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ORIGINAL ARTICLE

Sexual diversity and social stigmas in the SUS for the LGBTQIA+ community: observations from Rio de Janeiro

Diversidade sexual e de gênero e estigmas sociais no SUS em relação às pessoas LGBTQIA+: observações no Rio de Janeiro

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ABSTRACT This research, the result of a master's thesis presented in 2022, sought to unravel the social representations that accompany the population of Lesbians, Gays, Bisexuals, Transvestites, Transsexuals and Transgenders, Queers, Intersex, Asexuals and others (LGBTQIA+) in the hospital environment. The general objective was to understand the relationship that is established in the care of the LGBTQIA+ population in the hospital environment by SUS professionals. To achieve the general objective, two specific objectives were categorized: to analyze the perception of health professionals about sexual and gender diversity, and to identify possible discriminatory actions that generate violations of healthcare rights of the LGBTQIA+ population in the hospital environment. The methodological procedures included semi-structured interviews and field observation in a suburban hospital in the city of Rio de Janeiro, RJ and, in the methodological analysis, departed from the sociointeractionist perspective of Erving Goffman and the theoretical-conceptual debate based on the concept of stigma by the same author. It was concluded that the LGBTQIA+ population suffers prejudice in the hospital environment, given the lack of training of health professionals and social prejudice of those same professionals.

KEYWORDS Hospitals. Sexual and gender minorities. Social stigma. Unified Health System. Health promotion.

RESUMO *Esta pesquisa, resultado de dissertação de mestrado apresentada em 2022, buscou desvendar as representações sociais que acompanham a população de Lésbicas, Gays, Bissexuais, Travestis, Transexuais e Transgêneros, Queers, Intersexuais ou Intersexos, Assexuais e outros (LGBTQIA+) no ambiente hospitalar. O objetivo geral foi compreender a relação que se estabelece no atendimento à população LGBTQIA+ no ambiente hospitalar pelos profissionais do Sistema Único de Saúde. Para alcançar o objetivo geral, foram categorizados dois objetivos específicos: analisar a percepção dos profissionais de saúde sobre a diversidade sexual e de gênero e identificar possíveis ações discriminatórias que geram violações de direitos de assistência à saúde da população LGBTQIA+ no ambiente hospitalar. Os procedimentos metodológicos incluíram entrevistas semiestruturadas e observação de campo em um hospital do subúrbio na cidade do Rio de Janeiro; e na análise metodológica, partiu-se da perspectiva sociointeracionista de Erving Goffman e do debate teórico-conceitual a partir do conceito de estigma do mesmo autor. Concluiu-se que a população LGBTQIA+ sofre preconceito no ambiente hospitalar devido à falta de capacitação dos profissionais da área da saúde e ao preconceito social desses mesmos profissionais.*

PALAVRAS-CHAVE *Hospitais. Minorias sexuais e de gênero. Estigma social. Sistema Único de Saúde. Promoção da saúde.*

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Introduction

Brazil lacks a cultural tradition of respect and appreciation for human rights, seeing that there are still population groups subjected to prejudice and social exclusion.

Fundamental rights actually appear in the form of privileges for some social groups, while for the majority of the population, there is another reality, marked by unfair and violent social relations. There is a differentiated exercise of citizenship, experienced by all social segments in their daily relationships with those who are imbued with some type of authority, from doormen in school buildings, security guards in shopping centers, police officers, traffic guards, employees of public hospitals, etc., and among these segments there is the group of people Lesbian, Gay, Bisexual, Transvestite, Transsexual and Transgender, Queer, Intersexual or Intersex, Asexual and others (LGBTQIA+).

By being part of the nursing team for more than 30 years, 25 of which were in the Unified Health System (SUS), the main researcher accumulated experience in different situations, both in the role of professional and hospitalized user of the health service. During this period, he was able to observe and be aware of numerous episodes of Human Rights violations among the LGBTQIA+ population.

The multidisciplinary team, made up of health professionals, including nurses, nutritionists, doctors and managers, has the goal of offering a welcoming, qualified environment, ready to solve the user's needs. However, in the process in which the health professional works directly with the patient, he or she exercises some type of power in the relationship, regardless of the form and type of assistance provided. Whether during admission, collecting material for exams, administering medication, evaluating results, or monitoring the history of social life, providing support when a need is observed, among others, the health professional builds his or her interpretation of the individual patient he is treating.

It is in this context that we seek to unveil, based on Erving Goffman, the stigmas that are constructed for the LGBTQIA+ population. For Goffman, "social environments establish the categories of people who are likely to be found there"[1(5)]. However, when a "stranger" is presented, the first aspects allow us to predict his category and attributes, "his social identity"[1(5)]. People are perceived and idealized (positively or negatively) from normative perspectives. However, what is normal? Normal depends on the place an individual occupies in the social stratum.

Therefore, in a society like Brazil, which is homophobic and transphobic[2], there is a social identity of the LGBTQIA+ population that makes this work distressing and challenging. Some fellow health professionals construct their narratives about these individuals through stigmas, with arguments of lack of knowledge on the subject, or even making clear the intentionality of the discriminatory action, considering that the acceptable standard is that of heteronormativity. Thus, a patient is punished in the most diverse situations that deviate from the normative rules imposed by society in a compulsory manner, since the hospitalized patient has no way to react.

This article addresses the results obtained through semi-structured interviews carried out with health professionals from a municipal public hospital located in the North Zone of the city of Rio de Janeiro. Using the interview method as the primary tool for data collection, this study delves into the nuances of interactions between healthcare professionals and patients, especially focusing on the LGBTQIA+ community. The theoretical framework provided by Erving Goffman, whose work stands out in the field of sociology for its detailed examination of social interactions and the introduction of the concept of stigma[1,3], is central to the analysis and interpretation of the data collected.

Erving Goffman, in his studies, explores how social identities are constructed and

perceived in interactional contexts. According to Goffman[1,3], stigma is an attribute, behavior or reputation that can be used to discredit an individual in the eyes of society. In the context of interactions in the health system, this concept becomes crucial to understand how prejudices and lack of qualifications of health professionals can negatively affect the quality of care provided to the LGBTQIA+ population, potentially perpetuating discrimination and stigma.

The guiding questions of this study specifically inquire about the impact of professionals' lack of qualifications and prejudice in providing care to the LGBTQIA+ population in the SUS, questioning how these factors can alter the health-disease relationship. Furthermore, we seek to understand the extent to which discriminatory reactions on the part of SUS professionals can reduce opportunities to promote the health of the LGBTQIA+ community. Goffman's method, by bringing the concept of stigma to the center of the analysis, offers a valuable theoretical framework for interpreting social interactions in the hospital context, allowing a deeper understanding of the challenges faced by LGBTQIA+ patients in the healthcare system.

The general objective of this work was to understand the relationship established in the care of the LGBTQIA+ population in the hospital environment by SUS professionals. To achieve the general objective, two specific objectives were categorized: to analyze the perception of health professionals about sexual and gender diversity and to identify possible discriminatory actions that generate violations of the health care rights of the LGBTQIA+ population in the hospital environment.

This research is justified by its ability to enhance the debate around social issues that arise in society. There is a real demand regarding inequality in the treatment of the LGBTQIA+[4-9] population. It is noticeable on a daily basis that some health professionals, as well as administrative and support staff who provide assistance in the SUS, still believe that the LGBTQIA+ population is the cause of the emergence of various diseases, mainly sexual and mental disorders. This stigmatization violates the principle of equality in hospital care and creates discomfort on the part of this population in not using the SUS for treatment of illnesses.

Thus, fundamental principles of the SUS are completely disrespected, in which there is no equity, there is no equality in care, including with hospitalized users. In this sense, even though the patient is in a hospital environment, professionals are not prepared to receive them. From the moment they arrive at the hospitalization sector until the moment they are accommodated in their units, trans patients face situations of disrespect and embarrassment. However, it is this population that is especially vulnerable to rights violations, which include denial of the use of social names, prejudices during care and treatment – observing, for example, reduced attention from nurses towards these patients –, allocation to wards based on biological sex instead of gender identity, among other issues[7].

The hospital space can represent an adverse situation for the user: fear, insecurity, doubts, among other feelings. The user's or patient's journey in seeking medical assistance due to an illness is, in itself, marked by physical discomfort and, often, by facing the stigmatization associated with their social identity. When undergoing treatments or surgeries, individuals face changes in their daily routines. In the midst of these adversities, the expectation for a humanized and welcoming care environment is often not met. The lack of empathy and sensitivity on the part of professionals involved in therapy, as well as the negligence regarding the specificities of each patient, especially those belonging to the LGBTQIA+ community, highlights a critical challenge. This situation points to a significant gap in the effectiveness of Continuing Health Education, highlighting the need to review and improve care practices, to ensure that care is truly inclusive and respectful of different social identities.

Therefore, this article will introduce the fieldwork, discuss the methodological aspects and present the data from the empirical process and analysis. The latter aims to discuss the contradictions in the speech of the participating subjects.

Material and methods

The methodological direction adopted here was the interpretation of qualitative discourses on sexual diversity and health care for the LGBTQIA+ population, involving the discourse of interviewed health professionals who work in the hospital environment. The method was chosen because it adapts to the research objectives and the conceptual theoretical framework based on Goffman[1,3]. As this author himself proposes, social phenomena manifest themselves in relationships between individuals, in social encounters that represent, in their interactional essence, the social, cultural and political structures of the society to which the interlocutors belong. In this way, the methodology makes it possible to enter into the analytical, ideological and perceptive process of the components of the discourse enunciated in the interviews, as well as the comprehensive and critical aspects of a given social reality, here, the hospital[1,3].

For Minayo[10], the nature of the qualitative method resides in the ability to assimilate meaning and intentionality as an inseparable and intrinsic condition "to acts, relationships and social structures"[10(42)], understanding both social relationships and structures as dynamic, historical and contextual processes. producers of "significant human constructions"[10(42)], overcoming purely positivist aspects, without dispensing with them, in the search to associate scientific rigor with the complex findings in the reality of the subjective and objective field. Values, beliefs, representations, socio-historical context need to be incorporated into qualitative analyses, without losing sight of the complex sociological understanding that the researcher is of the same nature as his object. Minayo[10] also draws attention to another aspect inherent to social research, whether or not it is in the health field: the fact that it is intrinsically and extrinsically ideological. From the choice of the object to the results and analyses, questions of subjectivity permeate the entire construction of a study, based on historically constructed interests and worldviews.

To moderate the 'contamination' of these subjectivities in the critical understanding of reality and to avoid biases in the inferences of the results, the author places objectification as an essential condition for a good qualitative analysis, using, for this purpose, an effective and coherent theoretical and methodological framework. According to Minayo,

> It is up to the researcher to use an accurate theoretical and methodological instrument that equips them in approaching and constructing reality, at the same time, maintaining criticism not only of the conditions for understanding the object but also of their own procedures[10(42)].

Within the qualitative approach as one of the various techniques capable of providing a critical understanding of reality, there is the Socio Interactionist Critical Interpretation[1,3]. Therefore, the interviews presented here will be interpreted based on the theoretical framework and experience in the hospital environment. This proposal aims to enable the understanding of the meanings of the narrated speeches, seeking to decipher the ideological content that supports the discourse.

The strategic choice of conducting five detailed interviews with health professionals in the hospital environment, in the context of the SUS, aims to achieve an analytical depth that responds in a meaningful way to the questions proposed by the investigation. The insertion in the hospital space, a place of complex interactions and often loaded with implicit meanings, offers a rich scenario to examine how communication and behavior occur in relation to the LGBTQIA+ population.

The incorporation of Erving Goffman's theories, specifically his ideas about stigma and social interaction, serves as a theoretical foundation for interpreting the data collected. Goffman[1,3] explored the way in which individuals manage their 'social identities' in different contexts and how stigmas can profoundly affect these interactions. By applying Goffman's concept of stigma to the analysis of the interviews, the objective was to uncover the layers of meaning surrounding health professionals' attitudes and behaviors towards LGBTQIA+ patients.

This dialogue between the answers obtained in the interviews and the theoretical debate on stigma allows us to identify how stigma is reproduced and manifested in the hospital environment. By highlighting this intersection, we sought to understand not only the explicit ways in which stigma presents itself, but also the subtleties and nuances that characterize the interaction between healthcare professionals and LGBTQIA+ patients.

The analysis therefore seeks to illuminate the 'cracks' through which the reproduction of stigma in health is present, examining both intentional and unconscious actions. In doing so, it is hoped not only to contribute to the academic debate on stigmatization and its consequences in the health care of the LGBTQIA+ population, but also to offer practical insights to promote positive changes in hospital practices. This dual approach makes it possible to confront prejudices, promoting a more inclusive and respectful care environment, aligned with the principles of equity and social justice in access to health. Despite trying to play a tolerant role, many professionals show the face of their discrimination in small phrases or words. Goffman[3(25)] states that

> When an individual plays a role, he implicitly asks his observers to take seriously the impression held before them. He asks them to believe that the character they see at the moment has the attributes he appears to have, that the role he plays will have the consequences he implicitly intends, and that, generally speaking, things are what they appear to be. Agreeing with this, there is the popular point of view that the individual performs and puts on his show 'for the benefit of others'.

When thinking about stigma and its social construction, Goffman's social interactionist methodology starts from analyzes of everyday life. The author seeks to understand how individuals and/or groups present themselves in everyday situations. Given the proposition of an empirical research in the space-time of two years and the lack of time available to carry out a systematic search of the day-to-day life of a hospital and its service to the LGBTQIA+ population, and because it focuses on the care provided in a hospital environment, the efforts made were to analyze the discourses from the moment of the interview. We sought to understand how the interviewee expresses themself, directing and regulating impressions about themself when interactions occur. The interactions analyzed here were those that the interviewees reported in the interviews, as examples of how they deal with assistance from an LGBTQIA+ user/patient. Social interaction for Goffman is a form of co-construction of meanings, thus, we sought to understand, through interviews, the meanings constructed between the health professional (heterosexual) – the normal one – and the LGBTQIA+ user/patient – the stigmatized one.

Goffman assumes that an individual plays a role when speaking and that this role is for the benefit of the spectator – in this case, the interviewer[3]. In this social role, there is the sincere social actor and the cynical one. The sincere person is the one who is fully immersed in his discursive exposition and is convinced that the impression of reality he presents is the true reality. The cynical social actor is one who is not committed to his own narrative, he does not believe in his own performance, there is a lack of commitment. We sought to identify sincere and cynical actors in the interviews, as, for Goffman, the concepts of sincere actor and

cynical actor are used as analytical operators to understand communication strategies and representations of social roles.

Goffman's methodology can be applied to the case study presented here, as all social actors involved – the interviewees – work in the same hospital. Thus, the hospital was configured as the setting for these health professionals to act, seeking to understand how individuals are influenced in their actions by the representations they assume in their speeches. It is believed, like the author, that human behavior has different meanings in different contexts and that it is possible to relate them to a broader social context[3].

In the direct approach to research, it is important to clarify how the approaches were carried out. To participate in the study, the main criterion for selecting participants was to be an individual over 18 years old, work in a hospital environment and agree to participate in the research. An initial survey was carried out in order to identify possible participants. The researcher already worked in a hospital environment and, therefore, already had a relationship with potential research participants.

The process began by identifying potential participants through informal conversations in the hospital corridors, exploring the interest of individuals in contributing to research focused on improving the quality of care for the LGBTQIA+ population. After this initial survey and selection of participants, the formal approaches for the research began. This consisted of the identification of the researcher, how he managed to contact the person contacted (in the case of a third party recommendation), explanation of the research and invitation to give an interview about his experience on the topic covered.

Some consideration was taken to emphasize that the interview would aim to obtain general information on the topic, that anonymity would be maintained, that the person contacted would have complete autonomy to participate or not in the research and, if they were to accept, it would be carried out in date and location most convenient for the participant.

Participants were also given the researcher's telephone and email contact details in case they had any questions about the research or if there was a need to reschedule or cancel the interview. All necessary information is present in the Informed Consent Form (ICF) delivered before the interview. It should be noted that the identities of the participants were preserved.

When conducting the research, it was essential to evaluate the risks and benefits involved, especially as it was a study that included interviews. One of the risks identified is the potential discomfort that some participants could feel when answering certain questions. To mitigate these risks and guarantee the confidentiality and privacy of the information collected, it was ensured that the questions asked did not require the identification of participants. Furthermore, the significant benefits that research can bring to both participants and society were highlighted. It is expected that the study will contribute to an enriching discussion about the experiences of LGBTQIA+ users/patients in accessing hospital and health services, in addition to promoting better preparation of health professionals to adequately serve this population.

Regarding interviews and data collection, it was based on Triviños[11] and Mazini[12]. Any research that involves interviews faces methodological questions about how to do them. In this sense, some authors, regarding the semi-structured interview, highlight the formulation of questions that would be basic to the topic being investigated[11,12]. Furthermore, it is important for these authors to define what a semi-structured interview is. Triviños[11] and Manzini[13] have sought to define and characterize what constitutes a semi-structured interview. For Triviños[11(146-152)],

> [...] the semi-structured interview is characterized by basic questions that are supported by theories and hypotheses that relate to the

> research topic. The questions would give rise to new hypotheses arising from the informants' answers. The main focus would be placed by the researcher-interviewer. [...] The semi-structured interview favors not only the description of social phenomena, but also their explanation and understanding of their entirety, in addition to maintaining the conscious and active presence of the researcher in the information collection process.

For Manzini[13(154)],

> [...] the semi-structured interview is focused on a subject about which we create a script with main questions, complemented by other questions inherent to the momentary circumstances of the interview. This type of interview can make information emerge more freely and the answers are not conditioned to a standardization of alternatives.

The two authors refer to the need for basic and main questions to achieve the objective of the research being carried out. Manzini[12] highlights that it is possible to plan the collection of information by preparing a script with questions that achieve the intended objectives. The script would then serve, in addition to collecting basic information, as a means for the researcher to organize himself for the process of interaction with the informant. When presenting the results, the questions asked to research participants will be made explicit.

This research was approved by the Research Ethics Committee of the Sergio Arouca National School of Public Health – ENSP/FIOCRUZ (Opinion No. 5,579,831) and by the Research Ethics Committee of the Rio de Janeiro Municipal Health Department – SMS-Rio (Opinion No. 5,640,125).

Results and discussion

Minayo[10] considers that language does not bring pure experience, as it is organized by the subject through reflection and interpretation in a movement in which what is narrated and what is experienced are embedded in and by culture, preceding the narrative and the narrator. Therefore, the exercise of understanding and interpreting reports in the contexts in which they are presented requires ethics and clarity from the researcher when contextualizing the facts. The data will be presented in such a way that the information is clear to the reader. To present the subjects participating in the research, *table 1* is considered.

Table 1. Profile of interviewees

	Function/Position	Experience time	Formation time	Religion
Person 1	Nursing technique	21	30	None
Person 2	Nurse	21	32	Catholic
Person 3	Nursing technique	7	17	Catholic
Person 4	Nursing assistant	35	aprox. 40	Catholic
Person 5	Nurse	36	Did not answer	Catholic

Source: Own elaboration, 2022.

In *table 1*, it is possible to see that the interviewees who were willing to participate in this research are, in their entirety, female, mostly, with more than 20 years of experience. Of the five interviewed, four profess Catholic Christianity as their religion. Of the five participants, only one did not answer the time since graduation, but based on their working time, it can be deduced that the majority have more than 30 years of training in their field of expertise.

Regarding questions about the importance of the participants' role in hospital care, and whether they believe they are doing a good job (and why), *table 2* was made to contribute to the interpretation process.

Table 2. Role of the function and professional performance

Participant	What is the importance of your function in hospital care?	Do you believe you are doing a good job? Why?
Person 1	My role is to 'take care' of assistance, not only physical but also psychological, meeting the user's needs.	Yes, I always believed. Because it's what I like to do, it's the profession I chose and here I work as a nursing technician, but I'm also a trained nurse.
Person 2	It is the leadership of the team and planning of patient care, provision of material for a shift, direct assistance to the patient, the client, depending on the user of the SUS, which has several nomenclatures.	I think it could be better because of, how can I say, the system that the city hall imposes on us. The government in general, the SUS has a lack of material, material of poor quality, sometimes unprofessional for the group's work demands and the requests from the clientele, which are a lot and we are sometimes unable to reciprocate this demand. This makes me frustrated, it makes us very frustrated sometimes.
Person 3	Well, the biggest function in nursing is 'care'. We have this function, and I think every professional should have it. In nursing, we have this in mind, 'care', attention to the patient. Our main objective, in our profession, is 'caring' in general.	Yes, I believe so. Because for me, the patient, I see him as a whole, I have empathy for him. I imagine myself as if I were in his position. So, I try to do the best I can, being attentive, observing the signs, listening to him. I think one of the most important things we need is to listen to the patient. And do everything we do with love to take care of the other. To take care of human beings, we have to have love in what we do. I won't even say love for human beings, but if you have love for what you do, you take care of it and take good care of it.
Person 4	My role is to 'take care' of the patient, in the best way possible.Save lives if they are at risk.	I think so. I'm helping someone and being helped too, exercising my humanity by putting myself in other people's shoes many times. This is very important. Acting like this implies considering that tomorrow it could be you in that situation, or a relative of yours, or a friend. It is essential to work with this perspective
Person 5	It's about 'taking care' of patients with dignity, in the best way possible, in short.	Yes. Because the purpose of my profession is to do good work, with quality, assistance, with quality, in general. Researcher's re-examination:But do you believe you are doing a good job? Answer: I always have, I will continue to do so until the end, God willing

Source: Own elaboration, 2022.

All participants, except person 2, regardless of their role, used the term 'caring' when responding about the importance of their role in the hospital environment. This demonstrates that health professionals are aware of their importance in the medical context, of their responsibilities in the hospital environment. When asked if they believed they were doing a good job, they all said yes. Only person 2 highlighted the frustrations of the work environment:

> *[...] the SUS has a lack of material, material of poor quality, sometimes unprofessional for the group's work demands and the requests from the clientele, which are a lot and we are sometimes unable to reciprocate this demand. This makes me frustrated, it makes us very frustrated sometimes.*

It appears that this person, as Goffman claims, is a sincere actress. She did not naturalize the problems or romanticize her role in the hospital environment. She highlighted that issues relating to the work environment prevent her from doing a better job.

Regarding the issue of the exceptional, the diverse, the five participants were asked whether, in their experience, there are population groups that experience difficulties in hospital treatment? If so, which group and why? If not, why? In *table 3*, their responses are listed.

Table 3. The first impression

Participant	In your experience, are there population groups that experience difficulties in hospital treatment? If so, which group and why? If not, why?
Person 1	Unfortunately, yes, we know that this exists. That's what happens, you know, we are still, in relation to many, myths, beliefs and even respect for others, ourselves, and sometimes we want to select the assistance. Some examples I have are that we have to look at the client as a whole, we cannot see religion, race or what they did or didn't do. Our role here is to provide assistance. But we know that if a patient who killed or raped a child or something comes here to our care, the care will not be the same as for any other person, right?! At the moment only these.
Person 2	I think it's due to the difficulty of getting here to the hospital, due to the delay in SUS care, so to speak. Due to the regulatory system, I think it greatly harms client treatment, which takes a long time to reach the final point, which is hospital care. Was it that question? I think so, was it more or less that? I think people that are poorer, with little 'knowledge'. Let's say, it's more difficult to get there even because of the clarification of some situations. The doctor says, they don't understand; we say they don't understand.
Person 3	Yes, I believe so. Due to the lack... the main problem in the reality of our lives, within the health institution, in general, is the 'lack of knowledge'. Many times it is the lack of knowledge, recycling, knowledge, evolution. We are evolving, people nowadays have ways of thinking, ways of acting. And so, the lack of knowledge sometimes makes us make mistakes, commit errors in some procedures, in some behaviors. And sometimes it's not even good for patients. For certain patients, it affects the psychological aspect, even more so if they are weak, depending on us, sometimes it even interferes with their evolution, with the improvement of that patient's health.
Person 4	Yes, because there are still many racist people. There are a lot of people who look at you, and think you're a cook, a cleaner, they don't treat you like a human being, they throw things away, there are few of them, but there are.
Person 5	Yes, every day we see this type of situation. It is mainly people at the outpatient level that we see the difficulty in assistance, the difficulty in achieving adequate, dignified treatment, unfortunately we see the end of several services that are extremely essential for patients, in short, this is a daily occurrence.

Source: Own elaboration, 2022.

Regarding population groups that may suffer some difficulty in the hospital environment, the participants stated that there are. However, the group itself, remembered, were the poorest and blackest. Class and race prejudices were remembered, this demonstrates that class and race are more present in the daily lives of these subjects, making them identify more with their everyday reality.

However, when directing attention to the LGBTQIA+ population, the responses changed, as can be seen in *table 4*.

Table 4. Identification of the LGBTQIA+ population and preparation of health professionals

Participants	Do your work activities include caring for patients from the LGBTQIA+ population? How did you identify that such a patient belongs to this population?	How did you feel caring for this patient or patients? (question whether this professional was prepared, whether it was an 'easy' or 'difficult' service)
Person 1	We, 'here in this unit, we provide assistance to this type of population and we have an infectious disease unit here, right, which is PID and it's common for us to have this type of people, right?', huh! The number is very large, the group of gays, right! And what happens? The service, I, as a professional, care for them like any other person, understand?! Respecting and caring. Re-examination. But how do you identify that this person is part of this population? A: 'Today it is very easy to identify these types of people', because today, 'with liberalism, right?!' and with the respect that we have to have for them, they already come with the 'trade name', they identify themselves, and then when they talk, when they walk, you start to notice something different, you know, you can clearly see, 'when they don't speak, you can visibly notice that there is something different'.	There's still a lot of taboo around this, right? 'It's a new thing', they are increasingly imposing themselves, having a place in society, and what happens? I'll tell you about my recent experience, I was in a surgical clinic and one of the patients, one of the clients, was in a women's ward, and one of the clients, when I went to see it, when I went to provide assistance, I realized that something was different, 'because, like, they will be 100% a woman', there will always be something, some characteristic of their sex at birth, you know?! And what happens, I went to have a good day, I went to talk to this person, this person answered me, and there from the voice, I also saw that it wasn't, right?! And even so, he had a social name and in this unit, 'he was in a women's ward because it's right, it's the law'. But I treated them normally, like any other client. Immediately, as much as you don't want to discriminate or treat as a whole, there is a certain difference. 'You notice that your look at that person is different', not the care, the care will be the same, if you have to provide assistance you will, but there is a difference. I don't know how to express myself here, but you see that there is something different. 'What is that person doing there in a female ward, since the genitalia of that person, of that patient I'm referring to, was male'. Because I prepared this patient for the surgical center, so I ended up seeing a female face, with a male organ, with the speech trying to be feminine, but there is something masculine. And so, the impact, you look at it like this, is a very big impact. Re-examination: Given all of this, did you feel prepared for that service? A: No, you get used to the service. I need to provide assistance and I will assist that person who is there, but we are not prepared to assist these types of people. Was the service, in your opinion, easy or difficult? A: It became easy, because with our experience, we see the patient as a whole, but at first, it was difficult.
Person 2	Care, we care. Because the service is public, we sometimes observe it. Because in the sector where I currently work, the clientele is female, we can tell by the person's posture, the clothes they wear, sometimes we notice that they are different from the majority, that's it.	No. It wasn't difficult. I treat it normally, I give that distance that we always give from the patient as a professional, treating them with respect, because each patient has a, how can I say it, the term is escaping me, a specificity. No, a different characteristic, so to speak. And we try to get close to the patient according to each one's characteristics, right?! Not a difficulty in general, even because of the years of experience I have, it makes it easier for me to approach the client.

Table 4. Identification of the LGBTQIA+ population and preparation of health professionals

Participants	Do your work activities include caring for patients from the LGBTQIA+ population? How did you identify that such a patient belongs to this population?	How did you feel caring for this patient or patients? (question whether this professional was prepared, whether it was an 'easy' or 'difficult' service)
Person 3	Yes, we already do. And we often identify by social name and depending on the patient's situation, if he has time with you, if he feels comfortable with you, sometimes he tells us his situation, his life. Yes, we do, I have seen several patients.	So many times I found myself, like, not knowing how to behave, how, as incredible as it may seem, we are dealing with people all the time, with illnesses, with molestations, but we end up, 'prejudice is a something that (sometimes) is within us, and even if you don't want to go through it, you end up dealing with it or not knowing the right way to deal with it due to lack of knowledge', really clarification, understand? Reinquire: Q: Did you not feel prepared, was it not easy? A: No, no. I didn't feel prepared, I think the issue of prejudice, even as health professionals, who deal with various people, various behaviors, we are not prepared. I didn't feel prepared to assist in some of the cases that came to me, no.
Person 4	Some names you've never heard of, I've already taken care of people at PID, we take care of people, we take care of human beings, no matter what they are. You have to treat people well and with affection, because often people have problems and it's not even that and they imagine a lot of things.	Normal, because it's a human being, you have to treat them normal. 'Not having any scruples, like I don't have any'. It was easy, because people, as I already said, you have to take care of the person thinking about tomorrow: if it were a member of your family, if it were a friend, would you treat them badly? No. Why then will you treat the other person badly? I think so.
Person 5	Yes, especially working with PID patients, without any problems, I always had a good relationship and always identified with great respect and I never had any problems. Normally, 98% of them tell us, if it's in a specific sector, they always tell us.	Normal, always trying to listen to social issues, when they have them, when they feel free to talk... listen and deal with them in the best possible way, talking, supporting, advising, in short. I identified a lot, I thought it was really cool. Professionally, we can act directly, and even on the psychological factor we have great influence, when it suits this type of patient.

Source: Own elaboration, 2022.

In *table 4*, person 1, it is possible to recognize in this part the complexity and nuances of internalized prejudices and social stigmas that persist among health professionals in relation to the LGBTQIA+ population, even in contexts in which professional ethics require respect and equality of treatment. The use of the expression 'trade name' by the interviewee to refer to the identity of a trans woman illustrates a lack of recognition of the legitimacy of the patient's gender identity, reflecting a disconnect between expected practices of respect and inclusion and the nurse's personal attitudes.

Furthermore, the interviewee's admission that respect for the LGBTQIA+ population is seen as a professional obligation, and not necessarily as a personal conviction, highlights an important challenge in promoting equality in health care. This suggests that, although policies and training can instruct professionals about the importance of respect for all patients, including those from the LGBTQIA+ community, effective change in attitudes may require a deeper effort to raise awareness and deconstruct prejudices.

The finding that differential treatment is perceived even by those who intend not to discriminate indicates that prejudice is not only explicit, but also operates subtly in everyday interactions. This involuntary recognition of a 'different look' for LGBTQIA+ patients reveals how stigma and discrimination are ingrained and how they can negatively influence the healthcare experience for these individuals.

This conclusion, therefore, points to the

need for continued education and awareness-raising work in the health sector, aiming not only at formal adherence to non-discrimination policies, but also at a deeper transformation in the personal attitudes of health professionals. This involves developing a deeper and more empathetic understanding of the lived realities of the LGBTQIA+ population, overcoming stereotypes and prejudices to promote a truly inclusive and respectful care environment.

Person 2 showed a degree of understanding regarding stigmas; still carries the idea of 'presenting something different', but, in its sincerity or 'cynicism' (characteristic of the cynic), she positions herself in a more impartial way regarding the service aimed at the LGBTQIA+ population. Person 3 states that she identifies the LGBTQIA+ population by their social name, and, if there is interaction in the hospital environment, some end up sharing their life experiences. In terms of preparation to care for this population, person 3 did not feel prepared, assuming that part of this situation is due to deep-rooted prejudice. However, even if this does not change the quality of the work, it changes the way of treating the patient, which can generate discomfort in subjects who belong to the LGBTQIA+ population.

Person 4, when he understood which people the acronym LGBTQIA+ was referring to, immediately associated them with the environment of the Infectious Parasitic Diseases (IPD) sector in hospitals. In this sense, even though there is awareness that this population is more vulnerable to infectious diseases for different reasons, in 35 years of experience, finding LGBTQIA+ people just in this specific environment validates the work discussed by Guimarães[4] when stating that the LGBTQIA+ community cannot access the SUS because of the stigma they suffer at all hierarchical levels of the public health structure.

The existence of legislation that represents this population is only symbolic when there is no effective application. The presence of a regulatory and supervisory system is fundamental to ensuring the rights of the LGBTQIA+ community. Another issue raised (or not) by person 4 is the perception that the lack of scruples makes it easier to serve people from the LGBTQIA+ community. However, it is not clear whether this person understands the true meaning of the word, which in this context would be 'careful'. In other words, do you need to be a non-careful person to work in the healthcare sector? Or just to treat LGBTQIA+ people?

Person 5, in her speech, brings her experience with the LGBTQIA+ population in the DIP environment as well. In this sense, it can be said that there is a direction in the statements that makes this health environment more accessible to this population. However, when it comes to direct service to this user/client population, the professional brings this into her life as a positive challenge.

In general, none of the participating professionals were/are prepared to care for the LGBTQIA+ population; even those who claim to be, have compared us to 'things' that need to be 'resolved'. Humanized treatment is not discussed in any of the statements, which demonstrates that hospital care is not qualified to serve LGBTQIA+ people. If they need to, they may suffer prejudice associated with socially imposed stigmas and the personal discrimination of each health professional, who either treats them with care or treats them without scruples.

Final considerations

Here we sought to measure the intensity of stigma, prejudice and discrimination towards the LGBTQIA+ population. We went into the field to understand the perceptions of health professionals who work in the hospital environment and how they interact with patients that belong to this population.

From Goffman's point of view[1,3], it can be stated that the mark attributed to the stigmatized subject always places those who stigmatize them in a position of superiority and

normality, based on various socially imposed preconceived and normative social markers, resulting in a 'deteriorated social identity' of the stigmatized subject. Of the types of stigma, all

> carry the same sociological trait, the stigmatized individual is unable to achieve full social acceptance, whose relationship with others focuses precisely on the 'derogatory' attribute and the impossibility of seeing other characteristics of their personality[14](33).

We sought to support the discussion based on themes, presenting the results in tables, outlining the discussion based on the contradictions in the speech of the participating subjects. It is understood that the fundamental role of stigma, as a determinant of social inequality, constitutes an element of power and domination, in which, in an essentially discriminatory way, certain groups are excluded or valued, involving the process of labeling and stereotyping triggered by various mechanisms, including in the hospital environment.

About the guiding questions of this research – how does the lack of qualifications and prejudice of professionals in caring for the LGBTQIA+ population in the SUS change the health-disease relationship?; and can discriminatory reactions on the part of SUS professionals reduce opportunities for promoting the health of LGBTQIA+ people? –, we can say that the lack of qualifications and prejudice on the part of these professionals when serving the LGBTQIA+ population was made clear. These reactions prevent, as already highlighted in 2018, in a work published by Guimarães, the inclusion of this population in the SUS in search of health care in primary care.

Regarding the first specific objective – analyzing the perception of health professionals about sexual and gender diversity – it was observed that the perception of health professionals about sexual diversity is still, in general, driven by the persistent biomedical model based on binarism of the subjects and the limitations of the biological body. The subjectivities of professionals regarding their view of the health of the LGBTQIA+ population were made explicit so that they could be interpreted. The professionals' difficulty in addressing users' sexual orientation and gender identity demonstrated that the taboo of talking about sexuality even in these times and other subjective formations that include prejudice and religiosity hinders professionals' understanding of sexual orientation and gender identity as concepts incorporated in the analysis of the social determination of health.

In respect to the second specific objective – identifying possible discriminatory actions that generate violations of the health care rights of the LGBTQIA+ population in the hospital environment –, this was not specifically evident. Not in a physical way, but symbolic violence was evident in some of the speeches analyzed.

The present study has some limits, however it is believed that the results obtained here demonstrate how much stigma persists and operates 'incarnated' in the subjectivities of individuals according to different socio-historical contexts and experiences. In addition to responding to the objectives, they will be able to contribute to the planning of professional training strategies.

Collaborators

Santo AN (0000-0001-9937-4034)* contributed to the design of the work, collection, analysis and interpretation of data, and writing of the article. Vasconcellos LCF (0000-0002-7679-9870)* and Pereira EA (0000-0001-6681-5016)* contributed to the critical review activities. ■

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