ORIGINAL ARTICLE

Experiences of Family Medicine Specialists in Providing Health Care for Lesbian, Gay, Bisexual and Transgender Patients: A Qualitative Study in East Coast Peninsular Malaysia

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ABSTRACT

INTRODUCTION: Lesbian, Gay, Bisexual and Transgender (LGBT) patients continue to report discrimination in healthcare setting despite the efforts of the primary healthcare offering community friendly services in Malaysia. This qualitative study aimed to provide understanding of this current issue and to explore the challenges that family medicine specialists (FMSs) from East Coast of Peninsular Malaysia face when dealing with LGBT patients. **MATERIALS AND METHODS:** 30 FMSs working in East Coast Peninsular Malaysia were interviewed through a phenomenological framework using semi-structured in-depth interviews of LGBT patients. The interviews were recorded in audio format, transcribed verbatim, and subjected to Braun and Clarke's thematic analysis. We discerned common themes that can be elucidated through the lens of Leininger's Theory of Culture Care (TCC) and the Sunrise Enabler Model (SEM). **RESULTS:** Three overlapping themes of the transcriptions were developed; (1) Multidimensional understanding of LGBT described how FMSs saw the LGBT community as diverging from societal norms, yet acknowledge their vulnerability as integral members of the society, (2) obstacles to providing culturally competent care stemmed from inadequate training, an unsupportive clinic environment, and the self-stigma experienced by patients, and (3) barriers to incorporating spiritual needs for holistic care arose in situations where there was insufficient spiritual health training or a preference to concentrate on physical and emotional well-being to uphold trust. **CONCLUSION:** The findings on this study reflect the need for proper training of healthcare personnel to deliver a holistic, culturally competent care for LGBT patients. A collaborative effort with relevant authorities is also needed to successfully overcome those challenges.

Keywords
LGBT, Sexual and Gender Minority, Primary Care, Family Medicine Specialist, Spirituality.

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INTRODUCTION

The stigma and discrimination against Lesbian, Gay, Bisexual and Transgender (LGBT) individuals in healthcare settings has also resulted in delayed health-seeking behaviour, inappropriate treatment and limited health prevention, leading to their poor health outcomes.[1,2,3] Studies done in Malaysia reported that LGBT patients continue to face unfriendly practices that hinder them from receiving optimal health care.[4,5] In contrast, international studies involving health care practitioners (HCPs) from various fraternities revealed conflicting results on this matter.[6,7,8] Most studies were found to have a low discriminatory intent while interacting with LGBT patients. Among the identified barriers include inadequate knowledge, limited training, different personal values and inconvenient health settings.[9,10] Those studies, unfortunately, were conducted in countries that

are socio-culturally different from Malaysia. So far, only one published quantitative study researching among Malaysian doctors on the factors affecting their provision of care to transgender (TG) patients.[11]

The LGBT phenomenon in Malaysia is criminalised under the Civil and Sharia Laws.[12] The practice is considered a highly unacceptable culture that needs to be curtailed. Many agencies in Malaysia have been trying to integrate strategies to provide spiritual support to LGBT patients to discourage the deviant lifestyles[13] and to maintain overall good health.[14] Thus, this study attempts to explore the experiences of family medicine specialists (FMSs), in providing healthcare for LGBT patients in Malaysia and their possible role in providing spiritual care.

MATERIALS AND METHODS

This qualitative study employed a phenomenological approach to delineate meanings and essence of FMSs experiences in relation to care for LGBT patients in the east coast of Peninsular Malaysia.[15]

Participants

FMSs with experience caring for LGBT patients for at least a year in the east coast of Peninsular Malaysia, specifically in the states of Kelantan, Terengganu, and Pahang, were selected using the purposive sampling method. Purposeful sampling, a common method in qualitative research, helped us choose FMSs who felt they were experienced enough about the topic when we anticipated a limited number of FMSs agreeing to join due to the taboo nature of the topic.[15] The rationale behind requiring at least one year of experience for FMSs likely stems from our previous observations. FMSs may have substantial exposure to LGBT health during their training in the Masters programme. This exposure includes a six-month posting in the medical wards, including the Infectious Diseases Clinics, during their first year of the Master's programme. Additionally, they also receive exposure in year 3 and 4 during outpatient attachments, along with one year as an FMS where they are formally registered in the Malaysian National Specialist Registry.

The first author (S.N.M.A.) collaborated with the Departments of Health from each state in Peninsular Malaysia to identify the appropriate FMSs in the centre. Details of the study published in a poster was advertised via WhatsApp all the relevant groups. Interviews to select FMSs were conducted between February and November, 2020. In all 50 eligible FMS participants were approached but 17 of them declined to participate for personal reasons, such as time constraints, discomfort with the topic questions and unfamiliarity with qualitative research. However, the sample collected in this study were based on saturation theory. Interviews were halted at 30 interviewees, as the study reached data saturation, indicating that no additional data had been obtained.[16]

Procedures

The study was approved by the Human Research Ethics Committee of the Universiti Sains Malaysia (Reference number: USM/JEPeM/19080451) and Medical Research and Ethics Committee (MREC), Ministry of Health Malaysia (Reference number: NMMR-19-2251-50051 (IIR). A semi-structured interview (SSQ) guide was created based on the relevant literature searches, theory and research questions. Initially, three participants were interviewed for the pilot study, to determine the content and feasibility of the guided questions.[17] The results of the pilot studies were not included in the final data collection. No changes were made to the SSQ. Interviews with the FMS participants were then scheduled for a mutually convenient method of communication and time. The face-to-face or online interviews were conducted either in Malay or English after the participants consented and were audio-recorded. Confidentiality and anonymity regarding the names and working place were reassured. Each interview lasted for about 60 minutes. All interviews were conducted by S.N.M.A. and field notes were made immediately after the interviews. Additionally, participants were required to complete a socio-demographic form.

Data Analyses

The audio recordings made were immediately transcribed verbatim, de-identified and checked for accuracy. NVivo

12 software was used to store, organize and facilitate analyses of the themes.[18] Thematic analyses, employing Braun and Clarke's six-step framework, was utilized.[19] S.N.M.A. (the master's student) and R.M. (the main supervisor, an expert in qualitative studies) independently reviewed the five transcripts multiple times to familiarize themselves with the data. Subsequently, an initial list of codes was generated in NVivo®, and discussions took place among the researchers. Once consensus was reached on the codes, they were consistently applied to the transcripts. S.N.M.A. then continue the process individually. Each transcript underwent examination before consolidating identified themes into an interconnected framework, encompassing themes, subthemes, and axial coding.

To ensure trustworthiness, reliability, and accurate coding, discussions with the research supervisors (R.M. and M.M.Z.) were conducted multiple times to cross-verify all codes in the interview transcripts, ensuring confirmability.[20] Any conceptual differences in thematic analysis were addressed and revised, leading to the development of additional preliminary themes. Additionally, a co-researcher (S.D.), specializing in sexual minority studies, was enlisted to review and discuss the coding and early themes emerging from all transcripts, providing valuable feedback for naming and redefining the themes.

Ultimately, consensus was reached on the themes, subthemes, and axial coding. The transcribed material was shared with selected participants for review to validate the results and enhance credibility. Various alternative interpretations were considered, with none presenting a contradictory perspective to the obtained results.

RESULTS

The socio-demographic profiles of the thirty FMSs who participated in this study are depicted in Table I.

Three main themes emerged: (1) a multidimensional understanding of LGBT, (2) obstacles to providing culturally competent care and (3) challenges to incorporating spiritual needs for holistic care (Table II).

Table I: Participants' socio-demographic profiles, n=30

Variables	n (%)
Age (years)	
30-39	10 (33.3)
40-49	10 (33.3)
50-59	10 (33.3)
Gender	
Male	7 (23.3)
Female	23 (76.7)
Ethnicity	
Malay	27 (90.0)
Chinese	1 (3.3)
Indian	1 (3.3)
Others	1 (3.3)
Religion	
Islam	27 (90.0)
Christianity	0 (0.0)
Buddhism	1 (3.3)
Hinduism	1 (3.3)
Others	1 (3.3)
Duration of practice as FMS	
>15 years	8 (26.7)
10-15 years	7 (23.3)
5-9 years	6 (20)
<5 years	9 (30)
Current place of practice	
Kelantan	14 (46.7)
Terengganu	5 (16.7)
Pahang	11 (36.7)
Pathway of training	
Master	26 (86.7)
Parallel	4 (13.3)
Special interest	
Infectious disease	6 (20)
Non-communicable disease	4 (13.3)
Men health	2 (6.6)
Women health	6 (20)
Children health	6 (20)
Adolescent health	4 (13.3)
Geriatrics	2 (6.6)
Palliative care	1 (3.3)
Pre-hospital care	1 3.3)
Wound care	1 (3.3)
Dermatology	2 (6.6)

Theme 1: Multidimensional Understanding of LGBT

The findings show that FMS viewed this phenomenon from both, a personal and professional view.

Deviation from Social Norms

FMSs have demonstrated a professional understanding of the LGBT community, which they defined as a group of people who have an alternative sexual orientation. They agreed that the LGBT phenomenon in Malaysia is still considered aberrant and does not conform to the social norms.

Malaysia as a whole did not recognise LGBT as this phenomenon contradicts with our culture, traditions and also religion. This is simply not our norms –D03

FMSs also highlighted that they do not deny the rights of LGBT people to obtain access to healthcare. They have no reservations about providing care to LGBT patients and none declined to offer services.

Table II: Experiences of FMS in providing health care for LGBT patients

Themes	Subthemes	Axial Coding
Multi-dimensional understanding of LGBT	Deviation from social norms	Alternative sexual orientation Deviation from the culture and religion
	Vulnerable members of society	Key population for HIV/AIDS and STI Vulnerable to mental health and substance Decline in morality and family formation
	Lack of formal training	Lack of formal training during postgraduate Current practice guided by some informal training and ensuing experiences Low level of comfort due to lack of training
Obstacles to providing culturally competent care	Existence of stigma	Persistent stigma among untrained staffs Presence of inner stigma among LGBT
	Challenging patients' personalities	Over-friendly, flirty and extremely sensitive personalities especially among TG patients Difficult to engage in consultation due to their secretive attitudes
	Unfavourable clinic setting	Multiple layers of clinic flow when accessing healthcare Use of sharing room during consultation
	Limited spiritual knowledge and expertise	Lack of knowledge in spiritual health Lack of referral network for spiritual health Equating spirituality to religion
Barriers to incorporating spiritual needs for holistic care	Concerns of losing patients' trust	Apprehension about stigmatizing patients Fear of jeopardizing treatment plan
	Priority in managing physical well-being	Physical health is the main priority The provision of care is considered as an added bonus

Regardless of whether they are LGBT, prison inmates or drug users, we have the duty to treat everyone equally. That's our oath and ethics – D28

Vulnerable Members of Society

HIV transmission trend attributed to the LGBT community has been voiced out by all FMSs and becomes a big concern to them.

The trend of HIV transmission in Malaysia has shifted from people who inject drugs towards sexual transmission. Nowadays, MSM (men who have sex with men) is the main key population– D08

Almost all of their LGBT patients also predispose to other high-risk behaviours.

My patients were mostly engaged in promiscuity. They are also more likely to develop addiction to alcohol, cigarettes or other substances – D24

Other FMSs raised the possible issue of mental health because of disobeying social norms and values.

Theme 2: Obstacles to Providing Spiritual and Culturally

Four main obstacles to providing spiritual and culturally competent care were identified as below:

Lack of Formal Training

LGBTs are regarded as a sexual minority group with high vulnerability towards physical and mental health. They possess distinct cultural values of their own that shape their lifestyles. Additionally, their complex personalities may require tailored approaches to management of their health compared to other patients. The lack of adequate training leaves FMSs feeling ill-prepared during consultations with LGBT. Almost all FMSs remarked that they never had formal education to deal with LGBT patients during their training. They stated that their current practices are solely guided by the experiences they earned when dealing with HIV (human immunodeficiency virus) or STIs (sexual transmitted infections) cases. Only a few attended special courses.

I can recall attending men and women conferences a few years back. I found these courses were very beneficial– D22

While two FMSs who underwent parallel pathways for FMS training reported that some LGBT health modules were available during their training.

They also expressed their concerns and the need for training that may necessitate a different framework for engaging positively with sexual minorities. Anticipated training would involve learning about sexual and gender minority terminology, developing sensitive and affirming communication skills, and establishing referral networks.

Existence of Stigma

Stigma is another source of difficulty when dealing with LGBT patients. FMSs voiced out that stigma is now no longer as strong as it used to be. However, it may still exist among healthcare providers (HCPs) who have never been trained for IDs.

I believe the stigma is lessened now. We are more receptive towards them. We do not hate or discriminate them even though we disagree with their lifestyles – D23

Internalised stigma is another fascinating area that could be a barrier to LGBT patients seeking healthcare. The

FMSs noticed that some patients experienced self-stigma, which manifests as excessive anxiety and paranoia about being stigmatised which could also be related to their previous negative experiences in the society.

I noticed that they are overly concerned about societal stigma. They feel insure, very sensitive and paranoid. They have the impression that they are being stigmatised by us – D26

Challenging Patients' Personalities

LGBT patients also have distinct personalities that can make provision of care challenging.

As a male physician, I found that TG patients can be a little flirtatious. To put it another way, they might be over friendly. Few times they say "Doctor, can I have your phone number?" It is not a very pleasant feeling – D22

Another FMS pointed out that TG patients are "extremely sensitive" especially when they must be called by their preferred names instead of their registered names. Some FMSs also described LGBT patients as "secretive" as they tend to keep their status to themselves because of the fear of stigma and discrimination.

Unfavourable Clinic Setting

FMSs raised two more issues related to clinical settings as barriers to maintaining the privacy and confidentiality of LGBT patients. First, every patient had to go through several steps before seeing a doctor. This may hinder LGBT patients to access healthcare.

Patients must first pass through a number of layers every time they want to see us. A screening counter for example. As you can imagine, maintaining privacy for LGBT patients is a challenge in primary care – D16

Second, most LGBT clinics have consultation rooms set up in a shared space. Building a rapport with patients in such an environment is difficult; hence, LGBT patients find it hard to disclose their sensitive health concerns. To overcome this barrier, some FMSs have taken the initiative as below:

In my clinic, in the afternoon, [the] methadone clinic will be the STI clinic. So, this clinic has its own access, waiting area and dedicated team. It has more privacy. – D13

When asked about the need for a special LGBT clinic in primary care, FMs responded in various ways. Some felt that this extended scope clinic will further jeopardise their confidentially as they need to disclose their sexual orientation before being enrolled in the programme. Others agreed because the TG status is already known by observing their cross-dressing appearance.

Theme 3: Barriers to Incorporating Spiritual Needs for Holistic Care

Our study yielded another spectrum of viewpoints on implementing spiritual health for LGBT patients. Some FMSs objected to spiritual care, whereas others agreed that spirituality is important but difficult to incorporate into their daily practice. They attributed the difficulties to a lack of spiritual knowledge and expertise, concern of losing patients' trust and priority in managing physical well -being.

Limited Spiritual Knowledge and Expertise

Spiritual health is a crucial part of the wellness and has been recognised as one of the protective factors for various health problems.

If we look at the research in adolescents, it has been proven that spirituality is a protective factor for many things, including physical and mental health. It certainly has [a] significant role in healthcare – D21

D03 pointed out spiritual care is one of the family medicine's principles in providing comprehensive care. She expressed her frustration and illustrated her point of view by demonstrating how a loophole in giving spiritual care resulted in further physical health threats to LGBT patients.

They usually come to us with STI, we treat them. Patient is happy, we are happy. However, they usually come back to us for similar complaints. Yes, we can re-treat. But deep inside, we do feel

frustrated. For me, apart from harm reduction strategies, […] they need spiritual help too. I think we failed to give a whole-person care. – D03

Many FMSs equated spiritual advice with religious guidance. So as the D22, believed that spiritual advice should be provided by religious experts who are qualified by education, training and experience in the field. The FMSs felt a need for a different approach when consulting with the LGBT community, which requires sensitivity. There was consensus among FMSs that addressing these issues requires individuals with spiritual knowledge and expertise. However, most FMSs acknowledged their own limitations in this regard.

Personally, I'm not a religious expert. In general, I think [an] FMS is not the right person unless you have that core knowledge – D22

Collaborating with a religious organisation to provide spiritual care for LGBT patients is one example of overcoming limitations. However, most FMSs lack this referral network because they are unsure to whom they should refer to. Only a few FMSs are aware of the network's existence with the Department of Islamic Development Malaysia (JAKIM) or the local Islamic Office. They are aware that these departments offer counselling services for marital affairs. Some FMSs lamented the lack of incorporation of spirituality into healthcare, viewing it as an unprofessional aspect of their practice. They equated spirituality solely with religion and noted the absence of spiritual health education in the curriculum.

We have long been taught not to touch on religion when providing healthcare services to our patients. It is somewhat regarded as unprofessional, especially in today's secular world – D04

Only a few FMSs were seen to be more concerned about not imposing personal religious beliefs when providing healthcare to their patients. The diversity of religions and races in Malaysia also imposes a great challenge to the FMSs to deliver culturally acceptable care to patients.

To be honest, it would be difficult to talk about spiritual health in a multi-diverse society. For example, if an Indian comes to see me, I wouldn't know his religion. Even for Muslims – D20

Concerns of Losing Patients' Trust

Several FMSs felt hesitant to discuss spiritual care because of their apprehension about losing patients' trust. They were concerned about being accused of stigmatising their patients and imposing their own personal beliefs on them.

I'm afraid that if we start giving spiritual advice, they will feel stigmatised, as if we are judging them. We want to avoid that stress. We want to treat him in such a way that he will not be ashamed to return for follow-up – D28

Others agreed that spiritual care could be integrated but that it should be tailored to the individuals, as not all LGBT patients require spiritual assistance. Some are even content with their sexual orientation, so spiritual guidance would be unnecessary in that case. It should only be reserved for those who wish to be guided spiritually.

It sounds so holistic to us if we can incorporate spiritual health to them, but is that what they really want? If yes, go ahead. But if not, you should work on establishing a good, trusting relationship – D26

Priority in Managing Physical Well-being

Despite agreeing that spiritual care is an important component of holistic patient care, most FMSs remarked that their primary role is still to attend to physical well-being of LGBT rather than spirituality.

It is our responsibility to treat patients holistically, but I would put the spiritual part last. Now, our primary role is to help them not to be in infectious state, treat the physical health first – D27

Furthermore, D12 supported that the most LGBT patients who came to them were seeking medical treatment rather than spiritual guidance. Therefore, the provision of spiritual care is just as additional help. D23 suggested that the best time to introduce spiritual care is after physical health issues have been resolved.

DISCUSSION

In this study we adopted Leininger's Theory of Culture Care (TCC) and the Sunrise Enabler Model (SEM) to understand the experiences of FMSs in providing healthcare for LGBT patients in Peninsular Malaysia.[21] TCC is founded by Madeline M. Leininger focusing on culture as key concepts in providing culturally competent care while SEM supports the understanding via seven essential components that influence a person's perception towards a particular culture group: education, economic, political and legal, cultural values and beliefs, social and kinship, religion and philosophy and technology.[21,22] These factors then have an impact on how HCPs deliver care and make decisions.[21] Our study showed that the FMSs participants' provision of care was mainly influenced by their education, religion, culture and environmental factors (Figure 1).

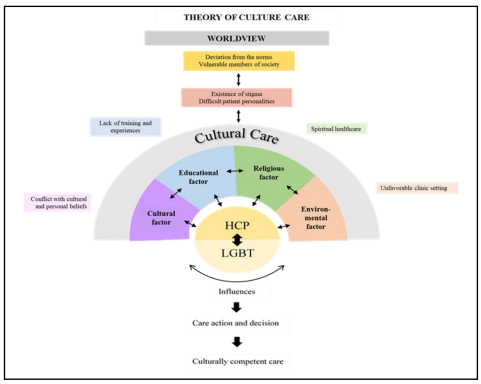

Figure 1. Adapted theoretical framework from Leininger's Theory of Culture Care with Sunrise Enabler Model.

FMSs revealed sufficient understanding regarding the LGBT phenomenon as they knew that LGBT community have unique healthcare needs that require special attention. However, FMSs had neither received any formal training nor had the resources necessary to adequately understand the culture-spiritual care for LGBT patients. This fact has been reflected in the participants' lack of comfort and stigmatisation when dealing with LGBT patients. This is in line with other studies that have identified training deficiencies as the main hindrance to providing non-discriminatory care to LGBT patients.[9,10]

Personal beliefs, cultural values and religion have important influence in our practice on LGBT patients.[23] Regardless of their race and religion, FMSs agreed that LGBT people have a deviant lifestyle that contradicts the social norms. However, the clash of these values did not prevent FMSs from providing care as FMSs were able to set aside their personal values. Similar findings of low discriminatory intent have been found in studies conducted among Malaysian doctors and HCPs around the world.[6,8,11]

Our healthcare services still lack cultural sensitivity, particularly for vulnerable populations. Building trust in the healthcare system is challenging, thus hindering individuals from feeling comfortable enough to disclose their problems, seek treatment, or counselling without experiencing distress or fear of social stigma.[5] The LGBT community, in this context, faces heightened vulnerability to physical and mental health issues due to their high-risk behaviours.[1] Providing non-judgmental management is crucial to prevent further harm to both individuals and the community.[1]

Unfavourable environmental factors, such as sharing rooms with non-LGBT patients during consultations, have also hampered the provision of care in dealing with sensitive issues.[24] However, FMSs were seen as trying to accommodate LGBT patients' needs by addressing TGs by using their preferred names, being extra sensitive to their cues, focusing on positive engagement and attempting to resolve the privacy issues.[25] This study also revealed that our provision of care to LGBT patients still focus largely on HIV/AID and STI management, with little focus on mental services, but none have experience in dealing with gender-affirming services, such as hormonal therapy and surgery.[4,5]

Lastly, FMSs are thought to have the responsibility of providing a wide range of care. However, when asked about integrating spiritual needs for LGBT patients during consultations, as many studies found it most FMSs gave a differing stances. Even though most are aware of the Hadith reported by Abdullah ibn Amr where the Prophet Muhammad (Peace and Blessings be Upon Him) said, "Convey from me, even a single verse," (meaning to convey even short message from al-Quran and Sunnah to

other people who may not be aware of it) - they feel uncomfortable due to a perceived lack of knowledge. The FMSs are uncertain about when and how to convey the message properly, so that the advice will be positively received. Because of that, most decided not to give spiritual advice remain silent or delayed giving opinions because they were afraid of causing patients distress if the messages / advice were wrongly provided, which would later have an impact on healthcare delivery.[27] Nevertheless, they agreed that spiritual health is an important dimension of health of LGBT that could improve patients' health outcomes.[27,28] They added that spiritual input should be given by those with qualified spiritual knowledge and expert in the area. A few FMSs believed that spirituality is something personal and imposing personal values is unacceptable in the medical profession. Controversy surrounds the role of spirituality in medical practice and has been extensively discussed in several/other studies worldwide.[29,30]

To address the discomfort and lack of training among FMSs in implementing spiritual health for the LGBT community, collaboration with Islamic authorities is crucial. This is particularly vital as 80% of the LGBT community are Muslims and require spiritual and religious support. The Department of Islamic Development Malaysia (JAKIM) has been proactive since 2015, engaging in outreach activities in identified LGBT areas to encourage participation in treatment and rehabilitation programmes. This effort aligns with Core no. 4 of JAKIM's Fourth Strategy (2015-2019), which emphasises strengthening understanding of Islamic teaching and appreciation of Islam to foster the best generation.[31] JAKIM also collaborates with government bodies, universities in Malaysia and LGBT-related NGOs to raise health awareness and provide spiritual support for the LGBT community. They co-initiated guidelines with the Ministry of Health for managing gender health issues in clinics and participated in the National Strategic Plan for Ending AIDS 2030.[32] Some researchers also suggest Islamic psycho-spiritual therapy to be implemented for LGBT Muslim patients.[1,33] Thus, FMSs should recognise these initiatives and collaborative efforts. They should utilise available modules in implementing spiritual health for their patients so that they gradually feel confident discussing this aspect with them.

According to the World Health Organization (WHO), health includes physical, mental, and social well-being, not just the absence of disease, with ongoing debate about spiritual health.[34] Some advocate adding a 'spiritual dimension' to the WHO's definition, as seen in the Regional Office for the Eastern Mediterranean (EMRO's) publication in 2006. However, others caution against this due to potential misunderstandings between spirituality (personal seeking of connection with God) and religiosity (focus on religious teaching and practice or ibadah), as these concepts are different yet interrelated.[34] Such misunderstandings complicate delivering Islamic knowledge respectfully, as mentioned in the Quran: "Call (people) to the path of your Lord with wisdom and good lessons and argue with them in a good way" (Surah Al-Nahl: 125).[35] This could complicate issues, potentially causing stigma or judgment, discouraging seeking help from healthcare facilities, and further spreading diseases.[36,37]

Lassiter et al. (2020) discovered that combining spirituality and religion significantly impacted mental health outcomes, particularly among religious gay and bisexual men with higher spirituality levels. Conversely, religion without enriching spirituality was linked to mental health issues in this group. They recommended integrating spirituality into interventions to enhance mental health outcomes in this community.[27] Similarly, in Malaysia, Draman et al. (2016) interviewed eight male-to-female transsexuals who faced challenges with their transsexuality during adolescence and encountered discrimination in employment and religious settings as adults. Despite this, they appreciated religious authorities who understood their unique challenges and showed empathy, providing them with religious support, which improved their spiritual health and later encouraged them to follow the true path.[38]

Our study also supports the importance of spiritual health in LGBT care. Mokhtar et al. (2018) argue that all Muslim doctors should incorporate the principle of Maqasid Shariah, which emphasises protecting life and future

generations, while also upholding our Muslim medical oath. FMSs should integrate both religious teachings and medical knowledge into patient care and prioritise the well-being of all individuals, regardless of their religion, background, or past actions.[39] Additionally, due to the sensitive nature of this work, FMSs need to collaborate with psychologists, psychiatrists, and members of the Islamic Department to build confidence and effectively convey Islamic knowledge through simple advice as encouraged by Hadith or psycho-spiritual therapy.

Several limitations in this study includes participations of FMSs were mostly Malays which did not reflect the true ethnic proportions in Peninsular Malaysia and the LGBT community in this region is not as prevalent as other parts of Malaysia. Therefore, we recommend subsequent qualitative studies to be conducted in other regions as well.

CONCLUSION

In conclusion, this study has shed light on the sensitive issue of LGBT in east coast of peninsular Malaysia and the current situation related to the challenges faced by FMS when dealing with LGBT patients. The findings of this study reflect the need for proper training of healthcare personnel to deliver holistic approach, spiritually and culturally competent care for LGBT patients.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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REFERENCES

1. Syed Jaapar, S. Z., Muhamad, R., Abdul Razak, A., & Bakar, M. Construction of Sexual and Gender Minority Identity among Malay-Muslim Natal Females: A Meta-Synthesis. IIUM Medical Journal Malaysia. 2023 ;22(3):1-14. https://doi.org/10.31436/imjm.v22i3.2169.
2. Ayhan CHB, Bilgin H, Uluman OT, et al. A systematic review of the discrimination against sexual and gender minority in health care settings. Int J Health Serv. 2020;50(1):44-61.
3. Laiti M, Pakarinen A, Parisod H, Salanterä S, Sariola S. Encountering sexual and gender minority youth in healthcare: an integrative review. Prim Health Care Res Dev. 2019;20:e30
4. Gibson BA, Brown SE, Rutledge R, et al. Gender identity, healthcare access, and risk reduction among Malaysia's mak nyah community. Glob Public Health. 2016;11(7-8):1010-25.
5. The Human Rights Commission of Malaysia. Study on discrimination against transgender persons based in Kuala Lumpur and Selangor (right to education, employment, healthcare, housing and dignity); 2019. 67 -9 p.
6. Moll J, Krieger P, Heron SL, Joyce C, Moreno-Walton L. Attitudes, behavior, and Comfort of Emergency Medicine residents in caring for LGBT patients: What do we know? AEM Educ Train. 2019;3(2):129-35.
7. Abdessamad HM, Yudin MH, Tarasoff LA, Radford KD, Ross LE. Attitudes and knowledge among obstetrician-gynecologists regarding lesbian patients and their health. J Womens Health (Larchmt), 2013;22 (1):85-93.
8. Banerjee SC, Walters CB, Staley JM, Alexander K, Parker PA. Knowledge, beliefs, and communication behavior of oncology health-care providers (HCPs) regarding lesbian, gay, bisexual, and transgender (LGBT) patient health care. J Health Commun. 2018;23(4):329-39.
9. Carabez R, Pellegrini M, Mankovitz A, Eliason M, Ciano M, Scot M. "Never in all my years...": Nurses' education about LGBT health. J Prof Nurs. 2015;31 (4):323-29.
10. Snelgrove JW, Jasudavisius AM, Rowe BW, Head EM, Bauer GR. "Completely out-at-sea" with "two-gender medicine": a qualitative analysis of physician-side barriers to providing health care for transgender patients. BMC Health Serv Res. 2012;12(1):110-22.
11. Vijay A, et al. Factors associated with medical doctors' intentions to discriminate against transgender patients in Kuala Lumpur, Malaysia. LGBT Health. 2018;5(1):

61-8.
12. Syariah Criminal Offences. Syariah criminal offences (federal territories) act 1997 - Act 559 (esyariah.gov.my). Act 1997; Available from: http://www2.esyariah.gov.my/esyariah/mal/portalv1/enakmen2011/Eng_act_lib.nsf/858a0729306dc24748257651000e16c5/bced11b697691518c8256826002aaa20?OpenDocument.
13. Asian pacific research & resource centre for women, monitoring report: LGBTIQ+ rights in Malaysia; 2020: 26 p.
14. World Health Organization. Review of the constitution of the World Health Organization: report of the executive board special group; 1998. Available from: https://apps.who.int/iris/bitstream/handle/10665/79503/angr2.pdf?sequence=1&isAllowed=y.
15. Creswell JW, Poth CN. Qualitative inquiry and research design: choosing among five approaches Sage Publications; 2017. 109-12.
16. Dworkin SL. Sample size policy for qualitative studies using in-depth interviews. Arch Sex Behav. 2012;41(6): 1319-20.
17. Van Teijlingen ER, Hundley V. The importance of pilot studies. Soc Res Update. 2001; 35.
18. Castleberry A. NVivo 12 [software program]. Version 10. QSR International; 2012. Am J Pharm Educ. 2014;78(1).
19. Maguire M, Delahunt B. Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. AISHE-J. 2017; 9(3).
20. Thomas E, Magilvy JK. Qualitative rigor or research validity in qualitative research. J Spec Pediatr Nurs. 2011:16(2):151-5.
21. Leininger MM, McFarland MR. Madeleine Leininger's theory of culture care diversity and universality. Nursing Theories and Nursing Practice. 2010:317-36.
22. Leininger MM. Sunrise enabler model. 2004. Available from: www.madeleine-leininger.com/cc/sunrise.pdf.
23. Mohamed N, Peck CW, Senekal J. Perceptions of interprofessional collaborative practice in South Africa: A systematic review. Health SA. 2024;29:2413..
24. Muhamad R, Horey D, Liamputtong P, Low WY, Sidi H. Meanings of sexuality: views from Malay women with sexual dysfunction. Arch Sex Behav 2019;48 (3):935-47.
25. Bass B, Nagy H. Cultural competence in the care of LGBTQ patients. StatPearls Publishing 2022. Available from: https://www.ncbi.nlm.nih.gov/books/NBK563176/
26. Mohd Noor UM. AL-KAFI# 261 : Tidak menyampaikan ilmu kerana gagap [Internet]. Pejabat Mufti Wilayah Persekutuan. 2016 [cited 2024 Apr 29]. Available from: https://muftiwp.gov.my/ms/artikel/al-kafi-li-al-fatawi/1290-al-kafi-261-tidak-menyampaikan-ilmu-kerana-gagap
27. Bhat KK, Yadavannavar MC. Role of spirituality in health care: knowledge, attitude and practices amongst medical professionals in a tertiary care hospital. Int J Community Med Public Health. 2016;3(11):3212-5.
28. Lassiter JM, Saleh L, Grov C, et al. Spirituality and multiple dimensions of religion are associated with mental health in gay and bisexual men: results from the one thousand strong cohort. Psycholog Relig Spiritual. 2019;11(4):408–416.
29. Isaac KS, Hay JL, Lubetkin EI. Incorporating spirituality in primary care. J Relig Health. 2016;55 (3):1065-77.
30. Lucchetti G, Lucchetti ALG, Bassi RM, et al. Integrating spirituality into primary care. Primary Care at a Glance - Hot Topics and New Insights [Internet]. 2012:54-61.
31. Md Yusof MI, Abdul Kadir MN, Ibrahim M, Ahmad K, Mohd Noor M. Hadith shahih on the behaviour of LGBT [Internet]. Saadon SA, editor. Department of Islamic Development Malaysia; [cited 2024 Apr 28]. Available from: https://www.islam.gov.my/images/ePenerbitan/Hadis-hadis_Sahih_Berkaitan_Perlakuan_LGBT_BI.pdf
32. Abdullah Z, Sa'ari CZ, Wei Chang, L. Transgenderisme di Malaysia: pelan bimbingan kembali kepada fitrah dari perspektif psikospiritual Islam: Transgenderism in Malaysia: Guide plan back to fitrah from Islamic psychospiritual perspective. Afkar: Jurnal Akidah & Amp: Pemikiran Islam. 2018;20(2):279-322
33. LGBT Malaysians' Human Rights Protected By Federal Constitution: Religious Minister. Code Blue Health is human right [Internet]. 2023 Oct 18 [cited 2024 Apr 29]; Available from: https://

codeblue.galencentre.org/2023/10/18/lgbt-malaysians-human-rights-protected-by-federal-constitution-religious-minister/
34. World Health Organisation. Health and Well-Being [Internet]. www.who.int. World Health Organisation; 2023. [cited 2024 Apr 29]. Available from: https://www.who.int/data/gho/data/major-themes/health-and-well-being
35. Osman MIF. AL-KAFI #1030: Manakah lebih utama berdakwah kepada orang Islam atau bukan Islam [Internet]. Pejabat Mufti Wilayah Persekutuan. 2019 [cited 2024 Apr 29]. Available from: https://muftiwp.gov.my/ms/artikel/al-kafi-li-al-fatawi/2994-al-kafi-1030-manakah-lebih-utama-berdakwah-kepada-orang-islam-atau-bukan-islam
36. Rauch R. Attempts to Reform the WHO Definition of Health (1997–1999). In: Peng-Keller S, Winiger F, Rauch R, editors. The Spirit of Global Health: The World Health Organization and the "Spiritual Dimension" of Health, 1946-2021 [Internet]. Oxford Academic Books; [cited 2024 Apr 29]. p. 161–81. Available from: https://doi.org/10.1093/oso/9780192865502.003.0008
37. Wright AJ, Stern S. The role of spirituality in sexual minority identity. Psychol Sex Orientat Gend Divers. 2016;3(1):71–9.
38. Draman S, Maliya S, Liyana A, et al. Psycho-social and spiritual backgrounds, experiences, and needs as a transsexual: a qualitative study within Persatuan Insaf Pahang. IMJM. 2016;15(2):27-36.
39. Mokhtar RH, Draman S, Ramli AS. How should Muslim doctors deal with the LGBT issue? Free Malaysia Today. 2018 Aug 10 [cited 2024 Apr 29]; Available from: https://www.freemalaysiatoday.com/category/opinion/2018/08/10/how-should-muslim-doctors-deal-with-the-lgbt-issue/