



Experiences of patients with disabilities and sexual or gender minority status during healthcare interactions

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Received: 23 January 2023 / Accepted: 10 November 2023

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Abstract

Aim The purpose of this study was to examine the lived experiences of lesbian, gay, bisexual, transgender, queer, and other (LGBTQ+) people with disabilities when interacting with healthcare professionals related to their gender identity, sexuality, and disability.

Subject and methods Historically marginalized groups face many inequities in health care. However, little is known about the intersectional experiences of LGBTQ+ people with disabilities when receiving health care given their likelihood to encounter multiple marginalizations. Data were collected via the 2019 National Survey on Health and Disability (NSHD) and included a sample of 197 LGBTQ+ respondents with disabilities living in the USA. Quantitative data and demographics were analyzed using descriptive methods. Qualitative data were analyzed using deductive and inductive methods.

Results Of the LGBTQ+ respondents with disabilities, 72.2% avoided discussing their gender or sexual identity with their healthcare providers, with 9.8% never disclosing their identity. Qualitative analyses revealed themes centered around experiences of negative interactions with healthcare providers, including fear, distrust, and avoidance of care (40.1%), dismissal or denial of treatment (30.5%), and assault or aggressive activity (4.1%), although some reported no problems or need to discuss their LGBTQ+ or disability identities (14.7%).

Conclusion LGBTQ+ people with disabilities reported high rates of negative experiences disclosing gender or sexual identity and/or disability with healthcare providers. Further research is needed to determine whether negative interactions with medical providers may be caused by a lack of medical understanding, false assumptions about the de-sexualization of disabled people, or ignorance about LGBTQ+ identities.

Keywords Disclosure · Disability · Sexual and gender minority · Healthcare providers · LGBTQ+

Introduction

In the United States, the intersection of disability and LGBTQ+ identity can be fraught with obstacles to well-being. People with disabilities face large structural barriers to health care ranging from inaccessible transportation, lack of health insurance, mobility issues, and high cost of care, to care providers' lack of expertise in care for disabled patients (Hall et al. 2019; Meade et al. 2015). Similarly, LGBTQ+ experiences with harmful structural barriers such as employment discrimination, housing precarity, limited access to health insurance, discrimination in healthcare, and hostile legislation negatively impacts physical and mental health (Gonzalez and Henning-Smith 2017; Valdiserri et al. 2019). At the intersection of sexuality, disability, and health care, studies explore barriers

The National Survey on Health and Disability (NSHD) is administered by the University of Kansas Institute for Health & Disability Policy Studies and funded by the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR, project #s 90IFRE0050 and 90DP0075). The contents of this manuscript do not necessarily represent the policy of NIDILRR, ACL, or HHS and you should not assume endorsement by the federal government.

The views expressed are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the United States Government.

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to health care for LGBTQ+ adults, barriers to health care for people with disabilities, intersectional health disparities, and disclosure decisions. Disabled LGBTQ+ people are more likely to report diminished measures of health status, including increased incidence of migraine, greater depressive symptoms, and diminished cognitive functioning, compared with disabled non-LGBTQ+ people (Streed Jr. et al. 2021). Disabled people who are on the gender diverse spectrum are more likely to report unmet health care needs compared to cisgender disabled people (Mulcahy et al. 2022). There is a rich historical literature of these issues and deep theoretical insights into the always complex calculations people with multiple marginalized identities undertake when navigating health care (Rodriguez-Roldan 2019) as well as the ways LGBTQ+ people maximize resilience (Hunter et al. 2020). Taken together, these various bodies of scholarship weave a tapestry about the relationship between disabled LGBTQ+ adults and medicine, health, and sickness.

Recent research on the barriers to care for people with disabilities and marginalized gender and sexual identities provides multiple and compounding explanations for why individuals might want to conceal a disability or a LGBTQ+ identity in a medical setting. Open discrimination and fear of medical judgement or stigmatized diagnoses silences many (Lagu et al. 2022; Rossman et al. 2017). Equally harmful is the possibility that the medical provider is uneducated about, or worse, feigns understanding of, how a disability, sexual practice, or gender identity impacts health and wellness before offering medical treatment and advice (McGlynn et al. 2020; Nowaskie and Sowinski 2019). The well-documented disbelief of pain reports or symptoms that doctors apply unevenly and in discriminatory ways for racial, LGBTQ+ people and for people with disabilities goes to further discourage disclosures of disabilities or minority identities (Apodaca et al. 2022; Hintz 2022). Misjudgments of levels of ability, especially for those who disclose a disability (Iezzoni et al. 2021), and assumptions about inherent heterosexuality (Zeeman et al. 2019) or the irrelevance of sexual or gender identities regularly stand in the way of a healthy doctor/patient relationship (Rossman et al. 2017), as medical providers often eschew a patients' expertise of their own bodies and experiences. These are the strongest mufflers of patient self-disclosure once in a care provider's office. In the public health literature, a recent larger study of barriers to care for people with disabilities who also identified as LGBTQ+ provided insight into the experiences and choices of patients around decisions to disclose both their disabilities and/or their LGBTQ+ identity with their health care providers. Overall, the NSHD dataset illuminated a handful of significant findings, including disproportionate incidences of LGBTQ+ people with disabilities having autism spectrum diagnoses, unmet healthcare needs, inadequate provider

networks, and being refused medical services, that warrant further study (Hall et al. 2020).

Patient disclosure of both LGBTQ+ status and disabilities has a long history that does little to inspire trust of medical professionals among patients. A vast humanities scholarship documents a litany of medical responses to disclosure throughout the twentieth century that spanned from public shaming to incarceration and from talk therapy to lobotomy. These medical responses reflected the personal care decisions of the attending doctors as well as various forms of discrimination at work within the larger society. Consequently, historians have also traced the way that multiple and intersecting oppressed identities have often translated into medical violence after disclosure, observation, or assumption (Batz 2018; Bayer 1987; Terry 2010). In response to mistreatment at the hands of mainstream medicine, there are also rich and varied histories of oppressed groups taking medicine into their own hands with countless examples ranging from the Black Panther's Sickle Cell Anemia and community clinic programs (Bassett 2016), to the LGBTQ activist challenging the inclusion of homosexuality and Gender Identity Disorder in the DSM (McHenry 2022) and the creation of LGBTQ-friendly health services (Martos et al. 2017), to disability activists fighting for adequate Medicaid funding, preservation of the Affordable Care Act, and the right to receive medical and related supports in the community rather than being institutionalized (Nichols 2017). As these identity-based medical responses importantly met the needs of some that felt betrayed or distrustful of mainstream medicine, they also often exacerbated the absence of quality care for people who had multiple intersecting oppressed identities. These trends have deep historical roots in long-standing medical discrimination, ignorance, and the intersection of multiple oppressed identities.

A mixed-method approach was chosen to comprehensively address the dearth of knowledge regarding how LGBTQ+ adults with disabilities choose to disclose aspects of their identity to their healthcare providers. This study explored the incidence of two forms of patient concealment when in consultation with medical providers: of a disability diagnosis or LGBTQ+ identity. Looking at the intersection of disability and LGBTQ+ status is a relatively new undertaking among medical scholarship, setting aside the more than century-long pathologization of LGBTQ+ people themselves (Hall et al. 2020). By employing both quantitative data from a large survey and qualitative insights from long-form questions with disabled adults in the United States, the research aimed to offer a comprehensive and nuanced understanding of this complex issue. The mixed-method approach allowed for a holistic examination of the barriers, experiences, and disclosure decisions faced by disabled LGBTQ+ individuals in medical settings. This study's focus on self-disclosure decisions and rationales expands a

very small body of literature that explores the intersection of disability, LGBTQ+ status, and disclosure decisions, providing critical insights into what aspects of identity LGBTQ+ adults with disabilities choose to disclose, why they do so, and their past disclosure experiences with healthcare providers. These insights can be applied to inform policymakers in the development of inclusive healthcare practices and policies, fostering more equitable and accessible healthcare environments for LGBTQ+ people with disabilities.

Methods

Theoretical framework

This study lies at the intersection of multiple bodies of academic literature both within and beyond the health sciences. As our research delves into the convergence of LGBTQ+ identities and a wide array of disabilities, the growing theoretical scholarship on the relationship between these two emerges as of significant value (Bone 2017). This study goes beyond the application of “crip theory” and “queer crip theory” to understand how both LGBTQ+ identities and disabilities often stand in for one another in mainstream society, meaning that queer people are often seen as innately disabled and disabled people seen as queer but rarely are queerness and disability both considered simultaneously (DREDF 2018).

We used the Social Ecological Model as the theoretical framework for this study. The social ecological model focuses on four levels of risk – individual, close relationships, community, and societal – and the interplay between them (Bronfenbrenner 1979, 1992; Golden et al. 2015). The social ecological model has been used with LGBTQ+ populations in previous research, particularly to identify multi-level solutions to problems LGBTQ+ individuals identified related to their healthcare (Ramsey et al. 2022). In this study, we consider disability status and LGBTQ identity at the individual level but also as factors that arise as part of close relationships, community, and society. In this study, we mapped participant responses across individual, relationship, community, and societal levels across healthcare experiences of LGBTQ individuals with disabilities.

Data source and sample

This study was a mixed-methods analysis of de-identified cross-sectional data from the second wave of National Survey on Health and Disability (NSHD) administered October 2019 through January 2020 (University of Kansas 2022). Participants were recruited for this online survey through disability-focused organizations, listservs, newsletters, and conferences in the United States, and via social media

outlets, as well as through Amazon’s Mturk panel (Ipsen et al. 2021). Eligible participants were any disabled United States or US territory resident who was at least 18 years old at the time of the study. Just over two thousand ($n = 2175$) participants completed the survey. The study was approved by the University of [redacted] IRB (Study #00147878).

Measures

Disclosure. Data on disclosure of gender identity, sexuality, or disability came from a qualitative question in the NSHD. Only LGBTQ+ respondents were asked, “Please share anything you would like us to know about your interactions with healthcare professionals as they relate to your gender identity, sexuality and/or disability.” Of the 427 LGBTQ+ participants asked, 197 chose to answer (41.7%).

Sociodemographic characteristics. Descriptive data used in this analysis were based on items asking participants to report their age, race and ethnicity, geographic area, marital status, employment status, level of education, health insurance, and disability type. Age was calculated using the survey completion timestamp and the participants’ birth month and year. Participants were asked to indicate the highest level of education they completed, their current marital status, employment status, health insurance status, and which one or more racial and ethnic categories best described their race and ethnicity: American Indian or Native American, African American or Black, Asian, Hispanic or Latino, Native Hawaiian or Pacific Islander, White or Caucasian, and Other. Geographic area was based on four Census regions: South, West, Midwest, and Northeast. Disability type was determined by asking participants “Of the options listed below, which ONE category would you use to describe your main disability or health condition?” Seven categories were listed with the order randomized for each participant: intellectual or cognitive, mental illness or psychiatric, physical or mobility, chronic illness or disease, sensory, developmental, and neurological.

Analyses

Informed by the Social Ecological Model (Bronfenbrenner 1979, 1992; Golden et al. 2015), two investigators conducted a detailed qualitative analysis by thoroughly reviewing open-ended responses provided by participants. This qualitative analysis was instrumental in building a narrative that supported the emerging themes and offered a deeper understanding of the issues at hand. Using deductive methods, the content from these open-ended responses was systematically mapped to an existing literature-informed framework (Miles and Huberman 1994; Strauss and Corbin 1990). In addition to the deductive approach, novel categories were inductively generated and collaboratively agreed upon during the review

of the open-ended responses, enhancing the richness of the qualitative data. For example, key quotations that were used to support Theme 1 (fear, distrust, and resulting avoidance of care) included statements such as “*I no longer visit any medical professionals at all,*” “*past negative experiences with medical providers have made me fearful and nervous about seeing the doctor,*” and “*people have said that my gender is a phase or a mental illness*” (see Table 1 for representative quotations of each theme).

To ensure the reliability of the qualitative analysis, a comprehensive codebook was developed through open coding. The codebook served as a structured reference for categorizing and interpreting the qualitative data. To further enhance the rigor of the analysis, intercoder reliability was meticulously monitored by comparing code usage. Any discrepancies that arose during this process were resolved through third-party adjudication by a senior researcher (D.M.) until consensus was reached. Demographic data were analyzed using SPSS Statistics v. 29.

Results

Participants in this study ($n = 197$) were majority white (72.6%) and from urban areas (85.7%). Participants were split relatively evenly across age groups (49.2% 18–34, 50.8% 35–64) as well as levels of education (48.7% no college degree, 51.3% with at least a college degree). More than 80% of participants reported that they were currently married and 11.3% reported that they had children. More than 88% of study participants reported that they had health insurance. Most participants were cisgender (84.5%) and more than 80% identified as gay, lesbian, bisexual, or something else; 9% identified as asexual and less than 1% identified as heterosexual. The most commonly reported disability type was mental illness (32%), followed by chronic illness (22.2%), physical disabilities (20.1%), and neurological disabilities (17.5%). Intellectual disabilities and sensory disabilities were the least commonly reported (4.1% and 3.6%, respectively).

Overall, participant responses showed negative interactions with health professionals. These negative interactions span issues related to communication and accessibility as well as criminal activity and assault.

Eight major themes related to the lived experiences of LGBTQ+ people with disabilities when interacting with healthcare professionals emerged from the qualitative analysis of interview transcripts: (1) Fear, distrust, and resulting avoidance of care, (2) dismissal or denial of treatment, (3) decisions of why participant chose not to disclose, (4) assumed heterosexuality, (5) lack of accessibility, (6) aggressive or assaultive activity, (7) no problems or need to discuss gender identity, sexuality, or disability status, and (8)

relevance of sexual and reproductive health. Representative quotations of each of these eight key themes are provided in Table 1.

Discussion

This study investigated the reported experiences of patients interacting with medical care providers regarding their disability, sexuality, and or gender. An analysis of patient responses shows that historical trends around distrust, fear, and avoidance of care persist for LGBTQ+ patients and that also having disabilities compounds the continuation of these trends. This research shows that for many patients in our sample who are both LGBTQ+ and disabled, this intersection of identities rarely results in a positive interaction with medical professionals.

While medical professionals regularly argue that knowing more about their patients allows for higher quality of care (Street and Haidet 2011), there is significant evidence, including from the survey used for this article, that full disclosure of both disability and/or LGBTQ+ status is far from assured and not always a medical asset to the patient (Ogden et al. 2020; Quinn et al. 2015). In this study, we tried to gain a better understanding of when patients choose to disclose, what they choose to disclose (LGBTQ+ status, disability (if multiple, which), neither, or both), what factors into these decisions, and how other demographic factors might play into these choices.

Judith Butler’s exploration of the concepts of social legibility, mournability, and dehumanization frequently draw upon medical examples as the combination of LGBTQ+ identities and disabilities are often at least partially unrecognized by medical care providers (Nagington 2016). As a result, it becomes impossible for providers to fully empathize with their patients. Both fear and actual experience of lack of recognition by medical providers influences disclosure decisions, especially multiple disclosures. As seen in this study, a patient in a LGBTQ+ affirming medical setting might disclose their queer status but refrain from sharing a diagnosis that might either foster disbelief or result in dismissal from the care provider.

Importantly, even among those respondents who chose to disclose their identity or their diagnoses with care providers, they rarely disclosed both to a single provider. As in existing work, patients used their personal discretion to share their health information with their health care providers either out of fear of mistreatment, to maintain existing care in a dearth of other options, assumptions of provider ignorance, accessibility, or previous negative experiences (Ayhan et al. 2020; Joudeh et al. 2021).

LGBTQ+ adults in this study who also have disabilities reported numerous overlapping intersections of negative

Table 1 Key themes and representative quotations**Theme 1: Fear, distrust, and resulting avoidance of care ($n = 79$, 40.1%)**

- “I no longer visit any medical professionals at all. In the past, even when they haven’t discriminated against me because of my gender, they have dismissed my symptoms as normal PMS [premenstrual syndrome] and told me to only come back when I’m actively killing myself. I didn’t think bleeding heavily for up to two weeks, experiencing flu-like symptoms, insomnia, severe migraines, active and passive suicidal ideation, dizziness, nausea, and so on every month was normal.”
- “Past negative experiences with medical providers have made me fearful and nervous about seeing the doctor and especially about seeing nurses, PAs, or specialists... The most negative experience I had with a doctor was when I was referred to a dermatologist for dermatitis on my arms and chest right after my mastectomy, and she asked if she could show the dermatitis to an intern in her office. I agreed, and then when the intern came in, she focused only on my trans status and how testosterone supposedly led to the issue (I am confident that that was not the case). The way she showed my body to this intern was incredibly objectifying, and I felt like a freak show. So, I am leery of doctors. I routinely put off care for anything worse than a cold.”
- “People have said that my gender is a phase or a mental illness... They also suggest I need a social worker instead of doing work on themselves. It makes me not want to go to hospitals or seek medical care.”

Theme 2: Dismissal or denial of treatment ($n = 60$, 30.5%)

- “I have been told, when trying to get an appointment with an endocrinologist to treat a brain injury and hormones issue, that ‘the doctor doesn’t treat transgender people.’”
- “I had a primary care doc refuse to write a new script for my hormones when my old one ran out. Even though I’d been taking same steady dose for years, and all labs came back good. Said he couldn’t treat me because ‘not qualified.’ This was at a religious-owned health care system.”
- “For the longest time, I felt like I didn’t get great gynecology care because I am a lesbian and have never had sex with a man. Doctors often want to skip tests.”

Theme 3: Decisions of why participant chose not to disclose ($n = 40$, 20.3%)

- “I’m honestly afraid of talking about my sexuality and gender with doctors because I’m afraid of being denied treatment. So many of the specialists I’ve seen were in faith-based practices, and so I have to prioritize staying alive over having my own identity respected.”
- “I always avoid. I’m 50. And my whole life if you told a health professional or anyone who has some sort of leverage or power over you your sexual orientation, it would be to your detriment. It hasn’t been too many years since the DSM III considered my sexuality a really bad thing. It was always safer not to tell. Things might have changed with some people, but not all. And the stakes are too high to just roll the dice.”
- “I usually talk about everything else but my sexuality with my health care provider unless it is specifically brought up. I do this because I live in a very conservative area with poor access to mental health care services, and I’m afraid they will refer me out to another therapist or doctor if I disclose my sexuality to them.”

Theme 4: Assumed heterosexuality ($n = 12$, 6.1%)

- “Most of them assume that I’m straight and want to get pregnant in the future. I wish this was not the case because they’ve avoided giving me medications because of the risk of pregnancy.”
- “Very upsetting when I’m going to gynecologist and forms are interpreted for it to be read by straight couples, and I am invalidated when I express that I don’t have the same needs as heterosexual couples. The assumption is that I’m straight and need the same things as everyone else.”
- “I have never been asked by a medical professional. I’ve always been assumed to be straight. Since they couldn’t help me anyways... I just move on and let them think what they want.”

Theme 5: Lack of accessibility ($n = 24$, 12.2%)

- “They ignore requests for simple communication accommodations and if you have trouble communicating as a result, they treat you like you’re a drug addict or intentionally noncompliant. I spent years without access to my anxiety medication because of that factor.”
- “My least favorite thing as a woman with mobility issues is visiting the OB/GYN. It’s hard to get up and balanced on the stirrups, then they always want you to scoot down closer. It’s almost impossible sometimes to do that, particularly the scooting. I had one OB/GYN forcefully grab my hips and pull me down, which actually made me cry because of the intense pain it caused.”
- “Accessibility is never provided. Often have to fight for it. When it is provided, there is a lack of quality for accessibility, such as ASL interpreters.”

Theme 6: Aggressive or assaultive activity ($n = 8$, 4.1%)

- “The last time I tried to get an annual gynecological exam, I had to deal with the practitioner trying to push unsolicited pseudoscientific autism ‘cures’ on me, and then her anger at my not wanting to discuss those making her so rough she hurt me during the exam.”
- “I’ve never been not afraid since I was coerced into treatment without my consent... I was actively attending biweekly therapy and bimonthly psychiatrist appointments before they had me committed. I desperately wanted treatment, just not to be locked up like a criminal and force-fed anti-psychotics.”
- “A nurse said I would be doing the world a favor by dying.”

Table 1 (continued)

Theme 7: No problems/need to discuss gender identity, sexuality, or disability status ($n = 29$, 14.7%)

- “I feel that there is no need to hide my sexuality from my providers as I think it is important for them to know everything there is to know about me to provide me with the best care possible.”
- “I’m lucky that I have a lot of providers in the [city omitted] area who know about pronouns and are culturally competent around Queer communities. I even have a few Queer providers.”
- “Lately some intake forms have had questions regarding sexuality or gender identity, and that makes me trust the doctors with my whole self.”

Theme 8: Relevance of sexual and reproductive health ($n = 18$, 9.1%)

- “I believe many medical professionals think that because of my disability, I am automatically not sexually active – and currently, I am not, which has made it difficult to get preventatives such as birth control pills, etc.”
- “Once they establish that my sexual practices are very low risk for STI, none of my docs care that I am bisexual (lifelong). I have certainly encountered a lot of bias and the presumption of promiscuity or high-risk sex, and did much more often when I was younger, but in recent years that hasn’t been an issue.”
- “Because my birth defect affects my genitourinary system, I have received a lot of harassment and shaming by healthcare professionals as it relates to my sexual activity. For example, when I was diagnosed with ovarian cysts, I had a nurse tell me I ‘wasn’t allowed,’ to use my birth control prescription to ‘start having sex...’ I’ve also had the most difficult time explaining to gynecologists why my genitals look different from normal patients’ and an even more difficult time understanding that I have total urinary incontinence. I was yelled at by a nurse for not ‘trying to void’ before an ultrasound, even though I have literally no control of my urinary bladder.”

interactions with medical providers. Some reported that medical providers regularly treated them as though they had no sexuality, and certainly not the possibility of a minoritized gender or sexual identity. In some extreme examples, some practitioners insisted that underlying diagnoses precluded even the possibility of certain sexual or gender identities for their patients. The long and horrid history of the pathologization of LGBTQ+ identities should leave providers deeply reluctant to assign causative or correlative effects between diagnoses and identities (Marton 2004), yet this research suggests that this practice too often persists. Regardless of the motivation for this treatment, this research shows, with a few notable exceptions, that such prevailing attitudes may have a widespread chilling effect on LGBTQ+ patients with disabilities disclosing their identities and/or diagnoses to care providers.

In order to improve quality and accessibility to care for LGBTQ+ adults who also have a disability, findings from this study argue not only for improved medical access but specifically for improvements to medical training and education in the areas of gender and minority healthcare and in the history of medicine among minority communities.

Limitations

The strengths of this study include the use of geographically diverse data and focus on multiply-minoritized population, LGBTQ disabled adults. However, there are limitations inherent to this study that are necessary to bear in mind when interpreting results. First, the sample used in this study is small. Though the 2019 wave of the NSHD contained 2175 participants, only the 472 LGBTQ+ respondents were

asked the open-ended, qualitative question on which this analysis is based. Further, 197 participants answered the question (42% response rate). Second, it is likely that participants with negative responses were more likely to participate. As a result, our results may show a negativity bias (Vaish et al. 2008). Third, the sample of LGBTQ+ adults with disabilities is majority white, urban, had access to health insurance, and reported a higher level of educational attainment than reported elsewhere in disability literature (Chevalier and Feinstein 2006). The lack of demographic variability makes it difficult to generalize our findings, or assess differences between racial groups, genders, sexualities, or disability types. Finally, the sampling technique used in the NSHD further limits the generalizability of this study. For example, the recruitment and survey administration methods used have likely resulted in the exclusion of LGBTQ+ adults with disabilities who are unhoused or incarcerated, biasing our results.

Future research

LGBTQ+ adults living with disabilities exist at the locus of overlapping multiply-minoritized identities. There is a dearth of information about how this multiply-minoritized status impacts access to healthcare, healthcare use, and overall health. Further research on concealment and disclosure of identity information to health providers by LGBTQ+ adults is essential. Quantitative data are needed to examine broader patterns in concealment and disclosure behavior. Likewise, use of rich qualitative data is essential to understand additional details related to the experience

of LGBTQ+ adults with disabilities. To that end, we hope to analyze subsequent waves of the NSHD that include questions and answers related to discrimination completed by more than 2000 disabled adults in the US.

Conclusion

Among LGBTQ+ participants who chose to answer the open-ended question about experiences with healthcare providers, we found that LGBTQ+ adults with disabilities reported high rates of negative experiences disclosing gender or sexual identity and/or disability with healthcare providers. We recommend further research regarding what types and to what extent healthcare provider training is necessary to reduce the fear, distrust, avoidance of care, dismissal, and denial of treatment. While the generalizability of this study may be limited, our findings suggest that protections against assault and aggressive activity must be instituted for LGBTQ+ patients.

Authors' contributions Conceptualization, K. B. A.M., D.J.M., J.P.H., and N.K.; methodology, A. M. K.S.G. D.J.M.; formal analysis, A.M., K.S.G., and N.K.; data curation, A.M. and N.K.; writing—original draft preparation, K.B.; writing—review and editing, A.M., C.G.S., A.M.W., and J.P.H. All authors have read and agreed to the published version of the manuscript.

Funding The National Survey on Health and Disability (NSHD) is funded by the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR project #s: 90DP0075-01-00 and 90IFRE0050-01-01). This work was supported, in part, by a fellowship (Mulcahy) from the Veterans Administration Office of Academic Affairs.

Data availability Inquiries about the survey and dataset can be made by contacting the NSHD Administrator at the University of Kansas Noelle Kurth, at pixie@ku.edu.

Code availability Inquiries about the code used can be made by contacting the corresponding author, Abby Mulcahy, at abigail.mulcahy@va.gov.

Declarations

Ethical statement All participants gave their informed consent to participate in this study. The study was conducted according to the guidelines of the Declaration of Helsinki and approved by the Institutional Review Board of the University of [redacted] (Study#00147878).

Consent to participate Informed consent was obtained from all participants involved in the original NSHD study. All consent procedures and documents were approved by the University of Kansas IRB (Study#00004253).

Consent for publication Not applicable.

Conflicts of interest Authors have no conflicts of interest to report.

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