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Experiences of Young Lesbian, Gay, and Bisexual Latinx People in Healthcare

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EXPERIENCES OF YOUNG LESBIAN, GAY,
AND BISEXUAL LATINX PEOPLE IN HEALTHCARE

by

CALEB ADAM HERNANDEZ

A thesis submitted in partial fulfillment of the requirements
For the Honors in the Major Program in Anthropology
in the College of Sciences
and in the Burnett Honors College
at the University of Central Florida
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ABSTRACT

Latinx lesbian, gay, and bisexual (LGB) queer community members have unique health needs compared to non-Latinx heterosexual patients, including sexual and mental health issues, and challenges in ability to access healthcare. But research is unclear whether LGB Latinx patients may also face double stigma related to their sexual orientation and race. This study examined this issue in experiences of queer and Latinx adults with healthcare providers. I conducted semistructured in-depth interviews with 13 LGB Latinx adults between November 2018 and February 2019. Interviews were audio-recorded, and transcribed. Participant's narratives show a compartmentalization of identity as they spoke of sexuality and race as largely separate. LGB Latinx patients also practice an active avoidance of healthcare and only seek it out in circumstances of dire need. My findings indicate that the quality of individual experience depends on key factors of the provider, in particular the provider's sexuality, gender, race, and ability to empathize. When LGB Latinx patients interact with like-identified providers, their experience is significantly more satisfactory, however, differently-identified providers who create open and non-judgmental communication with patients have the ability to provide this level of satisfactory service. More diverse staff in clinics as well as the presence of LGBT friendly symbols in healthcare facilities also contributes to a better experience for LGB Latinx patients. This study calls attention to the need for greater diversity of healthcare providers, new non-judgmental approaches in care delivery, and more specialized provider education to address LGB Latinx patients' needs.

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LGB LATINX HEALTH: WHAT SILENCES AND OMISSIONS TELL US

Lesbian, gay, and bisexual (LGB) members of the queer community have unique health issues and concerns compared to the normative heterosexual population. Anthropological, social science, and public health literature examine how some of these health issues are related directly to sexual practice, some from the increased abuse of drugs and alcohol, and others are avoidable ailments that arise out of inaccessibility to proper healthcare (Sabin, Nosek, Riskind 2015, 1831). LGB people are also less likely to have health insurance coverage (Durso and Meyer, 2012; Buchmueller and Carpenter, 2010). In addition to structural ways in which LGB people are marginalized, these health issues and concerns are the product of a stressful social environment that stigmatizes the LGB identity (Paine, 2018). Stigma as defined by Link and Phelan (2001, 377) exists at “the convergence of interrelated components” including “labeling, stereotyping, separation, status loss, and discrimination together in a power situation that allows them.” The LGB identity is subjected to each of these forces and can be seen through various stigmatizing experiences such as how the disclosure of sexuality can lead to the legal loss of occupation, the long standing model of homosexuality as mental illness in academic scholarship, the fact that there are slurs specific for LGB identities, and the prevalence of widely circulated stereotypes of gays, lesbians, and bisexuals. This stigma can be understood within the conceptual framework of the minority stress model: the excess stress that is felt when one is the member of a marginalized group in society (Meyer, 1995; Chulani, 2018). While this model is rooted in the analysis of mental health outcomes, scholars have identified stable connections between the minority stress model and physical health as well (Baptiste-Roberts et al, 2016).

Members of the LGB community who also identify as racial minorities, such as Latinx, experience this stress on the axis of both sexuality and race. This can be understood through an intersectional lens. Intersectionality is a theoretical perspective developed by feminist scholar Kimberlé Crenshaw in 1989 that analyzes how connected systems of power work to oppress the most marginalized in society (Mackinnon, 2013; Cho et al, 2013). When viewing through the lens of intersectionality the experience of LGB Latinx people differs from that of LGB white people and Latinx people. However, intersectionality transcends the concept of double stigma as it moves perspective from the microscopic individual to that of the macroscopic in terms of social hierarchy. This is evident in the study of the LGB Latinx community, their experiences of marginalization are tied to the relations of power exercised over them. Intersectionality rejects “single-axis thinking [as it] undermines legal thinking, disciplinary knowledge production, and struggles for social justice” (Cho et al, 787, 2013). So called single-axis thinking also inhibits understanding how these facets of identity are directly influenced by the experience of each other, for LGB Latinx people race is sexualized and sexuality is racialized. This could manifest as LGB Latinx people being perceived as exclusively heterosexual because of their Latinx identity. By following these trails of thought intersectionality allows one to view the origin and production of power in society. Intersectionality recognizes that Latinx LGB people experience stigma for their race as well as their sexuality, and these elements of identity are interdependent. Stigma can be understood at three distinct levels: (a) as related to the individual, and may manifest as internalized homophobia; (b) as experienced in the social realm, and may develop into hate crimes or micro aggression in everyday interactions; and (c) as structural which is evident in institutionalized inequities, including legislation, that demonizes LGB identity

(Bolderston and Ralph, 2016, 208). These three levels of stigma affect LGB people synergistically and lead them to respond with various coping mechanisms.

This stigma is present in various institutions in society, one that is particularly relevant for the LGB community due to their unique health concerns as a result of stigma is the institution of healthcare. Despite recent attempts in healthcare to adjudicate discrimination against LGB people by developing new legislation that ensures access and fair treatment, there is plenty of research to suggest continued inequity between heterosexuals and those who identity as LGB. These inequities manifest as “denial of care, substandard care, and disrespectful or disparaging remarks made about patients and/or their partners” (Bolderston and Ralph, 2016, 209).

Anthropological literature explains that LGB patients face blatant discrimination but also are confronted with refusals of acknowledgment, in particular when patients are ignored when they discuss specifics of their sexual history or make mention of their partner (Robertson, 2017). LGB patients are also made to feel invisible in healthcare settings, as if there is no space for them there (Meer and Muller, 2017; Landry, 2017). Anthropological literature explains that this invisibility that LGB patients face in the healthcare system is, in part, the product of poor or incomplete medical education of healthcare providers (Baker and Beagan, 2014). One primary example of an opportunity physicians have to learn about LGB health issues and concerns comes from limited cultural competency trainings that focus solely on the transmission of HIV/AIDS in men who have sex with men and therefore completely excludes women and bisexual patients and ignores all the other facets of understanding those who are LGB (Robertson, 2017). Medical students are taught to focus narrowly on risk behaviors and identify if patients are considered “at risk,” and if so, they are then expected to make arrangements to get the patient tested (Robertson,

2017). While this type of education is important it leaves out many significant LGB health concerns. For cultural competency to be truly effective it needs to be developed to reflect the needs of the broader LGB community as opposed to simply men who have sex with men. Education of sexual minority health is inconsistent and lacks mainstream implementation by healthcare providers, if this education was standardized to some degree it could be beneficial to patients and providers alike.

Cultural competency emerged as a response to the health outcome disparities and differentiated health concerns of minority communities. Anthropological literature explains that its goal was to create culturally sensitive care through trainings that aimed for providers to glean a semblance of understanding about other cultural practices and meanings relevant to health, and this would allow patients to feel more comfortable and heard in their interactions within western biomedical practice (Baker and Beagan, 2014; Bolderston and Ralph, 2016). Literature on LGB cultural competency is severely limited and, even within journals that outline the disparity in care, explain the necessity for greater inclusion of LGB health needs in educational literature (Landry, 2017; Bristol et al, 2018). Another approach termed structural competency aims to train providers to be aware of structural limitations to care, including socioeconomic barriers, health insurance coverage, and access to services (Metzl and Hansen, 2013), but this model may also fall short if LGB patients' needs are not explicitly included in such programs. This approach of structural competency is successful in that it recognizes the institutional forces that work against minority communities who are barred from receiving adequate care due to facets of their identity. The focus of the majority of literature for healthcare professionals is on the unknown factors of LGB identities such as the fluidity of sexuality and understanding gender as a separate

construct. After these terminologies are explored the literature opens a small commentary around the appropriate ways to interact with LGB patients; these suggestions call providers to create room for patients to present their identities and to be affirmed as valid (Landry, 2017; Bristol et al, 2018). While this scholarship begins to open a dialogue regarding LGB experiences in healthcare, they fail to address the lack of education in the primary healthcare training of providers at every level of healthcare. These recommendations in the scholarship are strictly supplemental and not required for those working in the healthcare sphere, and indeed many healthcare providers have reported little to no training on the specific needs of the LGB community (Landry, 2017; Bristol et al, 2018). Therefore, providers lack an understanding of how to interact with LGB patients as functioning members of society (Heyes et al, 2016). Cultural competency was developed with the best intentions but leaves much to be desired in terms of successful methods to create environments for minority status communities (Baker and Beagan, 2014; Robertson, 2017). Thus, it is no surprise that those that identify as LGB find dissatisfaction with the level of care they receive in their encounters with providers. Across the social science and public health literature the reasons for this dissatisfaction center on similar themes: discrimination, lack of knowledge, harmful assumptions, stigma, racism, and condescending communication (Bonvincini & Perlin 2002, 116-120; Felner et al, 2018, 185-189; Sabin et al, 2015, 1834). These encounters facilitate a culture in the LGB community to emphasize an active avoidance of healthcare; this avoidance of healthcare has the predictable consequence of less preventable care for this population (Bonvincini & Perlin 2002). LGB patients experience greater difficulty finding providers they are comfortable and open with than non-LGB patients (Furin, 1997; Khalili et al, 2015; Martos et al, 2018). When LGB patients do

seek care they often opt to not disclose their sexuality, a necessary factor for prescribers to be aware of in many contexts, out of the fear of the provider's reaction (Durso and Meyer, 2012). When patients do not disclose their sexuality to providers (or providers fail to ask about that) they are leaving out necessary information that can lead providers to understand their needs more accurately, this can be in terms of testing or counseling. Patients often have a level of psychological discomfort discussing issues of sexual health with providers who they are uncomfortable disclosing their sexuality with (Newman et al, 2008). If there is not room for disclosure, how can patients feel agency to ask questions about safe sex practices?

As previously discussed, Latinx LGB people have a larger set of issues to overcome than white LGB people in terms of dealing with healthcare and in its relationship to their racial identity as well. LGB People of color traditionally practice more avoidant healthcare behavior and have a worse history of physical health than white LGB people (Molia et al, 2014). In some cases, social science literature explains, even healthcare spaces that have been declared as LGB friendly can be hostile toward people of color and therefore cannot be trusted (Felner et al, 2018). This illustrates the unique difficulty that LGB Latinx people face when attempting to seek healthcare.

Another facet of the LGB Latinx identity is one that is culturally constructed. Many Latinx cultures have historically been hypercritical of LGB identity. As anthropologist Matthew Gutmann argues (2003), lesbians, gays, and bisexuals are often seen as perverse and exemplify the antithesis of desired heteronormative characteristics for men and women. Lesbian women are perceived as power hungry masculine machines and gay men as feminine and passive (Gutmann, 2003). In Latin American contexts masculinity has been traditionally defined by "concepts of

authority and tradition,” but these ideas do not allow the expression of emotion and work to limit men to distinctly the “macho” construction of masculinity (Gutmann, 2003, 30). The term *machismo* has been used to articulate this phenomenon but has been criticized for being too essentializing of Latin American masculine identities (Gutmann, 2003). Scholarship of Latina sexuality has also been criticized and reevaluated. For example, much research has positioned white liberalism as a progressive influence, but that assertion ignores the nuanced nature of individual contexts and localities (Gonzalez-Lopez & Vidal-Ortiz, 2008). This challenges the notion that Latinas experience exclusively negative associations with sexuality due to culturally constructed norms that facilitate oppressive expectations. There “are always competing and contradictory [cultural models]” that make “space for sexual pleasure within Latina/o culture” (Juárez & Kerl, 2003, 31). Gutmann also notes that while there are certain complexities to these notions and they are changing slowly with the integration and development of new operations in society, these antiquated ideologies of masculinity and femininity still impact Latinx understandings of sexuality and gender currently in their countries of origin and in other cultural contexts among the diasporas as well.

There is much research detailing the disparities present in healthcare for those who identify as LGB. However, there is a significant gap in anthropological and social science knowledge regarding how sexuality and race interact in the public health sphere. Glimmers of such information appear in some social science articles which present the conundrum that LGB people of color are unsure if they are facing discrimination or stigma due to their sexual minority status or due to their racial minority status (Paine 2018, 356). This research sought to examine LGB persons’ perspectives and experiences of seeking healthcare. My findings indicate that

LGB Latinx patients practice an active avoidance of healthcare and only seek it out in circumstances of dire need. My data also show that the quality of individual experience depends in particular on the provider's sexuality, gender, race, and ability to empathize. When LGB Latinx patients interact with like-identified providers, their experience is significantly more satisfactory, however, differently-identified providers who create open and non-judgmental communication with patients have the ability to provide this level of satisfactory service. I argue that LGB-specific medical training, more diverse staff in clinics, as well as the presence of LGBT friendly symbols in healthcare facilities contributes to a better experience for LGB Latinx patients and is necessary for improved health outcomes in this population. This research is significant because it expands our understanding of how young LGB Latinx people experience healthcare seeking, and therefore the data from this research has the potential to inform healthcare services offered to this population.

In the following sections I will describe my methodological approach and then follow with a Prelude in which I explain the intersectionality aspect of my findings, and two chapters that present my findings and analysis: (1) "Only Under Dire circumstances" and (2) "Are There Providers Like Me?." In the concluding chapter, I explain the significance of this project and consider future research directions that could build on these data.

RESEARCH DESIGN AND METHODOLOGY

This was a qualitative study that utilized the anthropological methods of semi-structured interviews and participant observation. My research question that guided this project was:

What are the experiences of Lesbian, Gay, and Bisexual Latinx people in healthcare?

To answer my research question, I conducted data collection on UCF campus and at The Center from November 2018 to February 2019. To investigate the interaction of Latinx and LGB identities, I defined eligibility criteria for research participants as people who identify as lesbian, gay, or bisexual (LGB) as well as Latino/Latinx. The inclusion criteria also limited the sample to English-speaking, 18-29 years old people. My exclusion of non-English speaking individuals was to ensure that I could comprehend participants without the assistance of a translator. I limited age to 29 years in order to have a clearer picture of the population; by narrowing to this age group, I was able to reach a saturation of ideas with fewer research participants. In terms of gender, those who identified as genderqueer, non-binary, transgender, or agender were permitted to participate if meeting the full eligibility criteria.

The sample size for the semi-structured interviews included 13 participants ages 19 to 24, who self-identified as follows: four lesbian, three gay, and six bisexual (see Sample Characteristics Table). The specificity of my inclusion and exclusion criteria allowed me to reach saturation of themes within this sample (Strauss and Corbin 1998). The number of subjects was determined by the time it took to reach diminished returns (Weiss 1995, 21). This means that the answers and explanations that the participants provided to my questions reached a point of repetition and therefore the data reached a saturation of themes.

I recruited participants in three locations: on the UCF campus, at The Center— a non-governmental organization (NGO) located in downtown Orlando that provides advocacy services to the LGBT community including HIV testing, and on the social media Instagram. My recruitment methods included the following:

(1) **UCF campus:** I sought permission from faculty to make short 2-3 minutes announcements in various classes and distribute my flyer with the Explanation of Research form. Interested participants were able to keep the information and contact me via my Knights email. I also asked faculty to post my flyer on their Canvas pages. Furthermore, I requested the permission of various sites on campus to post my flyers in their space, such sites are the student Wellness Center and Pride Commons.

(2) **The Center:** I sought permission from the Executive Director, George Wallace, to recruit from The Center prior to data collection. I obtained permission from The Center to post my flyer as well. Following their approval, I announced my project at support groups and workshops held at The Center. During these announcements I distributed my flyer with the Explanation of Research form. I also volunteered weekly behind the front desk assisting with incoming calls and queueing patients to receive HIV and STI testing. Post testing, I would distribute my flyer with the Explanation of Research form. Interested participants were able to keep the information and or approach me personally at The Center or contact me via my Knights email.

(3) **Social Media:** I created a post on Instagram that shared the information on my flyer as well as the Explanation of Research form. My Knights email was posted for any questions or

for further correspondence regarding interest in participation. I reposted the project information on Instagram several times during the data collection phase due to the fact that Instagram posts scroll down and disappear from view as new posts are made.

Interested participants from any of the above recruitment sites were able to contact me directly via my provided Knights email address, and all correspondence was deleted upon completion to ensure confidentiality. I obtained verbal consent for data collection by inviting those fitting my inclusion criteria to participate with an explanation of the research and an expressed desire to interview them based on their self-declared identities. I obtained verbal consent, rather than written, for additional confidentiality of participants (DeWalt and DeWalt 2011, 216-219). I then offered the participant a hard copy of the explanation of research for their records, allowed the informant to decide if they wish to have a copy, electronic via email or otherwise, and then provided them the opportunity to ask questions about the research and the form. I did not commence the interview until I answered any questions from the participant and they verbally agreed to the items listed on the explanation of research form. To ensure additional confidentiality, I employed verbal consent. Correspondence to arrange interviews took place using my Knights email. After interviews were set, no communication took place until the morning of the interview, where I would send a friendly reminder email to thank them for participating while listing the time and location of the interview. I maintained multi-site participant confidentiality by using pseudonyms in my personal field notes and password protections on my laptop computer. I alone recruited and collected data for this research project. I met with participants face-to-face on the UCF campus in private venues such as reserved private study rooms in the UCF John C. Hitt library for the interviews.

The interviews followed a preconstructed semi-structured Interview Guide (see Appendix B), with 18 specific questions falling under four categories of inquiry: (1) Background Knowledge, (2) Health Seeking Behavior (3) Experiences of Discrimination, and (4) Providers of Color. The interview guide was constructed after careful consideration of preexisting literature. I utilized follow-up probes after the core questions in response to the feedback of the participant. I chose to include health insurance information as one of the background knowledge questions posed to every participant because of its significance in accessing healthcare. This semi-structured interviewing process has shown great flexibility in addressing both primary topics and more nuanced ideas that I was able to pursue with the probes (DeWalt and DeWalt 2011, 139, 145-150; Fetterman 2010, 40-41). Interviews were recorded with a Sony audio recorder with the permission of the participant. Transcripts were coded, and data analyzed for themes using the Grounded Theory approach (Charmaz, 2014). I also took additional notes using a pen and a notepad regarding the specific behaviors and expressions of the participant during each interview. I volunteered at The Center under the assumption that The Center provides services to my target population. I acted as an observer, present to gain a greater understanding of the experiences of the LGB community within the healthcare process. This experience of participant observation helped me as the researcher to move past two-dimensional understandings toward a deeper knowledge of the participants experience (DeWalt and DeWalt 2011, 92).

Sample Characteristics Table

<u>Research Participant</u> (n = 13)	<u>Self-Identification</u>	<u>Age</u>	<u>Health Insurance Status</u>
Xia Marcial	Lesbian	21	Medicaid
Ana Sol Garcia	Bisexual	21	Private Insurance
Daphne Ortiz	Lesbian	20	Private Insurance
Marco Torres	Gay	21	Medicaid
Christina Velez	Lesbian	22	Private Insurance
Julia Bonilla	Bisexual	22	Private Insurance
Destiny Gonzales	Bisexual	19	Private Insurance
Gabriel Martinez	Gay	19	Uninsured
Sylvia Flores	Bisexual	22	Private Insurance
Giovanni Cortes	Gay	19	Uninsured
Sara Leon	Lesbian	24	Uninsured
Felix Nieves	Bisexual	20	Private Insurance
Alison Tijerina	Bisexual	22	Medicaid

Reflexivity

During my fieldwork I experienced some challenges, as well as some rewarding moments. I found some difficulty in recruiting potential participants at The Center; despite providing information regarding the study to many who had come to The Center for testing, I received no official statements of interest sent to my UCF Knights email, the primary method of communication. At the end of the project, I understood this challenge to be mainly due to the population The Center serves in Orlando—many of the patients do not identify with the LGBT

or Latinx community, and therefore did not meet the eligibility criteria for my study sample. For future research, I would attempt to observe and recruit at The Center's branch in Kissimmee, which was constructed with the purpose to specifically serve the high volume of LGBT Latinx peoples who reside in that area and opened shortly before my project began.

Aside from overcoming recruitment challenges, I found it extremely rewarding to conduct interviews with this population and found myself talking with participants long after interviews had ended about various topics.

I am also an insider of the inclusive criteria I selected for interviews, a 21-year-old gay Latinx man, therefore my own experiences as an "insider-outsider" serve as an important resource and a point of departure that inspired and grounded this ethnographic project (Sherif 2001, 436-447). My positionality presented both challenges and advantages. It was challenging to separate my own experiences in dealing with healthcare from this project. I had to be aware and intentional to ensure my research was not being guided by my own narrative or assumptions. However, my positionality was advantageous in my communication with participants. I was able to relate to many of them and our shared identities made it easier and more comfortable for them to open up to me about their experiences.

PRELUDE: INTERSECTING IDENTITIES?

I have utilized the theoretical framework of intersectionality to guide this research project and its implications can be seen in my construction of the interview guide as well as in my data analysis. The concept of intersectionality as developed by Kimberlé Crenshaw (1989) provides an understanding of the multi-faceted nature of identity.¹ Researchers analyze pieces of identity such as sexuality, race, class, sex, ability, and gender as interconnected and interdependent. Each of these factors of one's identity and background have the potential to be subjected to discrimination against the individual (and collective), and the combined impact of these factors can be better understood when these are considered together, rather than conceptualizing them as individual and distinct from each other. Therefore, the interactions between sexuality, race, class, sex, ability, and gender are powerfully limiting for marginalized categories of identity such as, for example, for a disabled gay lower socioeconomic class black transgender woman. It is this intersectionality of experiences that initially motivated my research question to investigate experiences as framed by race and sexual orientation together.

In this research, the participants were required to identify as racially Latinx and as lesbian, gay, or bisexual in terms of sexuality to be eligible. Factors such as class, gender, ability, and sex were not indicative of eligibility, but I paid attention to those factors on an individual level to understand participants and their personal narratives and interactions in society. The analytical lens of intersectionality views these pieces of identity as inseparable in terms of the way a person is viewed by others and by society at large; a person is perceived and treated with

¹ (Mackinnon, 2013; Cho et al, 2013)

specific intentions accordingly. People are marked by others with labels that highlight these facets of their identity.

This led me to the assumption that participants would discuss their identity as interconnected and inseparable, however through these interviews I found this was not the case. When speaking to participants, I found they tended to compartmentalize each facet of their identity—Latinx identity and LGB identity—and only bringing one or the other to attention when prompted to answer a question that it bore relevance to. In fact, research participants spoke of their labeled identities as separate and made differentiations between them frequently, but they did not take the time to emphasize their interconnectedness. When announcing identity, participants separated each facet and highlighted it as they saw necessary. As a consequence, I captured this separateness of identities in most of my study data as evident in the two following findings chapters. However, some data did bring the two identities together as is evident in the section about “The Fear of Latinx Providers.”

This finding of participants conceptualizing LGB and Latinx identities separately may have been influenced by the way certain questions were posed on the interview guide. For instance, when I asked about experiences of discrimination, I focused on asking about specific instances of racism or homophobia separately. Perhaps if the question posed had incorporated both racism and homophobia in one question there would have been a natural inclination for participants to discuss both race and sexuality simultaneously. However, when I did make the effort to ask participants a question that merged the two identities, a question that asked: Are you more uncomfortable when you are discriminated against for your sexuality or your race in healthcare settings?, I found that participants were quick to state one or the other without

hesitation. Only two out of 13 participants stated that they would be unable to select one or the other or that both were equally terrible experiences. The rest of participants made a clear selection of either racism or homophobia with differing types of reasoning and examples that were distinct. It is possible however, that even this attempt to merge the two facets of identity—sexuality and race—may not have been sufficient since the question may have encouraged participants to separate them due to the wording that prompted them to select one or the other as most uncomfortable. To further explore this understanding of identity as interconnected or as compartmentalized, it would be beneficial to pose more questions that made the attempt to merge facets of identity together.

SECTION 1-Only Under Dire Circumstances:

The findings in this research highlight the perspectives LGB Latinx patients have toward healthcare and the various obstacles they encounter when deciding to seek care. In this chapter, I focus on my findings with participants which presented themselves in two main categories from their narratives: (a) because of reluctance to seek care, patients opt to seek healthcare only in circumstances that warrant severe urgency; and (b) healthcare environments are frequently inaccessible and/or unwelcome for LGB Latinx patients. While conducting these interviews, I could feel the heightened tension this population experiences; I could hear the frustration in their voices when they spoke of harsh adversity and discrimination. Sitting across from them I could see discomfort in their eyes as they explained again and again what it was like to be themselves in a space that does not want to recognize their existence. In response to these circumstances, this population practices an active avoidance of healthcare. This continues until their situation escalates to the point that this avoidance is no longer safe or possible. At this tipping point, they then find a systematic series of obstacles that stand in their way between meeting with a prescriber.

(a) Circumstances of Urgency

Necessity Over Frivolity and The Practice of Self Care

One initial question I posed to all participants asked them to describe the circumstances that would cause them to seek out healthcare. Only two participants said they would seek

healthcare as the result of minor conditions such as a cold or a rash, and one of them, Marco Torres, is a self-proclaimed “hypochondriac.” This behavior was in opposition to the vast majority of respondents that emphasized an avoidance of healthcare. This avoidance, as qualified by data, suggests that patients would only seek a healthcare provider out of true necessity. This finding is exemplified by the answer of Ana Sol Garcia, a Bisexual identifying Cuban-American:

If something really dramatic or excessive happened. Like if I was having the flu or a broken bone or something like that. I usually don’t go to the doctor for cough or for anything so, it’d have to be like I’m dying, near death, to go and seek healthcare.²

Ana Sol, like many others, responded to this question without hesitation; this tendency to postpone seeking healthcare was expressed easily. As shown by Ana Sol, the severity of a health concern that warranted a trip to a healthcare facility was often put in terms of death or dying. Respondents found it difficult to justify a trip to the doctor’s office for anything less.

The perspective surrounding this phenomenon is multifaceted and derives from the intersection of this population’s identity. To start, it was often explained by respondents in the terms of a shared Latinx identity that, they argued, rebuked the notion that one should go to the doctor at the onset of any ache or pain. This cultural perspective was then reinforced by the difficulty found in accessing care and fears of discrimination due to race and sexuality. These fears are a response to lived experiences of being

² Interview with Ana Sol Garcia, December 2018.

Othered by healthcare providers. Gabriel Martinez, a gay identifying Puerto Rican, emphasized the cultural aspect of this avoidance:

I'm Puerto Rican, so we kind of tough it out like in every Latin culture. We just tough it out, we don't really go to the doctor, but you know when you really feel like you're going to die you just pay them a visit.³

Gabriel moved to the United States from Puerto Rico eight months ago and described no change to his Healthcare seeking behavior after settling down; he has yet to have a doctor's appointment since moving.

Daphne Ortiz, a lesbian identifying Colombian American, voiced the presence of this perspective by discussing her mother's attitude toward healthcare as influenced by her Colombian background:

I guess, in being a Latinx person, part of my culture comes from very Colombian standards as to how healthcare works. So, my mom's side of the family does not believe in healthcare whatsoever. She comes from a very strict background that says, 'If you're in pain, rub some dirt in it and you'll be fine.' A lot of the time she struggles with believing that there are circumstances that would require healthcare.⁴

Daphne smiled as she relayed this to me, it gave me the impression that she had heard that adage many times and looked at it with some amusement. I am almost sure she had rubbed dirt in her wounds before. Daphne, however, went against this precedent and began seeking healthcare on her own after being institutionalized for a severe eating disorder. While staying in that institution, Daphne used the opportunity to address persistent physical symptoms she had been experiencing including ceaseless abdominal cramping and a bleeding colon. This led to a

³ Interview with Gabriel Martinez, February 2019.

⁴ Interview with Daphne Ortiz, January 2019.

diagnosis of Crohn's disease and since has led to a slew of healthcare appointments with a variety of providers much to her family's chagrin:

Right before I had been diagnosed with Crohn's disease, I was diagnosed with an eating disorder as a result of dealing with all of the stress of repressing my sexuality most of my life. [laughs] So when I told my Colombian family I said, "I'm seeing a nutritionist, a therapist, a psychiatrist, and most importantly a gastroenterologist." All of them were like "Why are you seeing four doctors? That's stupid. That's some Brujeria!"

Daphne's circumstances say quite a lot about being LGB and Latinx. As an LGB person, Daphne experienced unique pressure from society as a sexual minority. This pressure manifested psychologically into an eating disorder causing Daphne significant bodily harm. Daphne found it complicated to seek medical assistance due to the stigma of sexual minority status and the fear of discrimination as well as from her cultural Latinx identity that promotes a disengagement with healthcare.⁵ Daphne did not attempt to seek healthcare until she was forced through institutionalization, and, after that, her severe medical case encouraged her to reposition her relationship with healthcare. This repositioning was not the norm for most participants and as a result avoidant behavior persisted. Many respondents had not been to a healthcare appointment in years, some of their only experiences being in childhood to receive required vaccinations for school.

Xia Marcial, a lesbian identifying Colombian American, had this exact experience but perhaps for a different or overlapping reason:

Growing up my parents didn't have money for healthcare, we would only go to the doctor if it was something really serious. If I'm sick, we would wait it out, it

⁵ Research shows that Latino patients harbor more distrust toward medical doctors than do Whites, in particular when it comes to "the fiduciary ethic, technical judgment, and interpersonal competence of doctors" (Sewell 2015).

was only a last resort to go and see a doctor. Only ever if it's serious. I kind of grew up with that mentality so I don't ever go to a doctor really. We don't even do checkups annually. I was never raised with that. We would only do it if the school forced my parents to do it which was like when I'm moving into a new school, you know? When you would go from elementary to middle and needed to get immunizations and things like that.⁶

Xia brought up a significant point: cost. Healthcare is expensive and many Latinx families are unable to afford its services. This has lasting impact: Xia now has Medicaid health insurance, thus a certain level of access to meet with healthcare providers, but because of growing up “with that mentality,” she does not ever see a doctor. Parents establish patterns of avoidance in childhood that persist past the point of financial access. It is important to note that Xia's avoidance is also influenced by her lesbian identity. Xia experiences discomfort at the thought of disclosing her sexuality to a prescriber. It is seen on a basic level that a cultural avoidance and fiscal obstacles can meet to create a massive barrier to seeking healthcare.

Even when respondents have had frequent interactions with healthcare due to dire circumstances, after the resolution of their concern they find themselves reverting to patterns of avoidance. Destiny Gonzales, a bisexual identifying Venezuelan, had a significant number of interactions with providers in infancy due to the discovery of a brain tumor and subsequent complications. She found that after the resolution of those issues she stopped going to healthcare appointments with any regularity. She explained that growing up she had very little recollection of those experiences in healthcare and embraced the idea that one should only go if it is “serious”

⁶ Interview with Xia Marcial, December 2018.

or “important.”⁷ Destiny’s case shows the persistence of cultural and familial perspective; despite a series of intensive health issues in infancy, she was still raised to seek healthcare as a final recourse.

In lieu of seeking healthcare, LGB Latinx youth rely on other methods to manage their health problems. These include self-medicating with over-the-counter products, using home remedies, and utilizing support systems with family members, friends, and significant others. Each of these methods provides an integral coping mechanism for this population.

Nearly every respondent made a mention of a favorite over-the-counter item that they used frequently to alleviate pain or general discomfort. These medicinal items give participants the ability to monitor and control symptoms to avoid needing the advice of a medical professional or the authorization for prescription drugs. Alison Tejerina, a bisexual identified Colombian American, linked her use of over the counter medications with the severity of her health concern.

Yeah, if I just have a cold, I’m obviously just going to take Dayquil, but if I were to, for example, break a bone or something that I can’t fix on my own by going to CVS, I’m definitely going to go get some help.⁸

While seeming tentative to talk at first, Alison was comfortable drawing the line between what warrants a trip to the doctor’s office versus a trip to a CVS: “something that [she] cannot fix.” Alison and other participants alike exercise a measure of control over their

⁷ Interview with Destiny Gonzales, February 2019.

⁸ Interview with Alison Tejerina, January 2019.

own wellbeing by using over-the-counter medications. This practice is both a response and perpetuator to avoidance of seeking healthcare.

Giovanni Cortes, a gay identifying Puerto Rican American, explained his use of over-the-counter medications was due to a partial mistrust of providers. It was easy to hear the annoyance in Giovanni's tone; he carried obvious disdain for healthcare professionals.

I'd seek healthcare for serious injuries in which I would have to seek healthcare. If it is able to be solved without professional healthcare, I'd opt for that. I'm not going to the doctor so he can do whatever and end up just putting me on some Tylenol. I can take Tylenol myself or if I'm starting to feel sick, I'll have some Vitamin C.⁹

I came to find out that Giovanni's sister worked as a healthcare professional and much of his mistrust came from her skepticism toward the doctors she worked with. He trusted his sister's opinion greatly and even mentioned he would never visit a provider without first double checking his sister's opinion of them and their practice. This provides another example of the power of familial attitude and perception of healthcare in determining health seeking behavior: because his sister is highly critical of healthcare, Giovanni refuses to utilize it as an option unless for "serious injuries."

Sylvia Flores, who identifies as bisexual and is of multi-racial descent, primarily Mexican and Cuban American, shared a personal rule with me:

⁹ Interview with Giovanni Cortes, February 2019.

If I get a cold or if I feel something coming on, I'll start to take over-the-counter medications like Ibuprofen or Nyquil. My sickness has to last more than three days for me to even consider a healthcare appointment.¹⁰

I was surprised by Sylvia's stipulation; she was steadfast that she would not "even consider a healthcare appointment" until her sickness lasted more than three days. For Sylvia time was a measure of severity and a meaningful one at that. In the meantime, she emphasized the importance of using over-the-counter items to abate symptoms and potentially wave away the source of illness. These over-the-counter items facilitate the avoidance of seeking healthcare for LGB Latinx patients.

Other methods respondents used to cope with feeling unwell included natural home remedies such as tea, lemon, honey, and shots of liquor. Sara Leon, a lesbian identifying Nicaraguan American, reported this finding candidly: "That's the way, a shot of whiskey if your throat is sore, hot tea and lemon, that's really common."¹¹ Sara and other respondents explained that these remedies had been passed down generationally from their grandparents to their parents to them; a few coined them as "a Hispanic thing." These remedies brought a sense of comfort to them even outside of their intrinsic medicinal value.

Many participants expressed a tendency to network in times of need. When they begin to feel under the weather, they would phone a friend, facetime their mom, or enlist their significant other to care for them. Julia Bonilla, a bisexual identifying Argentinian American, was quick to say she relied on her mother for advice when feeling under the weather: "I honestly just ask my mom, I'm like 'hey, my throat is sore and I'm feeling such and such way,' so she will say to take

¹⁰ Interview with Sylvia Flores, February 2019.

¹¹ Interview with Sara Leon, February 2019.

such and such medicine and she's always right."¹² Julia's trust in her mother to help her make the right decisions about what over-the-counter items to take was clear. I was sure that those phone calls were the first step in a ritual of healing. Christina Velez, a lesbian identifying Nicaraguan American, seemed less excited than Julia to have someone help care for her: "Most of the time my girlfriend will make me take medicine and I don't want to take any medicine, I just want to sleep. But she forces me to take something like Nyquil or Dayquil or whatever."¹³ At the end of this sentiment Christina's pouty face broke out into a smile: while she accepted these small acts of care from her girlfriend begrudgingly, it was obvious they brought her great comfort. Meaningful relationships with the people in their lives were extremely important to all participants and trusting these relationships for advice regarding difficulties with health helped ease their burden. Participants utilize any and all resources at their disposable to reduce their need to see a healthcare provider. Creating a healthcare appointment is always a last resort.

These approaches to self-managing health permeated my interviews with this population. These LGB Latinx people tended to exercise significant control over their own circumstances, using over-counter-medications to mitigate symptoms and avoid seeking out healthcare providers. Respondents were comfortable navigating within their personal communities to seek answers to health concerns. This dynamic is self-sustained to a certain capacity: until the health concern reaches a certain threshold, this cycle of self-care continues. This can lead to members of the population not seeking out a provider for early signs of persistent illness, continuously

¹² Interview with Julia Bonilla, January 2019.

¹³ Interview with Christina Velez, January 2019.

adjudicating the symptoms without addressing the problem. This can lead to the issue being exacerbated when it could have been absolved at a much earlier point.

(b) The Issue of Environment

Difficulties of Insurance

Another factor preventing LGB Latinx patients from seeking healthcare is insurance coverage. In the United States, access to healthcare is determined by the patient's ability to pay for services and medications. Insurance is used to facilitate this process; however, three out of thirteen participants had no healthcare insurance of any sort, three participants relied on state-funded Medicaid, and the remaining six participants had some form of privatized insurance provided by their parents or through their personal occupation. It is an obvious barrier to care to not have insurance but even those with insurance find using it is not always easy or reliable. Medicaid insurance is a category of aid offered to low-income families and is regulated on the state level. Unfortunately, access to Medicaid is difficult and many poor families are denied access to its benefits (Sommers & Grabowski 2017, 695). This leaves many underprivileged people without any insurance at all. It has been found that both "men and women in same-sex" relationships [have] significantly lower rates of health insurance coverage and higher rates of unmet medical needs than individuals in different-sex relationships" (Buchmueller & Carpenter 2010, 495). This existing research highlights one unique inequity for members of the LGB

community. These participants without insurance avoid seeking healthcare unless absolutely necessary because the cost is tremendous.

Sarah Leo is uninsured and could not imagine a life where health issues did not first need to be analyzed as “bad enough” to warrant a trip to the provider’s office: “The times I have gone to a doctor’s office...it ranges anywhere from \$50.00 to \$100.00. I’m not sure if it’s considered normal but it’s definitely something you have to think about.”¹⁴ Sara when she has had to visit a doctor’s office opts to use acute medical facilities such as walk-in clinics and Planned Parenthood. While the services at these locations have been valuable for her, she wished for the ability to afford establishing a rapport with a primary care physician who would know her and understand her on a deeper level. That level of care, however, is out of reach for Sara.

Destiny Gonzales, while now covered by private insurance, experienced many years of hardship without health insurance after moving to the United States with her mother and her little brother from Venezuela in 2010: “Before my mother married my stepfather, we didn’t have insurance in the United States. From the year 2010 to 2015, no healthcare, and that was rough to say the least.”¹⁵ In that time, from 2010 to 2015, Destiny visited the doctor’s office only once due to a persistent sickness that left her bedridden for two weeks. Destiny wrung her hands as she told me of this; I could tell she was remembering how terrible it was, and she confessed she still felt guilty for costing her mother so much money with that visit. The price of receiving care is too high for patients to utilize healthcare facilities unless absolutely necessary.

¹⁴ Interview with Sarah Leon, February 2019.

¹⁵ Interview with Destiny Gonzales, February 2019.

Other participants who did have active health insurance found themselves struggling to navigate websites key to accessing facilities covered by their insurance. Xia Marcial, who has Medicaid insurance, attempted to find a primary care physician that was currently accepting new patients:

For some reason, Medicaid, their site sucks. So, I can't find exactly what I would like. When you're searching for a physician there are filters and you can specify what kind of doctor you want. I selected female. I would look at the ratings, I would look at so many stats. But everything was so disorganized and didn't make sense. I selected one that said they were accepting new patients and I thought that they were female, the site said they were female. But they're not, he identifies as a man. I'm like this is literally so annoying, why is this happening to me?¹⁶

Xia made the effort to find a primary care physician that she was comfortable with after feeling “deadly sick” for a week. However, due to an inconsistency of expectation regarding the provider's sex, she felt uncomfortable receiving care in that space at all. After leaving that healthcare appointment, Xia has yet to return to that office where she is technically an active patient. Xia mentioned there were a few occasions she has felt terribly sick and considered returning to the practice for assistance, but, after reflecting on the previous experience and the doctor's “creepy vibes,” decided to tough it out on her own.

Other participants had difficulty locating accurate information on the internet about healthcare facilities as well, stating that phone numbers, office hours, and current practitioners were often listed incorrectly. There were complaints as well about the difficulty to sort through the masses of information that would load in searches. Christina Velez made mention of this:

¹⁶ Interview with Xia Marcial, December 2018.

Whenever I look it up to go to the doctor under my insurance there is a lot that comes up but it's a lot and it's so overwhelming for me. So, that's why I kind of just don't put that much effort into it. I get so overwhelmed by it.¹⁷

Testimonies such as these suggest the importance of streamlining websites and webpages to encourage potential patients to feel confident creating healthcare appointments. Disorganization on this level reinforces the avoidant health seeking behavior that already permeates the LGB Latinx community.

Waiting Rooms and Perceived Bias

Waiting rooms are an integral facet of healthcare facilities, they act as the gateway between provider and patient. When respondents found themselves in circumstances they deemed dire enough for a visit to a healthcare facility, they inevitably ended up in waiting rooms that left much to be desired. Participants were looking for spaces to unwind in before appointments with providers that already put them outside of their comfort zone. To arrive at the healthcare facility and find an unwelcoming space often set the tone for a negative experience. Sylvia Flores opened up about the kinds of waiting rooms that made her feel unwelcome; while her critique is somewhat humorous, it speaks to a larger problem about what the providers find is important to communicate to the patients upon arrival:

It's like when the doctor's office have those rooms with the dingy posters that say 'don't smoke, this is what your lungs look like after.' And it's like you can add some vibrancy, you can make it fun, make it an inviting place. I'm tired of seeing stained chairs and carpets.¹⁸

¹⁷ Interview with Christina Velez, January 2019.

¹⁸ Interview with Sylvia Flores, February 2019.

By the time LGB Latinx people have made it to a healthcare facility's waiting room, they have already accumulated a variety of adversities that have accrued to a circumstance of dire need. To arrive in a space so uninviting and even dirty is almost disrespectful. Many research participants in this study brought up this observation. While Sylvia would opt for a waiting room that is colorful and inviting, Destiny Gonzales preferred a plainer model:

If I were a prescriber, I would have my waiting room be very clear and concise. You come here to get treated and nothing that I think personally matters. I can put whatever amount of things on the wall and it doesn't matter to me. The patient should be most comfortable coming to the doctor as an unbiased person.¹⁹

This quote implies a significant connection between the provider and the waiting room, the waiting room often acting as an initial insight into the providers' personal perspective and potential biases. The centering of the waiting room around certain themes or ideas could cause potential discomfort for participants. For example, Julia Bonilla found herself increasingly uncomfortable visiting her primary care physician due to her prescriber's proselytization of faith:

My primary health care office makes gives off a vibe that unsettles me. My provider is very Catholic, and she has a ton of religious stuff and iconography in the waiting room and everywhere. It is kind of uncomfortable, it's not horrible because I have grown up in a Catholic household, but it just crashes with what my idea of what a medical setting should look like and I can only imagine what it be like if you weren't Catholic. I think it should be very neutral in regards to faith, I feel like if the doctor themselves ascribes to a certain thing that is okay but if the actual facility is overbearing in its message or whatever I feel like that it rubs me the wrong way.²⁰

This style of waiting room is ostracizing for anyone who does not ascribe to the same (or any) faith as the provider. Many LGB people feel heightened anxiety when entering spaces with

¹⁹ Interview with Destiny Gonzales, February 2019.

²⁰ Interview with Julia Bonilla, January 2019.

explicit religious elements; this comes from the expectations that those who are religious tend to be more discriminatory toward sexual minorities as evident in common religious doctrines, in particular Catholicism, which forbid or marginalize same-sex relationships.²¹ While many LGB and Latinx people are religious they are still aware of the increased potential for discrimination when religious symbolism is prominent. Julia, while being raised Catholic like her prescriber, still found it uncomfortable to see her faith displayed in a medical setting. It “crash[ed] with what [her] idea of a medical setting should look like.” Research by Bolderston and Ralph (2016) confirms this finding, LGB patients have an acute awareness of the spaces they occupy and are often on the lookout for signs of positivity and acceptance. This is not limited to the décor of the waiting room, but it extends to the attitudes of the receptionists and nurses as well. Having a positive congruence between the physical environment and those working in it is important in making patients feel welcome (Bolderston and Ralph 2016, 209). Waiting rooms and healthcare facilities should allow patients of all backgrounds to feel comfortable to receive care.

These criticisms of waiting rooms point to the importance of creating a waiting room space that is comfortable for patients. Waiting rooms are often the first impression that patients ascertain about the culture of the practice and the priorities of the prescribers. If one has an uninviting waiting room, it sets the tone as a bleak one. LGB Latinx patients who are in circumstances of dire need are looking for an environment that they can trust. To be able to enter a healthcare facility, take a seat, and feel at ease is a luxury LGB Latinx patients are not afforded

²¹ While religious institutions such as the Catholic church take specific positions on matters related to gender and sexuality in their doctrines, people who follow a particular faith vary in the degree to which they observe these rules. Therefore, it is important to not conflate religious affiliation and religiosity. For example, research shows that the vast majority of Catholics, including Hispanic Catholics, use contraceptive methods forbidden by the church (The Guttmacher Institute 2018).

in most places. While this chapter focused on LGB Latinx participant's healthcare seeking decisions and experiences within existing healthcare structures, in the next chapter I examine how these participants interacted with healthcare providers in relation to their own identities, perspectives, and backgrounds.

SECTION 2- “Are There Providers Like Me?”:

The findings in this section present the experiences of LGB Latinx patients with healthcare providers and research participants’ reflexivity about providers. In this chapter, three main thematic categories presented themselves from participants narratives: (a) encountering experiences of discrimination on the basis of race and sexuality; (b) the encouragement found in experiences of acceptance; and (c) participant’s conceptions of providers: what is ideal and what is avoided.

During interviews, when I asked questions that centered around recalling specific instances of discrimination, I was surprised at the ease of recollection participants had. In a heartbeat, they would begin a story of a time within a doctor’s office that led to great personal discomfort and/or a complete rejection of healthcare. When navigating this territory, participants reported being acutely aware of when they were being judged and what axis of their identity was under attack from healthcare providers. These stories solidified the compartmentalization of identity that permeated this research. Participants in this study tended to separate experiences of racism and homophobia and expressed being Latinx as separate from being LGB. In dealing with these discriminatory situations, participants felt ostracized from seeking healthcare even after overcoming all the initial obstacles in their way: capricious or inadequate insurance coverage, difficult and inaccurate websites, and hostile waiting rooms. Participants found themselves stuck with a provider who did not care to meet their needs or to acknowledge their identity. In stark contrast to these negative experiences were the times participants had been to see a provider that made space for their identity as LGB, as Latinx, or as both. These times of acceptance made a world of a difference for participants. This duality of experiences led to participants developing

strong opinions regarding what constitutes the role of a provider as well as what can providers do to create comfortable spaces for Latinx LGB people to seek healthcare.

(a) Experiences of Discrimination

Homophobic Assumptions and Preferential Treatment for White People

During interviews with participants, I found many of them were quick to recall an encounter they considered discriminatory or Othering²² by healthcare providers, from the check-in receptionists to the physicians themselves. Participants expressed their understanding of these encounters as targeting a specific facet of their identity, either sexuality as LGB or race as Latinx. Participants who were Afrolatinx had a particularly acute awareness and recounted a larger set of experiences that discriminated against their racial identity. Sylvia Flores, who is Afrolatinx, noted a distinct transition in treatment from her childhood pediatrician's office to her current primary care physician's office:

Oh yeah, absolutely. Not so much when I was younger because my pediatrician was Egyptian and so was my allergy specialist who was his wife. So, from ages six until I was about ten or eleven, I dealt with them. I didn't have any issues like that, the nurses were of all races, it wasn't until I started getting a primary doctor where it was sort of like people speaking AT you instead of TO you. I guess I have a very soft voice so I sound childlike on the phone when I call to make appointments and then when I show up and I tell them my name they would look surprised and say "Oh that's not what I was expecting when I read the name."

²² The concept of "Othering" has been detailed by scholars such as Edward Said as a model of analysis for the practices and discourses that essentialize categories or groups of people and label them wholly different. This difference is associated with a negative connotation and is perceived to be deviant from dominant culture particularly that of Western culture (Said, 1978). The ideas that an inherent difference exists that is central in Othering also functions to justify further marginalization of these groups.

Also, I noticed that when I show up with an appointment, I'm waiting like an hour and a half and white people who call in that morning to get an appointment are getting taken in first.²³

Growing up, Sylvia felt very comfortable at her pediatrician's office. She spoke highly of him as a provider and the care he offered. She highlights the diversity of the staff in seeing "the nurses were of all races." Participants paid close attention to the construction of the environment around them as an indication of the care they would receive. Sylvia noticed at her new primary care physician's office that preferential treatment is given to those who are white, in terms of waiting to see the providers and the way she is spoken to by receptionists. Sylvia implies that her differential treatment comes with being a minority in the town she lives in. She refers to it as a very "white area":

I know when I go in it's all white people. I don't see any people of color, not even like a nurse practitioner person of color, it's all white people. It's a little uncomfortable, especially when I have to ask for things like I'll say, "Can I get a note for work and something for school?" and they look at me as if I don't go to school, as if they're surprised I have a job, they look at me like I'm dumb or if I don't understand. It's like "No, I have a right to be here, I have a right to be helped. I know what's going on."²⁴

Sylvia's experience was the feeling of being a burden for asking staff to accommodate basic needs. The act of receiving a doctor's note for work or school, which can be a requirement to receive excused absences and is a standard occurrence, was experienced by her as a major inconvenience for staff. Sylvia saw a clear differentiation of treatment between herself, an Afrolatinx woman, and other patients of her primary care physician who are white, as she observed that they are seen more expediently, talked to with more consideration, and helped with

²³ Interview with Sylvia Flores, February 2019.

²⁴ Interview with Sylvia Flores, February 2019.

greater enthusiasm. Sylvia has not returned to her primary care physician's office for two years, her last experience being so uncomfortable that she opted to go to a walk-in clinic instead when she found herself suffering severe flu symptoms.

Other participants experienced racial discrimination that went beyond preferential treatment to White people and micro-aggressions. Marco Torres, a gay identifying Peruvian American, explained that his provider made him feel very uncomfortable during the check-in to his appointment. Marco had tried many different doctor's offices and none of them made him feel very comfortable, so he reached out to some friends who recommended he visit their primary care physician despite the office being out-of-network for his insurance. Upon arriving, Marco approached the front desk to check-in. After doing so, the receptionist called him up and asked for his insurance card. Marco then explained he would be paying for the appointment out of pocket. "Is there a reason you don't have insurance?" The receptionist snapped, "Is it because you're undocumented?" Marco's eyes rolled as he repeated the encounter during our conversation, and I could feel his annoyance and his frustration. "No, I do have insurance, you are just out of my network,"²⁵ Marco replied. Marco then left the office without going to his appointment and never went back to that doctor's office. Marco was upset that his status as a citizen of America was being questioned on the basis of his race as Latinx and felt that there would have been no way the receptionist would have asked that question to a White patient.

Participants also explained that many of their experiences with discrimination in healthcare came from interactions with family members. Specifically, providers came across as

²⁵ Interview with Marco Torres, January 2019.

extremely impatient with participants who served as translators for parents who spoke little to no English. Xia Marcial provides an example of this occurrence. Her father has had difficulties with his health in recent years, and she is afraid of situations where she cannot be with him at the doctor's office to facilitate communication between providers and her parents:

I am really uncomfortable when I go to the doctor with my family, specifically with my father because he is an older Hispanic man. My parents don't speak good English, it's a broken English. Communication can be really hard, and I've grown up as the translator of the family and every time we go to the hospital it's me translating. I can see the annoyance of the doctors and the nurses. Everyone is always pretty rude and annoyed as far as I could tell.²⁶

Despite the discomfort she feels dealing with the situation of acting as a translator, she prefers it to her father facing providers on his own and receiving inadequate care and resulting miscommunication. This circumstance is not unique to Xia; other participants such as Sylvia Flores and Ana Sol Garcia regularly attend doctor appointments with family members to ensure fair treatment and full communication. These participants found that front desk staff such as receptionists and secretaries were the most obstinate to assist non-English speaking people. This finding underscores the need for providers to be understanding of language barriers and try to work with patients to help them come to a mutual understanding of their health and the actions needed to be taken to increase wellness (Fadiman 2007).

Sara Leon's experience was slightly different, the discriminatory treatment not having to do with translation of English to Spanish. Instead, it centered around a dismissal of her family's methods for coping with death. In 2014, her grandfather was losing a fight with diabetes and she

²⁶ Interview with Xia Marcial, December 2018.

went with her family to the hospital to spend time with him and celebrate his life. When she arrived she noticed her family was facing resistance:

I remember being in the hospital when he was passing away, it was like a three-day thing. When we were visiting there were a lot of us, we are a big family and there are a ton of kids and we were all coming to see him. The hospital was in Alabama, a predominately white conservative place and the hospital was no different. It was the worst place I have been in regard to racism in a healthcare setting. They were very uncomfortable with us being there and they were very rude. My aunts are very loud and there are a bunch of kids and we were the only Hispanic people there. They didn't say anything that was explicitly awful, but you can tell when people are tense and don't want you there. It was almost like they didn't like our family dynamic. If we had questions, they were very short as if they had something else to do that was more important than dealing with us with "those people."²⁷

Sara raises a good point: the geographic location one seeks care in can make a big difference in the treatment one can find. In areas that are more urban and have a higher percentage of Latinx residents (and providers), it is more likely that Latinx people will be comfortable navigating healthcare spaces without fear of discrimination against their racial identity. In Alabama, this was not the case for Sara and her family. Sara opened up about the frustration she felt that the providers viewed her family's way of dealing with grief as disruptive and inconvenient. Sara said providers were short with her and her family and did not make them feel welcome at all.

Participants further experienced circumstances of discrimination in regard to their sexual identity as LGB. The doctor's office was rife with assumptions of heteronormativity, this made participants feel invisible as if their identity as Lesbian, Gay, or Bisexual was impossible or non-existent. Xia Marcial faced this assumption time and time again in her visits to the gynecologist.

²⁷ Interview with Sara Leon, February 2019.

After years of an irregular period, Xia decided it was time to figure out her cycle, so she made an appointment with a gynecologist that was covered by her Medicaid insurance. At this point she was apprehensive about what the appointment would be like; it was her first time going to a gynecologist and she had always felt uncomfortable with healthcare providers in any capacity. When she arrived, the doctor insisted on giving her a pregnancy test despite her protests that it was absolutely unnecessary to do so. Xia is a lesbian and had never had sex with a man. The idea that she had to take a pregnancy test was preposterous to her, but she did not feel comfortable disclosing her sexuality to the provider as an explanation for why the pregnancy test was pointless.²⁸ The provider's persistent urging betrayed their heteronormative assumption that Xia, if sexually active, would not only be having sex with a man but would be having penetrative sex with a man. The understanding of penetration as the key sex act has been problematized by scholars who found that (even) within heterosexual relationships, penetration is not always wanted or preferred (Potts, Gavey, Grace, & Vares, 2003). Despite this, Xia hoped her insistence and initial refusal would be enough to prevent a pregnancy test:

They didn't know I was a lesbian. Which was so funny because they just assumed... I would go and I would tell them, "My period is weird, don't get it much." And they would say, "Okay we are going to give you a pregnancy test," and I would say, "I don't need that, it's just my period," and she said, "I don't care you could be a fucking nun and I'm still going to give you a pregnancy test." I would say, "Um, okay cool." I'd get weirdly paranoid that I was pregnant because I don't know what if I'm the next virgin Mary or something? [Laughs] I don't know, it's a scary thing. But it definitely made things uncomfortable to have to take all these god damn pregnancy tests when I know its going to come back and turn out to be negative every time.²⁹

²⁸ Research shows that disclosure of sexuality for sexual minorities such as lesbians, gays, and bisexuals is stressful for patients, and many patients do not seek care to avoid disclosure of sexuality (Durso & Meyer, 2012).

²⁹ Interview with Xia Marcial, December 2018.

It was difficult for me not to laugh with Xia when she was sharing her story. It seemed so ridiculous for her to have been tested for pregnancy so many times while never having had sex with a man. But this is not a laughing matter; the fact that Xia felt so unable to disclose her sexuality as a lesbian woman to her provider shows the fear she harbored at their potential reaction. Xia did not feel safe to communicate that facet of her identity and the provider strongly assumed that Xia was heterosexual no matter what and subjected her to a procedure that is not meaningful for lesbian patients. What does it mean that Xia's provider never considered the possibility that her patient could be anything but heterosexual? While this assumption of heterosexuality is damaging, it is not the only discrimination participants faced regarding their sexuality.

Some participants did decide to disclose their sexuality to their prescriber and, instead of acceptance or even indifference, were met with challenging notions and condescending disdain. This was the case for Daphne Ortiz, who identifies as lesbian, when she went to see a gastroenterologist to seek help about her bleeding colon and stomach cramping. As the doctor began a physical examination feeling her stomach and lower back, she asked Daphne if there was any chance she could be pregnant. Daphne quickly responded that, "No," there was no chance of pregnancy. The doctor seemed surprised and pressed Daphne to answer the question again, "But you're like twenty, there's absolutely no chance that you could be pregnant?" At this point Daphne decided it was logical to disclose her sexuality to her provider as a means of explaining there was absolutely no chance of pregnancy and her symptoms had to be coming from something else, so, she said, "No, I'm a lesbian." Here is where the doctor had the opportunity to

express acceptance for Daphne with a simple, “Oh, I see.” Instead however, things took a darker turn:

She was like “Oh, that’s such a shame.” And I was like, “Wait, what?” And she was like, “There’s another doctor here who is really pretty, and she is also a lesbian and it’s such a shame because you will never have children, you’ll never meet a husband.” I sat there in total shock. I sat there in awkward silence and in shock. I was like... Anyway... My colon hurts. Like? She took five more minutes of pressing some more on my stomach. Then she said, “Wait, how do you know?,” and I said, “How do I know what?” She was like, “How did you decide that you were gay?” You know how in that situation you want to educate that person about how it’s not a decision. But, whatever. [Laughs] She asked me that and I was like, “How did you know you were straight? Did you wake up one morning next to your husband and say, ‘I’m attracted to the opposite sex!’? She sat there for a minute thinking it over and I was like, “So, are you going to do your job?”³⁰

When Daphne disclosed her sexuality to the provider she was met with inappropriate inquiries. It is not acceptable for a provider to ask their patient to explain the fundamentals of sexuality, let alone to dismiss her patient’s sexual orientation as a loss of quality of life. Additionally, the provider betrayed her heteronormative assumption by presuming lesbians cannot get married or have children. Daphne was in pain, the reason she came to this doctor’s appointment was to be cared for, but there she was being questioned about something completely unrelated to her reason for visiting. Unfortunately, things did not get better for Daphne. After a few more moments of internal reflection the doctor launched into another series of invasive questioning about Daphne’s sexuality:

“Forgive me, I just need to ask.” And I was like, “What lady, what?” And she said, “You’ve never kissed a boy? You’ve never held hands with a boy? You’ve never even had sex with a boy?” That was when I was like, “Why are you even asking me these questions? I get that you’re curious but is that going to help my

³⁰ Interview with Daphne Ortiz, January 2019.

problem? The reason I'm here?" And she seemed surprised that I even brought that up, she was like, "Well, honestly the stress of coming out can really affect a person." And I was like... "Cool, yeah." She was trying to draw all of my problems back to being gay. There was no chance that my physical symptoms were stress related. There was blood coming out of me, I could tell that my esophagus was swollen. There were things that were showing me. At that point I hadn't even had the chance to bring up my genetic predisposition to Crohn's disease. I said, "I feel kind of uncomfortable." And she was like "Oh, no. No, no. I get it, you aren't used to the stress of coming out and it's probably what's causing all of these problems for you." She had yet to even look at my file or do anything and she's finishing up asking all of these questions and says, "Alright, well, I think you're all set." And I was like, "No. Hold on. There should be things happening right?" And she said, "What do you mean?" I said, "Shouldn't I be telling you about my family history that has like three diagnoses of Crohn's disease in the past ten years? My family obviously has a genetic predisposition to Crohn's and you're just attributing it to me coming out." And she was like, "Well, no because I think that really might be it." And I was like, "So you're not going to run any tests?" And she said, "Fine. We can order a colonoscopy or an endoscopy or whatever."³¹

Daphne had to fight to have her symptoms be taken seriously at all. Her provider became so focused on psychoanalyzing Daphne and blaming her sexual orientation that she failed to even begin to address any of Daphne's concerns. Providers are in a position of power and can assist patients in the form of testing, prescriptions, and lifestyle advice. Patients put faith in providers to help them through times of difficulty and to ignore them or chalk up all of their problems to their sexuality is a sheer act of willful ignorance. Daphne was tempted to never go back at all, and, if it was not for the severity of her condition, she would not have. When Daphne went in to have her colonoscopy performed, she was shocked to find the same provider was there to complete the procedure. Immediately, she felt panic rising in her chest and if it was not for the already administered anesthetic she would have protested and stopped the procedure from occurring. When she came to, she felt incredibly violated by the experience and before

³¹ Interview with Daphne Ortiz, January 2019.

committing to any new appointments or the viewing any results, she ensured she never saw the same provider again. After that, Daphne learned that she had early stages of Crohn's disease, validating her suspicions and highlighting the necessity of the procedure. Daphne was wrongfully given the responsibility to fight for her right to an impartial diagnosis, she was subjected to a fully homophobic attack by the physician, and she was nearly denied care. Daphne's experience raises serious issues about homophobia in healthcare—an attitude that is unacceptable and needs to be addressed in providers' training.

It is interesting to note that these experiences of discrimination for race and sexuality largely occurred in different spaces, racial discrimination was found to be most prominent when attempting to create appointments with receptionists, when interacting with nurses, and when requesting necessary documentation for work and school, whereas, discrimination on the basis of sexuality was found in interactions with doctor's in one-on-one contexts. This speaks to the nature of race and of sexuality. Race is unavoidably announced by appearance; participants verbalized that they could do nothing to hide their Latinx identity to blend in with White people. This contrasts with sexuality which can remain unknown until disclosed. This leads to discrimination which manifests in assumptions of heterosexuality. When participants feel bold enough to disclose their sexuality it is under necessity in direct conversations of providers. Participants seemed to be aware of this and grew to expect discrimination of one or the other kind, depending on the geographical context of the healthcare facility, from entering the waiting room to being led back to the offices by nurses racial discrimination is what to expect, but when patients found themselves within the office with the provider discrimination of sexuality was most prominent.

(b) Experiences of Acceptance

Paperwork and Conversations

Despite the plethora of bad experiences that participants could pull from memory, some were able to think of good experiences too. Experiences of validation and acceptance of identity; experiences that made them excited to seek care and facilitated a relationship between the patient and the provider. While these experiences were fewer, they made a big difference to participants. Each took painstaking care to praise providers who treated them like normal human beings. Many participants even recommended prescribers for me to pursue for my own personal health needs. The vast majority of these experiences of acceptance took place in spaces that visibly conveyed to be LGBT-safe practices designed specifically to meet the healthcare needs of the LGBT population. Thus, participants immediately felt these offices were well equipped to assist them. Participants also found that LGBT safe space providers were also more accepting of Latinx people. They reported little to no micro-aggressive behavior from providers and staff during their visit. Staff was seen as kinder, physicians as better listeners, and nurses as genuinely caring in comparison to other non-LGBT centered healthcare spaces.

One way that these LGBT healthcare facilities made participants feel more welcome was through the use of inclusive paperwork³². Sara Leon shares an example of what this was like when she checked-in to an appointment at Planned Parenthood:

They have sort of a checklist with how many people you've had sex with and the gender of the people you've had sex with in the past 12 months, if you know

³² Recent public health scholarship supports this finding by stating that patients prefer disclosing sexuality and gender identity in writing (Haskins, 2019).

whether any of your past sexual partners had an STI, what sexuality you identify with, what gender you identify as, what your preferred pronouns are, stuff like that. It's on a clipboard that they give you when you come in there and you fill it out and hand it back to them. They're pretty inclusive at Planned Parenthood.³³

Sara explained how surprised she was when she first visited Planned Parenthood to be tested for STIs and found that they were so considerate to ask these questions to every patient who walked through their door. Sara was happy that she did not have to verbally announce these things to the provider she was seeing, that they would be communicated directly through these written questions that they had explicitly asked on the forms, because they deemed them important to know. Sara was happy her provider would know from the beginning of their interaction that she was a lesbian who was “a bit promiscuous.”³⁴

Marco Torres, after trying provider after provider finally found a practice that made him feel comfortable enough to return after the first visit. This he considered nothing short of a miracle. What helped Marco achieve this comfort was very similar to what Sara found at Planned Parenthood: inclusive paperwork that asked questions pertaining to Marco's identity and sexual practices:

They asked initial questions about sexuality, preferred pronouns, sexual history, everything. The questions about sexual history were cool too because they explained why they were asking about it, “For the purpose of understanding STIs and STDs, what gender do you generally have sex with and what was the sex assigned at birth to the last person you had sex with?” Stuff like that.³⁵

As these narratives show, when providers create systems that promote disclosure of sexuality as normal and important, participants were very comfortable to open up to providers and share

³³ Interview with Sara Leon, February 2019.

³⁴ Interview with Sara Leon, February 2019.

³⁵ Interview with Marco Torres, January 2019.

information about themselves and their personal needs. It is as simple as creating a document to accompany other intake forms that can make a world of a difference to LGB patients.

Sylvia Flores, who had endured circumstances of racial discrimination at her primary care physician's office, found that when she visited an LGBT clinic for STI testing, she did not feel like she was being treated any differently from other patients because of her race as Afrolatinx. "When I walked in, I was helped right away, and everyone was really nice. It seemed like people were seen in the order they came in."³⁶ Sylvia was happy to see other people of color working at the clinic, it relaxed her from the start. She then sat, content to wait for her turn to be seen and tested, feeling it was logical and fair to organize patients as first come, first serve. Sylvia explained to me that she would be looking for an LGBT safe practice to be her next primary care office because of her experience at the clinic. She anticipated that a facility that was LGBT friendly would be more Latinx friendly as well. This connection was supported by her trip to get tested at the LGBT clinic.

Felix Nieves, a bisexual identifying Colombian Honduran American, since leaving his pediatrician's office has only ever gone to LGBT safe space healthcare facilities and says he would never go anywhere else. When he first became sexually active, he recognized the importance of finding a provider that could treat him without judging him for his sexuality. After talking with some friends, he was referred to a healthcare facility that specialized in LGBT care:

I went in to get on PrEP³⁷ because I slept with someone without a condom and I was pretty scared. I went in and part of their facility had already closed so they

³⁶ Interview with Sylvia Flores, February 2019.

³⁷ PrEP stands for Pre-Exposure Prophylaxis, and is an anti-HIV medication that prevents infection in those who are HIV negative. (n.d.). Retrieved from <http://www.whatisprep.org>

were technically unable to give it to me that day because a lot of stuff was going on but they found a way to give it to me that day, to start that day, so they went above and beyond just to get me onto their healthcare and to get my healthcare to cover certain things. It's very comforting to go there. Everyone is helpful, the receptionists, the nurses, the people in charge.³⁸

Since that first visit Felix has been back a number of times, building relationships with the staff and the doctors there. Felix admits he would be apprehensive to seek healthcare services anywhere else. He was glad to have found somewhere that was not only open to his identity but also happy to help him with other LGBT resources. When there is community there is solidarity. Working in a practice that has the specific mission of serving the LGBT community, staff members are either going to be members of the community themselves or strong allies. This leads to a culture that is very supportive of LGBT patients and fostering a caring environment for them. This type of experience is very different from anything else many LGB Latinx participants had ever experienced.

Many participants just wanted to be treated as normal people. Christina Velez explained how excited she was when her gynecologist took the disclosure of her sexuality as no big deal:

One time I went to the girl doctor, I was doing a girl check-up, and she was asking if I was sexually active and if there was any chance of me being pregnant and I was like, "No." And she was like, "Are you sure?" And I said, "Yeah." Then she was like, "Are you sure? Are you sure?" I said, "I'm gay, like stop, I have a girlfriend." And she said, "Oh, okay." And that was about it, she didn't pry about that anymore.³⁹

While Christina found her gynecologists insistence annoying, she was relieved when her answer settled that question out of her mind. After that her gynecologist tailored

³⁸ Interview with Felix Nieves, February 2019.

³⁹ Interview with Christina Velez, January 2019.

questions toward her sexual practices and even asked how her girlfriend was doing from time to time. This interaction of normalcy meant a great deal to Christina.

The Power of Symbols

In conversations with participants, symbols were seen as unanimously beneficial for creating a comfortable environment for the LGB Latinx population. Every participant agreed that seeing LGB positive symbols in any capacity at a doctor's office (posters or pamphlets in the waiting room, pride flags anywhere in sight, pride pins on the lapels of staff and providers, etc.) increased the likelihood that they would feel more at ease to disclose their sexuality to their provider as well as feel more comfortable seeking care at the facility in general. Christina Velez put it best when she said, "When I see symbols of the LGBT community, I'm like, Oh, yeah. I love this gay shit."⁴⁰

Participants also stressed the importance of seeing symbols of racial diversity as well. Ana Sol Garcia made mention of her favorite poster to see, "You know the one I'm talking about, right? The poster with all the hands with different skin tones holding each other in a circle? It's so cute and it makes me feel so happy and comfortable to see."⁴¹ Participants also considered a diverse staff at a healthcare facility a symbol of racial inclusion and acceptance. When more people of color were employed at a practice, participants felt safer and more open in their dialogues with staff and physicians alike.

⁴⁰ Interview with Christina Velez, January 2019.

⁴¹ Interview with Ana Sol Garcia, December 2018.

(c) Conceptions of Providers

Ideal Communication and Demographic Preferences and The Fear of Latinx Providers

One final question I posed to participants asked them to imagine the perfect doctor for themselves, the kind of doctor that would make them the most comfortable seeking healthcare at their earliest sign of need. Participants answered this question in a variety of ways, some emphasizing facets of personality and disposition, while others emphasized demographic information such as race, sexuality, and gender.

Ana Sol Garcia has a history of visiting prescribers that have written off her concerns about her own body. Since she had her IUD implanted, she has experienced “severe abdominal cramping and persistent pelvic pain.” In an effort to relieve her pain from her IUD, Ana Sol has made many appointments with providers who deem her circumstances as inevitable and untreatable. She explained to me that during those appointments she never felt that the doctors listened to her. It’s no wonder that after these experiences the facet of a prescriber that she focused on to construct her ideal was that of personality and communication style:

Someone who really listens to me and takes my feelings into consideration when ordering tests and things of that sort. I just feel like healthcare providers don’t listen to their patients, they try to look for a solution without trying to figure out the problem. I want a doctor who will listen.⁴²

Participants do not want to voice their concerns for those to only fall on deaf ears. It is difficult to speak up to a provider to begin with, but to do so and then have one’s feelings be invalidated

⁴² Interview with Ana Sol Garcia, December 2018.

is aggravating and an indication that one does not matter to the provider. Other participants expressed the importance of humility in a provider, when doctors behave pompously and refuse to listen to the patient's observations about their health, there is a problem. The reason the patient came to see the doctor is because they sense something was off-kilter within them. Therefore, in patient-centered care, the experiential "embodied" knowledge that comes from listening to one's body should be included as a form of "authoritative knowledge" in the provider-patient conversation (Browner and Press 1996).

When it came to demographic preferences, research participants unanimously considered female providers to be ideal. Women were considered more open, accepting, and communicative than men. Participants also found it favorable to have genderqueer or gender non-conforming providers, who were considered just like women to be more open, accepting, and communicative. No participant opted for a man specifically and only two out of thirteen participants said they did not care either way if their ideal provider identified as a man, woman, or gender non-conforming.

The next piece of the provider's identity is where the results began to vary. Many participants stated a preference for providers of color, finding comfort in the solidarity of their identities as people of color. However, some participants stated that race would not be a factor in the construction of their ideal provider because, in their experience, providers of color have been equally as discriminatory toward them for their identity as LGB as White providers have been. This is where it came down to personal experiences and perspective.

Alison Tijerina was quick to say she would prefer a provider of color, “It’s random but I’m more comfortable around other minorities in general than when I’m around White people. I think that comes from the fact that I wasn’t always accepted by everyone everywhere and I feel like if I was White, I would have been.”⁴³ Because Alison’s trust is based on her experiences of acceptance from communities of color (and discrimination from White communities), it is logical for her to feel more comfortable with people of color. This line of thought was echoed by Gabriel Martinez who felt that he could trust other people of color to meet his needs and have his best interests in mind.⁴⁴

Ana Sol Garcia did not feel the same way: while she did not have a specific race/ethnicity preference in providers, she did report that in her experience with many providers of color she has faced discrimination and general hostility:

I have met a lot of person of color doctors that are just as mean as White people are. That is simply because they are doctors and feel entitled. I think doctors are very entitled people and want and think that because they are doctors, they have the final say over anything. They think they are the absolute answer and don’t listen to people. People of color tend to be more accepting and tend to listen to people more and don’t have that “I’m better than you” notion. But at the same time race doesn’t apply to being a doctor, because I’ve seen plenty prescribers of color be assholes simply because they are doctors.⁴⁵

Ana Sol had never had a prescriber with whom she was completely comfortable; she was frustrated in feeling like there was no way for her to win. After our conversation, she confided that she felt a new determination to seek out a provider that would meet her needs. Ana Sol brought up an interesting point: the role of a doctor in society is quite exclusive. It takes years of

⁴³ Interview with Alison Tijerina, January 2019.

⁴⁴ Interview with Gabriel Martinez, February 2019.

⁴⁵ Interview with Ana Sol Garcia, December 2018.

training, thousands of dollars, and the determination to succeed. When people of color become prescribers, they gain a new-found sense of power and control over the lives of others. This can warp their perspective and lead them to treating people as poorly as they are treated in other contexts.

An interesting finding emerged when I examined how study participants explained their preferential demographic characteristics of an “ideal” healthcare provider. Participants felt extremely comfortable with providers that were both Latinx as well as LGB or worked within an LGBT safe space facility but felt extremely uncomfortable with providers that only identified as Latinx. Xia Marcial was the first participant to showcase this thought process and explained it as follows:

I feel like it kind of scares me more and gives me more pressure to be and act as hetero[sexual] as I can be, which is not a lot, when the doctor is Latinx. For example, back home my doctor was very Hispanic, and I just take it that they are older and older Hispanic people are usually really closed minded. I feel that perception stems from my parents. Definitely. It’s kind of something that I’m always uncomfortable with when I’m in spaces with older Hispanic people. It’s more pressure for me to be trying to impress them. I think there is an anxiety associated with it, so I just avoid.⁴⁶

Without waiting for my follow up, Xia explained the reason for being apprehensive about having a Latinx prescriber is because their like-identity triggers her to assume that they will behave in the same way her parents do toward her sexuality, homophobically. Through Xia’s performative denial of her sexuality she feels she will come across as more “impressive” to older Hispanic people who she assumes would view her sexuality as negative if she were to be herself.

⁴⁶ Interview with Xia Marcial, December 2018.

Destiny Gonzales, who is Venezuelan, echoed this concept when I asked her about her Venezuelan prescriber's openness to her bisexuality:

Venezuelan people tend to be way less open about homosexuality in general, not to mention their opinion on being transgender. Jesus, that is a can of worms. I highly doubt I could tell him about my bisexuality, he couldn't say much but I feel like he would disapprove, which is why I wouldn't bring it up.⁴⁷

In other words, Destiny is wary that her prescriber will ascribe to the dominant cultural values of Venezuela that condemn homosexuality as wrong. Because of this fear, Destiny would not consider a Latinx provider ideal for her, especially one that is Venezuelan.

However, when providers were both Latinx and either LGB or working within LGB safe spaces, my study participants perceived them as the most ideal type of provider. Felix Nieves shared a good example of this perception. "Yes, my doctor is Honduran and Gay, so we're very close in that. I find it very comforting that he's not only Latinx and gay but also the same kind of Latinx."⁴⁸ Felix enjoyed relating to his provider in terms of both race and sexuality, being able to identify with him in such a way made him feel at ease. Daphne Ortiz holds the same view about her current provider who is both Colombian and works in an LGB safe space, and this combination makes a world of a difference for her as a patient. She explained this is the first provider with whom she has been able to open up and they were able to grow their doctor-patient trust to the point that Daphne was able to resolve a significant amount of trauma that she was unable to disclose to previous providers. This ability to be vulnerable came from the understanding that her provider not only understood Daphne's identity but accepted it

⁴⁷ Interview with Destiny Gonzales, February 2019.

⁴⁸ Interview with Felix Nieves, February 2019.

completely. These conceptualizations of ideal providers was important in that it presented the greatest evidence for the merging of sexuality and race for participants, the way they spoke of and weighed those facets of provider identity against each other showed the complex interconnectedness between them.

CONCLUSIONS AND SIGNIFICANCE

I have asserted through this research a complex understanding of the Latinx LGB community's relationship with healthcare as one that is nuanced and complicated by implications of stigma,⁴⁹ cultural conceptions, active avoidance of the health system, difficulty in access to care, experiences of discrimination, and personal perceptions related to individual experiences and family history.⁵⁰ Participants spoke readily on facing adversity when attempting to seek care; their stories were full of examples of providers' inappropriate conduct, inconsistent insurance coverage, and fear. While participants faced discrimination for both their race as Latinx and for their sexuality as LGB, they spoke of the two as separate and largely unrelated interactions. In most cases, this compartmentalization of identity can be attributed to the awareness individuals expressed of which element, their sexuality or their race, was being discriminated against. Because participants felt that providers discriminated against them based on one facet of their identity at a time and not collectively, they were prone to articulate those encounters as separate.

My interview narratives demonstrate that most cases of discrimination on the basis of race occurred in the organized process of seeking care in the healthcare system. This began from the first point of contact with receptionists and also included interactions with nurses. When participants were seen by the physician, however, a shift occurred: in these intimate interactions within the "doctor's office" is where the most instances of homophobic behavior occurred. After meeting with the physician, when the participants made their way out to complete their payment,

⁴⁹ For the definition of stigma that is most relevant for this study see Link and Phelan (2001).

⁵⁰ These findings are supported by other scholarship, including Bonvincini and Perlin (2002), Felner et al (2018), and Sabin et al (2015).

receive a prescription, or establish a follow-up appointment, they were met again with racist interactions. In terms of participants' conceptions of ideal providers, women and genderqueer providers were preferred by participants. This was because participants believed them to be better communicators and more open than men due to previous encounters in healthcare. It was also preferred for providers to be people of color and specifically Latinx when the healthcare facility was known to be LGBT friendly. In the case that the providers perspective on the LGBT community was ambiguous, participants did not have a racial preference due to homophobic encounters with white providers as well as providers of color. Indeed, "ideal provider" conceptualizations are complicated in that a Latinx provider might actually be less preferred than non-Latinx providers because of the potential for the dominant anti-LGB sentiments from the country of origin or within the diaspora making the provider homophobic. This was clearly evident in participants who had homophobic experiences with family members, and feared similar attitudes from a Latinx provider. This finding is where race and sexual orientation came together in an intersectional⁵¹ manner and is visible in how research participants are weighing the relative advantages and disadvantages of the provider's identity.

The discriminatory attitudes towards patients documented in this research highlight deficiencies in the providers' training. Participant's narratives suggest that there are important changes to make within healthcare to better meet the needs of the LGB Latinx population. Focus should be placed on healthcare providers to change the ways they are educated before being allowed to facilitate care to incoming patients. While cultural competency training has attempted

⁵¹ See: Mackinnon (2013) and Cho et al (2013) for intersectionality analysis.

to bridge this gap, it has proven largely unsuccessful, and thus should be supplemented with more rigorous curriculum that focuses on inclusivity.⁵² In terms of policy suggestions that emerge from this research, a federally mandated “diversity training” that focuses on the needs of LGB Latinx and other marginalized groups for providers at all levels, including staff, might prove useful in improving patient experiences. Additionally, a comprehensive and current list of providers who are LGB-friendly and have completed diversity training might be particularly useful in the LGB community as a way to minimize discriminatory encounters in healthcare and maximize the potential for effective care. Because LGB people have unique health concerns, there should be instruction for potential providers to familiarize themselves with these concerns and develop an understanding of how to assist patients effectively and without judgement. Part of provider education should include how to communicate appropriately with patients as many participants felt doctors, nurses, and general staff were unnecessarily coarse and lacked empathy. This implication is not limited to the LGB Latinx population and comments on healthcare at large, but rather a greater emphasis should be placed on individualized patient-centered care which may be effective in addressing these issues. Developing a dialogue with the patient that allows them to play an active role in the conversation could make a big difference because it provides room for all forms of identity to exist. It is essential that providers learn to communicate without judgement of patient identity—this judgement has created a cycle of mistrust and fear in participants who in response avoid healthcare further or refuse to disclose information that is necessary to help them achieve wellness and overall quality care.

⁵² See: Baker and Beagan (2014), Robertson (2017), and Bolderston and Ralph (2016) for cultural competency scholarship.

Another method that would greatly benefit LGB Latinx people in healthcare would be the integration of inclusive intake paperwork (Haskins, 2019). Participants who experienced clinical visits where providers used inclusive paperwork felt more comfortable disclosing their sexuality to providers on paper and were excited that the provider made room for the possibility of their identity. This would ensure that the LGB population was communicating important details that could impact the physician's input on how to proceed with the patient's health concerns.

Participants were also more comfortable seeking care in spaces that announced the acceptance of their sexuality and/or race through symbols (for example, posters, pamphlets) that were most commonly seen or not seen in the waiting room of the healthcare facility. As my study shows, the waiting room is impactful on participant's perception of the provider, and it serves as an initial insight to possible bias. These symbols have the potential to ostracize or welcome patients. When participants saw Catholic religious iconography, they developed assumptions about the provider that led them to believe it would be unwelcome to disclose their sexuality (The Gutmacher Institute, 2018). However, when they saw indications of LGBT pride or of racial solidarity, they felt more comfortable to be genuine and open with providers. Another indication of acceptance for participants was the staff of the healthcare facility, when a staff was seen to be made up of a diverse group of people they felt more at ease. This finding underscores that it is important to hire diverse staff not only because it reflects the population at large and brings important perspectives into any work setting, but also because staff fulfill a myriad of roles within the facility as people of color physicians, receptionists, and nurses are extremely helpful in making other people of color feel at ease in a healthcare facility. In sum, visible inclusion in a clinic can have important impact on the health outcomes of patients.

In further developing an intersectional analysis it would also be important to explore how race is sexualized and how sexuality is racialized in these participant's experiences. Examples of this can be seen through the reanalysis of certain findings through this lens such as participant's tendency to fear Latinx providers. This demonstrates sexuality as racialized; participants assumed all Latinx providers would be homophobic in encounters of disclosure. This perspective also exemplifies the Latinx identity of providers being sexualized as exclusively heterosexual. Exploring these types of themes on a deeper level would provide essential components to build an increasingly complete intersectional analysis.

The findings in this research make contributions to medical anthropology, queer studies, and public health scholarship. In terms of medical anthropology, this research expands our understanding of how LGB Latinx patients' experience and navigate an exclusionary and discriminatory system of healthcare, as well as how patients assign particular meanings to what might and what might not be safe for them, including the preference for "like them" providers as safest in a context of repeated experiences of inequities. The contribution of this research to queer studies is evident in the re-evaluation of current LGB patient's relationships to providers and healthcare as well as the exploration of the complicated issue of intersectionality and how it is not always articulated as a given by members of the population. Contributions to public health scholarship is seen in my findings that bring attention to the need for improvements in healthcare delivery, from medical and staff training to the symbology in the clinical spaces.

Future research on the LGB Latinx population should expand the age group as in this research I studied young LGB Latinx people ages 18 to 24. Young people generally have the privilege of choice when it comes to seeking care, only because they typically have fewer health

problems as compared to older adults. Therefore, for younger people an issue is only understood as of “dire need” when major accidents happen such as broken bones and ceaseless bleeding. Populations that are older can experience complications of health over concerns that younger populations would mitigate with over-the-counter items. Thus, researching LGB Latinx people across all age groups would show others’ experiences and interactions with healthcare, which in turn would give greater insight into the needs and challenges of this community more clearly. Another facet of research that requires further exploration would be that of disabled LGB Latinx people. While able-bodiedness was not a part of the eligibility criteria, I did not have participants who identified as disabled participate in my research. It would be most beneficial to understand the experiences of disabled LGB Latinx people, their unique health needs and concerns would add a great deal to their perspectives that is missing in able-bodied perception. The nuanced challenges they face could provide further clarity of healthcare experiences and healthcare seeking behavior. These contributions would help determine the necessary shape future provider education should take as well. Another particularity of identity that would be beneficial to explore in future research would be that of gender. Even in this research trends of experience presented themselves on the axis of gender. To analyze the nuances of healthcare encounters for men, women, and transgender identities would add an essential perspective to the understanding of LGB Latinx people. Future research could also benefit from working within the scope of one specialized healthcare locality, such as that of a gynecologist or an endocrinologist. This decision would narrow the scope of research to enable an increased understanding of participant experience within that specialization.

APPENDIX A: INSTITUTIONAL REVIEW BOARD APPROVAL



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Determination of Exempt Human Research

From: **UCF Institutional Review Board #1
FWA00000351, IRB00001138**

To: **Joanna Zofia Mishtal and Co-PI: Caleb Hernandez**

Date: **October 15, 2018**

Dear Researcher:

On 10/15/2018, the IRB reviewed the following activity as human participant research that is exempt from regulation:

Type of Review: Exempt Determination, Category #2
Project Title: Experiences of Young Lesbian, Gay, and Bisexual Latinx
People in Healthcare
Investigator: Joanna Zofia Mishtal
IRB Number: SBE-18-14407
Funding Agency: N/A
Grant Title: N/A
Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the [Investigator Manual](#).

This letter is signed by:

A handwritten signature in black ink that reads "Kamille Chaparro".

Signature applied by Kamille Chaparro on 10/15/2018 03:00:54 PM EDT

Designated Reviewer

APPENDIX B: INTERVIEW GUIDE

Project Title: “Experiences of Young Lesbian, Gay, and Bisexual Latinx People in Healthcare”

(After Informed Consent)

Thank you for agreeing to talk with me today. I’m Caleb Hernandez, and I’m an anthropologist based at the University of Central Florida. In this interview I’m interested in understanding your experiences in healthcare. All of the information you give me will be confidential – I will not ask you for your name or any information that could identify you. The interview is voluntary and it will take 20-40 minutes. Can I audio record our interview or would you prefer I didn’t? Would you like to start now?

Research Site: _____

Date: _____ Time: _____

Background Knowledge

1. Are you a young Latinx LGB person?
2. How old are you?
3. Do you have insurance? If so, what is its origin (job, parents, government)?

Health Seeking Behavior

1. What are circumstances that would cause you to seek healthcare? How much effort would you put into solving the issue on your own before involving a provider?
2. Do healthcare settings make you uncomfortable?
3. Do you have a primary care physician? If so, do you have an open and trusting dialogue with your provider? Or do you rely on acute medical facilities like the emergency room or urgent care?
4. How many times have you had a healthcare appointment in the past 5 years?

Experiences of Discrimination

1. Have you ever encountered homophobia in healthcare? Would you share the experience? How did you respond?
2. Have you ever encountered racism in healthcare? Would you mind share the experience? How did you respond?
3. Has a healthcare setting ever given off a vibe that unsettled you? What was that like?
4. Have you ever canceled a doctor’s appointment out of fear?
5. Are you more uncomfortable when you are discriminated against for your sexuality or your race in healthcare settings? Why? Which experience surprises you more?

Providers of Color

1. Describe the perfect healthcare provider. Have you attempted to look for them? Do you think it's possible to find them under your insurance plan?
2. Would you anticipate a provider of color to be more, or less, LGB friendly? Why?
3. Have you ever been to an LGB clinic? If so, which one? What was the experience like? If not, do you think you'd be more comfortable seeking care in that space?
4. If you were a healthcare provider how would you be intentionally inclusive of LGB people of color? What would you do differently than providers you've interacted with?
5. Describe the environment of a waiting room in a doctor's office that would make you feel most comfortable.
6. Would seeing LGBT positive symbols in the waiting room make you feel more at ease disclosing your sexuality to the provider?

Thank you for your time. Please contact me if there's anything else that you would like to add that you have not had a chance to say during this interview. Here's my contact information: Caleb Hernandez, Email: calebh97@knights.ucf.edu.

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