

PROUD STORIES PROJECT

LGBTIQ+ PATIENTS' SATISFACTION AFTER A NARRATIVE MEDICINE INTERVENTION AT THEIR PRIMARY CARE CENTRES

Community Intervention Study

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Voldria agrair sobretot a l'Anna, la meva tutora, totes les hores invertides a confiar en les meves idees, compartir els meus mal de caps, contagiar-me les ganes de fer recerca i sobretot per forçar-me a no conformar-me i deixar un futur millor del que m'he trobat.

*A tots, totes i totis els professionals i pacients de Trànsit per ensenyar-me tant des del respecte i la humilitat.
A la Dra. Garcia per ensenyar-me des de la senzillesa el que una operació tan màgica pot donar a una persona.*

*A la meva família, per ser el meu suport incondicional cada dia de la meva vida i de la carrera, per estimar-me i respectar-me en cada pas del meu procés.
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ABBREVIATES

ABS	Àrees Bàsiques de la Salut
CEIC	Comitè Ètic d'Investigació Clínica
EAP	Equip d'Atenció Primària
FTM	Female to Male
HIV	Human Immunodeficiency Virus
ICS	Institut Català de la Salut
IDIAPJGol	Institut Universitari D'Investigació en Atenció Primària Jordi Gol
LGBTIQ+	Lesbian, Gay, Bisexual, Transexual/transgender, Intersex, Queer, and others
MSM	Men who have Sex with Men
MTF	Male to Female
NBM	Narrative Based Medicine
PCC	Primary Care Centres
RGPD	Reglamento General de Protección de Datos
SC	Study Coordinator
SGM	Sexual Gender Minorities
SIAD	Servei d'Atenció Integral a les Dones
SMS	Short Message Service
SOGI	Sexual Orientation and Gender Identity
SPSS	Statistical Package for Social Sciences
TCAI	Tècnics en Cures Auxiliars d'Infermeria

ABSTRACT

Background

Sexual orientation and gender identity, have remained invisible in healthcare services, and studies researching LGBTIQ+ health indicate that the discrimination and stigma felt by this community, are affecting their health. On the daily basis, professionals do not know how to behave and what to say to their LGBTIQ+ patients as they were never trained for it. Satisfaction is never used as an objective way to understand those inequalities, even though it is a valid method. Narrative medicine, a new model for empathy, reflection, and trust regarding patient-health care professionals, uses close reading and reflective writing to improve this relationship and enhance all the humane parts of it.

Objective

The aim of this study is to assess LGBTIQ+ patients' satisfaction after a narrative medicine intervention on primary care professionals (nurses, doctors, TCAI ("*tècnics en cures auxiliars d'infermeria*") and administrative staff), in comparison to their satisfaction previous to the intervention, and in comparison to not doing it (control group).

As secondary objectives, we pretend to determine the overall satisfaction, discrimination perception and the frequentation of LGBTIQ+ patients in their Primary Care Centre (PCC).

Study Design

This study has been designed as a community intervention study.

Study population

LGBTIQ+ patients over 18 years old, who used public health services in the last 10 years and are part of the 12 centres participating in the study. They must agree to participate in it.

Methods

Among all the centres in the Health Region of Girona, 6 centres will be chosen as the exposed group and 6 will be the control group. 372 of these centres' LGBTIQ+ patients will be the sample, and since it is a hidden population, we will combine the snowball method and volunteering as sampling methods. On the exposed group, a narrative medicine session with some patients will be done to collect written experiences on accessing health as LGBTIQ+, and then a session with the exposed centres' professionals will include a read-through of those texts and a debate on how they felt and how they would change these situations. A validated survey that assesses patient satisfaction, frequentation, and perception of discrimination will be applied to both exposed and control groups at the baseline and 6 months after the intervention. Results will be assessed through a mix model controlling the covariates.

Keywords

LGBTIQ+, narrative medicine, health inequalities, primary care, medical humanities, hidden population

INTRODUCTION

According to the World Health Organisation, “sexuality is a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.” (1) Each individual is a combination of gender and sexuality, and both have biological and social components. (2)

Glossary

A glossary of the most essential terms can be found hereunder for a better understanding of all the concepts and dimensions of gender and sexuality.

- ▶ **Gender:** defines the social attributes that define the “man” and “woman” dichotomy, as well as the social relationships. It is important to differentiate between gender and sex, that is, gender identity vs being male or female (expressed by genitals, hormones, and genes... defined by biological sex).
 - ▷ **Gender identity:** refers to the inner and individual experience of someone’s gender. It is a subjective feeling of whether they identify, as male, female, non-binary, genderqueer or anywhere along the gender spectrum. Gender identity may be the same as or different from the sex assigned at birth, and it is separate from someone’s sexual orientation.
 - ▷ **Gender expression:** is defined by the external presentation of a person’s gender, which includes the clothing style, make-up, and hairstyle. It is usually dichotomised from masculine to feminine (with androgyny in between).
- ▶ **Transgender or trans:** is an umbrella term, since it describes people who do not identify or conform to the sex they were assigned at birth. They might alter their appearance through hormonal therapy and/or surgery, to affirm their gender identity. In medical terms: MTF (Male to Female) typically describes a person who identifies as female but was born with male genitalia; the term FTM (Female to Male) is used for the reverse. Sometimes they reject the binary nature of gender and identify as genderqueer, androgynous or non-binary.

- ▶ **Intersex:** it refers to people with bodies (reproductive systems, chromosomes, or hormones) that are not easy to categorise as male or female. They can have different gender identities.
- ▶ **Sexual orientation:** it is typically described by 3 dimensions: behaviour, identity and attraction. They may have inter and intrapersonal differences, as well as change over time, and may be influenced by the social context. In research and public health, the terms MSM (men who have sex with men) and WSW (women who have sex with women) are used to avoid the incomplete overlap between the 3 dimensions, and describe people who engage in same-sex behaviour, regardless of their identity.
- ▶ **Heterosexual or straight:** refers to a person who is attracted mainly to people of the opposite sex or gender identity.
- ▶ **Gay or homosexual:** refers to a person (usually men) who is attracted mainly to people of the same sex or gender identity. It can also be used in women.
- ▶ **Lesbian:** refers to a woman who is attracted mainly to other women.
- ▶ **Bisexual:** refers to a person who is attracted to people of the same sex or gender identity and another sex or gender identity. It can include attraction to all kinds of genders.
- ▶ **Asexual:** refers to a person who does not experience sexual feelings or desires towards anyone.
- ▶ **Queer:** refers to a person who does not identify with the binary terms that describe sexual, gender and sociopolitical constructed identities.

Although the LGBTIQ+ community is often tied together as a homogeneous group, it is important to understand the ethnic, age, socioeconomic status, and identity diversity that it contains, as it reflects the cultural diversity of the general population itself. [\(2-6\)](#)

Representation in the system

Sexual orientation and gender identity (SOGI) questions are rarely included in daily forms and multinational questionnaire studies. The most recent and extensive survey from Ipsos in 2019, including 19000 people from 16 to 74 years old in 28 countries asked their participants about their sexuality and their gender identity. Results showed 80% of respondents answered as heterosexual, 11% as bisexual or homosexual and 9% didn't answer; 1% described themselves as transgender and <1% as non-binary (*Figures 1 and 2*).

GENDER IDENTITY AND SEXUAL ORIENTATION BY GENERATION (GLOBAL COUNTRY AVERAGE)

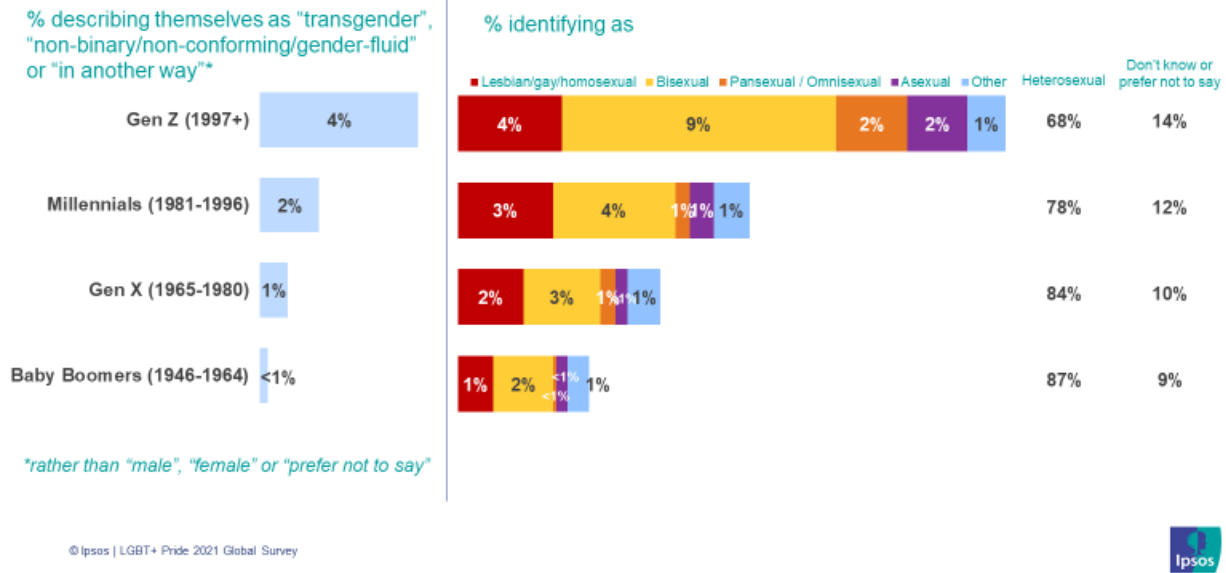
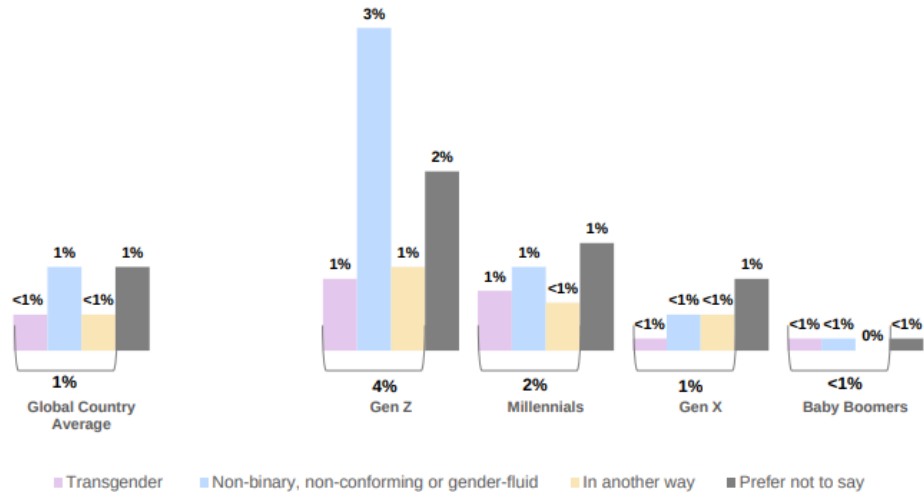


Figure 1. Gender identity and sexual orientation by generation (Z)

Q. How do you currently describe yourself?

- Gen Z: Born 1997 and later (i.e., no older than 23/24)
- Millennials: Born 1981-1996 (i.e., ages 24/25-39/40)
- Gen X: Born 1965-1980 (i.e., ages 40/41-55/56)
- Baby Boomers: Born 1946-1964 (i.e., ages 56/57-74)



Base: 19,069 online adults aged 16-74 across 27 countries
 * Online samples in Brazil, Chile, mainland China, Colombia, India, Malaysia, Mexico, Peru, Russia, South Africa, and Turkey tend to be more urban, educated, and/or affluent than the general population
 The "Global Country Average" reflects the average result for all the countries where the survey was conducted. It has not been adjusted to the population size of each country and is not intended to suggest a total result.

© Ipsos | LGBT+ Pride 2021 Global Survey

Figure 2. Gender identity by generation (Z)

When comparing these results with the 1973-2014 study of same-sex experiences (8), we see that 4.3% of participants identified as gay, lesbian, or bisexual, even though 9% had a same-sex experience as an adult (implying that half of them identify as heterosexuals); with a non-response rate of 1%.

It is important to emphasise that even though, the samples are different in number and representation, the increase of LGBTIQ+ respondents raised up to double.

In this same study, also, same-sex experiences doubled between the early 1990s and early 2010s; with a larger increase in women than men, which was attempted to be explained by different theories such as the erotic plasticity theory (this implies that women are more likely to experience with their sexuality) or legal and economic independence for women who decreased their reliance on heterosexual partnerships or the gain of visibility and public approval of lesbian culture. These numbers also grew among adolescents, both in same-sex relationships and sexual orientation (5).

All the changes we have been going through in the last 50 years, such as the acceptance of same-sex relationships, the support for same-sex marriage, the changes in policies, the fading of the stigma, the abundance of technology that facilitates access to same-sex relationships... brings us to this new results in those surveys.

A 2015 study of elderly patients in Ireland showed that 26% of participants were reluctant to reveal their LGBTIQ+ status for fear of a negative response, even though in the interviews, many positive encounters of coming out to healthcare professionals were relayed (9).

Spain excelled with above-average results in a European study as the most accepting country for the health needs and importance to know patients' SOGI and/or sexual characteristics (10).

However, this topic is still not asked in general nor in specific medical practice, and LGBTIQ+ patients remain unknown to the healthcare system, it is very likely that most clinicians have encountered them in their daily practices whether they were aware of their sexual orientation and gender identity or not (6). Clinicians must have this information on their patient's medical charts since there is evidence of prior bias (despite increasing social acceptance), the expectation of poor treatment and numerous health disparities based on a lack of culturally competent healthcare (5, 11).

Only if we collect data on the LGBTIQ+ population, will it be possible to end their invisibility and poor treatment in healthcare (4); which brings us to the next topic.

LGBTIQ+ inequalities and minority stress

In a recent Spanish study, a research group found out that only 0.4% in the last 6 years of publicly funded projects, included the LGBTIQ+ collective, mostly centred on Human Immunodeficiency Virus (HIV) and men who have sex with men (MSM) (12). It seems incongruous if we think of the legislation that prohibits discrimination based on sexual orientation and gender identity, and impulses equal care for all patients, that came out in Spain in 2015 (13).

These inequalities are rooted in heteronormativity, minority stress, experiences of discrimination and stigma; they can also vary among its population. Evidence implied that these patients usually report more disapproving experiences in healthcare which include poor communication or demeaning behaviour, and discontentment with the attention and care received.

This population's invisibility comes from the patient's reluctance to give away their SOGI information and a great discomfort or ignorance about the importance of this information (4). It is important to notice that the information gaps in scientific literature, particularly, affect intersex and trans people (14). Trans and gender-diverse people are reporting negative experiences in healthcare consistently relating to their gender identity, which has a negative impact on their emotional well-being (3, 14). On that topic, we must take into account that even in the collective, people carry markers of difference that can also meet to create even more marginalisation (4).

In the Opendoors project, “almost half of the respondents often or very often experienced, or overheard stereotypes, prejudiced views about LGBTI people as well as jokes made about someone’s sexual orientation, gender identity or sex characteristics (...) and one out of ten often or very often heard humiliation and intimidation to LGBTI people” (10). This demonstrates a non-inclusive LGBTIQ+ environment. Very similar numbers emerged in a meta-analysis of almost 400 studies in 19 countries, reporting 50% of verbal harassment experiences, 45% of sexual harassment experiences and 41% higher levels of discrimination (4).

One of the main causes of this inequality remains in being part of a sexual minority, as happens in other minorities, such as racial, religious, health, economic... “The minority stress model suggests that because of stigma, prejudice and discrimination, LGBTI people may experience more stress than non-LGBTI people and that it is this disproportionate experience of stress that can lead to increased incidence of physical and mental health problems” (4). Sexual minorities are more likely to report having chronic emotional or physiological issues, in comparison to heterosexual equivalents; and adjusted for sociodemographic characteristics, they were 1-1,5 times more likely than non-LGBTIQ+ to report adverse experiences with primary care (15). In adolescents, studies showed an increase in suicide attempts and poor mental health (5) in comparison to heterosexual youths; this information, also supported by substantial evidence, can be read in studies that conclude a higher proportion of depression and poor mental health in adult sexual and gender minorities (SGM) (16).

As we have seen in the past, the problem also lies in education and that is shown in several studies where patients and healthcare professionals reported very poor LGBTIQ+ health basic training, not to say low awareness of LGBTIQ+ issues and specific needs (4). “This lack of knowledge, due to lack of training and outdated medical curricula and textbooks, often combined with prejudices against LGBTI people by healthcare providers, represent a significant barrier for building an inclusive and non-discriminatory healthcare for LGBTI people” (10).

Access to health

The lack of well-trained professionals and the social stigma become an interference with the LGBTIQ+ community's access to health, as well as the misinformation and the feeling of being unwelcome. And even though research and studies have exposed those inequalities, there are almost no comprehensive plans or policies to overcome them, addressing LGBTIQ+ health and their needs (11). The few good practices that exist, are usually individual and not formal or legislated.

The main barriers are the fear of being unprepared or poorly equipped, unwelcoming, non-assertive talking about certain topics, the use of correct language, falling into prejudices and making hurtful assumptions. All these concerns are perceived from both perspectives, and adding this to previous bad experiences, LGBTIQ+ people might delay or avoid accessing healthcare and seek treatments (10).

In a 2009 survey, significant percentages of LGBTIQ+ individuals expressed concerns about accessing healthcare. More than half of the trans respondents feared that they would be rejected, and three-quarters of the respondents felt they would be treated differently from non-LGBTIQ+ patients (17).

We also must take into account that their own internalised stigma, which devalues themselves, can lead to these significant barriers to accessing healthcare. Then, in summary, translates into poor preventive health screening that they might need. This screening and first contact with professionals when a health issue appears reside basically in primary care. It is the first filter, and it should be the safest place to be vulnerable about every one of our illnesses or doubts. Also, the need to defend and promote health in this community falls on primary care (11).

Interventions in primary care centres, focused towards decreasing stigma in healthcare settings or increasing patients' disclosure of SOGI to providers, have the potential to increase the utilisation of primary and preventive healthcare services by LGBTIQ+ people in rural areas, for example (18).

Assessment and future proposals

Despite the health inequalities in the LGBTIQ+ population, a great part of the healthcare system still feels that these patients are okay with it and that they accept their conditions on health access (10). This was proven wrong by several studies that assessed the satisfaction among LGBTIQ+ patients with their healthcare system, where the patients perceived a lack of courtesy and respect shown to them by the employees relating to their SOGI (19 – 21). Additionally, cultural competencies that are attentive to race, ethnicity, and language (exclusive of SOGI) have demonstrated an improvement in patient satisfaction scores among those specific minorities (22).

In almost every study cited previously, the promotion of good training and quality information during medical school, are the main solutions for a better understanding and inclusion of LGBTIQ+ health.

This brings some issues because changing the curricula of universities and medical residencies is a long process, and training day-to-day professionals require money and research.

In some studies, workshops or case studies were recommended, such as involving health professionals and administrative staff, as they all have direct contact with LGBTIQ+ patients (given that patients often report that uncomfortable questions come up at the reception desk, not in the exam room). Also involving these patients in the training for sharing their experiences (10, 11, 14) and reflecting upon personal attitudes, could prevent them to provide their best care possible (6), which are valid options for a better practice. This collaboration could contribute to a collective goal of truly inclusive and equally accessible services for all.

To do so, it is very important for all professionals to collect data. Patients, too, need to understand and learn about why it is significant to communicate this information and feel comfortable knowing that it will be used appropriately. Therefore, it is critical that this data collection is done sensitively, without assumptions, and for each patient with any other sociodemographic data (11). In these cases, it has been shown that doing it online, at home or via tablets, provides better and more accurate results (4, 6).

This hidden and extended population deserves equal care and access to health because their identity and sexual orientation are only theirs, and no one to be questioned or discriminated against.

Since training is demanded by professionals to provide better care for them, narrative medicine, a novel method, is proposed.

Narrative medicine

Rita Charon describes narrative medicine as “medicine practised with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness” (23).

In a small revolutionary recent medical movement, called medical humanities or medical humanisation, Rita Charon, a U.S. doctor, came up with the term “narrative medicine” or “narrative-based medicine” (NBM) to explain a clinical form of medical humanities. This field emerged gradually from humanities, primary care medicine, contemporary narratology and the study of effective doctor-patient relationships.

In her first book, she talks about how human beings use narrative or storytelling naturally to explain or to understand everything that happens inside and around us; how we create stories and interact with each other using metaphors and other forms of figural language. She laments the incursion of corporate and bureaucracy into clinical practice and healthcare decisions, and that is what brings her to impulse the humanisation of it (23).

An important part of narrative medicine is close reading, which is a skill that can be applied in all areas of our professional lives like reading charts, listening to patients, mentoring students, writing and comprehending our reflections on care (23).

Furthermore, sometimes doctors lack the human capacity to interpret what patients need or explain, and also lack the extension of empathy toward those who suffer and join truthfully with patients in their struggles; and that is something that most patients long for. Charon claims that narrative medicine appeals to that and improves those skills (23).

This new tool is based mainly on reflective reading in small groups to create debate and encourage the participants to make their observations and interpretations, and to heighten their descriptive and comprehending capacities. Following this discussion, the participants are asked to write individual narratives or responses to encourage their own creative reflections. After that, the possibility of out loud reading in a safe space is given (24).

Dr Charon claims that a medicine practised with narrative competence will more easily recognise patients and their illnesses, communicate knowledge and concern, work with colleagues, and accompany patients and their families through difficult times. This approach could lead to more humane, ethical and possibly, effective care; which is what is lacking nowadays. By now, clinicians, students, literary scholars, writers, and patients with early work in narrative medicine have enthusiastic and grateful responses. Although, achieving narrative competence, is not a trivial goal (23, 25, 26).

Doctors' expertise in the scientific area is not always enough, they need the expertise to listen and understand their patients, to act best on their behalf. Nurses and social workers have these skills mastered, but this could also strengthen their capacities.

She claims that using narrative knowledge enables a person to understand the predicament another person might be in, by participating in their story with complex skills of imagination, interpretation, and recognition. This tool can help answer lots of actual medical problems such as its impersonality, its fragmentation, coldness and sometimes, lack of social conscience. In addition, as we have seen, it helps professionals understand the difficulties that being a caregiver brings to their lives and their own families, and it makes them better teachers, researchers, colleagues, and communicators (23). Likewise, she reckons that if the physician misses something in the patient's story, this might affect the future diagnosis and therefore, treatment and prognosis (27).

More and more studies are now assessing the NBM practises in healthcare professionals' training. Recent systematic reviews are analysing and synthesising those studies. Results have shown an improvement in empathy, communication, observation, and ethical reasoning skills in medical students; also as personal and professional growth and entertainment during the training (25). A 2019 review found evidence that narrative medicine is an effective pedagogic tool with a clear and replicable structure and methodology, mostly for medical students (26).

Other studies presented improvements in affiliation with colleagues (observed in better team cohesion), self and others awareness, satisfaction with work, sense of wellness, the strength of the patient-doctor relationship, doctor's reflection powers, and a decrease in clinician burnout (28-35).

Assessing feasibility, a study revealed that a monthly program was feasible in academic clinical settings; with engagement and support for implementation; even if it included staff training in narrative medicine; and supported by another study which concluded that this practice could be easily included on a daily basis (31, 36, 24).

Even more studies pointed to the capacity of practitioners to become more aware of social and political roles, as well as their way to interact with minorities and people in adverse circumstances. It might encourage them to take action, as it appeals to very deep empathy and self-awareness (37).

The problem comes when we realise that close reading takes practice, skill, and long experience with it, and it is not easy to master (23).

Another issue arises when lots of studies reveal the need for data that brings a clinical value to this technique, meaning that we need to compare the ideal practice of it with the real one. How these skills, proven in students, can be related and required to daily practice ([25](#), [26](#), [32](#), [34](#)). A systematic review also included the need to find clear and specific protocols and common methodologies in medical practice and in patients' lives ([36](#)).

To end this chapter, it is important to point out that primary care, although needed, has its limitations, like knowing the limits and when to stop to prevent abuses of power or even more so to increase pressure and stress among professionals ([37](#)).

JUSTIFICATION

When we think about the LGBTIQ+ community, we often overlook that insignificant actions, such as some looks, comments, or even prejudices could affect their health.

As seen in the introduction, we can understand that they are facing real problems in terms of health access and, thus, healthcare and health prevention. It is an invisible reality they are living and although lots of minorities are living it too, this one has poor research centred on them.

Narrative medicine has proven to be a significant tool and a new way of experiencing the patient-healthcare professionals' relationship. It brings mostly empathy and self-reflection, qualities that fit perfectly the needs of LGBTIQ+ patients, since they are never fully understood or majorly under-asked.

People who are not part of this community have a hard time realising the discrimination these people feel, and a storytelling tool directly appeals to a deep human part of each one of them and increases empathy towards the LGBTIQ+ community, seeing them as equals.

The NBM fits coherently in the National Healthcare System, since its principles and approaches are very complementary. It is also a right for them to be treated equally to anyone.

This study brings together these perspectives and does so in a way that represents a very diverse community, quests all the professionals in a healthcare centre creating a safe space for anyone that walks in and draws a new perspective on the Catalan healthcare system and their LGBTIQ+ patient's satisfaction.

HYPOTHESES

Main hypothesis

A narrative medicine intervention in a primary care centre will improve its LGBTIQ+ patients' satisfaction.

Secondary hypothesis

LGBTIQ+ patients will increase their frequentation to their PCC after the intervention.

LGBTIQ+ patients frequently feel discriminated when attending their PCC.

LGBTIQ+ patients will show less satisfaction with their PCC than the general population in the PLAENSA 2021 survey.

OBJECTIVES

Main objective

To assess LGBTIQ+ patients' satisfaction after a narrative medicine intervention on the primary care professionals (nurses, doctors, TCAI, and administrative staff), in comparison to their satisfaction previous to the intervention, and in comparison to not doing it.

Secondary objectives

To calculate if there is a change in frequentation in the LGBTIQ+ population at their PCC after the intervention.

To determine LGBTIQ+ perception of discrimination in their PCC.

To assess the overall satisfaction of LGBTIQ+ patients with their PCC.

METHODOLOGY

Study design

This is designed to be a community intervention study which includes an intervention group and a control group.

Study period

The study period is displayed further on in the *Figure 4*.

Study population

The study population will include LGBTIQ+ adults who are assigned to the primary care services of the Catalan Health Institute, particularly in 12 centres from the Girona Health Region.

The Health Region of Girona (*Figure 3* [\(38\)](#)) is formed by a group of Àrees Bàsiques de Salut (ABS), territorial units that concentrate their healthcare activity in PCC. Each ABS is constructed by an Equip d'atenció Primària (EAP), sanitary and non-sanitary professionals that direct and develop activities in the PCC. In Girona's Health Region, there are 41 EAP.



Figure 3. Primary Health Care Centres. Girona Health Region ([38](#))

Inclusion and exclusion criteria

Inclusion criteria:

- ▶ People who identify themselves as LGBTIQ+ (non-binary, trans, gay, lesbian, bisexual, asexual, intersex, or queer [an umbrella term that includes all non-normative SOGI, and not included in the ones before]).
- ▶ Patients who agree to participate in the study and have signed the consent form.
- ▶ Patients who use or have used the public healthcare system at least once in the last 10 years.
- ▶ Patients who are part of the 12 participating centres.

Exclusion criteria:

- ▶ Patients under 18 years old.
- ▶ Patients with cognitive or sensory impairment.
- ▶ Illiterate patients.
- ▶ People who cannot express themselves through written Catalan or Spanish.

Sample

Sample size:

Computations were carried out with a GRANMO calculator. The sample size has been calculated according to the main objective of the study, based on repeated measurements in two groups.

Accepting an alpha risk of 0.05 and a beta risk of 0.2 in a two-sided test, **186** subjects are necessary in the first group and **186** in the second to recognize as statistically significant a difference greater than or equal to 1.1 units (regarding different studies, this punctuation increase is feasible and significant ([41](#)), and in this study it would mean an increase of 1.1 out of 10 in the second satisfaction survey results).

The common standard deviation is assumed to be 5 ([41](#)) and the correlation coefficient between the initial and final measurement as 0.8 (understanding the type of population under study and previous studies ([8](#))). It has been anticipated a drop-out rate of 30% (since this study has a 1-year period between the two surveys, the delicacy of the matter, and the amount of non-respondent participants).

Sample selection:

We will conduct a cluster sampling to select the PPC which will be involved in the study, and then within each centre, a non-random sampling method will be applied to recruit LGBTIQ+ participants.

Firstly, cluster sampling will be done by separating all centres in the Health Region of Girona by population coverage (high, medium, or small). 6 of them will be randomly selected, with two of each category. Then, they will be contacted by email or phone and proposed to be part of the study. The professionals taken into account for every PCC are the doctors, nurses, administrative staff and TCAI that work there. If they do not agree, we will choose another centre with the same conditions. The 6 control centres will be selected to pair up with the chosen ones by population coverage.

Secondly, patients will be selected using a non-random sampling method, as some evidence points, when treating with a hidden population, to reach the maximum amount of patients, it is better to use at least, two non-probabilistic sampling methods ([39](#), [40](#)):

- ▶ Snowball sampling: it is a non-probability sampling method where new units are recruited by other units to be part of the sample.
- ▶ Voluntary response sampling: it is a non-probability sampling method where people volunteer themselves through posters and infographics in their PCC or local LGBTIQ+ organisations (making sure that those who answer are part of the collective).

By combining those two strategies, we will be able to reach out to all the patients who do not often go to their PCC, either for their good health or for fear of discrimination. And with the snowball method, as the people spreading the word will be their acquaintances, it will create a safer space and encourage participation.

Study period

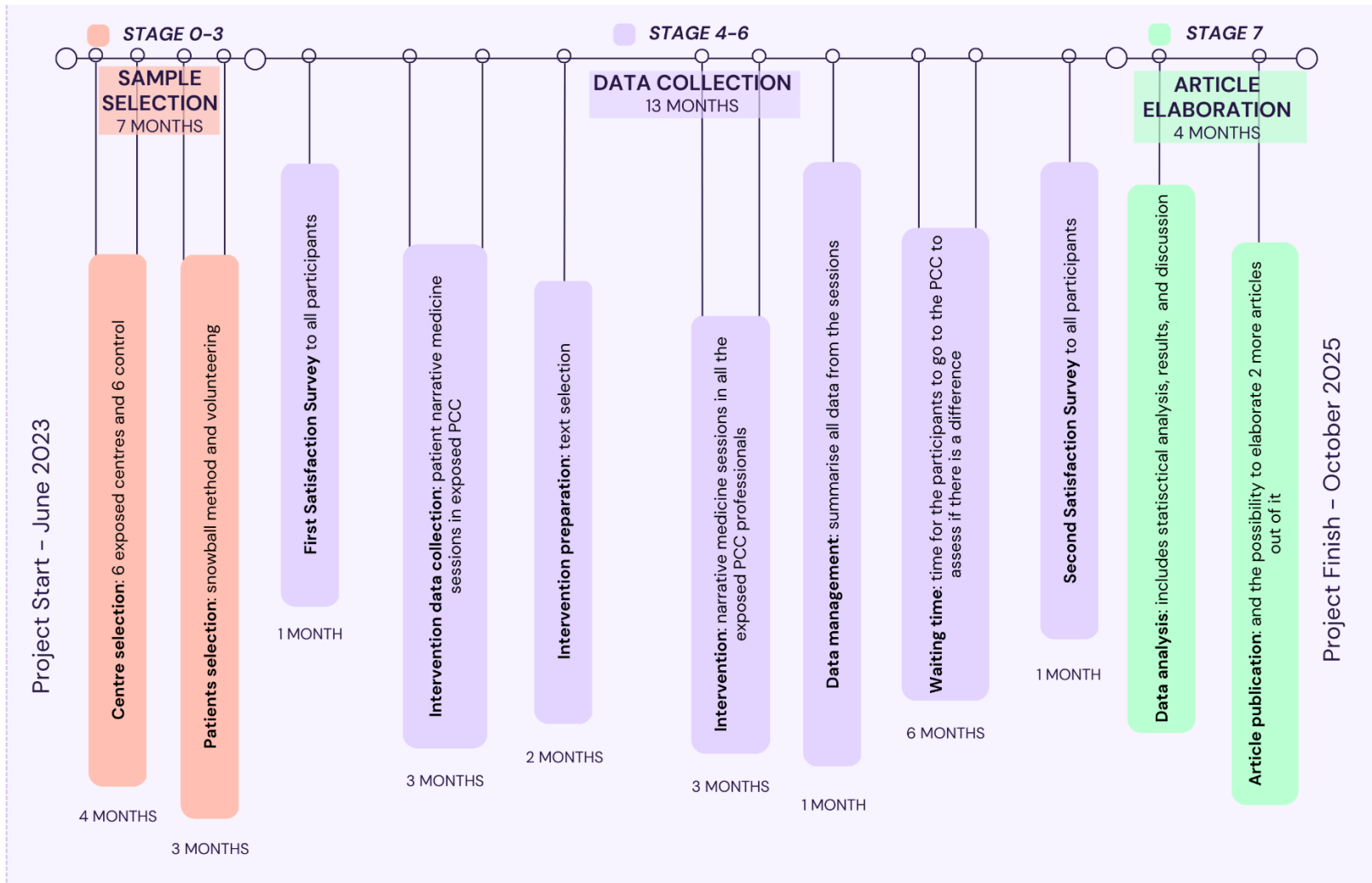


Figure 4. Study period diagram

Variables

Independent variable:

The independent variable of the study is the narrative medicine intervention. It is a dichotomous quantitative variable that will be expressed by the **intervention group** (the exposed PCC) as **yes** and the **control group** as **no**, referring to their exposition.

Dependent variable:

The main dependent variable of the study is **satisfaction**.

It is a continuous quantitative variable that is assessed by means of a validated satisfaction and experience questionnaire (see [ANNEX 1](#)) by the Institut Català de la Salut (ICS). This validated questionnaire, named PLAENSA, is available in both Spanish and Catalan versions. It is administered online every 3 years in overall Catalonia to assess the level of satisfaction of all the people attended by the primary care services of the ICS. Participants included are collected through Short Message Service (SMS), with inclusion and exclusion criteria. The questionnaire consists of 18 questions scored with a categorical ordinal scale of 5, a question assessed by the interval scale from 0-10 and a fidelity question. The dimensions taken into account are: user satisfaction, perception, and experience ([41](#)). A sensitivity analysis will be carried out, restricting the satisfaction dimension of the questionnaire.

Two questions were added (they are at the end of the PLAENSA survey, at [ANNEX 1](#)) to evaluate the secondary objectives, defining the following dependent variables:

- ▶ **Discrimination:** is a categoric polytomous variable. It will be asked in a way participants must answer by frequency, therefore we will be able to quantify somehow this feeling. It will be assessed on the baseline, the first survey, and can be compared to the second, after the intervention.
- ▶ **Frequentation:** is a categoric polytomous variable. It will be asked in a way participants must answer a specific number of times they have gone in their last year. It will be assessed on the second survey, since we are evaluating if the intervention could increase it.

Discrimination question

P103. Have you ever felt discriminated against or judged for your sexual orientation or gender identity in your primary care centre?

- ▶ Always
- ▶ Almost always
- ▶ Often
- ▶ Sometimes
- ▶ Never/almost never

Frequentation question

P104. In the last year, how many times have you gone to your primary care centre?

- ▶ >5 times
- ▶ 4–5 times
- ▶ 3 times
- ▶ 2 times
- ▶ 1 time
- ▶ 0 times, never

Covariates:

There are other variables that could affect our dependent and independent variables. As these variables could act as confounders, we will have to control them in order to increase the internal and external validity of the study. Among those variables, collected in *Table 1*, we find:

- ▶ Age: Continuous quantitative variable that will be expressed in years.
- ▶ Gender Identity: Polytomous qualitative nominal variable which can include male, female, non-binary or others.
- ▶ Education: Polytomous qualitative categorical variable which can include primary and secondary education, high school and advanced professional training/university.
- ▶ Occupation: Polytomous qualitative nominal variable expressed in specific and broad terms.
- ▶ Birthplace: Polytomous qualitative nominal variable, categorised as: Western European, Eastern European, Sub-Saharan, Other African, Asian, South and Central American, North American and other. This is a covariate to consider because there are differences between cultures regarding expressing feelings, and emotions or talking about oneself.
- ▶ Marital status: Polytomous qualitative nominal variable which can include single, married, unmarried partner, divorced, marital separation and widow.
- ▶ ABS: Polytomous qualitative nominal variable, with all the options.
- ▶ Sexual orientation: Polytomous qualitative nominal variable which can include straight, gay, lesbian, bisexual, asexual, queer, or others.

Table 1. Independent variable, dependent variables and covariates to consider in Proud Stories Project

	VARIABLE	TYPE	CATEGORIES OR VALUES
Independent variable	Narrative medicine intervention	Quantitative dichotomous	Yes/No
Dependent variable	Patients' satisfaction	Quantitative continuous	0-10 score
Secondary dependent variables	Perception of discrimination	Qualitative polytomous	Always/Almost always/ Often/Sometimes/ Never-Almost never
	Frequentation	Qualitative polytomous	0/1/2/3/4-5/>5 times
Covariates	Age	Quantitative continuous	-
	Gender identity	Qualitative polytomous	Male/Female/Non-Binary/ Others
	Education	Qualitative polytomous	Primary and secondary level/High School level/ Advanced studies level
	Occupation	Qualitative polytomous	-
	Birthplace	Qualitative polytomous	Western European/Eastern European/Sub-Saharan/ Other African/Asian/South and Central American/ North American/Other
	Marital status	Qualitative polytomous	Single/Married/Unmarried partner/Divorced/Marital separation/Widow
	ABS	Qualitative polytomous	-
	Sexual orientation	Qualitative polytomous	Straight/Gay/Lesbian/ Bisexual/Asexual/Queer/ Others

Data collection

Firstly, as previously mentioned, the recruitment of participants will be done through the snowball method, posters and infographics ([ANNEX 2](#)) in the chosen PCC and local LGBTIQ+ organisations (Punt Jove, Servei d'Atenció Integral a les Dones (SIAD), Centre Cívic...), all of them will advertise and share a QR or **link** that will take them directly to LimeSurvey, which is chosen as it has its servers in Europe and complies with the actual data protection regulations.

Whenever the participants agree to participate and inscribe through the link or QR, they will be directed to a LimeSurvey that contains (see below a summary in *Figure 5*):

- ▶ The first question will be regarding their personal PCC, and if it is not part of the study selection, they will not be able to participate. An option to leave contact information will be offered for further studies on the LGBTIQ+ population. Two more questions regarding their age and if they have used the public healthcare system at least once in the last 10 years will be asked to see if they meet the inclusion criteria. If an answer excludes them, the same message from above will appear.
- ▶ If they fulfil inclusion criteria: In this same survey, a link to the information sheet and informed consent form ([ANNEX 3](#)) will appear as they will have to read and sign them; then send it to the study coordinator email or printed and left at the front desk of their PCC. A third option could appear if LimeSurvey gives the option to read the forms and sign them in the same survey. Contact information (how and when they want to be contacted; this could be by mail, short message service (SMS), or telephone) will also be formulated here, assuring them their data will be coded and letting them answer freely and unapprehensively.
- ▶ A first survey including sociodemographic and SOGI questions ([ANNEX 4](#)) will be the next step to get all the covariates controlled and the SOGI charts on the participants.
- ▶ If they are patients from the exposed centres, they will be redirected to another set of questions regarding their willingness to participate in a group session and their time availability (morning, afternoon, or weekends). If they agree, another information sheet will be sent, with explanations of the part of the intervention they would be participating in. Only one consent form will be asked to sign.

There will also be the possibility to ask for all these forms at the front desk of their PCC (for them to fulfil wherever they feel more comfortable) and the option to return them fulfilled and signed physically, leaving them in a ballot box to preserve maximum privacy.

372 participants are expected to be reached within this data collection period, before the intervention.

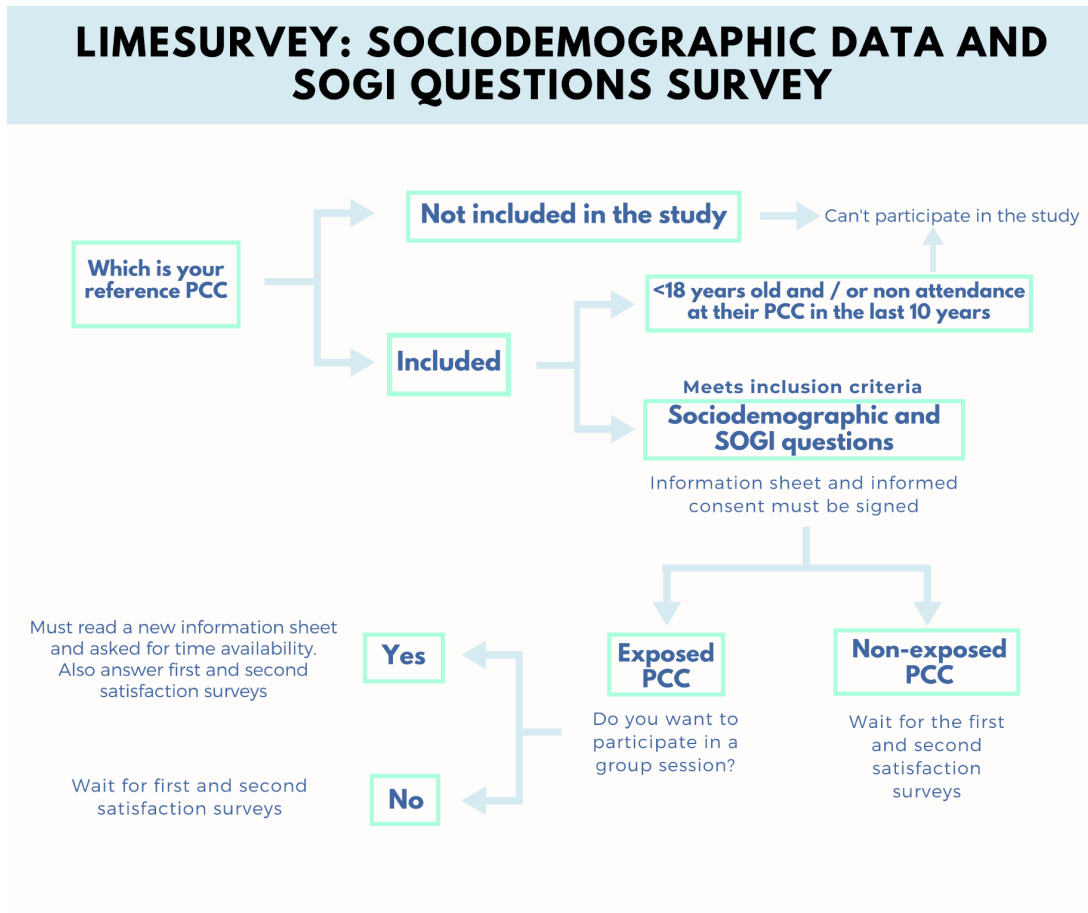


Figure 5. Summary of data collection through LimeSurvey

The patients, part of the exposed PCC, who agree on doing the group session will be again contacted and confirmed to participate in the narrative medicine session, proposing a schedule regarding their mentioned preferences, and separating the groups by time preference. It is expected to reach a maximum average of 14 participants per exposed centre.

Whenever we have all the sample recruited, the first PLAENSA survey will be sent to all participants to obtain answers on satisfaction, discrimination for SOGI and frequentation at their PCC. This will be done through LimeSurvey and also the physical option will be available at their PCC. The answers to these surveys will achieve the secondary objective regarding the discrimination felt by the participants and the overall satisfaction of LGBTIQ+ patients with their PCC in the Girona Health Region.

Participants will have a month to answer the PLAENSA survey, after that, the narrative medicine group sessions with the patients will be carried out on the schedules suggested and accepted by participants. For a better understanding, the intervention will be explained hereunder, combined with the resting explanations for the data collection.

Intervention

When previously explained all about narrative medicine, several studies, although proving very promising results and an impressive set of developed skills, presented the problem that some research and protocol elaboration is still missing. In this study, following all the researched bases and the main aims of narrative medicine, a new kind of intervention is designed.

The study intervention is mainly centred on the sessions with the professionals, but to get there, we must prepare a previous narrative medicine session that will work as data collection for the intervention.

The aim of the two sessions division, appeals to the need for anonymity, the creation of a safer space for each group, the advantages of more fruitful debates between similar communities, and the possibility of, in the future, using the results of this first phase and being able to apply only the intervention to the desired number of centres, as could be the scope of the whole Catalan territory.

Therefore, both sessions will be explained below:

Data collection for the intervention: *Narrative medicine applied to LGBTIQ+ patients*

We will already have the agreeing participants from the exposed group divided by time preference, this way we will have the groups for each centre, getting this way, the maximum participation we can, as nowadays, time is very limiting and could lead to a major percentage of withdrawal (42). Evidence has shown that 5–7 people per group is the best amount of people to conduct a narrative medicine session (23). If all the groups have the ideal number of participants, we estimate an average of 2 groups per PCC, meaning a maximum of 12 sessions with the patients in total.

Of course, an expert (with major studies like a master on narrative medicine or medical humanities), is required to conduct these sessions. They might need to be carried out at the same centre, at the Centre Civic or a place courtesy of local organisations. This consists of a four-part session:

- ▶ Before starting the intervention, it is critical to have all the Informed Consent Forms signed and an extra verbal consent for the session recording.
- ▶ Initially, it must start with a presentation and a creation of a safe space, asking all the participants for secrecy, non-judgement and respect. After this safer atmosphere is settled, some poems or short stories regarding LGBTIQ+ accessing healthcare will be read out loud (ANNEX 5 shows some examples, but they can be different).

- ▶ After that, the conductor will open up a debate about how they felt when they heard/read those stories or poems and ask them to share their feelings on this subject, mediating a conversation about how they perceive access to healthcare. This shall last a maximum of 30 minutes. This debate will increase the feeling of a safe space, and might them feel understood and listened, as most of them might have similar opinions and experiences. As a community, they might feel supported and will be respectful to each other.
- ▶ Then the conductor will bring up some papers and pens and ask the participants to write about an experience, a story, or something they have seen or felt while being LGBTIQ+ patients in public healthcare and how they think it could have been avoided. Anything is welcome as long as it includes reflexive writing. Anyone who knows how to write is valid for this exercise, mistakes are not important. This will not take more than 40 minutes.
- ▶ Finally, the participants who decide to read out loud these texts in a non-judgmental and safe space will have the opportunity to do so. This is very significant because like that it will be easier for them to open up and understand each other, bringing out empathy.

When the sessions are concluded, the study coordinators in collaboration with the narrative medicine expert will read through the data. The aim of this period, is to read all the texts written by the participants, edit them to be anonymous, prepare a selection that includes contrasting experiences and from different groups of the LGBTIQ+ community (i.e. if there are two gay men who explain similar stories, choose only one) and create a plan for future interventions regarding the centre's professionals. Mainly, the anonymous texts must be classified and divided by centres and experiences.

Intervention: *Narrative medicine applied to the PCC professionals:*

In each chosen centre, its respective employees will be categorised by their job position and then randomly distributed by groups of 7–10 people (those groups should always include at least one person from each professional category).

All these groups will be scheduled to have a 1-hour session during working hours, preferably from 14-15h, as it includes both morning and afternoon shifts. If we count on a medium of 50 professionals per centre, we will be doing 5–7 sessions per centre and a maximum of 42 in total. To increase attendance, a 2-day getaway trip to the Pyrenees with accommodation, diets, and activities expenses covered, will be raffled among the professionals participating in the sessions, as proven by several studies ([24](#), [31](#)).

This session, also conducted by an expert or a trainee in narrative medicine, has two main parts:

- ▶ Before starting anything, it is very important to have all the Informed Consent Forms signed and an extra verbal consent for the recording of the session. It is essential to make them understand that this is not an attack, but an opportunity to grow as professionals and health care practitioners.
- ▶ The conductor will read out loud the texts written by the patients in the first phase, selected to have different perspectives and different possible solutions, they must be from patients from other centres to guarantee anonymity. Copies will also be distributed to each participant if they want to read them by themselves or out loud. This part might take 10–20 minutes, depending on the length of the stories and the comments made by the professionals.
- ▶ After that, the conductor will open up a debate on how they felt when they heard/read those texts and will mediate the conversation. This shall last for the rest of the session. This is the main point in the study, as there will be representations of different points of view in patient care, the debate will be richer, and this is where empathy and self-reflection are supposed to start. Where also, the patients' ideas for avoiding those situations can help the professionals understand and do something about it.
- ▶ In the end, the conductor will recommend the professionals there to write their own reflective story or poem on their account and offer the possibility for it to be sent to the study coordinators as feedback.

This second phase of the intervention will be carried out on the PCC (increases attendance since it is their workplace). All the data collected in these sessions will also be managed by the study coordinators and the narrative medicine expert, since the recordings can be listened to create a document with the main points, main inquiries and opinions detailed, for a better understanding of their point of view.

Data collection after the intervention

When the intervention is finished, the study coordinators must send an email or SMS gradually to all participants (to avoid them all going at the same time), including the control group, to remember them to attend their PCC on the next 6 months to assess if there are any changes. This is intended to let the patients visit freely their respective centres, and to let a natural period of time sink in every professional, after their session. It is important to wait for 5 weeks if they have not answered and contact them again.

Finally, a year after the first survey, a second PLAENSA survey, and 6 months after the intervention, including the frequentation and discrimination questions, will be sent the same way as the first one to all participants, the same who answered the first PLAENSA survey, to assess their actual satisfaction with their PCC. Also, this second survey will achieve the secondary objective regarding the frequentation at their centres by the participants. This must be reminded one month's notice, and to increase participation, a 4-day trip to Malta with half board accommodation, transportation, and activities for two people will be raffled between participants answering this second survey ([24](#), [31](#)).

After this month's period for the participants to answer, the results will be managed and analysed by the statistical analyst to see if there are any differences between the control group and the exposed group, and the same patients during the 1-year period that passed between both surveys. A second consent form will not be required, since it is assumed that the first one will still be of use. The next months will be used to analyse all data and elaborate an article to be published.

STATISTICAL ANALYSIS

The statistical analysis will be performed by a statistical analyst.

Descriptive analysis

The dependent variable, which is satisfaction, will be summarised using medians and interquartile range (IQR) since they are quantitative discrete variables (i.e. score). The secondary dependent variables are categoric and will be described by N (%) as relative and absolute frequencies.

This analysis will be stratified by the intervened centre and the control centre.

Additional stratification will be done by the covariates.

Bivariate analysis

The difference in medians between the subjects assigned to the intervened or control PCC, will be tested using Mann-Whitney's U test for the continuous variables and CHI2 for the categoric variables.

To assess if the dependent variables significantly changed after the intervention we will use the Friedman test for VARIABLE CONTINUES and the McNemmar test for categorical variables.

These tests will be stratified by the covariates.

Multivariate analysis

Finally, multivariate models will be used to adjust for possible confounding. The effect of the intervention on satisfaction will be assessed through a mixed model adjusted by covariates, where the random factor is the individual.

These analyses will be done using the R or its amicable interface JAMOVI.

We will set a p-value of $p < 0.05$ as statistically significant, defining a 95% confidence interval for all analyses.

WORK PLAN

STAGE 0: Study design and bibliographic research (June 2023 – July 2023)

- ▶ 1st step: The study coordinator (SC) will initiate bibliographic research to start defining the aim of the study and the hypothesis. This research will be performed mainly in PubMed and will be focused on LGBTIQ+ healthcare, inequalities, satisfaction studies and narrative medicine.
- ▶ 2nd step: Study protocol will be developed, and it will include all the information about it, specifically: variables, objectives and the analytical framework. All of it is subjected to court modifications.

STAGE 1: Ethical evaluation (August 2023)

- ▶ The protocol will be submitted to the Comitè Ètic d'Investigació Clínica (CEIC) at Institut Universitari d'Investigació en Atenció Primària (IDIAP) Jordi Gol, for its revision and approval, all suggested variation will be considered.

STAGE 2: Initial coordination (September 2023 – December 2023)

- ▶ 3rd step: Choosing the centres that will participate in the intervention. This needs someone who prepares the selection and contacts them, it can be the SC. Also, this person needs to know what the study is about in case they have any doubts.

STAGE 3: Recruitment of participants and initial data collection (December 2023 – March 2024)

- ▶ 4th step (December–February): This requires posters and infographics being sent and posted on the centres, and other LGBTIQ+ local organisations ([ANNEX 2](#)), starting to ask people to spread the word (snowball method) and print Informed Consent Forms and Sociodemographic and SOGI questionnaires, that need to be in the front desk of all the PCC in case someone asks. The administrative personal needs to be informed what to do if someone requests one and where to put them (ballot box).
 - ▷ Participants from the chosen PCC must be reached out and asked to be part of the study.
- ▶ 5th step (March): the PLAENSA survey must be sent through their desired contact method, and also it must be printed and available at all centres if necessary. Schedules regarding the narrative medicine interventions must be sent and confirmed by the participants.

STAGE 4: Intervention part 1 (April 2024 – August 2024)

- ▶ 6th step (April–June): Data collection sessions of narrative medicine will be carried out on LGBTIQ+ patients. A narrative medicine expert is needed to conduct the sessions, this includes travelling commutes and diets.
- ▶ 7th step (July–August): Texts must be chosen and eliminate all the details that can compromise anonymity. This should be done by the same expert and aided by the study coordinators.

STAGE 5: Intervention part 2 (September 2024 – December 2024)

- ▶ 8th step (September–November): Sessions of narrative medicine will be carried out on the PCC professionals during their work hours. A narrative medicine expert or trainee is needed to conduct the sessions, this includes travelling commutes and diets.
- ▶ 9th step (December): Data collected by the recordings and possible texts sent can be managed and summarised. This could be done by the same expert and aided by the study coordinators. During the next months, SC must remind every participant to attend their PCC to assess some differences.

STAGE 6: Follow-up (May 2025 – July 2025)

- ▶ 10th step (May): PLAENSA survey must be sent again to all participants, and they must be reminded one month in advance. It must be sent through their desired contact method, and also it must be printed and available at all centres if necessary.
- ▶ 11th step (June): The data analyst must manage and analyse all data regarding both surveys and perform a univariate, bivariate and incidence rate analysis.
- ▶ 12th step (July): Whenever all data would be analysed, the results will be commented on and discussed with the team in a meeting.

STAGE 7: Article elaboration, publication, and divulgation of the results (July 2025 – October 2025)

- ▶ 13th step: Results obtained will be presented in an article with the corresponding structure. The article will be sent to different journals for publication. Dissemination of the findings in conferences and congresses related to Primary Care.
If they so wish, patients will receive the article with the published results.

Chronogram is displayed in *Table 2*.

Table 2. Chronogram of the study

DATE	2023							2024												2025								
	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN –APR	MAY	JUN	JUL	AUG	SEP	OCT		
STAGE 0: Study design and bibliographic research																												
Research																												
Elaboration of protocol																												
STAGE 1: Ethical evaluation																												
CEIC approval																												
STAGE 2: Initial coordination																												
Centre choosing																												
STAGE 3: Recruitment of participants and initial data collection																												
Sample recruitment																												
Survey																												
STAGE 4: Intervention part 1																												
Sessions																												
Intervention prep.																												
STAGE 5: Intervention part 2																												
Sessions																												
Analysis																												
STAGE 6: Follow-up																												
Survey																												
Analysis																												
Results discussion																												
STAGE 7: Article elaboration, publication, and divulgation of the results																												
Elaboration and publication																												

IMPACT ON NATIONAL HEALTH SYSTEM

The main impact expected during this study is the creation of a new, respectful and caring environment for the LGBTIQ+ patients. The fact that the intervention is planned on all the professionals of the centres, increases the possibility for the patients to feel welcome at all places.

This brings us to believe that they will be going to their appointments, increasing frequentation, and this will delve into preventive medicine and follow-up on their health issues.

As it is designed, it gives patients the ability to speak for themselves, without the pressure of the system, and empowers them to render their real opinion and appeal to the empathy of the professionals who care for them.

From this topic and some objectives previously mentioned, we could even prepare one or two more articles, regarding their experiences with the system, their usual frequentation to the PCC or even the discrimination felt.

In case the results were highly positive, and the professionals were welcoming and excited about it, it could be extrapolated to all of Catalonia or even Spain, just doing the intervention as the first data collection phase has enough variety to be representative. Narrative medicine sessions, like the ones designed here, could be done at any PCC that asks for it and impact lots of lives.

Also, as the non-discrimination law in both Catalonia and Spain indicates, this project could contribute to complying with it. Incorporating the specific needs of the LGBTIQ+ collective, guaranteeing the right to receive healthcare and health services in objective conditions of equality, by creating a protocol with a specific action ([13](#), [43](#)).

ETHICAL CONSIDERATIONS

This protocol will be carried out in accordance with the requirements expressed in the Declaration of Helsinki. Furthermore, it will be presented to the CEIC of the Institut Universitari D'Investigació en Atenció Primària Jordi Gol (IDIAPJGol) for the evaluation and approval of the legal aspects of this project. If there are any suggestions in this regard, the study will be modified as necessary.

Every participant will receive the information sheet and will be required to sign the informed consent form ([ANNEX 4](#)). The freedom to participate shall be guaranteed, and participants shall be treated with dignity and respect for their autonomy to stop participating in the research at any time, understanding that this would be better for them, without any prejudice.

In terms of the risks and benefits of the study, this research does not involve physical or psychological risks, nor does it have institutional implications for the participants. The main potential benefit is that the knowledge derived from this study will contribute to a better understanding of the experiences and feelings of the LGBTIQ+ community regarding their primary care attention.

The processing of data collected by this study will be carried out in compliance with Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016, on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (Reglamento General de Protección de Datos [RGPD]), and the Organic Law 3/2018, on Data Protection and the guarantee of digital rights.

The data protection plan is discussed below:

Data to be processed and formatted:

Data will be coded. All session groups will be identified with a code, represented by sequential numbers. The coding of interviews will prevent the participants of the study from being identified; at the same time, during the recording, the person will not be named by name or surname, or any personal data that can be linked to the participants, in order to preserve their identity. The audio recordings of the interviews and their transcriptions will be stored on a tablet-type electronic device belonging to a designed PCC, which will be protected physically under lock and key and electronically by means of the centre's own internet security system. This data will be stored in encrypted form (i.e. accessible through a password) for five years on the ICS servers and then destroyed.

Who will process the data?

The data controller is the ICS.

On the basis of legitimacy:

Informed consent will be requested (Additional provision 17.2.a LOPD-GDD).

IT tools:

Data will be stored on an ICS server. The research team will not carry out any exchange of this data with other actors, therefore no platform such as Google Drive, WeTransfer, Dropbox, etc. will not be used. The data will be stored in a coded Excel spreadsheet (accessible through a password) and then statistical software will be used to analyse the encrypted data (without any personal data).

International transfer of data:

No international transfer will take place in the framework of this project.

High-risk processing:

This study does not include any of the following high-risk situations for data processing: neither data profiling nor data or automated decision-making, the use of artificial intelligence tools nor the use of data mining techniques with Big Data technologies, nor the use of biometric systems, nor use of geolocation systems. In accordance with the established article 35 of the RGPD, the project does not have the necessary characteristics to require the corresponding impact assessment to be carried out.

Information and consent form

These are attached in [Annex 4](#).

Participants may exercise their rights of access, rectification, deletion, opposition, limitation of processing and portability of data (LOPD-GDD), by contacting directly with the principal investigator of the project and may contact the Data Protection Delegate through email dpd@ticsalutsocial.cat.

In conclusion, autonomy, beneficence, no malevolence and justice will be considered in every step of the study.

BUDGET

In this study, the budget regarded, includes all the possible expenses that would be necessary to carry it through, such as personnel expenses, necessary purchases to execute the data collection and other costs (publication expenses, printing surveys and forms...).

1. Personnel expenses:

Personnel needed to be hired additionally for the research project are:

- ▷ Statistical analyst: Calculating a 40€ hourly rate and 30-hour task for analysing all survey data, it would sum up to 1200€.
- ▷ Narrative medicine expert or trainee: that will carry on with all sessions and will evaluate and choose the texts. Calculating a 40€ hourly rate, including all commutes and sessions and analysis, it would raise up to 230h, so 9200€ in total.
- ▷ 2 study coordinators: needed to organise everything, send and reach out the surveys, and schedules, and answer questions on all participants. Calculating a 40€ hourly rate, doing something about 50h each, it would be 4000€.

2. Execution expenses:

- ▷ The articles and publications consulted for the development of this study had non-additional costs.
- ▷ The petrol used by the narrative medicine expert when travelling to the different PCC in the Girona Health Region in order to carry out the sessions will be paid at 0.5 cents per km. It has been calculated an amount of 2500 km, which sums up to 1250€.
- ▷ The narrative medicine expert's diets must also be taken into account. All sessions must take an amount of 54 days. Counting 15€ per meal, it might reach up to 810€.
- ▷ It has been decided to bring food and snacks at every session to encourage participants to be part of it, so if we count an amount of <54 sessions, and count 20€ for each set, it would sum up to 1080€.

3. Publication expenses:

- ▷ We assume the costs of reviewing, editing, formatting and preparing the digital data will be 2000€ when publishing the results of the study in Open Access. If we count on publishing 2 more articles, this would reach 6000€. And if we want to publish on another journal it can get to 3000€ more.

- ▷ If decided to be presented at a National Congress, the expenses involved would be approximately 1000€.
- ▷ A linguistic correction is needed for each article, so at a 150€ rate for each study, it could reach 450€.

4. Other expenses:

- ▷ Printing about 400–600 copies of the physical surveys, information and consent forms, and texts, this would reach 60€.
- ▷ Bringing pens for the patients to write in, to each session, might reach 10€.
- ▷ Printing about 72 posters to post on the PCC participating, might reach 72€.
- ▷ Printing an amount of 600 infographics (having 20 per centre), might reach 1800€.
- ▷ Transportation, half board accommodation and some activities expenses covered trip to Malta for 4 days and 2 people will be raffled among all participants that fulfil both surveys, and that would mean an expense of 700€.
- ▷ An all-expenses covered 2-day getaway in the Pyrenees for 2 people will be raffled among all the professionals participating in the sessions, which would mean an expense of 300€.

The total would reach an amount of 30.932€ as summarised in *Table 3* below.

Table 3. Budget summary for the study

ITEM	UNIT COST	HOURS/UNIT	TOTAL
Personnel expenses			
<i>Statistical analyst</i>	40€	30h	1200€
<i>Narrative medicine expert</i>	40€	<230h	<9200€
<i>2 Study coordinators</i>	40€	50h each	4000€
Execution expenses			
<i>Travel by car</i>	0.5 cents/km	2500 km	1250€
<i>Expert's diets</i>	15€/day	54 days	810€
<i>Food for each session</i>	20€/session	54 sessions	1080€
Publication expenses			
<i>Linguistic correction</i>	150€	1-3	<450€
<i>Article publication</i>			
<i>Open Access</i>	2000€	1-3	<6000€
<i>Other journals</i>	1000€	1-3	<3000€
<i>National Congress</i>	1000€	1	1000€
Other costs			
<i>Copies</i>	0.1 cents/copy	<600 copies	<60€
<i>Pens</i>	0.5€/pen	20 pens	10€
<i>Posters</i>	1€/DINA4 poster	72 copies	72€
<i>Infographics</i>	3€	600 units	1800€
<i>Malta travel</i>	700€	1 (includes 2 people)	700€
<i>Pyrenees getaway</i>	300€	1 (includes 2 people)	300€
TOTAL			30.932€

STRENGTHS AND LIMITATIONS OF THE STUDY

Limitations

Selection bias: as the object of study is a hidden population, the sample cannot be chosen randomly, therefore there is this selection bias. Anyway, the way this study is designed, and the fact that almost everything can be done online, provides far greater privacy; which is good for this population. Also, all data will be coded, guaranteeing as much privacy as possible, leading to a major number of participants in comparison to not doing it this way.

Since the LGBTIQ+ collective is very diversified, it will be very difficult to get a full representation of each subgroup, this community is as varied as humankind. As the groups will be created by time availability, they might never fully represent the community, but having that many groups and participants, trying to reach out to as many people as possible, we hope to get close to a real representation.

It is important to notice, that the PCC participating in this study, will have agreed previously and that is a problem since it suggests more predisposition and possibly less usual discrimination towards the collective, limiting the external validity.

Also, an influential withdrawal factor could be that the control group does not hear from the study investigators for a year and might not want or remember to answer again, a month's notice will be carried out to avoid forgetting individuals.

To minimise this bias, two trips have been purchased to do a raffle between the participants, one for the patients (a 4-day trip to Malta for 2 people) and one for the professionals (a 2-day getaway trip to the Pyrenees for two people). We hope this will motivate and recruit more participants.

The centres will not be categorised by the socioeconomic status of the patients, as the intervention is centred on the professionals in this study and not the patients.

Information bias: it is significant to notice the fact that almost no professionals are trained in narrative medicine or close reading. To have an excellent development of these sessions, it would be better to train everyone in it, even the patients. This would take a lot of money and time, therefore, to minimise the bias, the conductor of the session must be trained in narrative medicine, getting more accurate results, and helping the participants go through it.

The fact that it is a recent field of study, and there are not many evidence-based protocols, could lead to a non-professional intervention or poor results. But at the same time, doing more studies on it will get more evidence and new protocols, or at least engage more people to do so.

Honesty bias could appear whenever the participants answer any survey or write the texts or participate in any debate. To minimise this limitation, the creation of a non-judging safe space, and the possibility to do the surveys at home, might let them be more honest and true to their answers.

Strengths

Narrative medicine is a novel methodology, and it has not really been explored in Spain as much as it has been in the U.S. or the U.K. bringing us the chance to explore a new way of healthcare attention, combined with the previous ones. Narrative medicine gives the closeness and empathy that the LGBTIQ+ community needs to be heard and understood, it gives them the chance to be open about their worries and validate their feelings. Therefore, opens the minds of a big amount of healthcare professionals and provides a self-reflection that simple training never could. It appeals to their empathy and their humanity, and it could have a real impact on their way of dealing with patients.

The fact that the chosen centres are quite representative of a Health Region, gives this study the external validity to bring it to a higher population of a higher sample, using directly the intervention phase to apply it in all other PCC in Catalonia.

If the author and part of the investigation team were part of the LGBTIQ+ community or experienced the narrative medicine method on their own (as this could be the case), they would have the first-hand knowledge and sensitivity to solve the study objectives in an effective, caring and non-stigmatising way.

FEASIBILITY

As previously mentioned, narrative medicine studies are as feasible as any other kind of intervention studies ([21](#), [26](#), [31](#)). Even though we need a person trained in narrative medicine, all the other actions and needs are the same as any other Primary Care or community intervention study.

This study will take place in Girona's Sanitary Region, as it is a very reachable area and representative of the country. Most of the time, the PCC in this region are willing to participate in these actions and always want to improve their care.

No complimentary tests will be necessary beyond the ones that are commonly performed in Primary Care Assistance.

In conclusion, we think that the study is more than feasible and the benefit will outshine all the possible complications.

As it is a non-expensive study and not very long, offering a great change in the system is worth this amount of time and money.

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ANNEX 1

(CAT) **Pla d'enquestes de percepció, experiència i satisfacció d'usuaris del Servei Català de la Salut**

Atenció primària: medicina familiar i infermeria comunitària

P1. Què opina dels diversos canals que es posen a la seva disposició per a rebre atenció del CAP/Centre d'Atenció Primària?

- ▶ Perfecte
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P2. Què opina de la facilitat perquè li donin visita pel dia que a vostè li va bé?

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P3. Tenint en compte l'hora de visita que li han donat, què li sembla la puntualitat perquè l'atenguin?

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P4. Valori el soroll que hi ha habitualment a la sala d'espera.

- ▶ Gens
- ▶ Poc
- ▶ Normal
- ▶ Força
- ▶ Molt

P5. Quina impressió té de la neteja del CAP/Centre d'Atenció Primària?

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P6. Què opina del temps que li dedica el/la metge/essa quan l'atén?

- ▶ Perfecte
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P7. Quina disposició té el/la metge/essa per escoltar-lo i fer-se càrrec del que a vostè li preocupa de la seva salut?

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P8. Què li sembla la predisposició del/la metge/essa perquè vostè pugui donar la seva opinió?

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P9. El/la metge/essa li dona la informació que necessita sobre la seva malaltia, el tractament que fa, etc.?

- ▶ Sempre
- ▶ Gairebé sempre
- ▶ Sovint
- ▶ Poques vegades
- ▶ Mai/gairebé mai

P10. El/la metge/essa li dona la informació de manera que pugui entendre-la?

- ▶ Sempre
- ▶ Gairebé sempre
- ▶ Sovint
- ▶ Poques vegades
- ▶ Mai/gairebé mai

P11. Té la sensació d'estar en bones mans?

- ▶ Sempre
- ▶ Gairebé sempre
- ▶ Sovint
- ▶ Poques vegades
- ▶ Mai/gairebé mai

P12. Com valora el tracte, amabilitat, que té amb vostè el/la metge/essa?

- ▶ Perfecte
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P13. Quina disposició té l'/la infermer/a per escoltar-lo i fer-se càrrec del que a vostè li preocupa

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament
- ▶ No he estat atès per infermeria (**Pregunta filtre: SI RESPONEN: No he estat atès per infermeria, directament enllaçar amb P16**)

P14. Com valora el tracte, amabilitat, que té amb vostè l'/la infermer/a?

- ▶ Perfecte
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P15. Té la sensació d'estar en bones mans?

- ▶ Sempre
- ▶ Gairebé sempre
- ▶ Sovint
- ▶ Poques vegades
- ▶ Mai/gairebé mai

P16. La informació que li donen els diferents professionals (personal mèdic i/o d'infermeria) sobre el seu problema de salut és coherent, és a dir, és coincident entre ella?

- ▶ Sempre
- ▶ Gairebé sempre
- ▶ Sovint
- ▶ Poques vegades
- ▶ Mai/gairebé mai

P17. Quan ha estat atès per l'/la especialista o l'hospital, els seus professionals del CAP/centre d'Atenció Primària tenen informació del que li han fet?

- ▶ Sempre
- ▶ Gairebé sempre
- ▶ Sovint
- ▶ Poques vegades
- ▶ Mai/gairebé mai

P18. Com valora l'atenció que rep del seu CAP/Centre d'Atenció Primària fora de l'horari habitual?

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P19. Com valora el tracte, amabilitat, que té amb vostè el personal administratiu?

- ▶ Perfecte
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P20. L'atenció que ha rebut en el seu CAP/Centre d'Atenció Primària, li ha permès mantenir i/o controlar el seu estat de salut?

- ▶ Perfectament
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P21. Com valora l'atenció que rep del seu CAP/Centre d'Atenció Primària quan l'han atès presencialment?

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P22. Com valora l'atenció que rep del seu CAP/Centre d'Atenció Primària quan l'han atès per telèfon?

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P23. Com valora l'atenció que rep del seu CAP/Centre d'Atenció Primària quan l'han atès a través d'Internet (eConsulta)?

- ▶ Perfecta
- ▶ Molt bé
- ▶ Bé
- ▶ Regular
- ▶ Malament

P101. I ara per acabar, valori de 0 a 10 el seu grau de satisfacció global amb el seu CAP / ambulatori. (Si hagués de posar una nota del 0 al 10, quina nota li posaria? Tenint en compte que 0 vol dir gens satisfet i 10 molt satisfet.)

0	1	2	3	4	5	6	7	8	9	10
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P102. Si pogués triar, continuaria venint en aquest CAP/Centre d'Atenció Primària?

- ▶ Sí
- ▶ No n'estic segur/a
- ▶ No

P103. Alguna vegada s'ha sentit discriminat/da/di o jutjat/da/di per la seva orientació o identitat de gènere al seu CAP/Centre d'Atenció Primària?

- ▶ Sempre
- ▶ Gairebé sempre
- ▶ Sovint
- ▶ Poques vegades
- ▶ Mai/gairebé mai

P104. En l'últim any, quantes ha anat al CAP/Centre d'Atenció Primària?

- ▶ >5
- ▶ 4-5
- ▶ 3
- ▶ 2
- ▶ 1
- ▶ 0

(ES) Pla d'enquestes de percepció, experiència i satisfacció d'usuaris del Servei Català de la Salut

Atención primaria: medicina y enfermería familiar y comunitaria

P1. ¿Qué opina de distintos canales que se han puesto su disposición para recibir atención del CAP/Centro de Atención Primaria?

- ▶ Perfecto
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P2. ¿Qué opina de la facilidad para que le den visita para el día que a usted le va bien?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P3. Teniendo en cuenta la hora de visita que le han dado, ¿qué le parece la puntualidad en ser atendido?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P4. Valore el ruido que hay habitualmente en la sala de espera.

- ▶ Nada
- ▶ Poco
- ▶ Normal
- ▶ Bastante
- ▶ Mucho

P5. ¿Qué impresión tiene de la limpieza del CAP/Centro de Atención Primaria?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P6. ¿Qué opina del tiempo que le dedica el/la médico/a cuando le visita?

- ▶ Perfecto
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P7. ¿Qué disposición tiene el/la médico/a para escuchar y comprender lo que le preocupa de su salud?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P8. ¿Qué le parece la predisposición del/la médico/a para que usted pueda dar su opinión?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P9. ¿El/la médico/a le da la información que necesita sobre su enfermedad, el tratamiento que hace, etc.?

- ▶ Siempre
- ▶ Casi siempre
- ▶ A menudo
- ▶ Pocas veces
- ▶ Nunca/casi nunca

P10. ¿El/La médico/a le da la información de manera que pueda entenderla?

- ▶ Siempre
- ▶ Casi siempre
- ▶ A menudo
- ▶ Pocas veces
- ▶ Nunca/casi nunca

P11. ¿Tiene la sensación de estar en buenas manos?

- ▶ Siempre
- ▶ Casi siempre
- ▶ A menudo
- ▶ Pocas veces
- ▶ Nunca/casi nunca

P12. ¿Cómo valora el trato, amabilidad, que tiene con usted el/la médico/a?

- ▶ Perfecto
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P13. ¿Qué disposición tiene el/la enfermero/a para escucharle y comprender lo que a usted le preocupa de su salud?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal
- ▶ No he sido atendido por enfermería (**Pregunta filtro: SI RESPONDE: No me ha atendido el personal de enfermería, enlazar con P16**)

P14. ¿Cómo valora el trato, amabilidad, que tiene con usted la/el enfermera/o?

- ▶ Perfecto
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P15. ¿Tiene la sensación de estar en buenas manos?

- ▶ Siempre
- ▶ Casi siempre
- ▶ A menudo
- ▶ Pocas veces
- ▶ Nunca/casi nunca

P16. ¿La información que le dan los diferentes profesionales (personal médico o de enfermería) sobre su problema de salud, es coherente, es decir, es coincidente entre ella?

- ▶ Siempre
- ▶ Casi siempre
- ▶ A menudo
- ▶ Pocas veces
- ▶ Nunca/casi nunca

P17. Cuando le ha atendido el/la especialista o en el hospital, sus profesionales del CAP/Centro de Atención Primaria tienen información de lo que le han hecho?

- ▶ Siempre
- ▶ Casi siempre
- ▶ A menudo
- ▶ Pocas veces
- ▶ Nunca/casi nunca

P18. ¿Cómo valora la atención que recibe en su CAP/Centro de Atención Primaria fuera del horario habitual?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P19. ¿Cómo valora el trato, amabilidad, que tiene con usted el personal administrativo?

- ▶ Perfecto
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P20. La atención que ha recibido en el CAP/Centro de Atención Primaria en los últimos 12 meses, ¿considera que le han permitido o facilitado mantener o controlar su estado de salud?

- ▶ Perfectamente
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P21. ¿Cómo valora la atención que recibe en su CAP/Centro de Atención Primaria cuando le han atendido presencialmente?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P22. ¿Cómo valora la atención que recibe en su CAP/Centro de Atención Primaria cuando le han atendido por teléfono?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P23. ¿Cómo valora la atención que recibe en su CAP/Centro de Atención Primaria cuando le han atendido a través de Internet (eConsulta)?

- ▶ Perfecta
- ▶ Muy bien
- ▶ Bien
- ▶ Regular
- ▶ Mal

P101. Y ahora, para acabar, valore su satisfacción global con su CAP/ ambulatorio (Si tuviese que poner una nota del 0 al 10, ¿qué nota le pondría? Teniendo en cuenta que 0 sería nada satisfecho y 10 muy satisfecho).

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

P102. ¿Si pudiese escoger, volvería a este CAP/ ambulatorio?

- ▶ Si
- ▶ No estoy seguro/a
- ▶ No

P103. ¿Alguna vez se ha sentido discriminadx o juzgadxx por su orientación sexual o identidad de género en su CAP/Centro de Atención Primaria?

- ▶ Siempre
- ▶ Casi siempre
- ▶ A menudo
- ▶ Pocas veces
- ▶ Nunca/casi nunca

P104. En el último año, ¿Cuántas veces ha ido al CAP/Centro de Atención Primaria?

- ▶ >5
- ▶ 4-5
- ▶ 3
- ▶ 2
- ▶ 1
- ▶ 0

ANNEX 2

Posters

PROUD STORIES PROJECT

FORMES PART DEL COL·LECTIU LGBTIQ+ I VOLS PARTICIPAR EN UN ESTUDI?

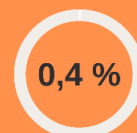


El col·lectiu LGBTIQ+ pateix discriminacions i prejudicis en el món de la salut des de fa anys, i l'evidència ha demostrat que això redueix la seva assistència als CAPs i per tant una pitjor prevenció de la seva salut.

"L'estigma, els prejudicis i la discriminació poden portar a la població LGBTIQ+ a un increment de problemes físics i mentals en comparació a la no LGBTIQ+."



En les últimes enquestes internacionals, fins a un 20% dels participants indicava formar part del col·lectiu



Tot i així, només un 0,4% dels projectes finançats per l'Estat, inclouen el col·lectiu

Les enquestes de satisfacció de l'ICS, en cap moment van incloure la identitat de gènere o la orientació sexual com una variable rellevant d'estudi

PROUD STORIES PROJECT PRETÉN AVALUAR I DONAR VEU A LA SATISFACCIÓ DELS PACIENTS LGBTIQ+ EN ELS CAPs DE GIRONA

QUÈ HAIG DE FER PER PARTICIPAR?

Si....

- T'identifiques com a part del col·lectiu LGBTIQ+
- Tens més de 18 anys
- Has utilitzat els serveis del CAP en els últims 10 anys
- Tens el CAP a la província de Girona

I vols formar part d'aquest estudi...

CATALÀ



ESPANYOL



Inscriu-te en el següent codi QR i completa l'enquesta per poder formar-ne part!

Per més informació, enviar correu a: cdeblas.girona.ics@gencat.cat

Infographics

PROUD STORIES PROJECT

FORMES PART DEL COL·LECTIU
LGBTIQ+ I VOLS PARTICIPAR EN
UN ESTUDI?



El col·lectiu LGBTIQ+ pateix discriminacions i prejudicis en el món de la salut des de fa anys, i l'evidència ha demostrat que això redueix la seva assistència als CAPs i per tant una pitjor prevenció de la seva salut.

"L'estigma, els prejudicis i la discriminació poden portar a la població LGBTIQ+ a un increment de problemes físics i mentals en comparació a la no LGBTIQ+."

20 %

En les últimes enquestes internacionals, fins a un 20% dels participants indicava formar part del col·lectiu

0,4 %

Tot i així, només un 0,4% dels projectes finançats per l'Estat, incloïen el col·lectiu

Les enquestes de satisfacció de l'ICS, en cap moment van incloure la identitat de gènere o la orientació sexual com una variable rellevant d'estudi

**PROUD STORIES PROJECT
PRETÉN AVALUAR I DONAR
VEU A LA SATISFACCIÓ DELS
PACIENTS LGBTIQ+ EN ELS
CAPs DE GIRONA**



QUÈ HAIG DE FER PER PARTICIPAR?

Si....

- T'identifiques com a part del col·lectiu LGBTIQ+
- Tens més de 18 anys
- Has utilitzat els serveis del CAP en els últims 10 anys
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I vols formar part d'aquest estudi...

Inscriu-te en el següent codi QR i completa l'enquesta per poder formar-ne part!

CATALÀ



ESPANYOL



Per més informació, enviar correu a:
cdeblas.girona.ics@gencat.cat

ANNEX 3

This annex contains:

- ▶ Information sheet for all the participants: in [Catalan](#) and in [Spanish](#).
- ▶ Information sheet for the patients doing the group session: in [Catalan](#) and in [Spanish](#).
- ▶ Information sheet for the professionals: in [Catalan](#) and in [Spanish](#).
- ▶ Informed consent form for the participants in the sessions: in [Catalan](#) and in [Spanish](#).
- ▶ Informed consent form for the participants only answering surveys: in [Catalan](#) and in [Spanish](#).

Full d'informació per a pacients (CAT)

Títol de l'estudi: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Em dirigeixo a vostè per convidar-lo a participar en un estudi d'investigació sobre atenció a les persones LGBTIQ+ i la seva satisfacció amb el seu CAP. Aquest estudi pretén avaluar la satisfacció dels pacients LGBTIQ+ en el seu sistema sanitari. La participació en aquest estudi és totalment voluntària, i podrà abandonar-lo en qualsevol moment, sense que això alteri la relació amb el professional sanitari ni es produeixi cap mena de perjudici en la seva assistència sanitària. El lloc de realització podrà ser el CAP, centre cívic o altres ubicacions.

Els objectius de l'estudi són:

- Valorar la satisfacció dels pacients LGBTIQ+ després d'una intervenció de narrativa mèdica als professionals del seu CAP. Comparant-la amb la seva satisfacció prèvia a la intervenció i amb no fer-ho.
- Determinar la satisfacció general dels pacients LGBTIQ+ amb els seus CAPs.
- Determinar la percepció dels pacients LGBTIQ+ de la discriminació als CAPs.
- Calcular si hi ha un increment de la freqüentació dels pacients LGBTIQ+ als seus CAPs després de la intervenció.

La recollida i anàlisi posterior de totes aquestes dades es durà a terme en compliment del Reglament (UE) 2016/679 del *Parlament Europeu i de Consell, de 27 d'abril de 2016*, relatiu a la protecció de les persones físiques pel que fa al tractament de dades personals i a la lliure circulació d'aquestes dades (RGPD), i la Llei Orgànica 3/2018, de Protecció de Dades i garantia dels drets digitals, i per això li comuniquem que vostè podrà exercir els seus drets d'accés, rectificació, supressió, oposició, limitació del tractament i portabilitat de dades (LOPD-GDD) contactant directament amb l'investigador principal del projecte (Clara de Blas Llobet: cdeblas.girona.ics@gencat.cat). Pot contactar amb el Delegat de Protecció de Dades a través de dpd@ticsalutsocial.cat.

Amb la signatura d'aquest document vostè dona el seu consentiment de forma expressa a fi que les seves dades siguin tractades amb finalitats de recerca en el marc d'aquest Projecte, de conformitat amb l'article 6.1.a, 9.2.a del RGPD. Els enregistraments de les entrevistes s'esborraran després de transcriure-les i les transcripcions seran guardades pels investigadors durant cinc anys i després destruïdes

L'informem del seu dret a retirar el consentiment per al tractament d'aquestes dades en qualsevol moment mitjançant l'adreça de correu electrònic cdebla.girona.ics@gencat.cat, així com del seu dret a presentar una

reclamació davant de l'Autoritat Catalana de Protecció de Dades front qualsevol actuació del Responsable del Tractament que consideri que vulnera els seus drets.

Comunicacions de dades

No es preveuen comunicacions de dades, més enllà de les previstes legalment, i de tercers que hagin d'accedir-hi per a la prestació d'un servei en el marc del desenvolupament d'aquest projecte en la seva condició d'encarregats de tractament.

Transferències internacionals

No es preveuen transferències internacionals de dades

Full d'informació per a participants (CAT)

Títol de l'estudi: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Em dirigeixo a vostè per convidar-lo a participar en un estudi d'investigació sobre atenció a les persones LGBTIQ+ i la seva satisfacció amb el seu CAP. Aquest estudi pretén avaluar la satisfacció dels pacients LGBTIQ+ en el seu sistema sanitari. La participació en aquest estudi és totalment voluntària, i podrà abandonar-lo en qualsevol moment, sense que això alteri la relació amb el professional sanitari ni es produeixi cap mena de perjudici en la seva assistència sanitària. El lloc de realització podrà ser el CAP, centre cívic o altres ubicacions.

Els objectius de l'estudi són:

- Valorar la satisfacció dels pacients LGBTIQ+ després d'una intervenció de narrativa mèdica als professionals del seu CAP. Comparant-la amb la seva satisfacció prèvia a la intervenció i amb no fer-ho.
- Determinar la satisfacció general dels pacients LGBTIQ+ amb els seus CAPs.
- Determinar la percepció dels pacients LGBTIQ+ de la discriminació als CAPs.
- Calcular si hi ha un increment de la freqüentació dels pacients LGBTIQ+ als seus CAPs després de la intervenció.

A partir de sessions en grup s'elaborarà una selecció per identificar els temes principals amb relació a l'atenció i les experiències dels pacients LGBTIQ+ en l'àmbit d'Atenció Primària. La seva participació no representa cap risc per la seva salut i pot ajudar a planificar futures intervencions en promoció de la salut. La nostra intenció és que rebí la informació correcta i suficient per tal que pugui avaluar i jutjar si desitja o no participar.

La investigació presenta dues fases:

A la primera fase es realitzaran les sessions de grup. Les sessions es faran en un espai previst com el CAP, centre cívic o altres ubicacions properes al CAP, i tindran una durada aproximada de 60-120 minuts. Durant la sessió es duran a terme diferents activitats que poden incloure lectura de relats, escriptura d'històries curtes o poemes i la realització d'un debat. A la segona fase es farà l'anàlisi qualitativa de les sessions. Les gravacions de totes les entrevistes seran transcrites literalment (per garantir la confidencialitat de l'entrevistat, es retiraran totes les dades personals).

La recollida i anàlisi posterior de totes aquestes dades es durà a terme en compliment del Reglament (UE) 2016/679 del *Parlament Europeu i de Consell, de 27 d'abril de 2016*, relatiu a la protecció de les persones físiques pel que fa al tractament de dades personals i a la lliure circulació d'aquestes dades (RGPD), i la Llei Orgànica 3/2018, de Protecció de Dades i garantia dels drets digitals, i per això li comuniquem que vostè podrà exercir els seus drets d'accés, rectificació, supressió, oposició, limitació del tractament i portabilitat de dades (LOPD-GDD) contactant directament amb l'investigador principal del projecte (Clara de Blas Llobet: cdeblas.girona.ics@gencat.cat). Pot contactar amb el Delegat de Protecció de Dades a través de dpd@ticsalutsocial.cat.

Amb la signatura d'aquest document vostè dona el seu consentiment de forma expressa a fi que les seves dades siguin tractades amb finalitats de recerca en el marc d'aquest Projecte, de conformitat amb l'article 6.1.a, 9.2.a del RGPD. Els enregistraments de les entrevistes s'esborraran després de transcriure-les i les transcripcions seran guardades pels investigadors durant cinc anys i després destruïdes

L'informem del seu dret a retirar el consentiment per al tractament d'aquestes dades en qualsevol moment mitjançant l'adreça de correu electrònic cdebla.girona.ics@gencat.cat, així com del seu dret a presentar una reclamació davant de l'Autoritat Catalana de Protecció de Dades front qualsevol actuació del Responsable del Tractament que consideri que vulnera els seus drets.

Comunicacions de dades

No es preveuen comunicacions de dades, més enllà de les previstes legalment, i de tercers que hagin d'accedir-hi per a la prestació d'un servei en el marc del desenvolupament d'aquest projecte en la seva condició d'encarregats de tractament.

Transferències internacionals

No es preveuen transferències internacionals de dades

Full d'informació per a professionals (CAT)

Títol de l'estudi: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Em dirigeixo a vostè per convidar-lo a participar en un estudi d'investigació sobre atenció a les persones LGBTIQ+ i la seva satisfacció amb el seu CAP. Aquest estudi pretén avaluar la satisfacció dels pacients LGBTIQ+ en el seu sistema sanitari. La participació en aquest estudi és totalment voluntària, i podrà abandonar-lo en qualsevol moment, sense que això alteri la relació amb el professional sanitari ni es produeixi cap mena de perjudici en la seva assistència sanitària. El lloc de realització podrà ser el CAP, centre cívic o altres ubicacions.

Els objectius de l'estudi són:

- Valorar la satisfacció dels pacients LGBTIQ+ després d'una intervenció de narrativa mèdica als professionals del seu CAP. Comparant-la amb la seva satisfacció prèvia a la intervenció i amb no fer-ho.
- Determinar la satisfacció general dels pacients LGBTIQ+ amb els seus CAPs.
- Determinar la percepció dels pacients LGBTIQ+ de la discriminació als CAPs.
- Calcular si hi ha un increment de la freqüentació dels pacients LGBTIQ+ als seus CAPs després de la intervenció.

A partir de sessions en grup s'elaborarà una anàlisi per identificar els temes principals amb relació a l'atenció i les experiències dels pacients LGBTIQ+ en l'àmbit d'Atenció Primària. La seva participació no representa cap risc per la seva salut i pot ajudar a planificar futures intervencions en promoció de la salut. La nostra intenció és que rebí la informació correcta i suficient per tal que pugui avaluar i jutjar si desitja o no participar.

La investigació presenta dues fases:

En la primera fase s'executaran les sessions en els pacients LGBTIQ+ participants, de les quals sortiran uns relats escrits per ellxs, que majoritàriament contindran vivències en centres de salut o l'àmbit hospitalari relacionades amb la seva condició LGBTIQ+, i com creuen que es podrien haver evitat.

En la segona fase, s'executaran les sessions en grup en un espai previst com el CAP, centre cívic o altres ubicacions properes al CAP, i tindran una durada aproximada de 60 minuts, coincidint amb l'horari laboral (preferiblement entre 14-15 h). Durant la sessió es llegiran els relats de pacients d'altres CAPs i s'obrirà un debat entre els professionals per expressar, en un espai segur, les opinions, propostes o experiències d'aquests mateixos. Les gravacions de totes les entrevistes seran transcrites literalment (per garantir la confidencialitat de l'entrevistat, es retiraran totes les dades personals).

La recollida i anàlisi posterior de totes aquestes dades es durà a terme en compliment del Reglament (UE) 2016/679 del *Parlament Europeu i de Consell, de 27 d'abril de 2016*, relatiu a la protecció de les persones físiques pel que fa al tractament de dades personals i a la lliure circulació d'aquestes dades (RGPD), i la Llei Orgànica 3/2018, de Protecció de Dades i garantia dels drets digitals, i per això li comuniquem que vostè podrà exercir els seus drets d'accés, rectificació, supressió, oposició, limitació del tractament i portabilitat de dades (LOPD-GDD) contactant directament amb l'investigador principal del projecte (Clara de Blas Llobet: cdeblas.girona.ics@gencat.cat). Pot contactar amb el Delegat de Protecció de Dades a través de dpd@ticsalutsocial.cat.

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L'informem del seu dret a retirar el consentiment per al tractament d'aquestes dades en qualsevol moment mitjançant l'adreça de correu electrònic cdebla.girona.ics@gencat.cat, així com del seu dret a presentar una reclamació davant de l'Autoritat Catalana de Protecció de Dades front qualsevol actuació del Responsable del Tractament que consideri que vulnera els seus drets.

Comunicacions de dades

No es preveuen comunicacions de dades, més enllà de les previstes legalment, i de tercers que hagin d'accedir-hi per a la prestació d'un servei en el marc del desenvolupament d'aquest projecte en la seva condició d'encarregats de tractament.

Transferències internacionals

No es preveuen transferències internacionals de dades

Consentiment informat participants sessions (CAT)

Títol de l'estudi: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Jo, _____ major d'edat, amb DNI

DECLARO QUE:

- He rebut informació sobre el projecte: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.
- He pogut aclarir tots els dubtes relacionats amb el projecte.
- De conformitat amb el que estableix el Reglament (UE) 2016/679 del Parlament Europeu i el Consell de 27 d'abril de Protecció de Dades (RGPD) i la normativa nacional d'aplicació, declaro haver estat informat dels meus drets, de la finalitat de recollida de les meves dades i dels destinataris de la informació.
- Compréc que la meva col·laboració en el projecte és totalment voluntària i tinc el dret a retirar-me del mateix en qualsevol moment, revocant el present consentiment, sense que aquesta retirada pugui influir negativament en la meva persona en cap cas.

Per tot això,

DONO EL MEU CONSENTIMENT A,

1. Participar en el projecte: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.
2. Que gravin l'àudio de la sessió de grup.
3. La transcripció literal de la meva gravació.

CIUTAT, DIA/MES/ANY:

SIGNATURA DE LA INVESTIGADORA PRINCIPAL

SIGNATURA DE LA PERSONA QUE PARTICIPA

Consentiment informat participants enquestes (CAT)

Títol de l'estudi: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Jo, _____ major d'edat, amb DNI

DECLARO QUE:

- He rebut informació sobre el projecte: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.
- He pogut aclarir tots els dubtes relacionats amb el projecte.
- De conformitat amb el que estableix el Reglament (UE) 2016/679 del Parlament Europeu i el Consell de 27 d'abril de Protecció de Dades (RGPD) i la normativa nacional d'aplicació, declaro haver estat informat dels meus drets, de la finalitat de recollida de les meves dades i dels destinataris de la informació.
- Compréc que la meva col·laboració en el projecte és totalment voluntària i tinc el dret a retirar-me del mateix en qualsevol moment, revocant el present consentiment, sense que aquesta retirada pugui influir negativament en la meva persona en cap cas.

Per tot això,

DONO EL MEU CONSENTIMENT A,

1. Participar en el projecte: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

CIUTAT, DIA/MES/ANY:

SIGNATURA DE LA INVESTIGADORA PRINCIPAL

SIGNATURA DE LA PERSONA QUE PARTICIPA

Información del estudio para participantes (ES)

Título del estudio: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Me dirijo a usted para invitarle a participar en un estudio sobre atención a las personas LGBTIQ+ y su satisfacción con su CAP. Este estudio pretende evaluar la satisfacción de los pacientes LGBTIQ+ en su sistema sanitario. La participación en este estudio es totalmente voluntaria, y podrá abandonarlo en cualquier momento, sin que esto altere la relación con el profesional sanitario ni se produzca ningún perjuicio en su asistencia sanitaria. El lugar de realización podrá ser el CAP, el centro cívico u otras ubicaciones.

El objetivo del estudio es:

- Valorar la satisfacción de los pacientes LGBTIQ+ después de una intervención de narrativa médica a los profesionales de su CAP. Comparándola con su satisfacción previa a la intervención y con no hacerlo.
- Determinar la satisfacción general de los pacientes LGBTIQ+ con sus CAPs.
- Determinar la percepción de los pacientes LGBTIQ+ de la discriminación en los CAPs.
- Calcular si hay un incremento de la frecuentación de los pacientes LGBTIQ+ en sus CAPs después de la intervención.

La recogida y análisis posterior de todos estos datos se realizará en cumplimiento del Reglamento (UE) 2016/679 del *Parlamento Europeo y de Consejo, de 27 de abril de 2016*, relativo a la protección de las personas físicas en relación al tratamiento de datos personales y a la libre circulación de estos datos (RGPD), y la Ley Orgánica 3/2028, de Protección de Datos y garantía de los derechos digitales, y por ello le comunicamos que usted podrá ejercer sus derechos de acceso, rectificación, supresión, oposición, limitación del tratamiento y portabilidad de datos (LOPD-GDD) contactando directamente con la investigadora principal del proyecto (Clara de Blas Llobet: cdeblas.girona.ics@gencat.cat). Puede contactar con el Delegado de Protección de Datos a través de dpd@ticsalutsocial.cat.

Con la firma de este documento usted dará su consentimiento de forma expresa con el fin de que sus datos sean tratados con finalidades de investigación en el marco de este proyecto, de conformidad con el artículo 6.1.a, 9.1.a del RGPD. Los registros de las entrevistas se borrarán después de transcribirlas y las transcripciones serán guardadas por las investigadoras durante cinco años y después destruidas.

Le informamos de su derecho a retirar el consentimiento para el tratamiento de estos datos en cualquier momento mediante la dirección de correo electrónico cdeblas.girona.ics@gencat.cat, así como de su

derecho a presentar una reclamación delante de la Autoridad Catalana de Protección de Datos frente a cualquier actuación del Responsable del Tratamiento que considere que vulnera sus derechos.

Comunicaciones de datos

No se prevén comunicaciones de datos, más allá de las previstas legalmente, y de terceros que tengan que acceder para la prestación de un servicio en el marco del desarrollo de este proyecto, en su condición de encargados de tratamiento.

Transferencias internacionales

No se prevén transferencias internacionales de datos.

Información del estudio para pacientes (ES)

Título del estudio: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Me dirijo a usted para invitarle a participar en un estudio sobre atención a las personas LGBTIQ+ y su satisfacción con su CAP. Este estudio pretende evaluar la satisfacción de los pacientes LGBTIQ+ en su sistema sanitario. La participación en este estudio es totalmente voluntaria, y podrá abandonarlo en cualquier momento, sin que esto altere la relación con el profesional sanitario ni se produzca ningún perjuicio en su asistencia sanitaria. El lugar de realización podrá ser el CAP, el centro cívico u otras ubicaciones.

El objetivo del estudio es:

- Valorar la satisfacción de los pacientes LGBTIQ+ después de una intervención de narrativa médica a los profesionales de su CAP. Comparándola con su satisfacción previa a la intervención y con no hacerlo.
- Determinar la satisfacción general de los pacientes LGBTIQ+ con sus CAPs.
- Determinar la percepción de los pacientes LGBTIQ+ de la discriminación en los CAPs.
- Calcular si hay un incremento de la frecuentación de los pacientes LGBTIQ+ en sus CAPs después de la intervención.

A partir de sesiones en grupo se realizará una selección para identificar los temas principales en relación con la atención y experiencias de los pacientes LGBTIQ+ en el ámbito de Atención Primaria. Su participación no presenta ningún riesgo para su salud y puede ayudar a planificar futuras intervenciones en promoción de la salud. Nuestra intención es que reciba la información correcta y suficiente para que pueda evaluar y juzgar si desea o no participar.

La investigación presenta dos fases:

En la primera fase se ejecutarán las sesiones, que serán grupales. Las entrevistas se podrán hacer en varios espacios como el CAP, el centro cívico u otras ubicaciones cercanas al CAP; tendrán una duración aproximada de 60-120 minutos. Durante la sesión se llevarán a cabo diferentes actividades que pueden incluir la lectura de relatos, escritura de historias cortas o poemas y la realización de un debate. En la segunda fase se hará el análisis cualitativo de las sesiones. Las grabaciones de todas las sesiones serán transcritas literalmente (para garantizar la confidencialidad del entrevistado, se retirarán todos los datos personales).

La recogida y análisis posterior de todos estos datos se realizará en cumplimiento del Reglamento (UE) 2016/679 del *Parlamento Europeo y de Consejo, de 27 de abril de 2016*, relativo a la protección de las personas físicas en relación al tratamiento de datos personales y a la libre circulación de estos datos (RGPD), y la Ley Orgánica 3/2028, de Protección de Datos y garantía de los derechos digitales, y por ello le comunicamos que usted podrá ejercer sus derechos de acceso, rectificación, supresión, oposición, limitación del tratamiento y portabilidad de datos (LOPD-GDD) contactando directamente con la investigadora principal del proyecto (Clara de Blas Llobet: cdeblas.girona.ics@gencat.cat). Puede contactar con el Delegado de Protección de Datos a través de dpd@ticsalutsocial.cat.

Con la firma de este documento usted dará su consentimiento de forma expresa con el fin de que sus datos sean tratados con finalidades de investigación en el marco de este proyecto, de conformidad con el artículo 6.1.a, 9.1.a del RGPD. Los registros de las entrevistas se borrarán después de transcribirlas y las transcripciones serán guardadas por las investigadoras durante cinco años y después destruidas.

Le informamos de su derecho a retirar el consentimiento para el tratamiento de estos datos en cualquier momento mediante la dirección de correo electrónico cdeblas.girona.ics@gencat.cat, así como de su derecho a presentar una reclamación delante de la Autoridad Catalana de Protección de Datos frente a cualquier actuación del Responsable del Tratamiento que considere que vulnera sus derechos.

Comunicaciones de datos

No se prevén comunicaciones de datos, más allá de las previstas legalmente, y de terceros que tengan que acceder para la prestación de un servicio en el marco del desarrollo de este proyecto, en su condición de encargados de tratamiento.

Transferencias internacionales

No se prevén transferencias internacionales de datos.

Información del estudio para profesionales (ES)

Título del estudio: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Me dirijo a usted para invitarle a participar en un estudio sobre atención a las personas LGBTIQ+ y su satisfacción con su CAP. Este estudio pretende evaluar la satisfacción de los pacientes LGBTIQ+ en su sistema sanitario. La participación en este estudio es totalmente voluntaria, y podrá abandonarlo en cualquier momento, sin que esto altere la relación con el profesional sanitario ni se produzca ningún perjuicio en su asistencia sanitaria. El lugar de realización podrá ser el CAP, el centro cívico u otras ubicaciones.

El objetivo del estudio es:

- Valorar la satisfacción de los pacientes LGBTIQ+ después de una intervención de narrativa médica a los profesionales de su CAP. Comparándola con su satisfacción previa a la intervención y con no hacerlo.
- Determinar la satisfacción general de los pacientes LGBTIQ+ con sus CAPs.
- Determinar la percepción de los pacientes LGBTIQ+ de la discriminación en los CAPs.
- Calcular si hay un incremento de la frecuentación de los pacientes LGBTIQ+ en sus CAPs después de la intervención.

A partir de sesiones en grupo se realizará un análisis para identificar los temas principales en relación con la atención y experiencias de los pacientes LGBTIQ+ en el ámbito de Atención Primaria. Su participación no presenta ningún riesgo para su salud y puede ayudar a planificar futuras intervenciones en promoción de la salud. Nuestra intención es que reciba la información correcta y suficiente para que pueda evaluar y juzgar si desea o no participar.

La investigación presenta dos fases:

En la primera fase se ejecutarán las sesiones en los pacientes LGBTIQ+ participantes, de las cuales saldrán unos relatos escritos por ellos, que mayoritariamente contendrán vivencias en centros de salud o el ámbito hospitalario relacionadas con su condición LGBTIQ+, y como creen que se podrían haber evitado.

En la segunda fase se ejecutarán las sesiones en grupo en un espacio previsto como el CAP, centro cívico u otras ubicaciones cercanas al CAP, y tendrán una duración aproximada de 60 minutos, realizándose en horario laboral (preferiblemente entre 14-15 h). Durante la sesión se leerán los relatos de pacientes de otros CAPs y se abrirá un debate entre los profesionales para expresar, en un espacio seguro, las opiniones, propuestas o experiencias de estos mismos. Las grabaciones de todas las sesiones serán transcritas literalmente (para garantizar la confidencialidad del entrevistado, se retirarán todos los datos personales).

La recogida y análisis posterior de todos estos datos se realizará en cumplimiento del Reglamento (UE) 2016/679 del *Parlamento Europeo y de Consejo, de 27 de abril de 2016*, relativo a la protección de las personas físicas en relación al tratamiento de datos personales y a la libre circulación de estos datos (RGPD), y la Ley Orgánica 3/2028, de Protección de Datos y garantía de los derechos digitales, y por ello le comunicamos que usted podrá ejercer sus derechos de acceso, rectificación, supresión, oposición, limitación del tratamiento y portabilidad de datos (LOPD-GDD) contactando directamente con la investigadora principal del proyecto (Clara de Blas Llobet: cdeblas.girona.ics@gencat.cat). Puede contactar con el Delegado de Protección de Datos a través de dpd@ticsalutsocial.cat.

Con la firma de este documento usted dará su consentimiento de forma expresa con el fin de que sus datos sean tratados con finalidades de investigación en el marco de este proyecto, de conformidad con el artículo 6.1.a, 9.1.a del RGPD. Los registros de las entrevistas se borrarán después de transcribirlas y las transcripciones serán guardadas por las investigadoras durante cinco años y después destruidas.

Le informamos de su derecho a retirar el consentimiento para el tratamiento de estos datos en cualquier momento mediante la dirección de correo electrónico cdeblas.girona.ics@gencat.cat, así como de su derecho a presentar una reclamación delante de la Autoridad Catalana de Protección de Datos frente a cualquier actuación del Responsable del Tratamiento que considere que vulnera sus derechos.

Comunicaciones de datos

No se prevén comunicaciones de datos, más allá de las previstas legalmente, y de terceros que tengan que acceder para la prestación de un servicio en el marco del desarrollo de este proyecto, en su condición de encargados de tratamiento.

Transferencias internacionales

No se prevén transferencias internacionales de datos.

Consentimiento informado participantes sesiones (ES)

Título del estudio: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Yo, _____, mayor de edad, con DNI

DECLARO QUE:

- He recibido información sobre el proyecto: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.
- He podido aclarar todas las dudas relacionadas con el proyecto.
- De conformidad con lo que establece el Reglamento (UE) 2016/679 del Parlamento Europeo y el Consejo de 27 de abril de Protección de Datos (RGPD) y la normativa nacional de aplicación, declaro haber estado informado de mis derechos, de la finalidad de recogida de mis datos y de los destinatarios de la información, y la Ley Orgánica 3/2028, de Protección de Datos y garantía de los derechos digitales,
- Comprendo que mi colaboración en el proyecto es totalmente voluntaria y tengo el derecho a retirarme del mismo en cualquier momento, revocando el presente consentimiento, sin que esta retirada pueda influir negativamente en mi persona en ningún caso.

Por todo eso,

DOY MI CONSENTIMIENTO A,

1. Participar en el proyecto: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.
2. Que se grabe el audio de la sesión de grupo.
3. La transcripción literal de mi grabación.

CIUDAD, DÍA/MES/AÑO:

FIRMA DE LA INVESTIGADORA PRINCIPAL

FIRMA DE LA PERSONA QUE PARTICIPA

Consentimiento informado participantes encuestas (ES)

Título del estudio: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

Yo, _____, mayor de edad, con DNI

DECLARO QUE:

- He recibido información sobre el proyecto: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.
- He podido aclarar todas las dudas relacionadas con el proyecto.
- De conformidad con lo que establece el Reglamento (UE) 2016/679 del Parlamento Europeo y el Consejo de 27 de abril de Protección de Datos (RGPD) y la normativa nacional de aplicación, declaro haber estado informado de mis derechos, de la finalidad de recogida de mis datos y de los destinatarios de la información, y la Ley Orgánica 3/2028, de Protección de Datos y garantía de los derechos digitales,
- Comprendo que mi colaboración en el proyecto es totalmente voluntaria y tengo el derecho a retirarme del mismo en cualquier momento, revocando el presente consentimiento, sin que esta retirada pueda influir negativamente en mi persona en ningún caso.

Por todo eso,

DOY MI CONSENTIMIENTO A,

1. Participar en el proyecto: PROUD STORIES PROJECT: LGBTIQ+ patients' satisfaction after a narrative medicine intervention at their primary care centres.

CIUDAD, DÍA/MES/AÑO:

FIRMA DE LA INVESTIGADORA PRINCIPAL

FIRMA DE LA PERSONA QUE PARTICIPA

ANNEX 4

The following surveys are mentioned to get the sociodemographic and SOGI data. They also must bring the patients to the Informed Consent Form.

These two links are first pilot tests, to understand how they will work, the ones carried out in the study will be using LimeSurvey.

The Catalan version is: <https://forms.gle/zkcCZpAg6db3Bkyx7>

The Spanish version is: <https://forms.gle/bxqufRhmFrKGySeM6>

They can be printed too also for the patients who don't have access to a network or a computer or phone.

The SOGI questions are provisional, since this study is waiting for a systematic revision that will include a validated survey of SOGI questions with citizen participation, from the IDIAP JGOL Centre.

ANNEX 5

Mariposa – @_marcoabraham

Vivo sencillamente porque el amor tiene formas y colores
Porque en silencio somos muchos
Y porque en la vida cabe más que un solo reino y un solo discurso
Yo soy la manifestación de algo especial
Y así de especial es mi orgullo y lo que siento
Un hilo de carne viva que por ser de carne, se arrastra con miedo en el suelo
La esencia de mis deseos formando algún tejido
Para envolver mi mente, para envolver mi cuerpo
Para cuidarme mientras miro al sol a través de la seda
Respiro poco y sueño
Que soy valiente y conquisto el cielo.
Quiero preparar un acto a través de lo que a veces quiero decir y no puedo
Porque me gusta vestirme extraño, simple
Desnudarme frente al espejo y saber qué quiero
Para cuando la crisálida o el clóset a mi alrededor se abran
Y me pose en la ventana viendo el reflejo de mis alas
Cuando encuentre el momento exacto en el viento
Para saber qué tan fuerte es mi pulso y el corazón que llevo dentro
Para cuando me precipite desde las alturas
Para cuando ya no tenga miedo
Para cuando pueda probarme, y probarles
Que no tenía una mejor opción que el vuelo
No somos distintos a las mariposas
No somos un misterio
La carne puede ser débil o bastante fuerte
Los cromosomas pueden ser como los de ellas o como los nuestros
Pero la magia, la metamorfosis
Lo que mueve tus alas y el sentimiento
No tienen genero
No tienes por qué saberlo y por qué entenderlo
Pero las mariposas nacieron para conquistar el cielo
Nacieron para conquistar el arte y nuestras paredes
El mismo tiempo si nos detenemos
A verlas
Desde el instante en que se atreven, hasta el instante en el que mueren
Después de tanta belleza
Buscando la luz, o de las flores el nectar
Llevando sus cuerpos quién sabe a dónde, y dejándonos el regalo de sus alas
Sus colores, y el recuerdo de su amor, que como cualquier otro amor, es perfecto.

Orgullo – @raulrib2

Ni lo sabes ni te importa,
si me acuesto o me levanto
con el manco de Lepanto
o con una que es muy corta.
No eres juez para este juicio,
ni para expandir murmullos,
que yo vivo con Orgullo
el amor sin el prejuicio.
Bollera la pelicorta,
maricón ese maganto,
no les importa el quebranto,
la gente no se comporta.
No les impongas cilicios,
ni les condenes al trullo,
por la fiesta y el barullo,
por el sexo y el fornicio.
Admite diversidad,
la clave está en el respeto,
aunque uno sea discreto
quiere visibilidad.
Ya pasó la oscuridad,
que haya leyes y decretos
cuyo afán y cuyo objeto
mejore esta sociedad.

Paréntesis - Alfredo Fressia

Cuando nació el sexo fue un destino. No se puede elegir ser poeta.

De las mujeres nunca amé a ninguna sin duda porque las amé en bloque. Fue un amor largo y sin alegría. Ellas también me amaron sin deseo y sin gozo.

Las miré con la nostalgia de una vida más bella. Cuando quise ser mejor quise ser mujer.

Después me olvidé. Devoré la costilla de Adán en la travesía del desierto. Fui hombre, poeta, amé a otros hombres. Tuve hambre.

Llegué a la playa de este mar eterno, al sur del Brasil. Mi olor es de sal virgen y de yodo azul. Sé que una mujer devolverá al mar el pez con una moneda en la boca.

Ella escribe mi poema. Yo aguardo.

mujer después - Angélica Freitas

queridos papá y mamá
les escribo de tailandia
es un país fascinante
hay hasta elefantes
y unas playas bien bonitas
pero no vine por eso
aunque me encanta el turismo
¿te acuerdas, pá, que decías
que yo parecía una chica
y mamá nos reprendía?
pues ya me volví mujer
me operé, ya soy mujer
y no tienen que aceptarme
no tienen ni que mirarme
pero ahora soy mujer

“La mayoría del tiempo el médico o médica general, están predispuestos a que lo que uno exprese en la consulta, el tono de voz y sus gestos del rostro cambian cuando uno revela su orientación sexual, se sienten incómodos, al saber que uno es persona LGBT prefieren centrarse en el tema de sexualidad y empezar a preguntar sobre los factores de riesgo a los que uno puede estar expuesto y no indagan antecedentes de salud de la familia o si uno tiene alguna enfermedad prevalente”. (Hombre homosexual)

“La cara del profesional de salud cambió totalmente, cambió de tema y dejó de seguir indagando, pasó a preguntarme otro tipo de cosas; la mayoría de las personas LGBT no nos gusta ir al médico general, así estemos enfermos, preferimos quedarnos en casa y realizarnos nuestros propios tratamientos caseros, por la incomodidad y molestia que se siente al ir al médico”. (Hombre bisexual)

“Somos personas y los problemas en salud son iguales para todos, entonces creo que tienen que estar enfocados en lo que tu consultas, por lo que tu doctor te trate no solo por tu orientación sexual; lo digo porque tuve una experiencia en consulta con una mujer médica general, usted por pertenecer al grupo LGBT ustedes hacen y deshacen con el mundo, cosa que no hacemos los heterosexuales, por tal motivo me rehusó a atenderlos, me dijo. Solicité cita con otro médico, cuando le pregunté sus motivos de no atenderme, expresó que se complicaba más el hecho por ser una persona transgénero”. (Mujer transgénero)

“Entender la construcción y las violencias por las que uno a veces pasa, porque yo creo que el médico muchas veces le hace sentir a uno miedo de ir, porque tú no quieres que te vulneren por ser persona LGBT, por eso es que yo creo que la gente termina yendo al médico general cuando ya es muy necesario”. (Mujer bisexual)