim of this review was to examine how stereotypes and bias influence the quality of nursing care in the palliative care setting. The studies which were included in the results were categorized based on their findings: heteronormativity and discrimination, disclosure, and family and next-of-kin. In this chapter, the findings will be discussed critically.

Heteronormativity and discrimination

Heteronormative assumptions have been felt by the members of the LGBTQ+ community in many parts of the health care setting, which were communicated through brochures, informative materials and forms about personal information. Røndahl et al. (2006) state that gay men actively try to hide their sexuality and refrain from communication with nursing staff addressing their sexual and gender identity in any way. The authors, furthermore, explain that due to heterosexual nurses being afraid of humiliating the members of the LGBTQ+ community, they use overly correct language, which might lead to misunderstandings and to a strained relationship between the nurses and the LGBTQ+ patients. Although some nurses try to incorporate sexual orientation and gender identity into conversations with the members of the LGBTQ+ community, as mentioned by Beagan et al. (2012), heteronormative language and stereotypes still prevail. Nurses, who participated in this study, mentioned the inevitability of making assumptions, because of the expectation that everyone is the same.

Discrimination is widely felt by the members of the LGBTQ+ community in health care settings other than the palliative care setting, as mentioned by Logie et al. (2019). Experience of stigmatization about sexually transmitted diseases and the human immunodeficiency virus (HIV) have been a common occurrence for LGBTQ+ patients, especially in the sexual health care setting, as described in this study. Myths about gay men being oversexed and seen as predators have been endorsed by male nurses and they have also mentioned not being comfortable to provide intimate care for a male LGBTQ+ patient, due to their fear of sexually stimulating the patient, as mentioned by Carabez et al. (2015). Many LGBTQ+ patients, in a study conducted by Logie et al. (2019), also mention assumptions and stereotypes being made about their sexual behaviour. These findings align with Beagan et al. (2012), who remark that nurses often link LGBTQ+ identities to being promiscuous and assuming they are more sexually inappropriate than their heterosexual, gender-conforming counterparts. As for the members of the LGBTQ+ community, there is a lack of open and honest conversation between them and their health care providers. Lindroth (2016) mentions that in the sexual reassignment setting, nurses and other health care professionals use language, which implies

that the patients must 100% identify themselves with their chosen gender. The author mentions expectations of gender-conformance and heteronormativity by the hospital staff, which the transitioning patient should fulfil. Participants in this study discuss gender as being either black or white for nurses, and there not being any fluidity within the gender reassignment process. A fear unique to the LGBTQ+ population, mentioned by Lindroth (2016), is being seen as a living teaching material for nurses and nursing students. Participants of this study reported instances in which a health care professional asked to see body parts of transgender patients, not related to their ongoing care issue. These encounters lead to situations in which the LGBTQ+ patients avoided the health care setting completely.

Another form of overt heterosexism mentioned by Røndahl et al. (2006), particular for the lesbian population of the LGBTQ+ community, are the routine heteronormative treatment options. During a routine sexual health care check-up, they have been asked to take pregnancy tests, although the patients disclosed their sexual identity to their nurses. This, in turn, lead to lesbian women feeling insulted and disrespected in their sexual orientation. Negative encounters within the health care setting shape the process of accessing care and the point in time, when the members of the LGBTQ+ community decide to seek out care, as mentioned by Rounds et al. (2013). Heterosexism and homophobia have also been mentioned as barriers to accessing the care settings, depicted in this study, due to patients having difficulties to advocate their health care needs within this setting by themselves. The members of the LGBTQ+ community report feeling unwelcome and unsafe in the health care setting.

Rounds et al. (2013) mention that the members of the LGBTQ+ community seem to grow distrustful of nurses and other health care providers, due to assumed stereotypization. Moreover LGBTQ+ patients reported doubting the health care advices they received from these providers. Logie et al. (2019) discussed heterosexism and cis-normativity as a barrier for the LGBTQ+ community to access health care services, especially sexual health care. The author described that assumptions of a patient's gender, sexuality and sexual practices affect the health and the well-being of the patient. In relation to those findings, Røndahl et al. (2006) stated that heteronormative assumptions are communicated to the LGBTQ+ community members via nurses, because they do not reflect on the language used when addressing a patient. The heteronormative norms in the health care setting have a restraining effect on LGBTQ+ patients.

A nurse's attitude towards and knowledge about the LGBTQ+ community also influences a community member's decision to seek out care. In Rounds et al. (2013), LGBTQ+ patients mention feeling judged about their sexuality and gender identity by nurses. These negative

reactions expressed themselves as nurses belittling the patients, making assumptions about their sexual activities or refusing to discuss the patients' specific health concerns. In correlation, Beagan et al. (2012) state that the main focus, when working with the members of the LGBTQ+ community, is often restricted to their sexuality and sexual health. Transgender patients get stigmatized especially, due to transsexuality having been categorized as a mental disorder for many years and nurses still considering them as abnormal, as stated by Rounds et al. (2013).

Vogelsang et al. (2016) discuss a lack of knowledge about the care, the different treatments and surgeries for transgender patients related to the general gender reassignment process. The transgender participants of this study mention having to educate nurses about their specific gender identities and health care needs. The transgender patients reported that they felt as if they were treated as a primary source of information for the nurses, who then did not intend to inform themselves elsewhere about LGBTQ+ related issues. In Aslan et al. (2019), nursing educators report that they were not willing to include LGBTQ+ specific issues in their courses for nursing students. As reasons for the exclusion of LGBTQ+ specific issues, they mention their own lack of knowledge about the LGBTQ+ community and their health care needs, an unwillingness to lecture about this topic and not deeming this topic as important for the education of nursing students. Nursing educators in this study also imply that they have never read any articles related to LGBTQ+ specific issues, yet they deem the education on this topic necessary, in order to gain knowledge about the health requirements of LGBTQ+ patients.

Practicing nurses mention that they are less experienced in caring for the members of the LGBTQ+ community, as stated in Beagan et al. (2012) and Carabez et al. (2015). A common viewpoint of nurses is that sexual orientation and gender identity do not matter, because of all people being the same inside. Furthermore, nurses in Carabez et al. (2015) discuss to never have received any kind of educational or organizational training on LGBTQ+ specific issues, and furthermore state there not being an actual need for an explicit education about LGBTQ+ community related subjects. Due to the lack of training, nurses do not only feel less comfortable in providing care for the members of the LGBTQ+ community and but also perceive a lack of confidence in working with LGBTQ+ patients. Carabez et al. (2015) discuss that nurses are faced with having to educate themselves about LGBTQ+ specific issues, if they want to provide a person-centred care for the members of this community. Aslan et al. (2019) explain that within the educational nursing context, the members of the LGBTQ+ community are oftentimes only mentioned in correlation with the human immunodeficiency virus, the acquired immunodeficiency syndrome (HIV/ AIDS) or homophobia.

The marginalization and oppression experienced by the members of the LGBTQ+ community, mentioned in Beagan et al. (2012), influence the health of LGBTQ+ patients, their health care needs and their health care experience. In Rounds et al. (2013) homophobia and transphobia are suggested as a main cause for a lack of quality in nursing care, followed by a lack of knowledge about the community and their specific health care needs. The transgender population of the LGBTQ+ community is the most at risk to receive a poorer quality of care, as they might even be forced to revert back to their birth gender and be denied treatments, due to nurses not being aware of care needs, treatments and procedures unique to the transgender community. As stated by Beagan et al. (2012), there is a need for nurses to be aware of how everyday interactions within the health care setting might unintentionally marginalize a LGBTQ+ patient and their social network, such as not asking a same-sex partner to participate in caring for the patient.

Rounds et al. (2013) mentions that although the LGBTQ+ community requires a culturally sensitive and community competent health care, there is only a limited amount of adequate providers available. The LGBTQ+ patients might have to do additional research in order to find a health care provider they feel comfortable with and who is competent to care for them.

Disclosure

Even if nurses have been able to acknowledge a patient's different sexual orientation and gender identity, they still struggle to find a way to incorporate the significance of a patient's disclosure into nursing practice, as stated by Beagan et al. (2012)

Especially for the transgender population of the LGBTQ+ community health care providers addressing them with the wrong name or gender pronouns, is a big concern, as seen in Vogelsang et al. (2016). Due to this misuse and, in relation to this, the denial of differences in gender and sexual orientation, mentioned by Beagan et al. (2012) and Rounds et al. (2013), transgender patients are at a greater risk to receive a poorer quality of care than their lesbian, gay and bisexual gender-conforming LGBTQ+ community members. Fears about breaches in confidentiality have been evident in many other health care settings other than the palliative care setting. Especially in the sexual health care setting, researched by Logie et al. (2019), the members of the LGBTQ+ community fear confidentiality might not be maintained by nurses. Due to fear of being outed to larger social communities, many LGBTQ+ patients decide to not disclose their sexual orientation and gender identity with their nurses. Fears of their privacy being violated are evident in the LGBTQ+ community. Andersen et al. (2017) mention, that LGBTQ+ participants felt the need to discuss their gender identity and sexual orientation more

frequently than their heterosexual, cisgendered peers. In a study, conducted by Røndahl et al. (2006), participants mention not wanting to disclose their sexual and gender identity with the nursing staff, because of an anticipated negative reaction. The decision of the LGBTQ+ patients to disclose their identity is heavily influenced by the fear of not getting their care needs satisfied and their need for secrecy about their everyday lives.

Rounds et al. (2013) raise the hypothesis that members of the LGBTQ+ community try to stay vague with their responses to questions about sexuality and gender identity, due to previous negative reactions of nurses, which ranked from grimacing, staring blankly, blushing or looking confused. Their sexual orientation or gender has often been openly discussed in the health care setting, while their health care needs might have been overlooked. Not being able to disclose this part of their identity has left LGBTQ+ patients wondering, if they should disclose any part of their identity to nurses. The participants in this study proceeded to describe the process of disclosure as stressful, because they could not imagine the reaction of their medical counterpart. Even if the nursing staff reacted positively to a patient's disclosure, worries about notes being left about their LGBTQ+ identity in their chart still remained. The LGBTQ+ patients fear they might still get sub-standard treatment by another nurse, if they do not approve of their sexuality or gender identity.

Rounds et al. (2013) discusses transgender and gender non-conforming patients being at a greater risk to receive a poorer quality of care, since they do not necessarily have the option to disclose their sexuality with their health care providers. They are also at a greater risk to be refused care, especially in the emergency care context, since there is a greater stigma surrounding transgender and gender-nonconforming specific health care issues, than lesbian, gay and bisexual health care issues.

In a study conducted by Vogelsang et al. (2016), transgender patients have purposely tried to withhold their gender identity and sexuality from nurses and other health care professionals, if possible. Transgender patients are expected to dress and act accordingly to their chosen gender by health care professionals. These reactions make the patients feel questioned regarding their identity and criticized for who they are by the nursing staff. The transgender participants mention being the driving factor in the gender reassignment process, because of them not having anyone who could advocate for them. On multiple occasions, health care professionals have asked transsexual patients, if they have tried to not be transsexual, denying their gender identity and lifestyle.

Lindroth (2016) discusses that sexuality only has a small place within the health care settings. According to the members of the LGBTQ+ community, they rarely get empathically questioned about their sexual practices and behaviours in a setting, in which they would feel comfortable to disclose their sexuality and gender identity. For the LGBTQ+ patients, an important part of their identity is absent while receiving health care. Nurses being aware of the sexual and gender identity of a patient and acknowledging that every person is different, leads to a better quality of care, as Rounds et al. (2013) conclude.

Family and next-of-kin

Due to family structures being described in a traditional, heteronormative language, the members of the LGBTQ+ community report nurses having a lack of knowledge about different family structures, especially, in the context of children health care, as mentioned by Andersen et al. (2017). Mothers and fathers, who identify as LGBTQ+, mention nurses assuming they are a child's relative or friend, rather than their parent. A feeling of not being as significant to the health care process of their child as the biological parent would be, arose when only the questions of the biological parent are being answered. Non-biological parents also discuss being more often criticized in their actions than the biological parent, due to them not bearing the child. This leads to the members of the LGBTQ+ community feeling insignificant and disrespected in the health care setting. In relations to these findings Kerppola et al. (2019) mentions that LGBTQ+ parents might not be treated as such by nurses. The participants in this study stated that gender and parental roles, as well as family constellations, were not taken into account on forms, medical records and during conversations in the children care setting. This study mentions the lack of recognition of the chosen gender identity of a LGBTQ+ parent and not feeling welcome within this particular health care setting. Concerning these findings, the felt experience of these parents might be due to expecting anticipated bias and discrimination in every setting, including the health care setting.

Röndahl et al. (2006), on the other hand, discuss how non-verbal communication about relationships within the LGBTQ+ community could negatively impact the health care experience of a patient. The author speaks of nurses and other health care professionals not acknowledging same-sex relationships, by acting like the partner does not exist or asking if a patient does not have other relatives, who might be able to take care of them. Röndahl et al. (2006) also remark that there is the possibility of an LGBTQ+ patient being isolated or rejected

from larger social communities or family members, so that they might not be able to have any support systems in place.

Poor quality health care

Poor quality health care is described as the leading cause for deaths within the health care system, since ineffective care harms patients more than healing them. To put it in numbers, 25% of deaths in hospitals can be attributed to the substandard treatment of conditions, such as the human immunodeficiency virus (HIV), tuberculosis and mental illnesses. People affected by these diseases might have access to care, yet the quality of care is so poor that the patients die due to the substandard conditions. Especially patients, who have been diagnosed with the human immunodeficiency virus end up dying due to receiving poor health care and being prescribed the wrong medicine to treat their illness. In general, 8.6 million patients all over the world die every year from conditions, which would be treatable by establishing a high quality health care. Especially within the primary care context, health care providers only follow basic clinical guidelines and routine screenings. Primary health care visits last around 5 to 8 minutes, which is not enough time to properly assess a patient's health care needs, counsel them and detect a patient's health care problem. Poor quality of care delays diagnosis and treatment. Poor health care services are delaying the process of improving patients' health at all income levels in all countries. Poor quality of care is defined as giving inaccurate diagnosis, medication errors, inappropriate or unnecessary treatments, inadequate or unsafe facilities and providers, as well as, a lack of adequate training. Approximately 30% of people all around the globe report negative encounters within the health care system, such as poor communication skills or rude health care providers. A high quality of care is essential for everyone and prevents patients from suffering, because of their illnesses and inadequate care. A higher quality of care leads to a higher survival rate for cancer and cardiovascular diseases. An important part of achieving a higher care quality is improving the knowledge and technical skill of health care professionals, concerning the communities patients live in and their specific health care needs. (Harvard Global Health Institute 2020; Mosadeghrad 2014; United Nations 2018; World Health Organization 2018)

A high quality of care relies on a nurse's competence to respect a member of the LGBTQ+ community in their sexual and gender identity, and acknowledge their relationships within the community, mentioned by Kerppola et al. (2019).

5. Recommendations for Research and Practice

Recommendations for Research

To date, there are no studies about the members of the LGBTQ+ community and their place in the health care system in German-speaking countries. In general, there is a lack of representation of the LGBTQ+ community within the European Union, since there is not a lot of data available on the amount of people, who openly identify as LGBTQ+ in these countries. Studies assessing the quality of care within the palliative care setting would also be recommended, since the amount of studies concerning the quality of health care in general are very limited. It would also be interesting to see, how nurses and other health care professionals could improve person-centred care in general, not limiting the study to patients living with advanced illnesses. As seen in this thesis, a study about improving the bereavement process for the members of the chosen family of a LGBTQ+ patient would also be recommended. Since the amount of people who openly identify as members of the LGBTQ+ community has risen within the last decade, a study or guideline on how to accurately address and refer to patients, with a different sexual and gender identification than heterosexual and cisgender, in the clinical context. At last, it would be interesting to know, how advanced care planning influences the quality of palliative care for the members of the LGBTQ+ community.

Recommendations for practice

A topic, which often arose from the studies selected for this thesis, was the lack of education about the LGBTQ+ community in general and their specific health care needs. Within the nursing, as well as, the medical curriculum, there is a need for education about sexually diverse people, transgender and gender-nonconforming people. In order to appropriately care for the members of the LGBTQ+ community, nurses have to know about the different family structures a person, who identifies as LGBTQ+, might be part of, in order to create a support system for the patient and address the bereavement process of the family members appropriately. Education also needs to focus on the general health care needs and especially on the needs at the end of a LGBTQ+ patients' lives. Nurses and other health care professionals also have to know about different legal issues the members of the LGBTQ+ community might face in every aspect of their lives, but also at the end of life. They need to be able to advice patients on how to appoint a health care proxy or a member of their chosen family as their next of kin.

Implementing clinical guidelines on how to use sexuality and gender inclusive language should also be a priority, especially guidelines on how to address the members of the LGBTQ+

community during assessments and interviews. Clinical forms should also include all sexualities, genders and family structures, in order to appropriately plan the care for the community members.

It is also important to destigmatize sexual orientation and gender identity, especially in relation to sexually transmitted diseases, such as the human immunodeficiency virus, and sexual promiscuity. In order to provide a person-centred, culturally appropriate care for the members of the LGBTQ+ community, nurses and other health care professionals need to create opportunities and safe environments for LGBTQ+ patients to disclose their sexuality and gender identity, ensuring confidentiality. These safe spaces could also be implemented into living spaces, creating LGBTQ+ inclusive living spaces within the palliative care setting and the long-term care setting.

To ensure a holistic care environment, nurses and health care professionals also need to be able to refer a LGBTQ+ patient gender and sexuality inclusive support groups for the patient and also their bereaved families, whether it be the family of choice or the family of origin. Nurses also need to start the missing conversation about end-of-life considerations and advanced care planning with the members of the LGBTQ+ community. They need to be advocates for the community members, ensuring that their last wishes are being carried out, and need to create a safe space for the LGBTQ+ patients to share their fears and health care needs at the end of the patients' lives.

6. Conclusion

The answer to the research question “How do stereotypes and bias influence the quality of nursing care, while providing care for the members of the LGBTQ+ community?” is extensive.

As seen in the definition of the World Health Organization (2019a) used to describe quality of care in the introduction, high quality health care needs to be equitable and person-centred. Discriminatory beliefs, as well as stereotypization and bias influence the care the members of the LGBTQ+ community receive within the palliative care setting. Nurses and other health care professionals discriminate against the community members, such as assuming sexual transmitted diseases, promiscuity, not focusing on a patient’s health care needs, but on their gender or sexual orientation, and, concerning the transgender population, bullying them into reverting back to their birth gender. According to the studies included in this thesis, their cisgendered, heterosexual counterparts do not have to face this kind of oppression, therefore, the care for the members of the LGBTQ+ community is not equitable.

The care the members of the LGBTQ+ community receive is also not people-centred, exemplified in the instances reported, the community members’ needs, preferences and wishes at the end of their lives are not being taken into account. Nurses assume heterosexuality and that every patient’s needs are the same, as seen in many studies which have been included in this thesis. Especially important for the palliative care setting is the deficiency of supporting the family of choice during the bereavement process and not being an advocate for needs of the bereaved members of the family of choice.

In conclusion, the literature suggests that a nurse’s stereotypes and bias against the members of the LGBTQ+ community influences the care they provide for the community members. Therefore, the members of the LGBTQ+ community receive a substandard quality of health care.

References

Abrams, M 2019, *Is There a Difference Between Being Transgender and Transsexual?*, viewed 2020, <https://www.healthline.com/health/transgender/difference-between-transgender-and-transsexual>

Almack, K, Seymour, J, Yip, A & Sargeant, A 2015, *The Last Outing: exploring end of life experiences and care needs in the lives of older LGBT people.*, The University of Nottingham, <https://www.nottingham.ac.uk/research/groups/ncare/documents/projects/srcc-project-report-last-outing.pdf>

Amnesty International 2020, *LGBTI Rights*, viewed 2020, <https://www.amnesty.org/en/what-we-do/discrimination/lgbt-rights/>

Andersen, AE, Moberg, C, Bengtsson Tops, A & Garmy, P 2017, 'Lesbian, gay and bisexual parents' experiences of nurses' attitudes in child health care-A qualitative study', *Journal of Clinical Nursing (John Wiley & Sons, Inc.)*, vol. 26, no. 23-24, pp. 5065-71, doi:10.1111/jocn.14006

Aslan, F, Şahin, NE & Emiroğlu, ON 2019, 'Turkish nurse educators knowledge regarding LGBT health and their level of homophobia: A descriptive–cross sectional study', *Nurse Education Today*, vol. 76, pp. 216-21, doi:10.1016/j.nedt.2019.02.014

Beagan, BL, Fredericks, E & Goldberg, L 2012, 'Nurses' Work With LGBTQ Patients: 'They're Just Like Everybody Else, So What's the Difference?', *Canadian Journal of Nursing Research*, vol. 44, no. 3, pp. 44-63

Boehmer, U & Case, P 2004, 'Physicians don't ask, sometimes patients tell: disclosure of sexual orientation among women with breast carcinoma', *Cancer*, vol. 101, no. 8, pp. 1882-9, doi:10.1002/cncr.20563

Bomba, E 2011, *Celebrating LGBT families of choice*, <http://www.epgn.com/columns/gettin-on/4158-16793270-celebrating-lgbt-families-of-choice>

Bridges, T 2017, *Shifts in the U.S. LGBT Population*, viewed 2020, <https://thesocietypages.org/socimages/2017/01/16/shifts-in-the-us-lgbt-population/>

Bristowe, K, Hodson, M, Wee, B, Almack, K, Johnson, K, Daveson, BA, Koffman, J, McEnhill, L & Harding, R 2018, 'Recommendations to reduce inequalities for LGBT people facing advanced illness: ACCESSCare national qualitative interview study', *Palliat Med*, vol. 32, no. 1, pp. 23-35, doi:10.1177/0269216317705102

Cambridge Dictionary 2014a, *Bias*, viewed 2020, <https://dictionary.cambridge.org/dictionary/english/bias>

——— 2014b, *Discrimination* viewed 2020, <https://dictionary.cambridge.org/dictionary/english/discrimination>

——— 2014c, *Prejudice*, viewed 2020, <https://dictionary.cambridge.org/de/worterbuch/englisch/prejudice>

— 2014d, *Stereotype*, viewed 2020, <https://dictionary.cambridge.org/dictionary/english/stereotype>

Carabez, R, Pellegrini, M, Mankovitz, A, Eliason, M, Ciano, M & Scott, M 2015, 'NEVER IN ALL MY YEARS...': NURSES' EDUCATION ABOUT LGBT HEALTH', *Journal of Professional Nursing*, vol. 31, no. 4, pp. 323-9, doi:10.1016/j.profnurs.2015.01.003

Cartwright, C, Hughes, M & Lienert, T 2012, 'End-of-life care for gay, lesbian, bisexual and transgender people', *Culture, Health & Sexuality*, vol. 14, no. 5, pp. 537-48

Currin, L 2015, *Family by Birth and Family by Choice*, viewed 2020, <https://www.atlantapsych.com/article/family-birth-and-family-choice>

deVries, B, Gutman, G, Humble, A, Gahagan, J, Chamberland, L, Aubert, P, Fast, J & Mock, S 2019, 'End-of-Life Preparations Among LGBT Older Canadian Adults: The Missing Conversations', *Int J Aging Hum Dev*, vol. 88, no. 4, pp. 358-79, doi:10.1177/0091415019836738

Donabedian, A 1988, 'The quality of care. How can it be assessed?', *Jama*, vol. 260, no. 12, pp. 1743-8, doi:10.1001/jama.260.12.1743

Fish, J & Williamson, I 2018, 'Exploring lesbian, gay and bisexual patients' accounts of their experiences of cancer care in the UK', *Eur J Cancer Care (Engl)*, vol. 27, no. 1, doi:10.1111/ecc.12501

Gold, M 2018, 'The ABCs of L.G.B.T.Q.I.A.+', *The New York Times*, viewed 13.11.2019, <https://www.nytimes.com/2018/06/21/style/lgbtq-gender-language.html>.

Graham, SM, Simoni, JM, Micheni, M, van der Elst, EM, Kombo, B, Sanders, EJ, Secor, A, Operario, D & Amico, KR 2018, 'HIV care engagement and ART adherence among Kenyan gay, bisexual, and other men who have sex with men: a multi-level model informed by qualitative research', *AIDS Care*, vol. 30, pp. S97-S105, doi:10.1080/09540121.2018.1515471

Hafeez, H, Zeshan, M, Tahir, MA, Jahan, N & Naveed, S 2017, 'Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review', *Cureus*, vol. 9, no. 4, p. e1184, doi:10.7759/cureus.1184

Harvard Global Health Institute 2020, *New Research: Poor-Quality Health Care A Leading Killer*, Harvard University, viewed 2020, https://globalhealth.harvard.edu/NASEM_globalqualitychasm

Herek, G 2012, *Definitions: Homophobia, Heterosexism, and Sexual Prejudice*, viewed 2020, https://psychology.ucdavis.edu/rainbow/html/prej_defn.html

Higgins, A & Glacken, M 2009, 'Sculpting the distress: easing or exacerbating the grief experience of same-sex couples', *Int J Palliat Nurs*, vol. 15, no. 4, pp. 170-6, doi:10.12968/ijpn.2009.15.4.41963

Hong, Q, Pluye, P, Fàbregues, S, Bartlett, G, Boardman, F, Cargo, M, Dagenais, P, Gagnon, M-P, Griffiths, F, Nicolau, B, O' Cathain, A, Rousseau, M-C & Vedel, I 2018, *Mixed Methods Appraisal Tool (MMAT)*, Canadian Intellectual Property Office.

Horne, C 2019, *Defining Your Family Of Origin & How It Impacts You*, viewed 2020, <https://www.betterhelp.com/advice/family/defining-your-family-of-origin-how-it-impacts-you/>

Hunt, J, Bristowe, K, Chidyamatara, S & Harding, R 2017, 'They will be afraid to touch you': LGBTI people and sex workers' experiences of accessing healthcare in Zimbabwe-an in-depth qualitative study', *BMJ Glob Health*, vol. 2, no. 2, p. e000168, doi:10.1136/bmjgh-2016-000168

——— 2019, 'So isolation comes in, discrimination and you find many people dying quietly without any family support': Accessing palliative care for key populations – an in-depth qualitative study', *Palliative Medicine*, vol. 33, no. 6, pp. 685-92, doi:10.1177/0269216319835398

Hutson, SP 2016, 'Climbing Back Up the Mountain', *American Journal of Hospice & Palliative Medicine*, vol. 33, no. 10, pp. 972-6, doi:10.1177/1049909115600857

Kerppola, J, Halme, N, Perälä, ML & Maija-Pietilä, A 2019, 'Parental empowerment—Lesbian, gay, bisexual, trans or queer parents' perceptions of maternity and child healthcare', *International Journal of Nursing Practice (John Wiley & Sons, Inc.)*, vol. 25, no. 5, pp. N.PAG-N.PAG, doi:10.1111/ijn.12755

Kortes-Miller, K, Boule, J, Wilson, K & Stinchcombe, A 2018, 'Dying in Long-Term Care: Perspectives from Sexual and Gender Minority Older Adults about Their Fears and Hopes for End of Life', *J Soc Work End Life Palliat Care*, vol. 14, no. 2-3, pp. 209-24, doi:10.1080/15524256.2018.1487364

Krehely, J 2009, *How to Close the LGBT Health Disparities Gap*, viewed 2020, <https://www.americanprogress.org/issues/lgbtq-rights/reports/2009/12/21/7048/how-to-close-the-lgbt-health-disparities-gap/>

Lam, A 2016, *Counting the LGBT population: 6% of Europeans identify as LGBT*, viewed 2020, <https://daliaresearch.com/blog/counting-the-lgbt-population-6-of-europeans-identify-as-lgbt/>

Lindroth, M 2016, 'Competent persons who can treat you with competence, as simple as that' - an interview study with transgender people on their experiences of meeting health care professionals', *Journal of Clinical Nursing (John Wiley & Sons, Inc.)*, vol. 25, no. 23-24, pp. 3511-21, doi:10.1111/jocn.13384

Logie, CH, Lys, CL, Dias, L, Schott, N, Zouboules, MR, MacNeill, N & Mackay, K 2019, '"Automatic assumption of your gender, sexuality and sexual practices is also discrimination": Exploring sexual healthcare experiences and recommendations among sexually and gender diverse persons in Arctic Canada', *Health & Social Care in the Community*, vol. 27, no. 5, pp. 1204-13, doi:10.1111/hsc.12757

Lopez, G 2018, *Myth #10: Drag queens and kings are transgender*, viewed 2020, <https://www.vox.com/identities/2016/5/13/17938130/transgender-people-drag-queens-kings>

Malia, M 2016, *Lesbian Stereotypes: The Worst (And Most Hilarious) Ideas Many Have About The Community*, Huffington Post, viewed 2020, https://www.huffpost.com/entry/lesbian-stereotypes-n_3808202?guccounter=1&guce_referrer=aHR0cHM6Ly93d3cuZ29vZ2xlLmNvbS8&guce_referrer_sig=AQAAAMlrT5LShQ2tY8-IdnPyP6ohrpfR1qhXEz3XSHke1JIBEbWrSYv3X_ZVCWt_ou8CuLoUMI2S2hlYktRs8ctXrk4rpk4sdp1OOzw-SaLz_WN1oY7qcAQZbhCHDvjsmGkmCQ_QUx1mtQ1_DUutFGZiGPPEG1-Acz48QyJiSpcr6n5

Merriam-Webster 2020a, *Heteronormative.*, viewed 2020, <https://www.merriam-webster.com/dictionary/heteronormative>

—— 2020b, *Heterosexism.*, viewed 2020, <https://www.merriam-webster.com/dictionary/heterosexism>

Mitchell, P 2008, *Patient Safety and Quality: An Evidence-Based Handbook for Nurses.*, Chapter 1: Defining Patient Safety and Quality Care, Agency for Healthcare Research and Quality (US), Rockville.

Moher, D, Liberati, A, Tetzlaff, J & Altman, DG 2009, 'Preferred Reporting Items for Systematic Reviews and Analyses: The PRISMA Statement', *PLoS Med*, vol. 6, no. 7, doi:10.1371/journal.pmed1000097

Moor, A 2019, *11 Stereotypes People Should Stop Believing About the LGBTQ Community*, viewed 2020, <https://www.msn.com/en-us/lifestyle/family-relationships/11-stereotypes-people-should-stop-believing-about-the-lgbtq-community/ar-BBW0GHX>

Mosadeghrad, AM 2014, 'Factors influencing healthcare service quality', *International Journal of Health Policy and Management*, vol. 3, no. 2, pp. 77-89, doi:10.15171/ijhpm.2014.65

OK2BME 2019, *WHAT DOES LGBTQ+ MEAN?*, <https://ok2bme.ca/resources/kids-teens/what-does-lgbtq-mean/>

Polit, DF & Beck, CT 2018, *Essentials of nursing research: appraising evidence for nursing practice*, vol. 9, Wolters Kluwer Health, Philadelphia.

Robinson, B 2018, *Bisexuality - the least common and most misunderstood of the three sexual orientations.*, viewed 2020, <http://www.religioustolerance.org/bisexuality.htm>

Röndahl, G, Innala, S & Carlsson, M 2006, 'Heterosexual assumptions in verbal and non-verbal communication in nursing', *Journal of Advanced Nursing (Wiley-Blackwell)*, vol. 56, no. 4, pp. 373-81, doi:10.1111/j.1365-2648.2006.04018.x

Rounds, KE, McGrath, BB & Walsh, E 2013, 'Perspectives on provider behaviors: A qualitative study of sexual and gender minorities regarding quality of care', *Contemporary Nurse: A Journal for the Australian Nursing Profession*, vol. 44, no. 1, pp. 99-110, doi:10.5172/conu.2013.44.1.99

Southern Adventist University 2019, *Google & Google Scholar*, viewed 2019, <https://southern.libguides.com/google/boolean>

Stossel, J & Binkley, G 2006, *Gay Stereotypes: Are They True?*, viewed 2020, <https://abcnews.go.com/2020/story?id=2449185&page=1>

Study.com 2015, *Heteronormativity: Definition & Concept*, viewed 2020, <https://study.com/academy/lesson/heteronormativity-definition-concept.html>

The National Health Service England 2018, *What end of life care involves*, viewed 2020, <https://www.nhs.uk/conditions/end-of-life-care/what-it-involves-and-when-it-starts/>

The Pennsylvania State University 2007, *Heterosexism*, viewed 2020, https://edge.psu.edu/workshops/mc/isms/page_10.shtml

The Williams Institute, USoL 2019, *LGBT Demographic Data Interactive*, <https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#density>.

Transgender Europe & Carsten, B 2020, *Trans Day of Remembrance (TDoR) 2018 Press Release*, viewed 2020, <https://transrespect.org/en/tmm-update-trans-day-of-remembrance-2018/>

U.S. National Library of Medicine 2019, *MeSH Database*, viewed 2019, https://www.nlm.nih.gov/bsd/disted/pubmedtutorial/020_490.html

United Nations 2018, *Dangers of poor quality health care revealed 'in all countries': WHO report*, viewed 2020, <https://news.un.org/en/story/2018/07/1013942>

Vancouver Island University 2020, *Myth Busting: LGTB Myths & Facts*, viewed 2020, <https://adm.viu.ca/positive-space/lgtb-myths-facts#>

Vogelsang, AC, Milton, C, Ericsson, I & Strömberg, L 2016, "Wouldn't it be easier if you continued to be a guy?" - a qualitative interview study of transsexual persons' experiences of encounters with healthcare professionals', *Journal of Clinical Nursing (John Wiley & Sons, Inc.)*, vol. 25, no. 23-24, pp. 3577-88, doi:10.1111/jocn.13271

Witten, TM 2014, 'End of life, chronic illness, and trans-identities', *J Soc Work End Life Palliat Care*, vol. 10, no. 1, pp. 34-58, doi:10.1080/15524256.2013.877864

World Health Organization 2018, *Low quality healthcare is increasing the burden of illness and health costs globally*, World Health Organization, viewed 2020, <https://www.who.int/news-room/detail/05-07-2018-low-quality-healthcare-is-increasing-the-burden-of-illness-and-health-costs-globally>

——— 2019a, *What is Quality of Care and why is it important?*, https://www.who.int/maternal_child_adolescent/topics/quality-of-care/definition/en/

——— 2019b, *WHO Definition of Palliative Care*, viewed 2019, <https://www.who.int/cancer/palliative/definition/en/>

Attachments

Climbing Back Up the Mountain: Reflections From an Exploration of End-of-Life Needs of Persons Living With HIV/AIDS in Appalachian Tennessee – Hutson et al. (2016)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Dying in Long-Term Care: Perspectives from Sexual and Gender Minority Older Adults about Their Fears and Hope for End of Life – Kortess-Miller et al. (2018)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

End-of-life care for gay, lesbian, bisexual and transgender people – Cartwright et al. (2012)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

End-of-Life Preparations Among LGBT Older Canadian Adults: The Missing Conversation – deVries et al. (2019)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Exploring lesbian, gay and bisexual patients' accounts of their experiences of cancer care in the UK – Fish et al. (2018)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

HIV care engagement and ART adherence among Kenyan gay, bisexual, and other men who have sex with men: a multi-level model informed by qualitative research – Graham et al. (2018)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Recommendations to reduce inequalities for LGBT people facing advanced illness: ACCESSCare national qualitative interview study – Bristowe et al. (2018)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

‘So isolation comes in, discrimination and you find many people dying quietly without any family support’: Accessing palliative care for key populations – an in-depth qualitative study – Hunt et al. (2019)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

‘They will be afraid to touch you’: LGBTI people and sex workers’ experiences of accessing healthcare in Zimbabwe – an in-depth qualitative study – Hunt et al. (2017)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

End of Life, Chronic Illness, and Trans-Identities – Witten (2014)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?		x		
	5.2. Are the different components of the study effectively integrated to answer the research question?	x			
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	x			
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	x			
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	x			

Physicians Don't Ask, Sometimes Patients Tell – Disclosure of Sexual Orientation among Women with Breast Carcinoma – Boehmer et al. (2004)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Sculpting the distress: easing or exacerbating the grief experience of same-sex couples – Higgins et al. (2009)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	x			
	1.2. Are the qualitative data collection methods adequate to address the research question?	x			
	1.3. Are the findings adequately derived from the data?	x			
	1.4. Is the interpretation of results sufficiently substantiated by data?	x			
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	x			
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

State Recognition of Same-Sex Relationships and Preparations for End of Life Among Lesbian and Gay Boomers – deVries et al. (2009)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
	<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?	x			
	4.2. Is the sample representative of the target population?	x			
	4.3. Are the measurements appropriate?	x			
	4.4. Is the risk of nonresponse bias low?	x			
	4.5. Is the statistical analysis appropriate to answer the research question?	x			
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

The Last Outing: exploring end of life experiences and care needs in the lives of older LGBT people – Almack et al. (2015)

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?	x			
	S2. Do the collected data allow to address the research questions?	x			
<i>Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.</i>					
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5. Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	x			
	5.2. Are the different components of the study effectively integrated to answer the research question?	x			
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	x			
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	x			
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	x			