

Editorial: Introducing the special collection on 'Palliative Care for LGBTQ2S+ Individuals and Families'

Kimberly D. Acquaviva and Denise Marshall

This special collection of *Palliative Care and Social Practice* features the work of top scholars in the fields of LGBTQ2S+ (lesbian, gay, bisexual, transgender, queer, and two-spirit) aging, health, and palliative care. While the authors of the articles in this special collection use a variety of acronyms to describe this population, we have opted to use the most comprehensive of the terms – LGBTQ2+ – in alignment with emerging best practice. The term 'two-spirit' may be unfamiliar to readers:

Two-spirit refers to a person who identifies as having both a masculine and a feminine spirit, and is used by some Indigenous people to describe their sexual, gender and/or spiritual identity. As an umbrella term it may encompass same-sex attraction and a wide variety of gender variance, including people who might be described in Western culture as gay, lesbian, bisexual, transsexual, transgender, gender queer, cross-dressers or who have multiple gender identities. Two-spirit can also include relationships that could be considered poly. The creation of the term 'two-spirit' is attributed to Elder Myra Laramie, who proposed its use during the Third Annual Inter-tribal Native American, First Nations, Gay and Lesbian American Conference, held in Winnipeg in 1990. The term is a translation of the Anishinaabemowin term *niizh manidoowag*, two spirits.¹

The articles in the collection approach the topic of palliative care for LGBTQ2S+ individuals from a variety of perspectives and collectively introduce readers to key issues facing this population near the end of life. Improving the quality of care provided to LGBTQ2S+ individuals and their families requires a multifaceted approach to understanding their needs and lived experiences

and then educating their care teams on how best to address those needs more fully.

In 'Family Perceptions of Quality of End of Life in LGBTQ+ Individuals: A Comparative Study', S. Alexander Kemery compares the experiences of an LGBTQ+ cohort with a non-LGBTQ+ cohort and identifies ways in which the two cohorts differ in terms of measures of quality of death and dying.²

In 'The Role of Hospice and Palliative Care in Supporting and Fostering Trust among the LGBTQ+ Population', Natasha Dhawan, Anais A. Ovalle, and Jonathan C. Yeh assert that '... hospice and palliative care teams ... play an increasingly important role in supporting LGBTQ+ individuals throughout the illness trajectory'.³ They discuss the critical need for clinicians to examine their biases and assumptions and thus seek out inclusive strategies and practices in order to deliver on the very mission of palliative care's whole person/caregiver mandate.

In 'Centering Sexual and Gender Diversity within Compassionate Communities: Insights from a Community Network of LGBTQ2S+ Older Adults', Pamela Grassau, Arne Stinchcombe, Roanne Thomas, and David Kenneth Wright share the findings of their focus group research regarding the Compassionate Communities movement and LGBTQ2S+ older adults in Canada. The authors assert, 'Explicit attention to how intersections between the past and the present might influence the health experiences of LGBTQ2S+ people is helpful in informing trauma-informed approaches to LGBTQ2S+ palliative care ...'.⁴ Furthermore, they state that trauma-informed practices are not unique for LGBTQ2S+ communities but rather

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Correspondence to:
Kimberly D. Acquaviva
Department of Acute and
Specialty Care, School
of Nursing, University of
Virginia, 4005 McLeod
Hall, Charlottesville, VA
22903, USA.
acquav@virginia.edu
Denise Marshall
Division of Palliative Care,
Department of Family
Medicine, McMaster
University, Hamilton, ON,
Canada

should be part of a larger hospice and palliative care imperative to embrace all aspects of anti-oppressive, equity-based, and trauma-informed policies and practices.

In 'Palliative Care Needs, Concerns, and Affirmative Strategies for the LGBTQ Population', Noelle Marie Javier provides a comprehensive overview of the key issues related to LGBTQ-inclusive palliative care and asserts that '[t]he provision and delivery of high-quality palliative, hospice, and EOL care starts with an understanding of the cultural framework that has shaped the life course of the LGBTQ population and the minorities within minorities subgroups'.⁵ Javier notes that barriers to comprehensive palliative care may include 'gaps in competency training for providers, paucity in research studies, variable resource allocation, financial constraints, and non-protective regulatory policies and practices' and continues on discussing the need for key strategies to mitigate barriers in ways that create therapeutic alliances and overall well-being.

In 'Advance Care Planning among Older Canadians amid the COVID-19 Pandemic: A Focus on Sexual Orientation', Brian de Vries, Gloria Gutman, Robert Beringer, Paneet Gill, and Helena Daudt describe the findings from a large national online survey in Canada regarding advance care planning (ACP). The authors' research supported their hypothesis that lesbian, gay, and bisexual individuals 'would be more likely than heterosexual persons to have prepared ACP documents and to have engaged in care discussions since the pandemic onset'.⁶

Finally, in 'Development and Evaluation of an LGBT education Programme for Palliative Care Providers', Claude Chidiac, Kate Grayson, and Kathryn Almack describe the development and evaluation of an educational program for health care professionals. This training program was delivered to and evaluated by 145 participants at four hospices across London and Essex, UK. Its aim was '... to increase health and social care professionals' awareness about the specific issues and needs of LGBT+ people and their families and partners living with advanced illness',⁷ while providing participants with specific strategies enabling them to recognize barriers to inclusion. They focused on helping participants gain inclusive skills appropriate for services while using a palliative approach to care.

As people who identify as queer (K. Acquaviva) and gay (D. Marshall) and whose personal and professional lives have been deeply impacted by these issues, we know firsthand how important it is to have high-quality palliative care that is sensitive and relevant to LGBTQ2S+ people. We know all too well the ways in which hospice and palliative care programs and services continue to fall short of welcoming, affirming, and respecting LGBTQ+ patients and families in need of care. We believe that when an LGBTQ2S+ person is living with a serious or life-limiting illness that would benefit from a palliative approach to care, they should be able to find a palliative care program staffed by professionals and volunteers who have the knowledge, skills, and experience needed not just for high-quality care, but also for care that is inclusive and affirming. We are delighted that this special collection of *Palliative Care and Social Practice* helps lay the groundwork for achieving this vision.

Conflict of interest statement

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