

CARING FOR LGBT-PATIENTS IN FINLAND AND
GERMANY: A COMPARISON OF PREPARATION,
ATTITUDE, AND RESOURCES OF NURSES

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The purpose of this thesis was to find out if the health needs of LGBT (lesbian, gay, bisexual, transgender) patient's play a role in the curriculum of nursing education, if personal influence affects the professional attitude when caring for these patients, and if and what kind of resources are available to further educate oneself for nursing of LGBT patients. The research was focused to find answers to these questions by gaining and analysing answers from Finnish and German nurses, and compare their answers in the end. The aim was to collect enough data for comparison and to be able to highlight problems within the fields of variables. The long-term aim was to gain answers that provide important information to health care educators and providers to improve the curriculum and resources, in order to impact the treatment and visibility of LGBT patients.

The theoretical framework dealt with different topics of health care needs of LGBT patient's, showing percentages obtained due to published researches in relation to heterosexual patients, and highlighting how and why the different health needs must be taken into account by health care professionals.

The results were obtained via quantitative research, done with two online surveys – one for Finnish nurses and one for German nurses.

The results showed that the majority of Finnish and German nurses did not receive education about LGBT patient's health care during the curriculum of their nursing education. Furthermore, personal attitude is not an influencing factor in how non-heterosexual patients are treated professionally. Resource availability differs between both countries, with Finnish work places providing more resources for their workers than Germany. Additionally, more Finnish nurses than German ones use available resources. The nurses of both countries would educate themselves further on the topic in form a schooling offered by their workplace, and would also recommend such a schooling to colleagues.

Key words: LGBT, homosexuality, transgender, equality, nursing education

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TERMINOLOGY

LGBT = an initialism meaning lesbian, gay, bisexual and transgender, which refers to non-heterosexual and non-cisgendered people.

Cisgendered = any person who identifies with the gender that they were assigned at birth.

1 INTRODUCTION

The name of the thesis is “Caring for LGBT-patients in Finland and Germany: A comparison of preparation, attitude, and resources of nurses”. This thesis is about the results conducted from two online surveys in Finland and Germany aimed at graduated nurses, and looks at their experience during their schooling to become nurses and their professional life regarding the nursing of patients of the LGBT community.

The motivation behind this thesis came from hearing about incidents about unfair treatment and discrimination in the health care of LGBT community members. This put the thought in motion how much emphasis – if any – is put on the needs of LGBT patients during the curriculum in Finland and Germany. Thinking about reasons of why LGBT patient’s needs may be missing from a curriculum led to two thoughts: personal and professional attitude, and resources to enhance knowledge and to guide. One big focus during throughout the curriculum was on the education and guidance of patients, but without proper resources, this cannot be put from theory to practice.

In the end, the following three variables were chosen to be researched: preparation during the curriculum, attitude, and resources.

A comparison of the results between two countries was motivated through the experience of having lived and received care in both, as well as having heard about incidents of discrimination and unfair treatment in the health care sector towards LGBT patients.

1.1 PURPOSE AND AIMS

The purpose of the research was to get an overview from two countries in terms of preparation, attitude, and resources of and for nurses when relating to the care of LGBT patients.

The aim of this research was to collect enough data between Finland and Germany in order to compare them with each other, and to find similarities, as well distinct differences. Additionally, the aim was to be able to highlight problems within the fields of variables, meaning for example a lack of certain resources for nurses in Finland; the variable being the resources available in said country.

1.2 GOALS

The goal of this research is to bring important information to nursing educators, nursing schools, hospitals, and also individual health care staff after reading the results. Nursing schools can take a look at their curriculum and include LGBT patients needs in a way, which may influence some of their students positively, and that may impact the way LGBT patients are treated at their workplace. Another possibility would be that nurses who answered the survey questions are interested to self-educate oneself further, thus impacting them on a personal level. On a larger scale, the goal is to bring information to nursing educators, nurses, health care workers, and society that has an impact on the treatment and visibility of LGBT patients.

2 THEORETICAL FRAMEWORK: HEALTH NEEDS OF LGBT PATIENTS

The main theory this research is based upon is that the health needs of LGBT people differ from those that identify as heterosexual. Various researches have been published dealing with topics such as mental health, substance abuse, and sexual health of LGBT people. An article published in BMC Psychiatry in 2008 deals with a systematic review of mental disorder, suicide, and self inflicted self harm in lesbian, gay, and bisexual people (King et al, 2008) and came to the conclusion that lesbian, gay, and bisexual people are at a higher risk of mental health disorders, suicidal tendencies, substance abuse, and self harm than heterosexual people. The systematic review was published in 2008, and a survey titled “Gay and Bisexual Men’s Health Survey” was conducted in 2011 by Stonewall and Sigma Research across Britain, offering a more detailed insight on various topics. While the 2011 survey excludes women who sleep with women, a 2008 survey conducted by Stonewall and Sigma Research named “Lesbian and bisexual women’s health check 2008” includes women who sleep with women. Both offer a variety of percentages regarding substance abuse, mental health, sexual behaviour, and also discrimination in healthcare. (Hunt, R. 2008 and Guasp, A. 2011.)

2.1 SMOKING, ALCOHOL AND DRUG USE

According to the survey by Stonewall and Sigma Research, 51% of gay and bisexual men have taken drugs in the year 2010, compared to only 12% of men in general who used drugs. One survey participant is being quoted, stating that in his opinion it is difficult to come in contact with other gay men unless one goes to clubs and pubs and “so much of gay socialising involves alcohol and often drugs”. Drugs mentioned in the results of the survey are cocaine, ecstasy, ketamine, mephedrone, amphetamines, GHB, tranquilizers, crystal meth, cannabis, and amyl nitrate. Another participant is quoted saying that in his point of view a lot of gay men seem dependent on drugs or take them, because it is part of the stereotype. He also states that more should be done to help gay men stop smoking or doing drugs. While drug use is not a phenomena only found in the LGBT community, the amount of overall drug use (once or recreational) has a higher percentage and thus is something that needs to be included in how health needs differ in this area. Numbers found by the survey of Stonewall and Sigma Research show the difference between men that have sex with men who smoke and drink alcohol and men

in general in terms of smoking and alcohol consume. 42% of gay and bisexual men consume alcohol three or more days per week, while 35% of men in general drink in the same time. 25% of men who have sex with men smoked when this survey was conducted (in 2011), and 22% of men in general (Guasp, A. 2011).

In 2008 Ruth Hunt and Doctor Julie Fish conducted a survey for Sigma Research called “Lesbian and bisexual women’s health check 2008”. In the key findings from that survey numbers are named in comparison with women in general. Continuing the theme of smoking, alcohol, and drug use in the LGBT community, it is presented that 40% of women that sleep with woman drink three times a week, compared to 25% of women in general. Women who sleep with women are five times more likely to have taken drugs, and 10% (one in ten) have taken cocaine, whereas only three per cent of women in general have taken this drug. The percentage of lesbian and bisexual women who smoke is roughly the same as those of men who sleep with men, but no number is given that represents the percentage of women in general. A participant of this survey is quoted saying that she believes that many lesbians (including only those who go to pubs and clubs) are at a higher risk of smoking and drinking, because there are only few alternatives where to meet with fellow lesbians – outside of a personal social network. Furthermore, the same participant states that there has been no targeted health promotion that features lesbians in 2008. Another participant even provides a solution on how to manage the smoking within the lesbian community, by suggesting that community groups should get involved with initiatives to quit smoking, and lesbian / bisexual support groups are needed (Hunt, R. 2008).

The theme of alcohol drinking, because of pubs and clubs being the only places to meet other LGBT people is repeated throughout both surveys.

While no survey in the style of the Sigma Research has been done for transgendered people, another research with 155 transgendered adults was conducted in the Mid-Atlantic region and published in ‘Drug and Alcohol Dependence’ in 2013. The result was that 26.5% of the participants reported non-medical use of prescription drugs, with not prescribed analgesics being the most reported substance. The non-medical use of hormones was reported by 30.3% of the 155 participants. Transgender people can use hormones to start transitioning (changing the outer appearance to match their gender), but in some instances (being homeless, no insurance, no family support) it can be difficult to get said hormones from a medical professional. While hormones should only

be taken with supervision of a professional physician, transgendered people might make use of non-medical hormones, meaning that they use hormones not prescribed and supervised by their physician. The Vanderbilt University Medical Center published “Key Transgender Health Concerns” on their website as part of a program for LGBT health. They state that the use of hormones has risks, as testosterone can damage the liver, if taken in high doses by mouth. Professional advice (and the monitoring to follow the hormone intake) cannot be given if a transgendered person does not have access to a medical professional or does not seek to see one (Vanderbilt University School of Medicine. 2012).

2.2 MENTAL HEALTH

Mental health includes many topics, such as eating disorders, suicidal thoughts, self-harm, depression, and many more. Both Sigma Research surveys provide answers about the mental health of men who sleep with men and women who sleep with women. Another survey conducted within the Dutch population shows similar results, stating that their findings showed “that sexual orientation was associated with mental (...) health” (Bakker, et al, 2006).

In the same survey, it is said that differences in mental health of heterosexual people and those that identify as a member of the LGBT community are primarily understood as a result of “minority stress” (Bakker, et al 2006). Minority stress is referred to by V.R. Brooks as the experience a person with a stigmatized social identity has. When reading the quotes given to the Stonewall and Sigmar Research 2011 survey, the topic of pressure from within the LGBT community is brought up. One participant states that the pressure on gay men to be thin and attractive exists, especially from other gay people (Guasp, A. 2011).

In the summary of the findings on body image and eating disorders in the same survey, it is written that 45% of men who sleep with men worry about their looks and at the same time wish they could think about it less. Furthermore, one in five gay and bisexual men have had problems regarding their weight or eating behaviour. About 32% of men who sleep with men have actually been told that the way they feel or think about their body and eating is problematic, but 77% of these people have never sought professional help (Guasp, A. 2011).

Taking women who sleep with women into account from the numbers from the lesbian and bisexual women's health check from 2008, one in five lesbian and bisexual women stated (or have been told) that their eating behaviour is problematic. Compared with the survey about men who sleep with men, the survey from 2008 names bulimia (one in ten women who sleep with women) and anorexia (7%) as mental illnesses dealt with in the past or present. It is not said that these women who sleep with women have been officially diagnosed, it is only stated that 2% of general population have been diagnosed with bulimia, and 1% with anorexia (Hunt, R. 2008).

Suicidal tendencies are higher in LGBT people than in the general population, stating that 5% of women who sleep with women have attempted to commit suicide in the year 2007 and 6% of men who sleep with men fall within that same category. In comparison, less than one per cent of the general population tried to take their life during the same timespan. (Hunt, R. 2008 and Guasp, A. 2011.)

The highest percentage of attempted suicides is found within the transgendered community. The National Gay and Lesbian Task Force and the National Center for Transgender Equality published the results of their survey in 2011, which showed that 41% of the participants have tried to commit suicide, compared to 1,6% of the general population. The study was conducted in the United States of America. G. Kenagy published an article in 2005 with the findings from two needs assessment studies in Philadelphia. The sample size that responded to the question via mail or face-to-face interviews was 182 people that identified as transgendered. The findings where, that out of the 176 respondents who answered the question if they have ever attempted to commit suicide, 30,1% said "yes". Those who did attempt to take their own lives were then asked, if they tried to commit suicide because they are transgendered. 49 respondents answered this question and 67,3% of those answered "yes". According to the discussion of the article, the findings "support data from previous studies that suicide is a major health concern among transgendered people" (Kenagy, G. 2005).

2.3 DOMESTIC ABUSE

Domestic abuse can come in form of physical, emotional, or sexual abuse. It is not exclusive to living together, but survey results also includes situations of domestic abuse experienced by LGBT members living with family members.

The Stonewall and Sigmar Research 2011 survey of men who sleep with men presented in their key findings that half of those that answered the questions have at least experienced one incident of domestic abuse by a family member or partner since the age of 16. In comparison, only 17 per cent of men in general experience one incident of domestic abuse since the age of 16 (Guasp, A. 2011).

When dividing the incidents into incidents with family members and incidents with domestic partners, key results are also provided. More than a third of men who sleep with men have experienced one or more incidents while in a domestic relationship with a man, and nearly one in four men experienced such an incident from a family member since the age of 16. When looking deeper into the answers found and provided by the survey, examples of domestic abuse and examples of how physicians have reacted when help has been wanted, are provided. A 47-year-old person from Scotland is quoted in his answer to going to his general physician, seeking help because of an abusive partner. The solution he got was “they didn’t have the experience and just suggested I sought help within the gay community.” However, he adds to his answer that – looking back – domestic abuse is not different in a gay domestic environment and “that I should not have been told that they could not help because I was gay” (Guasp, A. 2011).

As mentioned before, domestic abuse includes different forms of abuse, and in the answers of the surveys, respondents mention “emotionally and financially abusive relationships”, “mental abuse”, and a relationship that grew to be very violent. Since bisexual men are a part of the 2011 survey of Stonewall and Sigmar, a percentage of seven per cent has been given of domestic abuse experienced during relationships with women (Guasp, A. 2011).

18% of men who sleep with men said they had been time and time again belittled by a male partner, which lessened their self-confidence and left them feel worthless. 17% have been pushed, physically held down, or slapped with an open hand by a male partner. 15% have been kicked, bit, or hit with a closed fist. 14% were emotionally abused into having been stopped from seeing friends or relatives by a partner, 11% have been frightened that a closed one or they will be hurt, and 9% have been forced by a

male partner to have had unwanted sex, in blunt words: have been raped. Separation does not always end abuse, as 6% were continued to be abused after a break up, and 4% experienced death threats (Guasp, A. 2011).

At the end of the section about domestic abuse is the paragraph which highlights why domestic abuse needs to be addressed as a health issue: 78% of men who sleep with men who have experienced incidents of domestic abuse have never reported incidents to the police. And of those who did have the courage to report the incidents to the police, 53% were not happy with the way the police dealt with the situation (Guasp, A. 2011).

In the 2008 Lesbian and bisexual women's health check, the key findings are presented under the category of domestic violence, but in the part of the survey exploring the answers and findings deeper, the mention of domestic abuse in form of physical, sexual, and emotional abuse is made (Hunt, R. 2008).

The survey shows that one in four women who sleep with women have experienced domestic violence in a domestic relationship and in two thirds of these incidents they were in a relationship with another woman. The theme of being emotionally abused to the point of feeling worthless as being brought up in the survey about men who sleep with men, is also found in this survey. One in five women who sleep with women have experienced this emotional abuse. Physical abuse, in form of being pushed, slapped, kicked, or bitten, has also been experienced by the same amount of women. One in fourteen women who fell victim to domestic abuse had been forced to have unwanted sex. One participant is being quoted, as being a survivor of woman-on-woman rape, that she felt terribly let down by the lack of services available and the lack of awareness and that she had to cope largely on her own (Hunt, R. 2008).

Separation is – once more – not the means that puts an end to all abuse, as one in eleven women who sleep with women say that the abuse went on after a break-up (Hunt, R. 2008).

Four in five women did not report incidents of domestic abuse to the police and the few that did, only half of them were happy with how the police handled their situation (Hunt, R. 2008).

To represent the letter T in the LGBT acronym, the LGBT Youth Scotland released their findings from their survey in a publication called “Out of sight, out of mind? Transgender people’s experiences of domestic abuse” in August of 2010. 80% of the transgendered participants stated that they have been a victim of physical, sexual, or emotional abuse, although only 60% of those recognized the behaviour as domestic abuse. Stated as being the most frequently used type of domestic abuse towards transgendered people was transphobic emotional abuse (LGBT Youth Scotland, 2010).

Transphobic emotional abuse describes targeted hurtful abuse, disrespecting the transgendered person. Examples of such transphobic emotional abuse is the wrong use of pronouns (calling a female-to-male transgendered person still “she” when he says he is a “he”), to say that a transgendered person is not a real man or woman, or to not acknowledge the existence of Transgenderism in general (LGBT Youth Scotland, 2010).

Along with emotional abuse, 45% have experienced physical abuse, and 47% experienced sexual abuse.

The survey provides an insight on how this domestic abuse has impacted the respondents. A staggering 98% clearly identified at least one negative impact in their wellbeing as a result of domestic abuse. 76% experienced emotional or psychological problems as direct consequences following the abuse, with 15% saying that the abuse led to a suicide attempt (LGBT Youth Scotland, 2010).

24% of the transgendered people that fell victim of domestic abuse did not tell anyone about it, and 18% in total felt that it was “just something that happened” and 51% in general felt the last instance of domestic abuse experienced was wrong, but did not identify as a crime (LGBT Youth Scotland, 2010).

2.4 CANCER SCREENING

Cancer is not a disease that is exclusive to a certain sexuality, and lesbians, bisexuals, transgender, gays, straight people, asexual, and all sexualities in between are at risk of getting cancers. The topic of cancer is important in any community and has been a topic in the surveys by Stonewall and Sigmar in 2011 and 2008. In the Gay and Bisexual

Men's Health Survey conducted by Stonewall and Sigmar in 2008, the key findings present that just a third of men who sleep with men check their testicles every month as a preventative measure against testicular cancer. Only one in ten men who sleep with men have ever discussed prostate or bowel cancer with a physician, and only 3% have ever talked about lung cancer with theirs (and as seen above, smoking is a big part in the gay community, being a huge risk factor contributing to lung cancer) (Guasp, A. 2011).

In the results of the survey, it is presented that only 50% of men who sleep with men ever had their testicles checked by a professional. A staggering 96% of men who sleep with men over the age of 40 have never had a discussion about lung cancer, although it is one of the most common cancer in men in Britain. While mainly only percentages are presented about the topic of cancer screenings, one participant is quoted saying that more information should be available about general health, not just sexual health (Guasp, A. 2011).

The 2008 survey about women who sleep with women present in their key findings that 15% of women who sleep with women above the age of 25 never had a cervical smear test, compared to 7% of women in general. Shockingly, it is revealed that one in fifty women who sleep with women are refused to be given a cervical smear, even when requesting one. One in five who have not been tested have even been told that they are not at risk, due to sexual preference. A, at that time 38 year old, woman from the East Midlands recalls how she was taken off the list of getting regular cervical smear tests after coming out as non-heterosexual to her Practice Nurse. It took her roughly ten years to get that privilege back and in the end she felt as if she was educating her new Practice Nurse as to why these screenings are necessary for women of all sexual orientations. Although the risks exist, ignorance does too, as one in five women who sleep with women do not think they are at risk of cervical cancer (Hunt, R. 2008).

When researching transgender people and cancer risks, only partial results can be found. Transgendered people who are not transitioning with hormones and who are not using operations still have ovaries, cervixes, and testicles, hence they are still at risk of getting these kind of cancers. Research is done and needs to be done, as well as educational development to ensure the health of transgender people (LGBT Youth Scotland, 2010).

2.5 SEXUAL HEALTH

Sexual transmitted diseases are a risk for every sexually active person, but still, one in four men who sleep with men in the 2011 survey by Stonewall and Sigmar have never been tested for any sexually transmitted disease. One argument for not getting tested so far has been, as quoted by the survey, that there never have been any symptoms of an STI, hence no help had been sought after. Not worth the effort, or being too busy (9% of men who sleep with men) are also reasons as to why some men have never been tested before. 83% simply of those not tested so far also stated that they don't think to be at risk, while 13% admitting fear of being tested, and another participant stated that he did not know where to get tested (Guasp, A. 2011).

A complaint that came up twice when asked as to why some men who sleep with men have not been tested before has been that services are simply not available or open when needed, because of work (Guasp, A. 2011).

The percentage of men who sleep with men who have not discussed sexually transmitted diseases with their healthcare professional is 44%, but a quote of a young man states that his general physician simply refused to speak with him about sexual health due to his sexual preference.

The topic of school and sexual education there is brought up through two quotes saying that little to no sexual education on same-sex relationships have been provided during that time and that a lack of said education can constitute a negative health experience (Guasp, A. 2011).

In the 2008 survey of Stonewall and Sigmar of women who sleep with women, less than half of lesbian and bisexual women have ever been tested for a sexually transmitted infection, and over half of the women who sleep with women who have been tested, have tested positive for an STD. The theme of thinking of not being at risk, is present in this group as well, as three quarters of those not tested think of themselves of not being at risk (Hunt, R. 2008).

In general, over half of women who sleep with women have never been for a sexual health check up, some are too scared to get tested, some are in no hurry to get one, due to the absence of any symptoms, and 4% were told by healthcare professionals that they

did not even need a test. One woman who sleeps with women is quoted as having had no idea how many sexually transmitted diseases she could actually contract through lesbian sex. She complains about the little education and support for lesbians. Another woman adds that she feels that lesbians are invisible as sexually active people. A common misconception about lesbian sex is that the amount of STDs that can be contracted via intercourse is less, due to the absence of penile penetration, but this is false, due to the possibility of contraction via oral sex. A woman in the survey is asked if there is such a thing as safe sex for lesbian, which shows that education about dental dams for oral sex needs to be provided, along with education about how genital herpes can be spread, even if no penis was involved, as a woman was quoted that her doctor did not even know how she got it without penetrative sex (Hunt, R. 2008).

An article published in the International Journal of Transgenderism by Bauer, et al. about the sexual health of transgendered men who are gay, bisexual, or show have sex with men, a study conducted, in Canada, showed that transgender people may not use their sexual body parts, but dildos, fingers, or other sexual toys, mostly using condoms as a barrier on these, too. It was fairly uncommon that transgendered men engaged in genital sex, which was the biggest potential exposure to transmitting an STD. The sample size of this research is rather small, but shows a pattern repeated throughout further researches, that genital sex is a not as frequently used way of stimulating each other (Bauer, G, 2014).

2.5.1 HIV / AIDS

HIV / AIDS was an own topic in the 2011 Sigma study with interesting results. HIV is an on-going threat, as a cure has not been found yet, but education has done a lot about eradicating the stigma of HIV being a gay-man's disease. Still, it is an important topic to be discussed within the community of men who sleep with men, as anally unprotected intercourse puts a person at a huge risk of infection. According to the 2011 Stonewall and Sigmar survey 30% of men who sleep with men have never had an HIV test, and seven in ten gay men who haven't been tested say it's because they think they have not put themselves at risk. Another third says that the absence of HIV symptoms is their reasons for not getting tested. On the other hand, one in four men who sleep with men who have not been tested have not been offered a test and one in seven said that they do not know where to get tested (Guasp, A. 2011).

The answers for not having getting an HIV test in percentages are the following, as listed in the survey:

69% say that they don't think they have put themselves at risk, 33% say they've never had symptoms of an HIV infection, and 26% have never been offered a test. 17% are scared that it's positive, 14% find clinics intimidating, 13% do not know where to get a test, 10% are put off by the testing process, and 7% are scared that others will find out, if they test positive. 6% are too busy, 6% assume their HIV status is the same as their partner's, 6% rather not know their status, 3% are not aware of any benefits knowing their HIV status, and 2% have been told by a general practitioner or a health worker that they do not need a test (Guasp, A. 2011).

Looking at these answers, and looking back at the topic of education, a lot of education on both sides needs to be done. The survey states that these figures raise concerns about the money having been spent by the British Government on HIV awareness and prevention in recent years. But the figures also show that the education and awareness needs to reach the general practitioners, too, so that they do not tell patients that tests like these are not necessary (Guasp, A. 2011).

2.6 DISCRIMINATION IN HEALTH CARE

Discrimination is hard to put in numbers, but negative experiences can be put in percentages. In the 2008 lesbian and bisexual women's health check, half have had negative experiences within the last twelve month, and half of the women who sleep with women are not out (have not revealed their sexuality) to their physician. One in ten women reported that they have been ignored by healthcare staff after they did reveal their sexual preference, and only three in ten women who sleep with women said that healthcare professionals did not make inappropriate comments after they came out. When seeking a consultation, only in one in ten cases, the woman's partner was welcome (Hunt, R. 2008).

Looking at the results of the 2011 Stonewall and Sigmar Survey, a third of men who sleep with men have had a bad experience when they accessed healthcare services due to their sexual orientation, and a third of gay and bisexual men are not out to their physician (Guasp, A. 2011).

Why would it ever be okay to make an inappropriate comment about a person due to their sexuality, such as being gay must mean that a person is sleeping around, as it happened to a young man in South West England? Getting called names, such as poof, by reception staff is discrimination and does not create a welcoming environment. Medical professionals are supposed to be that: Professionals. Assuming a gay or bisexual man is HIV positive due to his sexuality is not professional, it is insulting.

The same goes for automatically assuming that a person is a woman or a man, just because they look like it. A man or a woman joining a patient to an appointment is not automatically a partner (Guasp, A. 2011).

Every human deserves respect. In both Stonewall surveys, recommendations are given how the situations on how to improve the medical environment can be improved. First and foremost is to understand the specific health needs of women who sleep with women and men who sleep with men, along with transgendered people, as listed above. Knowing about the higher suicide attempt possibility, their self-harm tendencies, drug habits, domestic abuse, and the absence of sexual education on same-sex during school. Staff should be trained better to approach situations right, to acknowledge that the patient is not heterosexual and welcome their partner into the consultation, but also be informed about the partner's right in case of a terminal disease, accident, or confidential information. Do not make assumptions about a person's sexuality, gender, partner, or lifestyle. To be clear about the policies at the clinic and to be visible about support of same-sex couples, transgendered people, and their health needs. (Guasp, A. 2011 and Hunt, R. 2008.)

3 DESCRIPTION OF RESEARCH

This research was done via quantitative research, creating and using two online surveys. A quantitative research is a type of research that is “explaining phenomena by collecting numerical data that are analysed using mathematically based methods (in particular statistics)” (Creswell, J. 1994).

Quantitative research was used, as it provided the best possibility to gather a large number of answers from two different groups: German nurses and Finnish nurses. Additionally, it allows for the direct comparison of numbers between both groups. The surveys were published online for the duration of one month and promoted on social media, as well as specific message boards.

In order to answer the research questions “the sample survey using different data collection techniques can be used to address descriptive questions, such as what, who, when and how questions” (Saks and Allsop, 2007). Out of the four research questions to be answered, two ask ‘how’ and the other two ask ‘what’, hence a sample survey was the best choice (Saks and Allsop, 2007).

The strengths of surveys on a general level is that the methods surveys use allow the researcher to find similarities and differences for comparisons. Additionally, it provides the researcher with an overview of the studied phenomenon (Saks and Allops, 2007).

Weaknesses of surveys are that while they measure phenomena in numbers, they are “incapable of capturing the meanings and perceptions of social actors and the context in which action is taking place” (Saks and Allops, 2007).

Preliminary surveys were tested a couple of weeks prior to publishing the final surveys, to test that the questions provide answers that are needed for the research questions. The surveys were published through the Webropol platform.

The surveys were published in two languages: German and Finnish. Native speaker skills of German were put to use for translating the survey from English to German, while the help of a native Finnish speaker was used for the translation from English to Finnish. It was decided against putting the English survey up, as the results of the research were to reflect those that had gone through the curriculum and gathered experience from the work life in Germany and Finland.

The questions of the surveys concentrated fully to answer the research question. This is why additional variables – such as gender, age, religion, or sexuality – were not included. Grouping answers into further categories and compare these with each other would have taken away from the research questions at hand.

The only requirement for the person answering the question was that the person is a nurse in either Germany or Finland. That is why the surveys were shared on social media platforms related to nursing. The surveys also needed to be presented in a neutral way, in order to respect the person's own views and ethics – meaning the questions must not sound judgemental. Sensible and neutral questions were for example, if the nurse's personal attitude influences the professional attitude. Such question needed to be sensible, so that it was not implied that the nurse would be a good or bad person for failing to not let attitudes influence each other.

3.1 RESEARCH QUESTIONS

In order to gain an understanding about the variables of nursing education, attitude, and resources available, these research questions were formed and answered:

1. What kind of preparation and knowledge for the care of LGBT patients is provided and shared during their curriculum?
2. How does the personal attitude towards LGBT patients influence the professional attitude?
3. What kind of resources are available for nurses and what level of willingness of educating oneself further exists?
4. How do the results differ between Germany and Finland?

3.2 DATA ANALYSIS

Data analysis is the approach that a researcher is using in order to “manage their data” (Moule, P. 2013), which is then used to “identify key patterns or features that are important when answering (...) research questions” (Moule, P. 2013).

The data for this research was analysed with the services offered by <https://www.webropolsurveys.com>. Editorial choices on how these tools present the answers for each questions allowed showing percentages. Percentages simplified

putting the answers into charts. To check the accuracy of each question and the percentage calculation by the online tools used, a manual check was done by calculating each percentage on paper with the help of a calculator. The numbers were in agreement with each other. Due to the large number of answers, percentages were rounded up or down.

3.3 STUDY PARTICIPANTS

The study participants (in quantitative researches the people being studied are called subjects or study participants) are the people providing the data used for analysis. They are chosen either randomly, or non-randomly by a set of variables in common that are important for the study (Beck and Polit, 2013).

The surveys were focused on graduated and working nurses, meaning nurses that have finished their vocational education in Germany or their nursing school education in Finland and are or were employed in either country.

The difference between becoming a nurse in Finland and a nurse in Germany is the form of schooling. In Finland nursing is a profession obtained through studying at a university of applied sciences. To become a registered nurse, the studies last 3 ½ years (seven terms) and consist of 210 ECTS (European Credit Transfer System) credits (Suomen sairaanhoitajaliitto ry, 2015).

In Germany becoming a nurse is done via vocational education. It requires theoretical lessons of at least 2100 hours at a vocational school and at least 2500 practical hours. The duration is three years and at the end a state examination has to be completed before graduating (Bildungszentrum für Gesundheit, 2015).

Nursing students were excluded from the surveys, as it was important for nurses to have completed their curriculum in order to answer the questions. Practical training are valid work experiences, but students are not a full member of the team, which was a requirement for answering. Variables such as gender, age, or sexual orientations were not included into the survey, as the research would have become too large if answers were also sorted into these variables, along with preparation, attitude, and resources.

4 RESULTS

The total number of answers received from the German survey was 636, while the Finnish survey got 167 answers.

4.1 PREPARATION

Based on the theory that LGBT patients have different health needs than heterosexual patients, the first question of the survey dealt with this assumption. Answers to the question “Are you aware that LGBT patients have different health needs than heterosexual patients?” were that 39% of German nurses were aware, while 61% were not. The answers from Finnish nurses showed that 51% had knowledge that different health needs exist, while 49% did not.

The first question did not come into play to analyse the preparation nurses received within their curriculum and schooling, as it was about personal awareness and knowledge.

Before asking specifically about LGBT-patients health needs and their role in the curriculum, it was asked in the survey if other sexualities apart from heterosexuality were discussed within their nursing education. The answers given showed that 50% of German nurses had discussed non-heterosexual sexualities, while the other 50% had not. Finnish nurses answered that 59% had discussed or been educated about this topic, whereas 41% had not.

As discussions are a part of studying, the next question asked if it was allowed to talk and discuss LGBT patients outside of the curriculum, meaning if it was okay to share personal or professional experiences. 83% of German nurses answered that it was allowed, as did 74% of Finnish nurses.

Shifting the focus to nursing education specific questions about health care needs of LGBT patients, the next question asked those answering the survey if said health care needs were included in their curriculum. Both groups – Finnish nurses and German nurses – showed a clear tendency that these needs were not included, as 84% of German nurses answered “no”. 90% of Finnish nurses gave the same answer

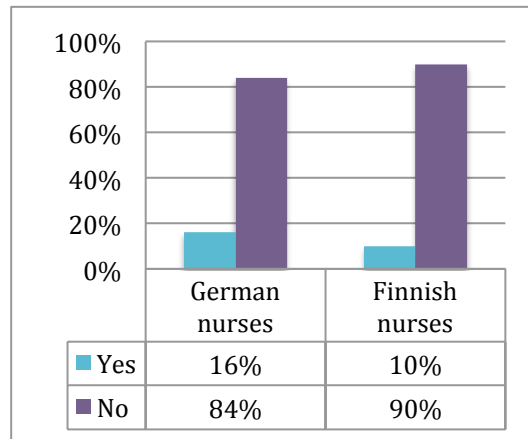


Figure 1: Answers to the question "Was it part of your curriculum to discuss the different health needs of LGBT patients?"

The topic of sexual health and safe sex of LGBT patients followed, with the question being "Were sexual practices and safe sex precaution of LGBT patients discussed during your nursing education?". The percentage of German nurses that answered with yes was 26%, while 74% answered that it was not discussed or part of the curriculum. When looking at the answers of Finnish nurses, the percentage answering with "yes" was 13%, which meant that 87% had answered with "no".

As 16% of German nurses and 10% had answered that LGBT-patient's health care needs were included in their curriculum, a closer look was taken which topics were discussed. This multiple-choice question gave examples of ten health care key aspects. Figure 2 shows these ten topics, along with the percentages given for each. The main key aspects discussed during their curriculum for Finnish nurses were sexual health with 58%, HIV/Aids with 60%, and sexual identity with 61%. The least discussed topics were smoking with 4%, cancer screenings with 4%, and self-harm 8%.

Looking at the answers from German nurses, the main focus was on HIV/Aids with 89%, followed by sexual health with 47%. The differences in percentages within the German nurses answers are not as big as with the Finnish nurses. The smallest percentages were given to smoking (29%), and self-harm (29%).

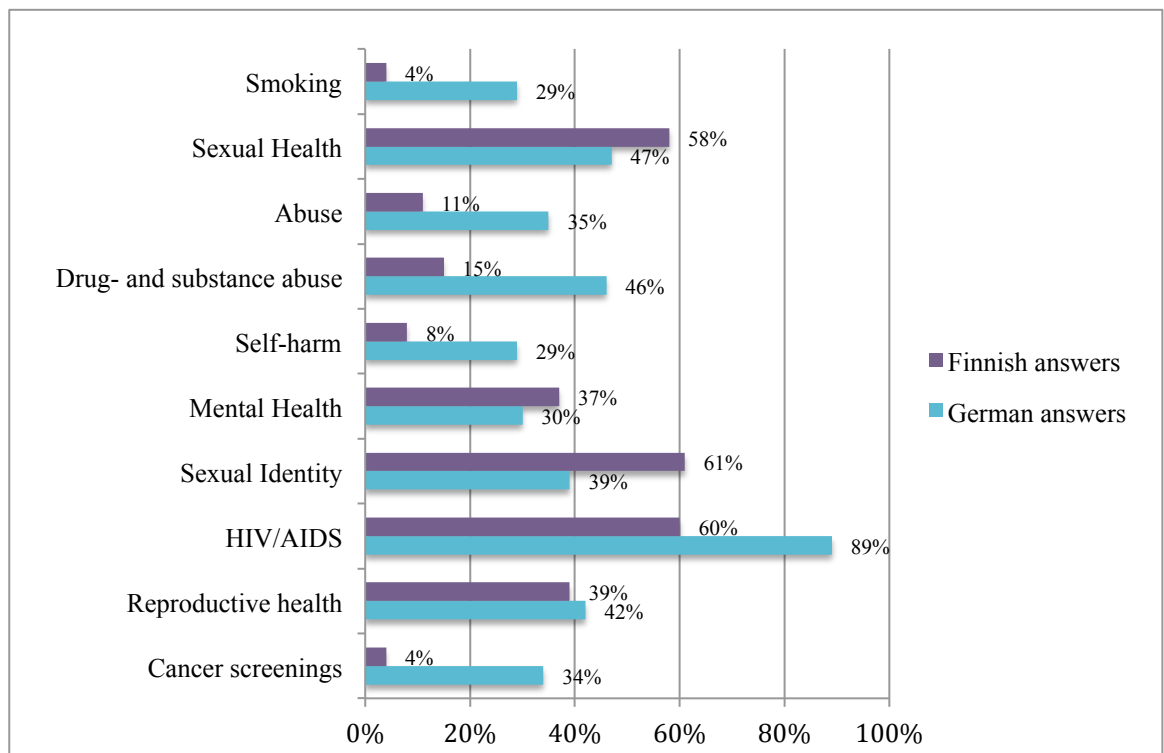


Figure 2 - Answers to the question "What topics of LGBT health needs were discussed during your schooling?". Multiple answers could be given.

The research question related to the topic of preparation was: “What kind of preparation and knowledge for the care of LGBT patients is provided and shared during their curriculum?”. Looking at the answers from German nurses, it can be seen that only a small percentage had the health care needs of LGBT-patients in their curriculum, meaning that for the majority no kind of preparation and knowledge was provided or shared. While the focus on the health care needs was only provided for 16% of German nurses, discussions about sexualities other than heterosexuality were part of the nursing education for half (50%) of the nurses. Discussions about LGBT-patients outside of the taught material of the curriculum was allowed for the great majority (83%).

Those nurses who were provided with preparation and knowledge for the care of LGBT-patients answered that the focus on key aspects of the health needs was mainly focused on HIV/Aids (89%), followed by sexual health (47%), and drug- and alcohol use (46%).

Looking at the results from the Finnish survey, only 10% answered that they received preparation and knowledge during their curriculum, while the vast majority of 90% did not. According to the answers given, 59% of the Finnish nurses did at least talk about non-heterosexual sexualities. Looking at the answers given from those that received

#preparation and knowledge during their nursing education, the three main key factors talked about were sexual identity (61%), HIV/Aids (60%), and sexual health (58%). However, the range of percentages between key factors shows that smoking (4%) and cancer screenings (4%) had hardly been a topic.

4.2 ATTITUDE

Moving on to the topic of personal and professional attitude, the question connecting preparation and attitude asked if the material presented in the curriculum was taught objectively – meaning that it was presented in a neutral or matter-of-fact way. 33% of German nurses answered with yes, whereas 7% said no. The rest of the votes (60%) went towards the third option: was not taught. The Finnish nurses had similar answers, as 35% said yes, 5% said no, and 60% reported that there was no material presented. While the answers were different from the question if the LGBT patient's health care needs were a topic of the curriculum, the way it was worded was different from it. The question asked whether material about LGBT patients was presented, not specifically health care needs.

The influence of a teacher's personal attitude – positive or negative - towards LGBT patients and how that influences the nurses attitude was the next question. 6% of the German nurses answered that their teacher's attitude influenced them, while 32% said that it did not. 62% answered that no attitude was detected at all. The Finnish answers share the same view with 78% saying that the teacher did not show any attitude. 4% answered with yes, and 18% with no.

Moving on from the topic of education, and to the attitude in their professional lives, the nurses were then asked if their personal attitude towards the LGBT community and lifestyle influences their professional attitude. 13% of German nurses said that this influence happens, while 87% answered that it does not. For 25% of Finnish nurses personal attitude influences their professional attitude, while for 75% this does not happen.

Connected to this, the next question was "Are you able to separate your personal attitude fully from your professional attitude?". 84% of German nurses are able to do this, while 16% are not. Looking at the Finnish nurses, 80% are able to separate their personal attitude from their professional one, and 20% do not.

Does the professional attitude change, when learning that a patient is a member of the LGBT community, was the next question. Only 1% of German nurses said that their attitude changes, whereas for 99% it does not. 7% of Finnish nurses answered that, yes, the shift in attitude happens, while for 93% no change in attitude happens.

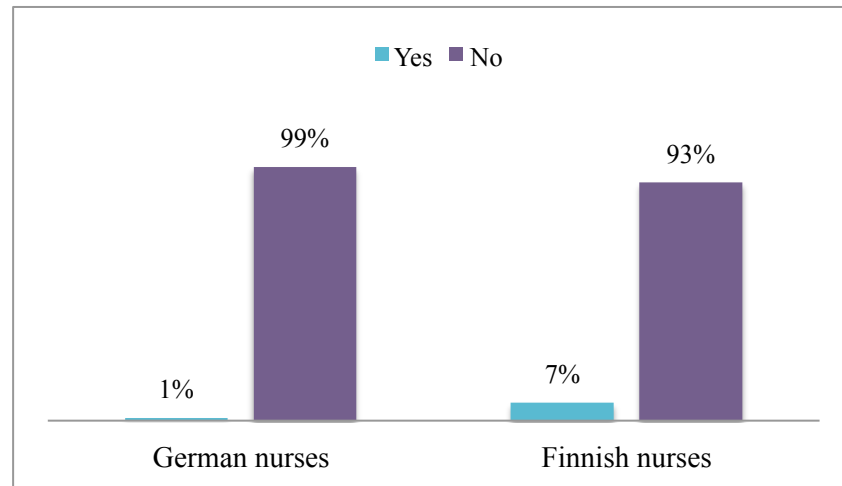


Figure 3: Answers to the question "Does your professional attitude change after you find out a patient is not heterosexual?"

Treating LGBT patients different than non-LGBT patients was the topic of the next question. 15% of German nurses answered that they treat non-heterosexual patients different than heterosexual ones. Finnish nurses answered that 7% of them treat their LGBT-patients different.

The research question related to the topic of attitude was: "How does the personal attitude towards LGBT patients influence the professional attitude?". Attitude can be influenced by a teacher, depending on how and if he shows a certain attitude towards LGBT-patients. 6% of German nurses and 4% of Finnish nurses may seem like rather small numbers, but still represent nurses that were influenced.

Professional attitude is also influenced by the nurses personal attitude, as shown by 13% of German nurses and 25% of Finnish nurses that expressed that this influence happens for them. However, 85% of German nurses and 80% of Finnish nurses answered that they are able to completely separate personal attitude from professional attitude.

Furthermore it is seen that there is a shift of attitude for 1% of German nurses and 7% for Finnish nurses when learning that their patient is not heterosexual.

4.2.1 Gender-neutral pronouns

A gender-neutral pronoun is “a pronoun which does not associate a gender with the individual” (UWM, 2015).

This means that it is not automatically assumed that the person one talks to identifies as female or male and uses the pronouns associated with these genders. Gender neutral pronouns in the English language are, for example, “they, them, theirs” in singular use, or “ze, hir” (UWM, 2015).

As German has female and male pronouns, the question was included in the German survey if the nurses automatically use these pronouns when meeting a new patient: 87% do, and 13% do not.

4.3 RESOURCES

Moving on to the topic of resources available for nurses and patients at the workplace, the first question relating to this variable asked whether resources were available at the workplace to learn more about LGBT patients. For 3% of German nurses those resources are available or are offered, though for 97% it's not. 16% of Finnish nurses have resources at the workplace to educate themselves further, and 84% have not.

To have a better understanding which resources are offered or available, the multiple-choice question asked those that answered the previous question with “yes”, to clarify. The biggest percentage of answers – 73% of German nurses and 70% of Finnish nurses – expressed that LGBT colleagues that are willing to answer questions are the biggest resource available, while DVDs or video material got the lowest percentage: 0% of German nurses and 11% of Finnish nurses. The percentage for books as resources offered and available were the same for German and Finnish nurses: 15%. The biggest difference of percentages between both countries was about the use of a sexologist as a resource. 0% if German nurses have that resource, while 26% of Finnish nurses do.

Magazines in printed form are made available and are offered for 6% of German nurses, while 19% of Finnish nurses have this option. Magazines in digital form are a resource for 8% of German nurses, and 19% of Finnish nurses.

Leaflets got the second biggest percentage in both groups – being available for 23% of German nurses and 37% of Finnish nurses.

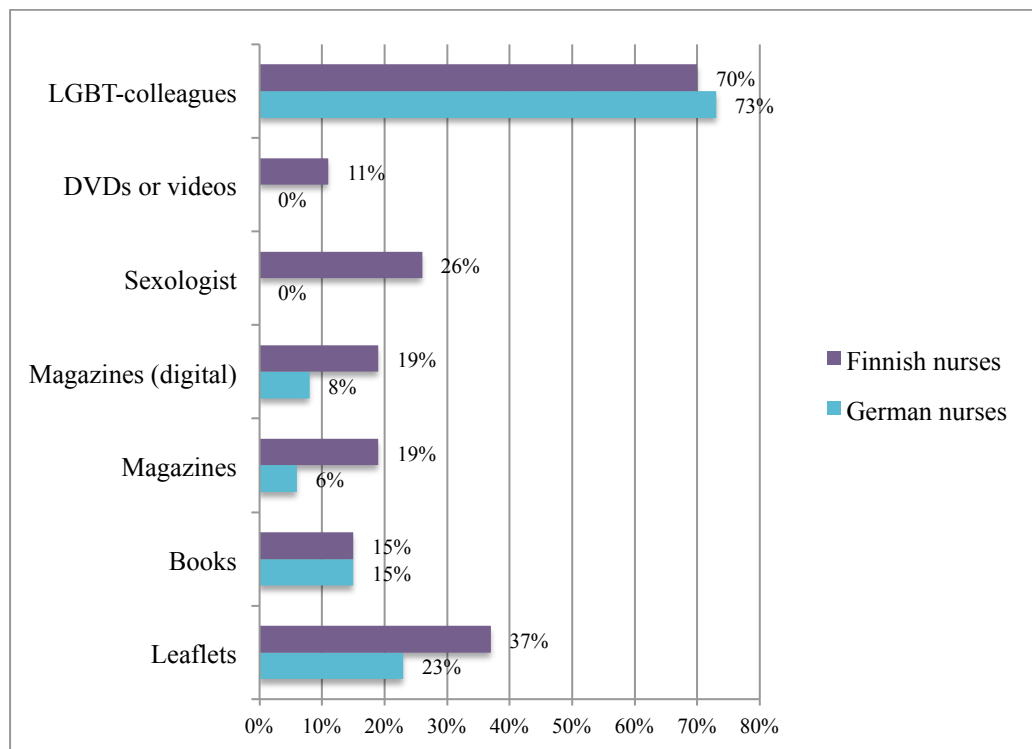


Figure 4: Answers to the question "If yes, in what form are the resources available (multiple choice)?"

When asked if resources that are made available and are offered at the workplace are used, only 11% of German nurses answered with yes, while 48% of Finnish nurses answered the same.

In case of questions regarding LGBT patients – health care needs or general questions -, do the nurses of both groups use media to inform themselves? 72% of German nurses do, mainly via the Internet – as do 58% of Finnish nurses. Only 1% of German nurses and 2% of Finnish nurses use books. The rest of both groups do not use any media.

Schoolings are another option of resource for further education, hence the last questions regarding the topic of resources were if one would consider attending schoolings on the topic of health needs of LGBT patients through your workplace and would one consider bringing the topic of schoolings on treating LGBT patients up as a suggestion for fellow medical staff members?

73% of German nurses would consider attending such a schooling, as do 85% of Finnish nurses. Suggesting a schooling to colleagues is something that 67% of German nurses would take into consideration, as well as 76% of Finnish nurses.

The research question to be answered with this part of the survey was: “What kind of resources are available for nurses and what level of willingness of educating oneself

further exists?’. It can be seen that only 3% of German nurses, but 16% of Finnish nurses have resources at their place of work for them to use. These resources come in the form of leaflets (23% of German nurses, 37% of Finnish nurses), and books (15% for both groups). German nurses do not have – according to their answers – access to a sexologist or have DVDs or videos available to use. However, Finnish nurses do, as 26% answered that they can contact a sexologist and DVDs or videos are an available resource. A resource that can not be provided by the work place for the workers, are colleagues that are part of the LGBT community and willing to answer questions.

While a variety of resources exist, not everyone uses them. Only 11% of German nurses do, but 48% of Finnish nurses do.

Level of willingness to educate oneself further is also measured by the question if information is sought after when questions about LGBT patients arise. 72% of German nurses use the internet to find answers, while 57% of Finnish nurses use the same platform. However, 27% of German nurses and 41% of Finnish nurses do not use media whatsoever. 73% of German nurses and 85% of Finnish nurses that would be willing to attend schoolings to gain further knowledge about the treatment and care of LGBT patients furthermore shows their level of willingness.

4.4. COMPARISON

How these results differ between Germany and Finland was the fourth research question to be answered with the surveys. In terms of preparation, both groups showed the same trend when asked if health needs of LGBT patients was part of their curriculum. The majority of answers from both groups was “no” – 84% of German nurses and 90% of Finnish nurses. The trend of both groups having similar percentages continues in the next question, when asked if discussions about LGBT patients outside their curriculum was allowed. Both groups answered ‘yes’, with 83% coming from German nurses and 74% from Finnish nurses.

The topic of safe sex and sexual practices was featured more in Germany than Finland, as 26% of German nurses answered that these topics were discussed within their curriculum, whereas only 13% of Finnish nurses chose this answer. Sexualities other than heterosexuality were discussed for only 50% of German nurses and 59% of Finnish ones. Looking at the list of topics that were discussed during the nursing education, both countries have the topic of HIV/AIDS as their most or second most discussed topic, but

while 90% of German nurses had this featured in their curriculum, only 60% of Finnish nurses did. Sexual identity is a topic that was discussed most in Finland (61%), but only got 39% of votes by German nurses. Gaps between the curricula of both countries are most prominent when it comes to the topic of self-harm, smoking, and cancer screenings. These topics got less than 10% each from Finnish nurses, while getting between 29-34% from German nurses.

Topics that share similar percentages are family and reproductive health, mental health, and sexual health.

Both countries answered that the knowledge about LGBT patients was presented in an objective way with 33% of German nurses answers and 35% of Finnish answers. However, German nurses voted with 60% and Finnish ones with 59% that no such knowledge was even presented. The teacher according to 62% of German nurses, and 78% of Finnish nurses did not present a positive or negative attitude. A difference in percentage is shown for the question if the personal attitude influences the professional one, as well as for the question if the nurses notice if they treat non-heterosexual patients different.

The biggest difference related to resources is if materials are available to be used by nurses to educate themselves further and if they use them. Only 3% of German nurses have access to these materials, compared to 16% of Finnish nurses. When asked if these material, for those that have access, are used by the nurses, only 11% of Finnish nurses said that they do, compared to 48% of German nurses.

Looking at the kind of resources available at the workplace, German nurses seemingly do not have access to a sexologist, as that answer got 0%, compared to the 26% of Finnish nurses. DVDs or video material also got 0%. A common factor of both countries are a LGBT colleague as a form of resource, as both countries gave the majority of percentages to this option.

To find information by oneself to gain education about LGBT patients, the Internet is the main source of information – getting 72% from German nurses and 57% from Finnish nurses.

The willingness to use schoolings as a form to gain more knowledge and get education about LGBT patients is present in 73% of German nurses and 85% of Finnish nurses.

Continuing the trend, Finnish nurses are also more willing to recommend such a schooling to colleagues.

Comparing the numbers from the answers, German- and Finnish nurses do share similar answers in terms of preparation and attitude. The main differences that can be found mainly in the resources part, as Finnish nurses have more access to resources through their work place, have a higher willingness to visit schoolings, and also seemingly use these resources more.

4.5 RELIABILITY AND VALIDITY

To assess the quality of a quantitative study, different criteria are used to do so. A very important one is reliability. Reliability “refers to the accuracy and consistency of information obtained in a study” (Polit & Beck, 2013) and is most often referred to the instruments or methods used to measure variables. Validity is used to assess the soundness of the evidence found by the study. It, too, is most often referred to the instruments or methods used to measure variables, but validity assesses if the methods used are “measuring the concepts they purport to measure” (Polit & Beck, 2013).

To establish validity, research helped to find out what questions needed to be asked in order to answer the research questions. This meant to find out how health needs of LGBT patients differ from non-heterosexual needs, what the most common health needs are, and what in what form resources about the LGBT community is available. After testing the surveys before putting the final ones online, it was ensured that the questions chosen answered the research questions. It was made sure that all questions were related to the research.

Reliability as a word could also be replaced by repeatability. Reliability for this research is ensured, because a different person can do this survey with new random sample groups in order to answer the research questions.

5 CONCLUSION

To conclude this research, according to the answers of the surveys, Finland and Germany share quite similar experiences in terms of preparation during nursing school, attitude and its influence, but both countries differ in terms of availability and access to resources at their place of work and their willingness to use them.

Similarities shared show that LGBT patient's health needs were not included in the majority of the curricula, although discussions about LGBT patients and experiences outside of the curriculum were allowed for both nurse groups. Health needs topics discussed with those that did receive education about LGBT patients, varied greatly between countries.

The research about attitude shows that it is not an influencing factor for the majority of both countries in how they treat their LGBT patients, and the majority of both nurses groups can separate their attitude from their professional life. Teachers that did present topics related to LGBT patients did so with a neutral, or matter-of-fact, attitude.

Resources however do not share as many similar majorities within the Finnish and German nurses groups. The willingness to use offered resources is clearly higher in Finland than it is in Germany, although some resources are offered in both countries. The forms in which these resources are available for use are more diverse in Finland, although an LGBT colleague is the clear main source of information for both parties.

As the majority of both countries would take a schooling to learn more about the LGBT patient's health needs and would recommend such schooling to their colleagues, willingness to educate themselves further is clearly shown if offered. Further research how these schoolings would look like, what material would be taught, and the way they are provided needs to be done with further research, although this research can be used as a basis to build upon.

This research can be used for nursing programmes in both countries to look at their curriculum and see if the LGBT patient's health care needs are included and in what form. Health care facilities can use this research to check if they offer resources and

where more resources might need to be offered or be made available. Forms in which these resources are available can be researched, or even created.

Holistic care is taught during nursing education, so sexuality and gender-identity must not be factors for discrimination. The same goes for a lack of knowledge due to missing education and resources. This research should be used as a foundation to build a lasting pillar of LGBT patient's health needs in the nursing education and everyday work-life.

6 DISCUSSION

This research was done in order to gain a look at how LGBT patients are taken into consideration as a topic during a nurse's education, how the attitude of a nurse can be influenced during their schooling and in what way personal attitude influences the way a LGBT patient is treated. Additionally, resources were looked at, because one reoccurring point during nursing school is that constant education of one's nursing skills is a must.

Looking at the specific results of topics that were discussed during the curriculum, most topics could be introduced during the curriculum quite naturally: when talking about heterosexual patients anyway. All topics on the list were talked about during the curriculum of the author and the incorporation of LGBT patients would have been great. The Internet provides countless amounts of resources for education about the health needs of LGBT patients, which could be used by teachers to educate. This research could become one of these resources. Educators might not only use it to check their curriculum, but to also look at their own attitude and if they let it shine through during education. While it was not specified if it was a negative or positive attitude of their teacher that influenced them, 6% of German nurses and 4% of Finnish nurses said that their own attitude was influenced nevertheless.

Increasing the knowledge of the staff at a health care facility was one of the suggestions of the University of Michigan's Resource Guide and increasing this knowledge starts at their education, and follows with offered resources and schoolings (University of Michigan. 2005). This thesis can offer suggestions about topics that need to be taught in the curriculum – and why -, as well as showing what resources could be offered at the work place. While Finnish nurses have access to a sexologist, none of the German nurses answered they do. The same goes for DVDs or videos. A question that could be further asked is: do such DVDs or videos exist in Germany? And what video material do Finnish work places provide and could it be used in Germany with voice dubbing?

This research can also be used to build upon, by researching certain points further. Gender-neutral patient forms could be the first step towards an LGBT inclusive health care facility (Miller and Weingarten, 2005).

Hospitals could build their own resource manual for their workers, as well as patients. Furthermore, the design of a LGBT inclusive waiting room and environment could be looked upon (University of Michigan, 2005).

The improvement for inclusion of LGBT patients must happen, as non-heterosexual and non-cisgendered patients are part of the nurse's job, whether they are out (meaning they openly talk about their sexuality or gender) or prefer to stay in the closet (meaning they hide their sexuality and true gender from society). As it is being taught in nursing school that no patient should be judged – regardless of age, gender, sexuality, religion, or any other factor -, it should also be taught that there are differences that need to be taken into account.

As the surveys for this research were shared on social media and Internet message boards, feedback to the question was immediate. Constructive criticism helped understand flaws in the questions. One piece of criticism received was that the survey was done in order to be answered from someone who is heterosexual. Another criticism was that some found it unclear if by asking “does your personal attitude influence your professional one” it was meant that only negative attitudes would change the professional attitude. A private message conversation with a gay nurse from Germany led to a discussion about how the researches about LGBT community related topics feel often done from a heterosexual point of view, even if the author is a member of said community. The idea that heterosexuality and that everyone has a female or male gender should be challenged, in order to change the nursing education in a way that talking about heterosexual and LGBT patients during the same lecture should become the norm.

However, the feedback that was most given after posting the link to the survey in the country intended, was that this research seemed very important to them, and many explained that they never really thought if they use inclusive language and terms towards patients. It sparked discussions about feminism, gender identity versus sexuality, and homophobia. Many asked questions how health needs differ and were surprised that they never really thought about these differences. This research hopefully keeps these discussions going and sparks new ideas for research.

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Read: 31.03.2014

Appendix 1 2(3)

- Krebsvorsorge

Wurden Informationen über LGBT Patienten sachlich unterrichtet:

- Ja
- Nein
- Wurde nicht unterrichtet

Hatte die (positive oder negative) Einstellung Ihres Lehrers einen Einfluss auf Ihre eigene Einstellung gegenüber LGBT Patienten?

- Ja
- Nein
- Keine Einstellung festgestellt

Beeinflusst Ihre persönliche Einstellung Ihre professionelle Einstellung gegenüber LGBT Patienten?

- Ja
- Nein

Sind Sie in der Lage ihre persönliche Einstellung von ihrer professionellen Einstellung vollständig zu trennen?

- Ja
- Nein

Ändert sich Ihre professionelle Einstellung wenn Sie erfahren, dass Ihr Patient nicht heterosexuell ist?

- Ja
- Nein

Bemerken Sie, ob Sie heterosexuelle Patienten anders als nicht-heterosexuelle Patienten behandeln?

- Ja
- Nein

Benutzen Sie automatisch weibliche und männliche Fürwörter (weibliche Fürwörter: sie / ihr, männliche Fürwörter: er / ihm), wenn Sie einen neuen Patienten kennenlernen?

- Ja
- Nein

Benutzen Sie geschlechtsneutrale Pronomen / Fürwörter, wenn sie einen neuen Patienten kennenlernen (geschlechtsneutrales Pronomen: hen)?

- Ja
- Nein

- Ja - Nein

Appendix 2 1(2)

Finnish survey

Olitko/oletko tietoinen siitä että LGBT-henkilöillä on erilaiset tarpeet kuin heteroseksuaalisella potilaalla? (Selitys: LGBT tarkoittaa lesbian, gay, bisexual, transgender. Eli lesbot, homot, biseksuaalit ja transgenderit. Mukaan kuuluvat myös kaikki muut kuin heteroseksuaaliset suuntaukset)

- Kyllä - En

Kuuluiko opetussunnitelmaan sinun terveydenhoito oppilaitoksessasi puhua LGBT potilaiden tarpeista?

- Kyllä - Ei

Oliko koulu aikanasasi soveliaista puhua luokassa LGBT potilaista tai kokemuksista heidän hoidostaan?

- Kyllä - Ei

Puhuttiinko koulutuksesi aikana LGBT potilaiden turvaseksi tai seksi harrastus muodoista?

- Kyllä - Ei

Puhuttiinko koulusi aikana yhtään mistään muista seksuaalisuuksista kuin heteroseksuaalisuudesta?

- Kyllä - Ei

Mitä mukana toimitettu aineisto LGBT aineisto koski (monivalinta):

- Seksuaalinen terveys
- Perheväkivalta
- Huumeiden ja alkoholinkäyttöä
- Itsensä satuttamista
- Mielenterveys
- Sukupuoli identiteetti
- Tupakointia
- HIV / AIDS
- Perhettä ja lisääntymiskeinoja

Appendix 2 2(2)

- Syöpä tutkimuksia

Oliko materiaali LGBT-potilaista esitetty neutraaliin sävyyn?

- Kyllä
- Ei
- Ei ollut mitään materiaalia

Aiheuttiko (positiivinen tai negatiivinen!) opettajanne käyttäytyminen LGBT-potilaita kohtaan muutoksiin teidän omissa asenteissanne?

- Kyllä
- Ei

-Opettajalla ei ollut erityistä asennetta asiaan

Vaikuttavatko henkilökohtaiset mielipiteesi ammatilliseen asenteesi (tarkoittaa: jos vaikka hyväksyt ainoastaan heteroseksuaaliset vai kohteletko jokaista potilasta tasavertaisesti?) ?

- Kyllä
- En

Voitko erottaa henkilökohtaiset mielipiteesi täysin mielestäsi ollessasi työtehtävissä?

- Kyllä
- En

Muuttuuko asenteesi kun kuulet/tai huomaat että potilaasi ei olekkaan heteroseksuaali?

- Kyllä
- Ei

Huomaatko kohtelevasi eri tavalla LGBT-potilaita kuin muita potilaitasi?

- Kyllä
- En

Onko työpaikallasi tarpeeksi tai ollenkaan resursseja opastaa työntekijöitä LGBT-potilaiden hoidossa?

- Kyllä
- Ei