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Editorial

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It is my pleasure to welcome you to the LGBTQ+ Special Issue of The British Student Doctor Journal.

We began work on this issue over a year ago and it has been a phenomenally inspiring journey. From an idea formed in response to both my lived experiences in the NHS, and as a witness to those of other LGBTQ+ people, it stands now as a powerful queer expression of resilience and pride. We partnered with GLADD, The Association of LGBTQ+ Doctors and Dentists, to co-publish this issue, and they have provided great support and a wonderful editorial exploring many of the themes which have been included in this supplement. There are a number of very exciting, thought-provoking, and educational articles which we are delighted to be able to share with you.

It was important for us to create an issue which celebrated and platformed the LGBTQ+ community. As part of that mission, we commissioned a wonderful queer artist, JanCarlo Caling, to design the beautiful bespoke art featured on the front cover of this special issue. In his own words, JanCarlo explores his work:

JanCarlo Caling (he/him) is a freelance illustrator based in Birmingham. He is currently studying a masters' degree in visual communication at Birmingham City University.

This illustration was motivated by the huge reach of the LGBTQIA+ community - from our influence on pop culture to the hardships that we have faced throughout history. I wanted to emphasize how diverse the community truly is, by featuring famous historical LGBQTIA+ icons of varying race and body shapes such as Marsha P. Johnson, Audre Lorde, and Keith Haring. I tied this all together to create something more contemporary by incorporating up and coming LGBTQIA+ activists such as Jamie Windust, Chella Man, and Eddie Ndopa. It is important to show the many faces of those who helped to shape the future of LGBTQIA+ people, especially those so often forgotten to history. These individuals pave the way for future generations of queer people by educating us, inspiring us, and fighting for our rights as humans. They deserve to be recognised, remembered, and celebrated.

You can reach me on Instagram: @jn_crlo or via e-mail me at jancarlo27.art@gmail.com.

As I reflect on this issue, I am reading through the aims I listed when scribbling plans in my notebook. *To platform, to inspire, to educate.* It is my hope that this issue is a steppingstone for aspirational queer medics to continue working on rectifying the inequalities that our community still faces and to achieve incredible things in the future. This special issue has certainly inspired me to do so.

We hope you thoroughly enjoy The LGBTQ+ Issue of *The British Student Doctor* Journal as much as we have enjoyed its curation. We would like to thank GLADD for their support and belief in this special issue, even when it was just a concept in my notebook; the authors for their hard work and for sharing their voices; the editorial team for their unwavering support; the peer reviewers for their rigorous evaluations; the faculty advisory board for their mentorship; and our publisher, Cardiff University Press.

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Editorial

GLADD, The Association of LGBTQ+ Doctors and Dentists

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Conflicts of interest:
I am Co-Chair for GLADD – The Association of LGBTQ+ Doctors and Dentists, a non-profit members organisation which represented LGBTQ+ doctors, dentists and medical/dental students in the UK. GLADD has financially supported this special edition of the BSDJ with sponsorship funding to advance the understanding of contemporary LGBT+ health issues in training healthcare professionals

It is with great pleasure that I write in advance of this LGBTQ+ Special Supplement of The British Student Doctor Journal. I would like to warmly welcome the readership to a timely and important discussion of the current state of LGBTQ+ health in the UK.

Modern healthcare is no longer strictly a series of means by which to diagnose and treat pathology. Understanding of the interplay between diversity, individual identity, and the wider society impacts on health has become increasingly more recognised as important. Unfortunately, however, there continue to be significant areas where the data have not been collected, or wherein data exist but have failed to be acted upon – to the detriment of the health of minority communities. The LGBTQ+ community is one such example.

We see, even in modern healthcare, that the spectre of Section 28 – a tremendously damaging piece of historical legislation, which prohibited "promotion of homosexuality" – lives on within the memory of our health service (Topping). While the rights (as enshrined in law) of lesbian, gay and bisexual people have improved in this country; there remains to be a significant disparity between legal rights and the actual, lived experiences of everyday inequalities. We live in a society where transphobia runs rife, with the trans community under near-daily siege by mainstream media and on wider social media platforms (McDowell).

Whilst the government and wider society fail to appropriately address issues pertaining to a raft of LGBTQ+ societal inequalities, it is clear that there is a role for the health service and healthcare providers in addressing this. Such matters of identity negatively impact on many areas of individual health when faced with discrimination and prejudice – both individual and institutional. The interactions between modern concepts of individual identity and the established model of medical care are complex, however in the pursuit of wellness and health, this model may well be failing queer communities (Halliday).

A key driver of health inequalities experienced by the LGBTQ+ community lies in the interactions between healthcare provider and individual identity. Precipitated by previous direct or indirect experiences of negative attitudes from healthcare providers, LGBTQ+ people often develop anticipation, or even fear of, negative attitudes. This phenomenon can drive patients to avoid disclosure of sexual orientation or gender identity to clinicians, or even avoid healthcare settings entirely; to the detriment of their own health (Bracho Montes de Oca et al).

To begin addressing these pervasive issues, it is evident that appropriate education for healthcare providers is of fundamental importance. Given the profound impact which poor communication skills from healthcare practitioners can have on the health of the LGBTQ+ community, this is a clear area for improvement. While developing and refining their communication skills, medical students, nursing students, and other trainee HCPs must be afforded adequate opportunity and space to practice communication skills specific to LGBTQ+ patients (Finn et al).

In consideration of such training, curriculum developers need to consider the implementation of practical support in LGBTQ+ specific training, particularly pertaining to communication skills. It is important, however, that these are co-produced with LGBTQ+ stakeholders to ensure that the community is well represented within healthcare training (Ching et al). In doing so, curriculum developers may well address key failings of previous curricula wherein the 'hidden curriculum' of LGBTQ+ interactions focus solely on risk behaviours and pathology (Helppi & Pliener).

One of the major movements towards addressing failings in LGBTQ+ healthcare in recent years are focussed on increased visibility. As an often-invisible protected characteristic, LGBTQ+ healthcare staff and patients can often feel a profound isolation within the health service, which can have significant negative impacts on wellbeing (Doherty). Initiatives to address this can allow peer networks of junior healthcare staff and students to connect, support one another, and even challenge the historic assumptions about LGBTQ+ healthcare held by the institutions within which they work and learn (Rojo et al). Further to this, projects aiming to provide visibility to LGBTQ+ patients can highlight advocates for them within a system in which they may feel powerless (Farquhar).

When considering what a modern healthcare system must do to facilitate equal and inclusive healthcare, it is vital to appreciate the importance of intersectionality. Society holds many complex and interwoven social barriers and discriminatory systems which convey worse outcomes to minorities within minorities (Melo). When devising health promotion campaigns, target groups are often identified, however, it is imperative that considerations be taken to avoid minority groups falling through the gaps (Binse).

Ultimately, it should not be the sole responsibility of LGBTQ+ students and clinicians to drive these changes. There needs to be increasing responsibility for allyship from educators, curriculum developers and institution leads alongside that of individual clinicians. Allyship from educators should take the form of involvement of LGBTQ+ individuals in the development and deployment of teaching and learning (Vincent & Quinney). Curriculum developers must provide institutional advocacy of inclusive curricula, with LGBTQ+ health topics woven throughout healthcare training programmes (Finn et al). For the individual ally within these healthcare systems, we must learn to optimise our allyship for minorities within minorities and be strong enough to hold the institutions in which we work and learn to account (Benfield).

I would like to thank the hard work of the BSDJ editorial team and the contributing authors for their dedication to advancing understanding of the state of LGBTQ+ healthcare. I am confident that the readership will enjoy an excellent curation of pieces, and hopefully have been provided the opportunity to learn, reflect, and grow as I myself have in the process of this editorial.

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Original Research

The representation of women who have sex with women (WSW) in sexual health promotion in England: a frame analysis

ORIGINAL RESEARCH

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ABSTRACT

Background: Women who have sex with women (WSW) are a marginalised group. WSW are assumed to be at low risk of sexually transmitted infections (STIs). However, they have similar rates of STIs to women who have sex exclusively with men. A lack of accurate and relevant sexual health information for WSW has been identified and highlighted as a barrier to good sexual health in this group. This study aims to explore how WSW and their STI risk are represented in sexual health promotion in England.

Methods: Organisations that produced sexual health promotion campaigns or policy were identified using a three-step Google search. Up to three materials from each campaign were chosen for analysis alongside policy documents. Frame analysis was used to identify and develop a thematic framework that identified common themes and assumptions from the data.

Results: 47 materials were included in the analysis: 5 policy documents, 11 posters, 11 leaflets and 20 online articles. 9 frames were identified and used to discuss the two overarching themes that emerged from these: over-representation of the penis and under-representation of WSW and their relevant sexual practices.

Discussion: This study suggests an androcentric and heteronormative framing of sexual health promotion, resulting in the erasure of WSW. Erasure perpetuates false narratives of low STI risk and symbolically annihilates this group, a form of symbolic violence. To address this issue, I suggest empowering WSW by acknowledging this erasure and developing new sexual health campaigns and policy with the participation of this group.

BACKGROUND

The term women who have sex with women (WSW) is defined as any woman, regardless of sexual orientation, that has had at least one sexual encounter with women. (1–3) This is a diverse and heterogeneous group and includes a vast spectrum of sexual identities. Of these, the most commonly cited in the literature are heterosexual, lesbian/gay, and bisexual. (4–7) For the purpose of this paper, I have focussed on cisgender women as the needs of trans and non-binary people are different (8,9) and are beyond the scope of this study.

The sexual health of WSW needs to be understood in the wider social and cultural context of English society. WSW are a marginalised group that experience systemic violence, social exclusion and victimisation. (10–12) All of these factors have been shown to adversely impact health. (13,14) WSW have poorer experiences of healthcare, encountering discrimination and prejudice from staff, as well as exclusion and marginalisation from the healthcare space as a whole. (11,15,16) In addition, WSW exhibit fewer health-seeking behaviours, and have low levels of disclosure of sexuality. (5,7,11,15–17)

WSW have been excluded from sexual health discourse and have been labelled as a 'low-risk' group for contracting and transmitting sexually transmitted infections (STIs). (5,11,18) Because of this assumption, little research is conducted around WSW and their risks of STIs compared to men who have sex with men (MSM) and heterosexuals, a gap in research that extends beyond sexual health. (14,18) This gap reinforces the assumption that WSW are not at risk of STIs. The invisibility of WSW occurs not only in research but in the physical healthcare spaces and sexual health clinics and is reflected in an absence of accurate and relevant sexual health information for this group. (12,19,20)

The erasure of WSW in sexual health discourse is not reflective of their real risks of STIs. STIs such as trichomoniasis, genital herpes, human papilloma virus (HPV), and human immunodeficiency virus (HIV) are transmissible through sexual contact between women, through cervicovaginal fluid and direct mucosal contact. (5,6) Although it is often assumed that the risk of STI transmission between women is lower than between people of the opposite sex, WSW have similar rates of STIs compared to women who have sex exclusively with men (WSEM). (6,21) In addition, women who have sex with both women and men have higher rates of most STIs than WSEM. (12,21–24)

The lack of relevant sexual health information for WSW has been highlighted as a barrier to good sexual health. (12,25–27) There is an absence of relevant and targeted sexual health information for WSW; an absence that is also present in English sexual health policy. (11,22,28–30,31) The aim of this study was to explore how WSW and their STI risks are represented in sexual health promotion in England, to contribute to understanding of the visibility and representation of this group in sexual health promotion, and to guide future sexual health promotion strategies.

METHODS

Our frame analysis explores how the framing of sexual health promotion presents WSW and their risk of STIs. Proposed by Erving Goffman, frame analysis is based on framing theory, which states that how a topic is presented to an audience (the 'frame') influences how people process what is presented. (32) Frames through which information is conveyed allows us to study the social construction of reality, which can subsequently influence peoples' choices and decision-making which is related to the information presented. (33) Although often used to study media communication and social movements, here it is applied to sexual health promotion campaigns and policy.

Data Collection

Two types of data were collected for this analysis. The first data set is sexual health promotion campaigns relating to STI transmission, treatment, and prevention. The second data set is sexual health promotion policy. Both of these were included to gain a broader understanding of sexual health promotion in England.

The search engine Google was used to find organisations that produced relevant campaigns and policy. Google was used to ensure that the data collected was the most current and accessible to the public. Data collection was divided into three steps, outlined below:

- **Step 1**: Search for sexual health campaigns. The following search terms were used: 'sexual health promotion England/UK'; 'sexual health campaign England/UK'; 'sexual health charity England/UK'; 'sexual health organisation England/UK'; 'sexual health NHS'; 'HIV campaigns England/UK'; 'HIV charity England/UK'. The organisations that produced sexual health promotion campaigns were mapped in Figure 1.
- **Step 2:** Search for sexual health promotion policy. The search terms used were: 'sexual health policy England/UK'.
- The organisations from this step were also mapped in Figure 1.
- **Step 3**: The webpages from the previous two searches were explored and any other relevant sexual health promotion organisation mentioned on these were added to the map.

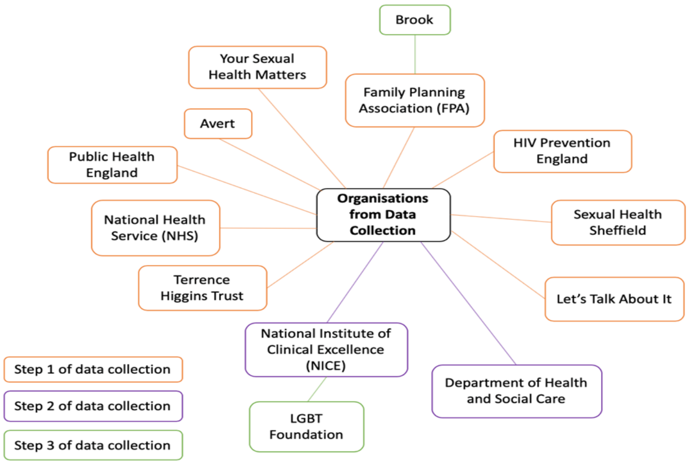


Figure 1: *Mapping of the organisations from the steps in data*

From these organisations, relevant campaigns and policy documents were identified according to the inclusion and exclusion criteria (Table 1). For each campaign, up to three materials were chosen to represent the breadth of the campaign. The full list of materials included in the analysis can be found in Appendix A.

Inclusion Criteria	Related to STIs, including HIV (testing, prevention and treatment). Ongoing campaigns, campaigns from the 3-year period prior to the start of the study (2017- February 2020), currently active policy documents. Campaigns and policy from England.
Exclusion Criteria	Focus on contraception, sexual pleasure, consent, sexual wellbeing, relationship and sex education, abortion, cervical screening, funding of services and clinic appointments, pre-exposure and post-exposure prophylaxis. Campaigns or policy from Scotland, Wales or Northern Ireland.

Table 1: *Inclusion and exclusion criteria*

The analysis of the data was conducted using the 'framework' method outlined by Ritchie and Spencer: familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation. (34–37) The thematic framework was developed from a priori and from emerging themes. It was edited during the indexing and charting phases to be more representative of the data. Further details on this process can be found in Appendix B. The thematic framework was mapped as shown in Figure 3.

RESULTS

47 materials were included in the analysis. These consisted of 5 policy documents, 11 posters, 11 leaflets and 20 online articles. A total of 9 frames were identified, defined in Table 2. The frequency of each frame in the data is illustrated in Figure 2.

Two key overarching themes emerged from the analysis of the frames: the over-representation of the penis and the under-representation of WSW and their relevant sexual practices. These themes are mapped in Figure 3.

DISCUSSION

Over-representation of the penis

One key theme that emerged in the analysis was androcentrism. Androcentrism refers to the positioning of male experiences and male bodies at the centre of a world view; at the expense of female, transgender, and non-binary bodies and experiences. (38) In this context, androcentrism was apparent through condom- and penis-centric discourse.

The most frequent frames in the data were 'condoms as universal', followed by 'anyone as susceptible to STIs'. It is hard to know whether WSW would consider themselves included in this latter frame. Although quite broad, surely encompassing WSW, it was also regularly accompanied with sentences like 'after unprotected sex', where unprotected sex was defined as sex without a condom. For example, "Safer sex involves using condoms correctly every time you have sex" (A06) and "Sex without using a condom is called unprotected sex" (A25). Therefore, the 'anyone as susceptible' message may have been overshadowed by the framing of 'condoms as universal'.

Condoms can be used by WSW when having sex with women. They can be cut and used as a dam (also known as 'dental dams', i.e. thin pieces of latex or polyurethane that act as a barrier between the mouth and the vulva/anus) or used on fingers and sex toys. This is included in the 'condoms as useful for WSW' frame. Unfortunately, this frame was only present in 9 of the 42 (21.4%) campaign documents, and never alongside the 'anyone as susceptible to STIs' frame. This suggests an assumption that only people with penises should use condoms.

Furthermore, in the 'oral sex as posing a risk of STI transmission' frame, oral sex was sometimes framed as a risk that could be reduced by using a condom (A24, A27, A40). In the absence of information that a condom could be used as a dam, this provides an additional assumption that oral sex must be performed on a penis.

The presence of condom-centric discourse combined with the absence of information about alternative uses of condoms frames sex as an act that necessitates a penis. It also frames STIs as a risk only present in sex that involves a penis, thereby creating a false assumption that sex between women carries no risk of STI transmission. This alienates WSW and the reality of their sexual practices; and leads to misinformation regarding their risks of STIs. This narrow framing of sex erases the variety of sexual practices that people engage in outside of vaginal/anal/oral penetration with a penis. (39)

Under-representation of WSW and their relevant sexual practices

The focus on condoms and androcentric discourse has left little room for information that is targeted or relevant to WSW. WSW were under-represented in the data. The 'WSW as having specific sexual health needs' frame was present in 12 materials (25.5% of the data), demonstrating that although WSW were included to some degree, they are also excluded from a large proportion of sexual health promotion.

WSW were framed as overlooked (see 'WSW as overlooked in sexual health' frame in Figures 2 and 3). There were two manners in which WSW were framed this way. Firstly, they were ignored in favour of groups perceived as being at 'high-risk' of STI such as MSM, Black and Afro-Caribbean populations, and young heterosexuals. Notably, the two government policy documents analysed (B1 & B2) did not once mention WSW, whereas they extensively discussed these 'high-risk' groups. Secondly, women more broadly and WSW specifically were acknowledged as under-represented in sexual health.

This gap was recognised by two policy documents and one campaign material. The Terrence Higgins Trust's 'Women and HIV' report explored how women are represented in HIV policy and research. The report stated that "all women as a whole are by default assumed to be heterosexual" (B5). The Trust's other report

Table 2

Description of frames with example from the data

Frame	**Description of frame with example**
Condoms as universal	Condoms portrayed as either the only method of preventing STI transmission, or as the best option. This also included mentions of vaginal/female condoms. *“Safer sex involves using condoms correctly every time you have sex” (A06)*
Anyone as susceptible to STIs	The statement or implication that anyone is at potential risk of contracting and transmitting STIs and the assertion that therefore everyone should get tested for these. *“Anyone who has sex can get an STI, you don’t need to have lots of sexual partners. Anyone can get and pass on STIs” (A23)*
Oral sex as posing a risk of STI transmission	Oral sex, either with a penis or on a vulva, positioned as a risky sexual activity that could result in STI transmission. This included mentions of condoms used for oral sex and mentions of dams, as these imply possible STI transmission. *"Yes, you could be at risk of an infection if a partner has licked, kissed or sucked your penis, vulva, vagina or anus.” (A07)*
Dams as a safer sex option	Any mention of dams (also referred to as ‘dental dams’ or as a latex or polyurethane square). *“A dam (sometimes called a dental dam) is a latex or polyurethane (soft plastic) square, about 15cm by 15cm, which you can use to cover the anus or female genitals. It acts as a barrier to help prevent sexually transmitted infections passing from one person to another.” (A07)*
Diverse sexual practices as posing a risk of STI transmission	Any mention of diverse sexual practices. Diverse sexual practices were defined as any sexual practice that was not penetrative sex with a penis or oral sex. *“Sharing sex toys has risks, including getting and passing on infections such as chlamydia, syphilis and herpes.” (A18)*
WSW as able to reduce STI risk when having sex with women	The implication that there are methods to reduce STI risks between women, such as the use of dams, gloves, or condoms on sex toys. *“You should always clean your sex toys before and after each use [...] We recommend always putting a condom on a sex toy and changing the condom between partner(s), and holes, to avoid infection.” (A22)*
WSW as having specific sexual health needs	Materials that were targeted to WSW, mentioned WSW as being at risk of STIs or having needs or barriers that might impact their sexual health. *“Lesbians and bisexual women are not immune from sexually transmitted infections (STIs), yet can be complacent about getting tested for them” (A28)*
WSW as overlooked in sexual health	The implication that WSW have an unmet need or are under-represented in sexual health. This included a statement of this, as well as the more subtle framing of WSW as under-represented by either emphasising other groups above WSW (e.g. MSM and young heterosexuals), and simply the absence of WSW in this discourse. *“There are very few sexual health services specifically for lesbians or bisexual women. Partly, this has been due to the epidemiology of HIV among gay and bisexual men, but it also reflects a wider invisibility of the needs of lesbian/ bisexual women in all aspects of health.” (A28)*
Condoms as useful for WSW	A statement that condoms can be used by WSW when having sex with women, such as being used as a dam or used on fingers and sex toys. *“You can also make your own dams from condoms, by rolling the condom out, cutting off the tip and the ring, and then along its length to create a rectangle” (A11)*

Figure 2

Frequency of frames in the data (n=47)

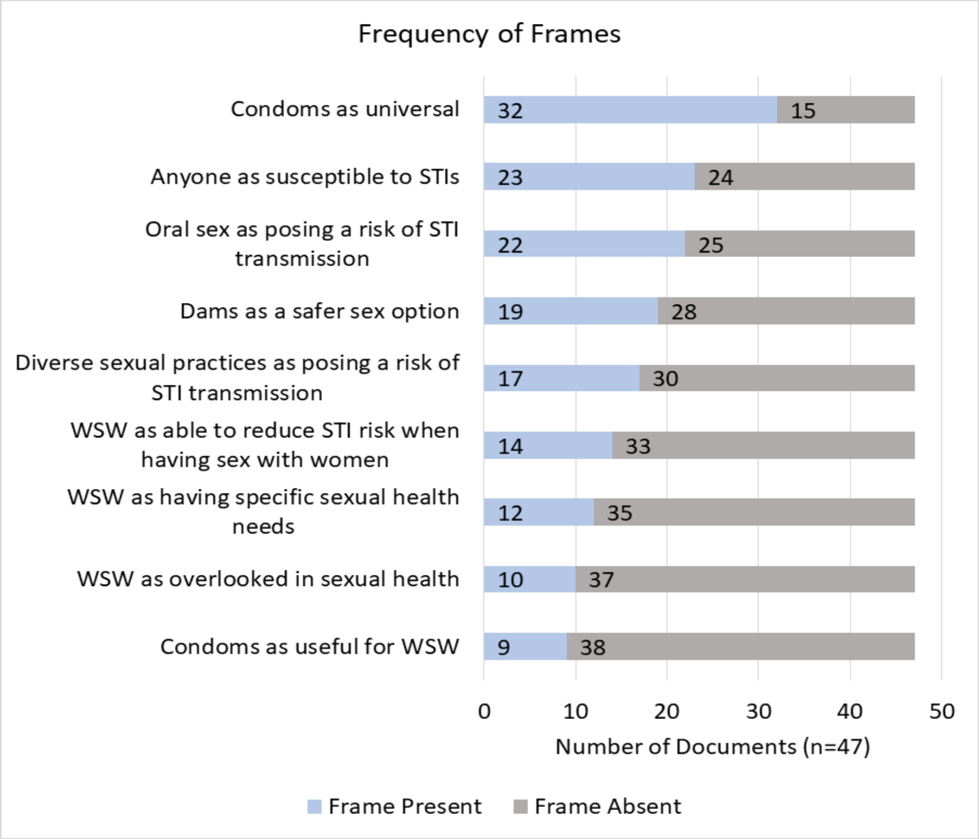
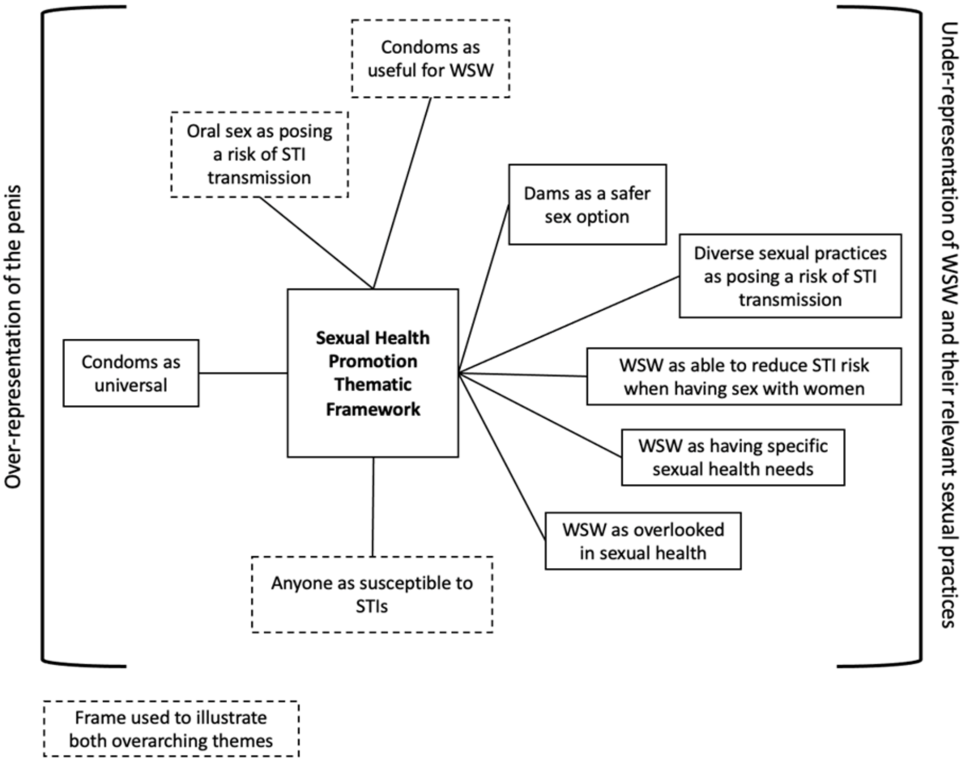


Figure 3

Thematic framework and overarching themes



entitled ‘State of Nation’ explored the burden and prevalence of STIs in England, and acknowledged the gap in STI data for WSW, going one step further to express that “these gaps highlight the erasure of identities” (B4). Bisexual women stated that the lack of sexual health services for this group “reflects a wider invisibility of the needs of lesbian/bisexual women in all aspects of health” (A28). Women as a whole were framed as under-represented, and a man’s perspective was prioritised. The ‘State of the Nation’ report described a “huge gap” in research on women and STIs and in the ‘Women and HIV’ report, the Trust stated that “women’s voices are not heard, and their experiences and needs are not sufficiently recognised, prioritised and met” (B5). This highlights the double burden that WSW face as both women and non-heterosexual.

Furthermore, sexual practices relevant to WSW were under-represented. WSW engage in both penetrative and non-penetrative sex, most commonly using sex toys and fingers for vaginal and anal penetration, oral sex on the genitals or anus and genital to genital contact. (6,22,25) These are referred to as ‘diverse sexual practices’, with the exception of oral sex which in this report is discussed separately as it appears more frequently in the data. The frames ‘oral sex as posing risk of STI transmission’ and ‘diverse sexual practices as posing risk of STI transmission’ inform us of how practices relevant to WSW are represented. Oral sex was discussed in 22 materials (46.8%); this does not reflect the prevalence of this practice. According to the National Survey of Sexual Attitudes and Lifestyle 3, the prevalence of oral sex on a partner of the opposite sex in a year is as high 80% in 25 to 34 year olds. (39) In addition, diverse practices were present in a relatively small proportion of the data compared to more ‘mainstream’ practices (oral sex and penetrative sex with a penis). These sexual practices are not unique of WSW and are carried out by heterosexual couples, and the under-representation of these may point towards a lack of interest or awareness of the diversity of sexual practices and as a lack of interest in WSW. (39)

There was a gap in information available for WSW to reduce their STI risks. The frames ‘dams as a safer sex option’, ‘WSW as able to reduce STI risk when having sex with women’ and ‘condoms as useful for WSW’ were often not found in the data (see Figure 2). ‘Dams as a safer sex option’ was the most frequent of these, but detailed information about the dam was only found in 6 documents. In comparison, the other 13 only mentioned the dam by name. This is significant as dams are infrequently used by WSW due to limited access, not knowing how to use them or how to negotiate their use. (27,30,40,41, 42) These issues could be addressed by providing more information in sexual health promotion.

To summarise, WSW and their relevant sexual practices were not included in the data to the same extent as men and heterosexuals, leading to the erasure of their identities in sexual health promotion.

Erasure of WSW in Sexual Health Promotionp

This study highlights heteronormative and androcentric assumptions of sex in sexual health promotion and supports previous criticism that WSW are not adequately represented in sexual health discourse. (10,11,26,28,43–45)
The justification for under-representing WSW in sexual health promotion has been an epidemiological one. The ‘high-risk’ groups mentioned above represent a significant burden of STIs, and dominate sexual health discourse. (10,11,26,43,44, 46, 47) Although WSW have lower rates of STIs than MSM and other ‘high-risk’ groups, they still carry a significant burden. It is estimated that over 1 in 10 women have had sexual contact with other women, a number that is rising over time. (39) WSW also have similar STI rates compared to WSEM, demonstrating that the sexual health needs of this group are not negligible. (12,21–24)

Furthermore, the epidemiological argument ignores the wider systemic impact that heterosexism and sexism have in the lives and health of WSW; the role that invisibility and erasure play in this. Symbolic annihilation is a term that has been used to describe the absence of socially disenfranchised groups from media representation. (45,48,49) Language and representation have the power to shape the social construction of reality, and therefore the representation of WSW in sexual health promotion can shape perceptions of this group. (48,50) The underrepresentation of WSW both constructs false assumptions of low STI risk and symbolically annihilates WSW and their experiences. (28,45,51) The representation of some groups and the erasure of others creates a dichotomy between ‘normal’ or ‘acceptable’ and ‘abnormal’ identities and behaviours. (49,52) The symbolic annihilation of WSW places this group in the latter category, facing social marginalisation and exclusion, while heterosexual identities are presented as desirable. This is a form of symbolic and structural violence that denies legitimacy of this group and socially disempowers them. (53,54)

Symbolic and structural violence are exerted on WSW as a result of heterosexism and patriarchal structures. Heterosexism is used to describe “the cultural ideology that perpetuates sexual stigma by denying and denigrating any nonheterosexual form of behaviour, identity, relationship, or community, “where sexual stigma refers to society’s antipathy towards non-heterosexual individuals. (55) In effect, heterosexism is the imbalance of power between heterosexual and non-heterosexual, where non-heterosexual identities are inferior and disempowered. Enforced invisibility of sexual minorities is one of the systems for enacting sexual stigma, and therefore enforcing heterosexism. (55) WSW face a double burden of discrimination due to both their sexuality and gender. They face the additional oppression from sexism, which refers to the subjectively unfavourable and favourable attitudes that enforce gender inequality, patriarchal beliefs and male domination of power and resources. (56) Both heterosexism and sexism stem from the same heteropatriarchal mechanisms of oppression working together to subordinate, disempower and control WSW. (56–60) The result of this oppression is marginalisation, social disenfranchisement, stigma and discrimination, which affect the health of this group, from assumptions of STI risk to experiences within the healthcare system. (13,30,61,62)

Erasure and invisibility are an actively harmful form of violence. The under-representation of WSW in sexual health promotion as revealed in this study demonstrates a complicity in these heteropatriarchal power structures. In order to address the underlying and systemic inequalities and marginalisation faced by WSW, we must improve and prioritise the representation of this group and directly challenge these power structures.

Patricia Hill Collins proposes a two-step process from erasure to empowerment: to recognise the process of erasure and to create space for new knowledge to be produced. (63) In the context of sexual health promotion, this may constitute directly acknowledging the gaps in sexual health promotion for WSW like in the Terrence Higgins Trust's reports 'State of the Nation' and 'Women and HIV', as well as Sexual Health Sheffield's lesbian and bisexual sexual health leaflet. This should be combined with a participatory approach to developing sexual health campaigns. Listening to the voices of the target audience is imperative to create a destigmatising, inclusive and successful campaign. (64)

An example of good representation is the LGBT Foundation's 'sex guides' that provide sexual health information for vaginal, anal and oral sex (A20, A21 and A22 respectively). These documents outline diverse sexual practices, multiple uses for condoms and include extensive and thorough information on how to reduce risks of STI transmission. This goes beyond the restrictive definitions that equates safe sex with condom use, and in addition is delivered with inclusive and gender-neutral language. The LGBT Foundation has developed these guides working with members of the LGBT community to empower them. (65)

Limitations and future research

This study provides insight into how WSW and their STI risk are represented in sexual health promotion, supporting conclusions from previous studies looking at WSW in sexual health discourse in England. (31) However, it has several limitations. The three-step Google search used for data collection was chosen as it gives a good indication of the materials that are easily accessible and available to the general public. This is particularly pertinent to WSW who may have limited access to sexual health information elsewhere. However, a Google search is not a systematic method of obtaining scientific literature and for this reason does not generate reproducible results. The full list of data analysed was therefore supplied in Appendix A.

A further key limitation of this study was that it does not explore the impact that sexual health campaigns have on peoples' perception of WSW and their STI risk, as well as the relative impact of each campaign. This would be useful to understand in order to contextualise the message of these as it is likely that bigger campaigns, such as Public Health England's Campaign "Protect Against STIs" (A14, A15 and A16) have a greater impact and scope compared to smaller campaigns such as Sexual Health Sheffield's campaigns (A26, A27 and A28).

CONCLUSION

This study demonstrates that developing sexual health promotion for WSW that is inclusive and relevant is both possible and desirable. However, the issue of erasure of WSW goes beyond health promotion and impacts the wider healthcare space. WSW face prejudice in clinics and have lower rates of health-seeking behaviours. (5,7) As such, attempts to tackle the invisibility of WSW should be wide-ranging. As future healthcare workers we must educate ourselves on the erasure of WSW and the social structures that contribute to this. With this knowledge, we can act as advocates for WSW not only in the field of sexual health, but in all health and social care. (66,67)

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APPENDIX A

LIST OF DATA ANALYSED

Number	Material Name	Campaign	Organisation
A01	Condom Flyer	Safe sex and an inclusive sexual health service.	Your Sexual Health Matters
A02	Own the Moment Poster	Safe sex and an inclusive sexual health service.	Your Sexual Health Matters
sA03	Could it Be Chlamydia? poster	Could it be Chlamydia?	Your Sexual Health Matters
A04	Summer Leaflet	Good Time Guide	Your Sexual Health Matters
A05	Freshers Leaflet	Good Time Guide	Your Sexual Health Matters
A06	STIs Overview	Sexwise Website	Family Planning Association (FPA) and Public Health England (PHE)
A07	Oral Sex and Sexually Transmitted Infections	Sexwise Website	Family Planning Association (FPA) and Public Health England (PHE)
A08	How to Use Condoms	Sexwise Website	Family Planning Association (FPA) and Public Health England (PHE)
A09	Sexually Transmitted Infections (STIs) Handout	Relationship and Sex Education Handouts	Brook
A10	Condoms Handout	Relationship and Sex Education Handouts	Brook
A11	Dental Dams webpage	STI Information	Brook
A12	Do I Have an STI? webpage	STI Information	Brook
A13	Six Reasons Why You Should Get Tested webpage	STI Information	Brook
A14	You Can't Always Tell Who's Got an STI poster	Protect Against STIs	Public Health England
A15	You Only Need to Have Unprotected Sex Once poster	Protect Against STIs	Public Health England
A16	Not all STIs Have Symptoms poster	Protect Against STIs	Public Health England
A17	Sexual Health webpage	NHS Live Well	National Health Service (NHS)
A18	Sex Activities and Risk webpage	NHS Live Well	National Health Service (NHS)
A19	Sexual Health for Lesbian and Bisexual Women webpage	NHS Live Well	National Health Service (NHS)
A20	Vaginal Sex	Sex Guides	LGBT Foundation
A21	Oral Sex	Sex Guides	LGBT Foundation
A22	Anal Sex	Sex Guides	LGBT Foundation
A23	Preventing an STI webpage	Let's Talk About It Website	Let's Talk About it
A24	HIV – The Facts webpage	Let's Talk About It Website	Let's Talk About it
A25	Young Person's Advice Guide webpage	Let's Talk About It Website	Let's Talk About it
A26	Preventing STIs webpage	STIs Info and Advice	Sexual Health Sheffield
A27	Getting Checked for STIs webpage	STIs Info and Advice	Sexual Health Sheffield
A28	Sexual Health for Lesbian and Bisexual Women	STIs Info and Advice	Sexual Health Sheffield
A29	Get It On Condom Card Scheme webpage	Get It On	Let's Talk About It
A30	What is a C-Card?	Young & Free	Terrence Higgins Trust
A31	Only 19% of People are Aware image	Can't Pass it On	Terrence Higgins Trust
A32	Charity quote image	Can't Pass it On	Terrence Higgins Trust
A33	Sadiq quote image	Can't Pass it On	Terrence Higgins Trust
A34	Oral Sex webpage	Improving Your Sexual Health	Terrence Higgins Trust
A35	Unprotected Sex webpage	Improving Your Sexual Health	Terrence Higgins Trust
A36	A Healthy Sex Life webpage	Improving Your Sexual Health	Terrence Higgins Trust
A37	I Use a Condom	It Starts with Me	HIV Prevention England
A38	When to Test Quiz webpage	It Starts with Me	HIV Prevention England
A39	Give HIV the Finger image	It Start with Me / National HIV Testing Week	HIV Prevention England
A40	HIV & Sexually Transmitted Infections leaflet	Fact Sheets	Avert
A41	HIV Transmission leaflet	Fact Sheets	Avert
A42	HIV and women who have sex with women leaflet	Fact Sheets	Avert
B1	A Framework for Sexual Health Improvement in England	Policy Document	Department of Health and Social Care
B2	Health Promotion for Sexual and Reproductive Health and HIV: Strategic Action Plan, 2016 to 2019	Policy Document	Public Health England
B3	C-Card Distribution Schemes: Why, What and How?	Policy Document	Brook and Public Health England
B4	State of the Nation	Policy Document	Terrence Higgins Trust
B5	Women and HIV: Invisible no Longer	Policy Document	Terrence Higgins Trust

APPENDIX B

STAGES OF DATA ANALYSIS

Familiarisation

I immersed myself in sexual health promotion available online. This gave me insight into recurring themes in these materials so that I could start to develop the thematic framework and enabled me to narrow down and focus my data collection methods.

Identifying a thematic framework

I reviewed the final selection of data, making a note of each theme that was present in each source. I initially wrote down the themes and issues that I knew would be relevant based on previous research and background (a priori issues) and then identified and added themes that emerged when reviewing the data. The themes were all developed with the research question in mind.

Indexing

After reviewing the data again, I cross-referenced each theme against the data to identify whether it was present. If it was, I inputted the relevant textual passage, imagery or data from that material into a Microsoft Excel spreadsheet with any relevant comments so that the passage would still be considered in the context of its source.

Charting

The data from the indexing stage was summarised into tables of themes (the frames) and cases. I included in this step all relevant quotes and imagery from the data from the indexing stage so that I could refer back to it more easily and facilitate interpretation. This allowed me to see the similarities and variation within the frames.

Mapping and Interpretation

This stage was guided by the research question. I explored the relationships between frames and the similarities and differences within and between these to try to understand the meaning, context and assumptions behind how WSW and their STI risk were represented.

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Discussion

What all doctors should know about trans health – a conversation between a medic and a sociologist

DISCUSSION

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ABSTRACT

This article offers guidance on how to engage with transgender patients – people whose genders do not correspond with the assignment made at birth. The format is that of a dialogue between a GP and an academic sociologist, both with a special interest in trans health. The authors provide their allied perspectives on possibilities for improved inclusivity in clinical practice. The approach taken intends to simultaneously be familiar and accessible to those with medical experience, while also engaging with nuanced elements to provide a firm conceptual foundation. Following an orienting discussion of sex and gender (and how 'the biological' and 'the social' relate), the article engages with key concepts and practices when meeting a trans patient for the first time. More specific examples such as history-taking, physical examination, and sex-based reference range interpretation are discussed. The article closes with some evaluative take home messages, emphasising the importance of avoiding common assumptions, and the need for continual development of inclusive curricula.

Who are we?

As someone who studied medicine in London in the 1990s, drifted into emergency medicine, then after a decade moved to general practice, I did not come across training in transgender health or an awareness of trans lives until I (knowingly) met my first trans patient in 2018. To say that I was unprepared was an understatement. Horrified by my abysmal performance, I began my own journey to enlightenment, starting with some frank conversations with trans people about where I was going wrong. Although my journey took me further than I expected, as I now work and teach in this area as a general practitioner (GP) with a special interest, I am always reminded that actually, it pretty much always comes back to the basics of not making assumptions. When you assume nothing, and ask if not sure, you'll consult more openly and allow your patient to fill in the gaps. Simple skills, like checking for a preferred name and asking about pronouns, can be extremely impactful and will open the door to a richer clinical interaction. Take this further, and you'll broaden your understanding of all people as unique.

In 2019, as I was expanding my own learning, I had the good fortune of meeting Ben Vincent, a non-binary academic sociologist and author of Transgender Health: a practitioner's guide to binary and non-binary trans patient care. (1) I devoured their book on a flight to and from a conference in Dublin, the perfect read for someone like me with a limited attention span! Tangible, digestible, and in a language that I could understand. One key lesson revolved around the message "nothing about us without us" ("Nihil de nobis, sine nobis"); the idea that no teaching should be decided or delivered without the full and direct participation of members of the group affected by, or the subject of, that teaching. This being an educational article, I decided that we should therefore write it together; myself a cisgender medic with first-hand experience of clinical practice and the ways in which medical education encourages us to think critically, and Ben to review and challenge this, with the intention of making up for what was missing at medical school.

Rather than merge our two styles, I decided to lift Ben's comments and directly place them on the page, giving you not only the bones of the writing process employed for this article, but sight of an invaluable sociological perspective. I call it flesh.

What should junior doctors and medical students know in regard to trans health?

This was the brief for the piece. When I first read it, my brain immediately jumped to presenting the myriad of evidence regarding gender identity and how this is formed, echoing traditional medical teaching on 'aetiology and pathogenesis', followed by 'symptoms and signs', 'diagnosis', etc. This approach, however, tends to pathologize diversity among numerous living systems, including we humans. Looking beyond the boundaries of medicine, there currently rages an ideological war on sex and gender, rife with misinformation, that has seen trans people impacted by a surge of transphobic hate crime and challenges to legal protections. Suffice to say, dissecting trans identities and disentangling the current discourse is not relevant to the fundamental teaching of the sensitive delivery of care, or to the application of affirmative consultation practices. As doctors, our duty is to treat the person in front of us in a non-discriminatory and non-judgemental way. The care of our patient must always be our primary concern. (2)

Ben: A decent foundation is really hard to deliver because that depends on a lot of concepts that aren't part of medical or scientific education, mainly to do with the philosophy of what things are (ontology) and the processes by which we know things (epistemology). The temptation to try and address this arises when overly simplistic notions of sex and gender – and the relationship between them – result in de-legitimisation of trans people's genders, or the legitimacy and necessity of gender-affirming medical interventions. Perhaps people are able to just accept that it's beside the point and the issue is more about providing equal access to care that is respectful and competent.

So, let's get started.

Medics should already appreciate the beautiful diversity of biology; the stunning variation in the way sex chromosomes are organised, express themselves, and are responded to. Differences of sex development are well understood and may well account for 1-2% of live births. (3) Chromosomes, sex hormones, internal reproductive anatomy and external genitalia are all biological traits housed under the label of 'sex'. Consider this a collective term but one that reflects substantial but often subtle variation. By contrast, the binary categorisation of sex, as 'male' and 'female', is based on observation of the external genitalia alone, and from this gender is assumed "it's a girl!", "it's a boy!".

Ben: I agree that sex is the association of particular phenomena with categories – male and female – that are initially determined by what we expect to find, or see develop, in people born with a penis or vulva, respectively. Beware the idea that a person's physiology, anatomy, or genetics fundamentally are 'male' or 'female' things. Otherwise, this logically backs us into the corner of talking about trans women having 'male' biology, trans men 'female' biology, and frames non-binary people's body parts in these terms. Doing so is political, not a foregone conclusion of a morally neutral scientific enterprise. Generally, the whole concept can be sidestepped – it is always clearer and more accurate, for example, to specify XX chromosomes rather than 'female' chromosomes, testes rather than 'male gonads', etc. with the added benefit of not alienating your trans patient from their experience of healthcare.

Gender identity is the personal sense of one's own gender, as being a man, woman, or something else. Like sex, this is unique to the individual. For most people, this overlays with the sex label assigned at birth. For trans people, this is not the case.

Ben: In terms of the individual, their gender identity is their gender, of course, but gender is also recognisable as a system of social division and organisation. Older academic contributions framed gender as the attribution of masculinity and femininity – behaviours, tastes, and stereotypes. As already touched upon, the concept of sex and the biological makeup of bodies cannot be conceptualised independently of language, culture, and subject *interpretation (such that 'sex' is also social). I add this because it's important to recognise the oversimplification of framing the concepts of sex and gender as separate and independent, even if they can have slightly different associations. I tend to refer to them as 'mutually co-constitutive'.*

How are trans identities experienced?

In its updated ICD-11, the World Health Organisation offers the diagnostic term 'gender incongruence' to describe an individual whose gender differentiates from that assigned at birth. (4) This has for the most part replaced 'transsexualism' along with a welcome departure from its classification as a mental or behavioural disorder. For some, but not all trans people, gender incongruence causes clinically significant distress, termed 'gender dysphoria'. Gender dysphoria (5) can be experienced in relation to the body (often but not exclusively linked with primary or secondary sexual characteristics), or in relation to navigating within a social context; how one is perceived, 'gendered', or in fulfilling a particular gender role. It should come as no surprise that gender dysphoria can have a profound impact on psychosocial functioning, manifesting as anxiety, low mood, substance misuse, disordered eating (particularly to restrict pubertal development), and suicidality. (6) 'Minority stress' compounds matters. This is the additional burden of stress experienced by individuals belonging to a particular minority group, and for trans people this could be the stress of concealment (of a trans identity), of living in an unsupportive family environment, of bullying, of discrimination, or stigmatisation, et cetera.

The concept of 'gender euphoria' is also important and describes the sense of fulfilment or joy that comes from living in ones acquired gender, of being affirmed by others or experiencing positive bodily changes.

Ben: How trans identities are experienced is also informed by social context; intimate elements of family behaviours and responses to gender exploration, on to peer (school, work) reactions, with key intersections of religion, culture, class, race/ethnicity, among many other social divisions. Some may consider their genders 'acquired', others may consider their gender was always what it was, and it simply took some time to realise because of the assumptions society places on people based on their bodies. Many other personal conceptualisations are possible, so it's important not to assume any particular relationship with the concept of gender, or with their gender history.

What is it that we need to distil for the purpose of our everyday practice?

As a junior doctor or medical student, you will likely meet your trans patient in the context of their particular clinical complaint, and by this, I mean a complaint likely to be no different to that of a cis (non-trans) person. You aren't required to know all there is to know about gender identity, but there are some helpful things to understand; tips that will gain you the trust and respect of your patient, and avoid you being tripped up legally and clinically. I want you to hone the skill of establishing how your patient wishes to be spoken to, and about, with regard to their gender, and to consider their individual biology when evaluating organs and their function.

Ben: This is spot on. Wouldn't change a word. Underscores that I think in talking about sex and gender, we should move away from these as medically orienting terms because they just introduce noise. To paraphrase a research participant, MOTs don't have a checkbox for 'Toyota' versus 'Ford'! I love this metaphor because it captures that there's not only more possible categories, but also no single standard within the named categories.

Consulting in an affirmative way

As a medic, you can have a profound impact on a person's healthcare experience simply with an enhanced awareness and sensitivity to your practice. Consulting in an affirmative way takes nothing from the clinical element while reinforcing good medical practice. This is what makes a good doctor, and it's simple.

Awareness should start from the first moment you meet your patient, so let's walk through a scenario.

We are trained to observe before anything else. Non-verbal clues – how well-kempt, what eye contact, what smell, do they look underweight? In the same way, our patient is reading us. What if the name on their file does not match what they are communicating by way of their gender expression? Do we seem perplexed?

For trans people, taking the decision to live in their authentic gender is known as social transition, and is often the first step to feeling more comfortable. This could involve a change of name, hairstyle or clothing, the use of a chest binder, body forms, or perhaps an adjustment to intonation.

"My file says Raymond, is this the name you use or is there another you would prefer?"

Asking someone their name and making an adjustment if appropriate is one of the best starts a doctor might make when greeting a trans person. Flowing on, establish the pronouns they use, as this will ensure that you communicate about them in the most appropriate way when writing up your notes.

Ben: The name question is great for everyone, even if it's a William who always goes by Bill, or someone who goes by their middle name, etc. If it's become apparent someone is trans ask "can I confirm your pronouns" not "what are your 'preferred' pronouns", as for most trans people their pronouns are not a preference out of multiple options but simply the correct mode of address. Giving your own pronouns is good practice too – if you can't definitively ascertain them from looking, neither can anyone about you. Some people choose to wear a badge or pin with this information, which can be a great relief for trans people to see.

Non-binary people have a gender identity that is neither exclusively male nor female. It is always worth establishing what the individual prefers as there is no certain way to know without asking. Clinicians should be cognisant to the gender signifiers patients may be using in order to signal how they wish to be gendered or referred to. If a person has not begun any kind of social transition, then their requested name and pronouns may be entirely at odds with what you might assume from appearance. Not all non-binary people will be aiming to appear androgynous, so be prepared for literally any combination of gender expression and name/pronoun use. A final point is that you may be the first person a trans person has ever talked to about gender, or they may have transitioned 50 years ago. You may see trans people of just about any age, and this doesn't infer how long since they transitioned, if they have!

By assuming nothing (about gender, but also about sex characteristics too) and checking on name and pronouns, you have a patient who is confident that you will speak to them and write about them in a sensitive way.

Ben: Indeed! You now have a patient who is likely deeply relieved that you have shown cultural understanding and sensitivity. This can make a huge difference to their ability to feel able to access healthcare. They may have potentially put off going to see any health professional out of fear for a long time or may have had to change practice after a bad experience.

With introductions out of the way and the doctor-patient relationship off to a good start, bring your focus to the clinical complaint and take a history in the usual way. History-taking helps to further explore a presenting complaint and formulate a working diagnosis. Woven into this are one or two considerations.

Some, but not all, trans people will access medical intervention (usually hormone therapy) as part of their transition process. This can help to better align physical characteristics and improve psychosocial and cultural functioning. Some people will undertake surgeries either privately or through the NHS with the same aim. This might include surgery to reduce or enhance breast tissue, genital surgery, hysterectomy, facial and vocal surgeries, et cetera.

Eliciting a 'transition history' might be important for your assessment, but make sure that you are able justify to your patient why this information is relevant to their particular clinical complaint.

Ben: A common problem trans people experience is colloquially called 'trans broken arm syndrome' – when seeking help with a medical issue completely unrelated to trans status, but the clinician inappropriately focuses on trans status, assuming there must be a link. It can therefore be especially helpful to explain your reasoning, or why a course of action is necessary.

Taking a comprehensive drug history will elicit whether or not your patient takes hormone therapy. In this context, be sure to enquire about "medicines prescribed or otherwise", as self-medication with hormone therapy is endemic in the UK and reflects the protracted waiting times for NHS gender identity clinic services. Being comfortable to ask about medicines purchased online will help to dispel fear or shame around this issue and might also uncover unsafe self-injection practices. Respect confidentiality, gently encouraging them to consent to you sharing this information with their GP so at the very least a harm-reduction arrangement can be considered.

When taking a sexual health history, it is important to know not only about the body of your patient but also about the body of their sexual partner(s). As for all patients, trans or not, what sex is being had, and with what body parts, is key here. And as you go along, check your assumptions. Have you assumed that your patient doesn't use his vagina for sex? Does he have a cervix or uterus, and what difference might this make in steering the screening and contraception advice you offer? Was his boyfriend also assigned female at birth, and how might that change the type of history you elicit? Finally, follow his lead with language; he may describe menstruation as "bleeds" rather than "periods", for example.

Ben: Another thing to avoid assuming is a trans person's sexual orientation, or sexual practices. A trans woman might be a lesbian, but in a relationship with another trans woman; a gay trans man may have receptive vaginal but not anal sex with a cisgender gay partner – and this information doesn't tell you anything about what body parts each person has, or what activity they may do.

Eliciting a social history, you might want to know a little about cultural or religious context, check they have secure housing and that there are no safeguarding considerations. Evidence suggests that one in four trans and non-binary people in the UK experience homelessness, (7) and negative social environments (e.g.: home, school, work) contribute to suicidality in young people. (8)

While being trans is certainly not a mental illness, patients often report strained mental health due to physical and social dysphoria, as well as minority stressors such as prejudice and discrimination. Ask someone about their mental wellbeing generally, and if you think it is relevant, about harmful coping strategies including food restriction, cutting, or illicit drug and alcohol dependency. Smoking is a standard question, and important in the context of hormone therapy.

Consider each component of the traditional history-taking structure and how it might be re-orientated to better accommodate trans people. Establish trust through openness and allow the patient to guide you if the territory is unfamiliar, for example self-medication, experience of belonging to an ethic group different to your own, et cetera.

Having taken a history, it is time to examine your patient. If you are of a different gender, be sure to offer a chaperone, and if you are not sure of their preference, ask. Be mindful that your patient may find being examined distressing, perhaps generally, or in relation to certain areas of their body. It might help in this scenario to 'check in' with them as you go along. Do not cut corners with your clinical evaluation, but perhaps think about your non-verbal body language in offering quiet acknowledgement. If someone wears a chest binder, might you capture the information you need without asking them to remove it? If not, how might you approach this sensitively?

A trans masculine person using testosterone therapy may have thinning of the vaginal epithelium (vaginal atrophy) making examination including cervical smear testing painful. Selecting a smaller speculum and using additional lubrication can help.

In the context of a sexual health complaint, what "lower surgery" a person has had, if any, might be clinically relevant. Penile skin inversion is the most commonly used technique in the UK for vaginoplasty, a type of genital reassignment surgery that offers a skin-lined neo-vagina by inverting penile skin. A minority of people might have required a segment of sigmoid bowel to be used instead, particularly in cases where penile development was insufficient. Taking only a vaginal swab from a skin-lined vagina risks missing an STI, as relevant pathogenic organisms predominantly infect genital mucosa, so consider the urethral mucosa and include a urine sample for NAAT (nucleic acid amplification test).

In this particular patient also note that the prostate gland is retained but won't be palpable rectally if a neovagina is present as it will lie anterior to the vaginal wall. Transvaginal palpation is possible (9)

Ben: Should a trans person be seeing you simply seeking a referral to a gender identity clinic, note that it is never appropriate to require them to be physically examined nor otherwise fulfil any expectation that might be had of what it means to be trans. Patients in England may choose to be referred to any of (and any number of!) the seven adult services across England, which all specify their referral requirements. As of the 2018 Service Specification, self-referral is also possible. GICs have their own referral forms – check what information is requested.

Examining your patient builds on the trusting relationship you have established from the start. Demonstrate through your own behaviours that you are thinking sensitively about the possibility of bodily discomfort, and while it is important to be clinically thorough, "check-in" with your patient as you go.

By way of investigations, you might wish to evaluate the results of a swab, blood or urine sample. It is here that you will bring together all of the information you have gathered to decide on tests that will help you to reach a diagnosis. In this context, apply critical thinking to your patient's unique biology, particularly when it comes to the correct interpretation of sex-based reference ranges.

Androgen (testosterone) use in someone assigned female at birth will induce erythropoiesis and increase haemoglobin, haematocrit and red blood count to the 'male' reference range. If a 'female' marker is linked to the testing facility, this might be falsely reported as an abnormally high result. Smoking in the context of testosterone use can compound blood thickening and push an individual towards polycythaemia, an increased blood viscosity that risks thrombosis. Apply the 'male' reference range and respond clinically if appropriate.

Another common laboratory test is eGFR. People presumed male at birth have a higher eGFR than people presumed female at birth at the same level of serum creatinine because the formula assumes a higher muscle mass in men. (10) Testosterone therapy may induce significant gains in muscle mass, oestrogen therapy to the contrary, so consider applying the eGFR reference range that best reflects your patient's dominant sex steroid/body composition.

There are currently no studies looking at the impact of gender-affirming hormone therapy on cardiac mass, but it would serve you well to think carefully when interpreting a cardiac troponin, as upper reference limits vary with recorded sex.

Considering all biological and physiological systems as unique and applying this to clinical practice ensures best quality care. It echoes back to the phrase "I'm asking (about hormone therapy or surgeries) because I want to make sure that I order the right tests and interpret them in the right way".

Having taken a history, examined your patient, and completed the appropriate investigations, you might conclude that they require admission to hospital. It should go without saying that appropriate ward placement where at all feasible is critical to preserving dignity and comfort.

Ben: Absolutely. Depending on personal circumstances, stage of transition etc., there may be times when some trans people may actually want to be on a ward of their birth assignment (whatever marker is on the NHS records). This may also pertain to the specific reason they're in hospital. I would say best practice when unsure is to speak to the patient and explicitly talk about what they would feel most comfortable with, including consideration of a private room if both desired and feasible.

When writing up your notes, be mindful to only reveal your patient's trans status if you have their permission to do so. For someone with a Gender Recognition Certificate (under the Gender Recognition Act 2004), disclosing without permission or cause could amount to a criminal offence. While there are medical exemptions in contexts relevant to clinical care, best practice is to obtain consent to discuss where necessary and explain why if requested.

Take home messages

Whatever type of doctor you become, consulting affirmatively and sharing good practice with colleagues including allied staff is a powerful way of transmitting this learning beyond the article. Set the tone. From one, to a team, to a department.

Assume nothing; about a person's name, pronouns, gender, karyotype, genital arrangement, hormone status, organs, or the sex they have and with whom. Always be ready to justify your rationale for proposing the questions that you do, examine thoughtfully and sensitively, and seek consent around trans status when writing up your notes. Expand your understanding of biological systems and see all bodies as unique. Challenge the binary.

Trans health cannot exist without trans rights, and if trans lives are to be lived without fear of depreciation, consider the broader context of allyship. Placing your pronouns in your email signature could be a positive first step towards awareness and inclusivity, as can calling out transphobia when you witness it.

As consumers of health education, you have a voice when it comes to curriculum content. Educating all healthcare staff to better understand trans identities and to interact with patients in a respectful and affirmative way is the responsibility of all health education institutions.

Ben: Ultimately, trans people are people just like everyone else, and deserve the right to self-determination and respect. By reorienting our worldview on gender and unlearning gendered assumptions and stereotypes, all patients, trans or not, stand to benefit.

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Discussion

It's not alphabet soup – supporting the inclusion of inclusive queer curricula in medical education

DISCUSSION

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ABSTRACT

Medical curricula have undergone somewhat of a change in response to the landscape of health and social care within the UK. One group that is particularly underrepresented within medical curricula is the LGBTQIA+ community; marginalising the community and potentially perpetuating the well-documented health inequalities experienced by LGBTQIA+ individuals. This article discusses the current representation of the LGTBQIA+ community within medical curricula and presents recommendations for more inclusive, contemporary practice. The authors champion for the creation of a culture centred upon education and advocacy. Co-creation of curricula is an important consideration ensuring that the burden does not fall to those with lived experiences to educate others. Health curricula need to evolve to represent the diversification of society and the associated healthcare and workforce needs. This discussion article serves to challenge the heteronormative assumptions within healthcare and proposes strategies for training the future workforce to deliver inclusive and supportive healthcare. It is pivotal to afford healthcare students with the opportunity to develop their communication and consultation skills, especially with regard to sensitive subject matters including sexuality, gender identity and sexual histories. By setting aside time for students to develop their professional scripts, there will be direct benefits for the patient community and those marginalised by current healthcare practices.

This discussion starter includes voices from both those with lived experience and advocates for the community, medical students and medical educators.

INTRODUCTION

The term queer has come to prominence within recent years, yet it remains widely misunderstood. As evidence regarding disparity of experience for minority groups mounts, now more than ever there must be a call to arms to ensure inclusive curricula. This article serves to advocate for a reimagining of medical curricula, as well as providing an introduction to some of the contemporary terminology and arguments regarding gender and sexuality, noting that educational curricula are typically heteronormative. This is not an issue of semantics or political correctness, but a public health issue, given the health inequalities that exist for the LGBTQIA+ community. The 2018 Stonewall report cited that 13% of LGBTQIA+ people had experienced unequal treatment due to sexuality and/or gender identity. (1) Further, 10% LGBTQIA+ people had been outed without consent in front of staff or other patients. The need for inclusive curricula has never been more important.

Terminology

Queer is an umbrella term used to describe individuals who are from sexual or gender minority groups. Typically, it is a term used by individuals who do not identify as heterosexual or cisgender. Historically, the term was used pejoratively but it has since become a re-appropriated term that is deemed inclusive by many, conveying both identity and community. However, it cannot be assumed that the term resonates with all individuals, nor should it be designated to people. Queer encompasses a plethora of identities, some defined, some yet to be defined. LGBTQIA+ is a widely accepted acronym that captures the range of gender and sexualities within the queer community. However, ignorance often results in the acronym wrongly being dismissed as "alphabet soup". The acronym LGBTQIA+, and terms relevant to queer culture, are defined in Table 1.

The need for inclusive queer curricula in medical education

It is well documented that sexual minority status is linked to stigma, stress, and health disparities(2). There is a need to both educate about, and be educated by, the queer community. Although internationally we are witnessing somewhat of a gender revolution, evidenced by the increased visibility and discussion of gender within politics and media(3), education has not kept pace. Medical education is no exception.

Research suggests that queer individuals face health disparities linked to societal stigma, discrimination, and denial of civil and human rights (4); this further serves to necessitate the need for critical analysis of medical education curricula. (3, 5-8) It is estimated that 2% of the UK population identify as LGBTQIA+(9), equating to roughly 1.4 million individuals accessing healthcare. A 2018 report showed that, of LGBT people surveyed, 1 in 7 (14%) avoided seeking healthcare for fear of discrimination of staff and that LGBT people face widespread discrimination in healthcare settings. This cements the need for comprehensive medical education surrounding the LGBTQIA+ community. This must extend beyond reducing individuals to increased health risks they may face, e.g. centring teaching on HIV around gay men, to a holistic educational approach which allows insight and understanding of LGBTQIA+ identities as a whole. (1)

There are also issues of inequality within the medical workforce. In 2016, The British Medical Association (BMA) and The Association of LGBTQ+ Doctors & Dentists (GLADD) co-authored a report concluding that a significant number of LGBTQIA+ NHS staff experience a negative working environment(10). Over 70% of respondents recounted negative experiences based upon their sexuality, reporting harassment and homophobic slurs(10). Adequate education and representation in medical schools, therefore, may also serve to normalise queer identities amongst peers and colleagues, improving experiences for LGBTQIA+ patients and staff.

The UK is behind - in 2007 The Association of American Medical Colleges (AAMC) recommended that "medical school curricula ensure that students master the knowledge, skills, and attitudes necessary to provide excellent, comprehensive care for [LGBT] patients" by including "comprehensive content addressing the specific healthcare needs of [LGBT] patients" and "training in communication skills with patients and colleagues regarding issues of sexual orientation and gender identity". (11) The UK's General Medical Council (GMC) is less explicit. Their guidance on transgender healthcare, for example, refers only to broad and all-encompassing principles of professionalism. (12) While the statements in Good Medical Practice are broadly inclusive, they are not explicit in their direct inclusion of non-binary or non-conforming identities. More troublesome is that, while the GMC advocate for keeping skills up to date, it refers to illness and disability in its guidance rather than identity and sexuality - this has potential to perpetuate negative connotations and contributes to the pathologising of LGBTQIA+ identities.

There is a clear need for more inclusive, gender-aware curricula that encourage students to sensitively explore the nuances of working with people who identify as LGBTQIA+.

Communication, consultation skills and curricular components

Communication and consultation skills

Communication and consultation skills are essential parts of medical curricula which require further attention to ensure inclusivity. In a study by Laughey et al., medical students' communication skills were criticised, specifically with regard to assumptions being made about patients' sexualities, typically heteronormative assumptions. (13-15) Students often cite discomfort in gathering information from patients with respect to their gender, sexual orientation and sexual history (13), and a similar phenomenon is reported with doctors. (16) We propose that providing students with more opportunities to rehearse and develop their professional scripts would go some way towards countering their discomfort.

Professional scripts are a rehearsed way of asking questions, seeking

Table 1

Glossary of key terms.

Key term	Definition
LGBTQIA+	An acronym which stands for: Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and Plus, which denotes the spectrum of gender and sexuality, and includes terms which are yet to exist. Importantly, some people also use the Q to refer to questioning, as well as queer; and not everyone in the Intersex Community identifies as LGBTQIA+.
Lesbian	Refers to a woman who is romantically or sexually orientated towards other women. Some non-binary people may identify with and also use this term.
Gay	Refers to a man who is romantically or sexually oriented towards other men. Can also be used as an umbrella term for lesbian and gay sexuality. Some non-binary people may also identify with and use this term.
Bi	This is an umbrella term used to describe someone's romantic or sexual orientation towards more than one gender. Some people will use the term pan synonymously with bi.
Trans	This is an umbrella term for people whose gender is not the same as the sex they were assigned at birth. There are a variety of terms that people who identify as trans may use to describe themselves including (but not limited to): transgender, gender-queer, gender-fluid, non-binary, agender, trans man and trans women.
Queer	Queer can describe anyone in the LGBTQIA+ umbrella and encompasses an intersection of identities. It may be used by those who reject specific labels that describe their romantic or sexual orientation, or gender identity. The term has its origins in a slur, and though largely reclaimed by the LGBTQIA+ community in the 1980s, it is still not embraced as a term by all.
Intersex	Intersex people are individuals whose anatomy or physiology differ from cultural stereotypes of what constitutes a male and female. Intersex people may be male, female or non-binary and can have any sexual orientation and they may not identify as LGBT+. In medical education, variations in sex characteristics are often taught as 'Disorders of Sexual Development', but this term has been rejected and pathologises what is simply a variation of normal.
Asexual	Asexual is an umbrella term used to describe a variation in levels of romantic and/or sexual attraction, including a lack of attraction. Asexual people often adopt the term 'ace' to describe themselves. Ace people may describe themselves using one or more of a wide variety of terms, including, but not limited to, asexual, aromantic, demis and gray or grey-As.
+	LGBTQIA is not an exhaustive list. There are infinite ways to think about and communicate gender identity and sexual orientation. The + indicates acceptance, celebration, support and solidarity with anyone whose gender identity or sexual orientation is beyond societal, cultural and community norms.
Cisgender or Cis	Someone whose gender identity is the same as the sex they were assigned at birth.
Heteronormative	The belief that heterosexuality, based on the gender binary, is the default or normal sexual orientation.
Cisnormative	The assumption that all people are cisgender.
Pronouns	Pronouns are defined as a word that when used by itself refers to either participants in a conversation or to someone mentioned elsewhere in a conversation with examples being she, they and him. More specifically to the LGBTQIA+ community these are known are gender pronouns. Examples include she/her, he/him, they/them, ze/zir and more. Ze/zir are often used by the non-binary and transgender community.
Gender	A complex social construct that usually refers to someone's gender identity. Although often expressed in terms of masculinity and femininity, gender exists on a spectrum and is not limited to the male/female binary.
Sex	Assigned to people, often at birth, as a result of their external genitalia. Often used interchangeably with gender, though the terms and concepts do differ.
Transitioning	The steps someone who is trans may undertake to live in accordance with the gender with which they identify. This can involve social transition (e.g. changing one's name or dressing in a certain way) or medical transitions (e.g. hormonal therapy, surgery). Everyone's transition will be unique to them and transition can involve many different elements. Importantly, no part of transition is required to justify being 'trans' and concepts like the notion of "passing", where people who are transgender can't be distinguished from those who are cisgender, contribute to a cis-heteronormative society.
Gender dysphoria	Negative feelings or emotions associated with a mismatch between someone's gender identity and the sex they were assigned at birth.
MSM	Men who have sex with men, or MSM, is used to describe a group of individuals that may include those who do not identify as homosexual or bisexual, who engage in sexual activity with other men.

consent or describing procedures. For example, students develop their own way to ask a patient to undress to an appropriate level relative to the physical examination about to be performed. By rehearsing and finding their own 'style' the student becomes more confident and comfortable. Script formation is often neglected by communication skills training. Medical schools must provide opportunities for students to develop and rehearse appropriate professional scripts to aid them in liaising with LGBTQIA+ patients.

Providing safe spaces for students to develop their comfort and lexicon is reported as advantageous for preparing students to professionally handle difficult or embarrassing situations (17-20). Such opportunities do not need to reside solely within the formal curriculum, many institutions use the arts and humanities as a way to provide informal opportunities for growth and development. (21) Body painting, for example, is well utilised as a tool to diffuse embarrassment and promote active and fun learning, whilst simultaneously providing students with opportunities to rehearse doctor-patient interactions. (17, 20) Medical students advocate for informal opportunities where they can 'perform the role of a doctor' within a safe place with peer support, devoid of the pressure of assessments such as OSCEs or judgement from faculty.

While modalities such as body painting have been typically used for surface anatomy education (22), as well as for script development, they also prepare students for physical examinations. When delivering formal and informal teaching and learning opportunities, one must be cognisant of the potential impact of the hidden curriculum(23). The notion of 'teaching by stealth' has been reported with respect to the delivery of socio-cultural curricular elements, for example professionalism. However, the hidden curriculum is subjective and individualised so cannot be relied upon as a mechanism by which learning outcomes can be achieved. (23) That being said, it is documented that students observe and imitate role models; thus educators should be mindful of their tacit and implied messaging through biases, language and assumptions. This can include stereotyping in clinical cases or assessment items and by pathologising the sexual spectrum. Further, signposting negative behaviours, such as dismissive communication or making assumptions about sexuality, must occur within the curriculum in order to prevent biases and inequalities from perpetuating within the educational and clinical spaces. In addition, an awareness of the hidden curriculum enables faculties to be conscious of their role in professional identity formation and in providing a supportive environment for students and simulated patients or healthy volunteers who identify as LGBTQIA+. (24)

Importantly, moving away from a hetero-cis-normative status quo in how communication skills are taught is something that will benefit all patients. Entrenched gender binaries harm everyone - assumptions regarding sexuality and gender are not exclusively damaging to the LGBTQIA+ community. For example, assuming a woman has a husband may be damaging to rapport as she may have an unmarried partner, be widowed, single or be in a same sex relationship. What starts as a queer issue, is, therefore, everyone's problem.

Curricular components

Anatomy and clinical skills provide prime examples of curricular components that have not evolved in response to movement in societal norms. There are a number of key considerations with respect to the anatomical and clinical skills curricula. One is that anatomy is taught in a binary context of male and female. Females are typically presented as a variant of male anatomy. Further, the surface and transformed anatomy for post-operative transitioning individuals is not explicitly taught within curricula or advocated for inclusion by regulators or accrediting bodies. That being said, it must be noted that transitioning and surgery are not prerequisites of being transgender.

There are multiple examples which illustrate the need for awareness of transgender anatomy. (25) Firstly, one surgical consideration is that trans men who have undergone subcutaneous mastectomy are left with large scars sub-pectorally; these scars could be mistaken for clamshell lung transplant scarring. Another example for trans men is the need to differentiate between inflammation or infection in the clitoris and labia of a woman against the clitoromegaly and labia atrophy(26) of a trans man who has undergone hormone therapy. An example of a consideration for trans women is that It should be understood that after a trans female has had a vaginoplasty that their neovagina created is a blind cuff (26), lacking a cervix and fornices, in addition to lying more posteriorly; thus, they are better examined with an anoscope.

Importantly, much as it is essential to communicate key learning points such as the above, members of the LGBTQIA+ community ought to also feature in the curriculum, where this is not centred on their gender or sexual identity. This may appear as multiple-choice-question stems, e.g., where a same-sex couple present with a child, the question is not centred on them being same sex; or a transgender person presenting with the flu. The "trans broken arm syndrome" refers to the medical profession unnecessarily relating all aspects of healthcare to someone's gender identity, i.e. an arm is simply a broken arm, regardless if the person is cisgender or transgender. This highlights how a key part of awareness raising may also involve highlighting when it is not relevant to raise a patient's gender or sexual identity.

Pronouns matter

As a term which we use to refer to ourselves and others, pronouns are one way in which we communicate. Pronouns are defined as a word that, when used by itself, refer either to a participant within a conversation, or to someone mentioned elsewhere in a conversation. Examples of pronouns include she, him, they, and ze. More specifically to the LGBTQIA+ community these may be known as gender pronouns. They are used to help those who identify as genders other than those they are assigned at birth to feel more aligned and present within their roles and to reduce dysphoria. A person's pronouns may, or may not, align with their gender presentation.

There is, concerningly, stigma associated with the use of pronouns both within the LGBTQIA+ community, as well as from those not within the community. A study from 2018 shows positive effects by teaching cis gendered individuals about the use of pronouns, and demonstrates that such education gives rise to increases in empathy. (13) Using people's preferred pronouns demonstrates respect and encourages inclusivity. Ensuring correct pronoun usage when communicating with patients and peers helps individuals to feel welcomed and safe within healthcare. It can be difficult to know someone's pronouns just by looking at their face, but there are ways to make it easier to ask and to use the appropriate pronouns for each individual. A way of asking for someone else's pronouns is as simple as telling yours to them. This can encourage others to disclose their pronouns to you. Everyone can make mistakes; if you know you have misgendered someone there is no better way resolve the situation but to apologise, correct yourself and move on. It is not appropriate to dwell on the situation, as this can cause additional discomfort for the person who has been misgendered.

Gender neutral language is another way of promoting inclusivity. An example of a gendered terminology still in use today is the phrase "Hello, ladies and gentlemen". A more inclusive, gender-neutral way of addressing an audience is "Hello everyone". Through a small change in phrasing, anyone who doesn't identify with male or female genders is now represented within your address. Drawing on an example more specific to the field of medicine, the use of the term 'patient' rather than 'he' or 'she' can increase inclusivity in regard to communication when a person's pronouns aren't known. One area of medicine that is particularly gendered is obstetrics and gynaecology, yet women are not the only service users of this speciality - transgender men or non-binary individuals may also be in need of their services.

Never assuming someone's pronouns, and asking patients for their pronouns, even in traditionally gendered specialities, helps to reduce stigma. Other ways to help reduce stigma concerning pronouns include highlighting your pronouns in your email signature; displaying pronouns in your social media bios; and including them on work badges alongside name and role.

We propose the use of pronouns should be made a standard part of consultations, as integral as confirming name/date of birth, consent, and preferred name/title. Respecting pronouns is an essential part of patient care and, most importantly, suicide prevention; for trans and nonbinary youth who report having their pronouns respected by all or most people in their lives attempt suicide at half the rate of those who do not. (27)

Advocating for others

Advocacy involves speaking up and supporting others when they are faced with inequalities or barriers to living and working in a safe and supported way. (28) All trainee or qualified healthcare professionals have the responsibility to advocate for others, yet advocacy is often overlooked by medical curricula. A lack of attention to advocacy-affirming curricula elements creates a hidden curriculum (24) that sends a message to students that advocacy is not an important or essential part of their current and future practice. Offering formal advocacy-centred curricula components and training within medical schools would go some way to addressing this issue.

Though systemic change is necessary, there are also ways that individuals can improve their advocacy for members of the LGBTQIA+ community. In regard to working alongside, or with, individuals who identify as LGBTQIA+, speaking up against homophobic slurs represents one way to support inclusivity. An interesting source for ongoing data on the use of homophobic slurs is nohomophobes.com, an online social mirror that tracks the use of homophobic slurs on Twitter, created by the Institute of Sexual Minority Studies on Services at the University of Alberta. (29) Since the inception of nohomophobes.com in 2012 until 30th November 2020, the slur "Faggot" was used 25,518 times, "so gay" was used 24,212 times, "no Homo" was used 20,177 times, and "Dyke" was used 12,694 times. Though this only represents discussions on Twitter, it does encapsulate the views of people from all over the world, including those from a variety of socio-economic backgrounds, people of multiple genders, and of various education levels. (29) When you are a witness to the use of homophobic slurs, particularly in a professional capacity, you should speak up against their use and support the person who is subject to attack. Attempting to educate others who use homophobic slurs or outdated language which could propagate inequality is another component of advocacy.

As well as overt forms of homophobia, such as the use of slurs, an understanding of microaggressions must also be embedded into the medical curricula. Microaggressions are described as "brief and commonplace daily verbal, behavioural, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative...slights and insults". (30) Considering microaggressions as a framework for thinking about discrimination emerged in the 1970s with respect to racial discrimination but has since been applied to other protected characteristics. (31) Raising awareness of microaggressions in medical curricula is especially important as they may arise out of implicit bias, and, therefore, be unintentionally perpetrated by people who do not mean harm. This is key, microaggressions are not about intent, but about impact, and may involve assuming heteronormativity, expressing discomfort at LGBTQIA+ experiences or generalising LGBT experiences. Concerningly, microaggressions are linked to poorer psychological outcomes in LGBTQ people, can threaten the patient-doctor relationship, and are linked to stress-related health problems. (31) Further, microaggressions can contribute to discrimination in medical education which leads to minority students underperforming academically when compared with peers. (32) This highlights the need to increase awareness and implement zero-tolerance policies in regard to microaggressions within medical education, as well as encouraging the need for reflection on personal biases.

Advocacy can take many forms. It is not just speaking up when you witness an injustice, but also campaigning for change on a more systemic level - be that within healthcare or within education. We should all be advocates, as relying on people who have lived experience of the LGBTQIA+ community alone to advocate for change puts an unfair onus on members of the community. This can increase inequality, as advocacy can demand significant energy and time and is most often unpaid and unacknowledged work. In encouraging advocacy, it is therefore important that this does not create an additional emotional and academic toll on students who are members of underrepresented groups, because these already face greater stressors and differential attainment. Encouraging advocacy and active allyship in all medical students may be achieved through educational interventions such as active bystander training; and by ensuring that medical schools and educators do not perpetuate views of advocacy being seen as in contrast with professional values.

There have been issues with those who adopt prominent roles as advocates being viewed as 'unprofessional'. This issue derives from a traditionalist and oppressive definition of medical professionalism (24), and action must be two-fold. Firstly, professionalism as a concept must be explored in transparent and open discussions between institutions and students, and institutions must be willing to listen to the concerns of students and reflect upon their own biases in the use of this term. Secondly, there is strength in numbers - if more medical students take up the mantle of advocacy against inequality and injustices, medical schools will be forced to re-evaluate outdated, status quo-maintaining conceptualisations of professionalism.

Health Inequalities & contemporary issues

Consideration of health inequalities and contemporary issues should be given in order to inform curricula development. Stonewall recommends that medical schools engage in a review of their curricula, standards and training to ensure that teaching, and associated training, covers discrimination, including homophobic, biphobic and transphobic language, as well as acknowledging the health inequalities facing LGBT people. (1) Further, it advocates for training on providing LGBT-inclusive care, including specific information on providing trans-inclusive care. (1) An example for curricula inclusion can be taken from a recent study showing that lesbians can have an increased risk of breast cancer due to shared risk factors including not having children; having children later in life; whilst also having higher rates of obesity, smoking, and alcohol use than heterosexual women.(33) The aforementioned example provides significant scope for scenario and clinical case development, or as a springboard for a health inequalities discussion within the formal curriculum. Although it is beyond the scope of this commentary to detail all health inequalities and issues faced by the LGBTQ+ community, medical educators must consider these issues when designing curricula content.

Summary of recommendations for institutions, educators, and students

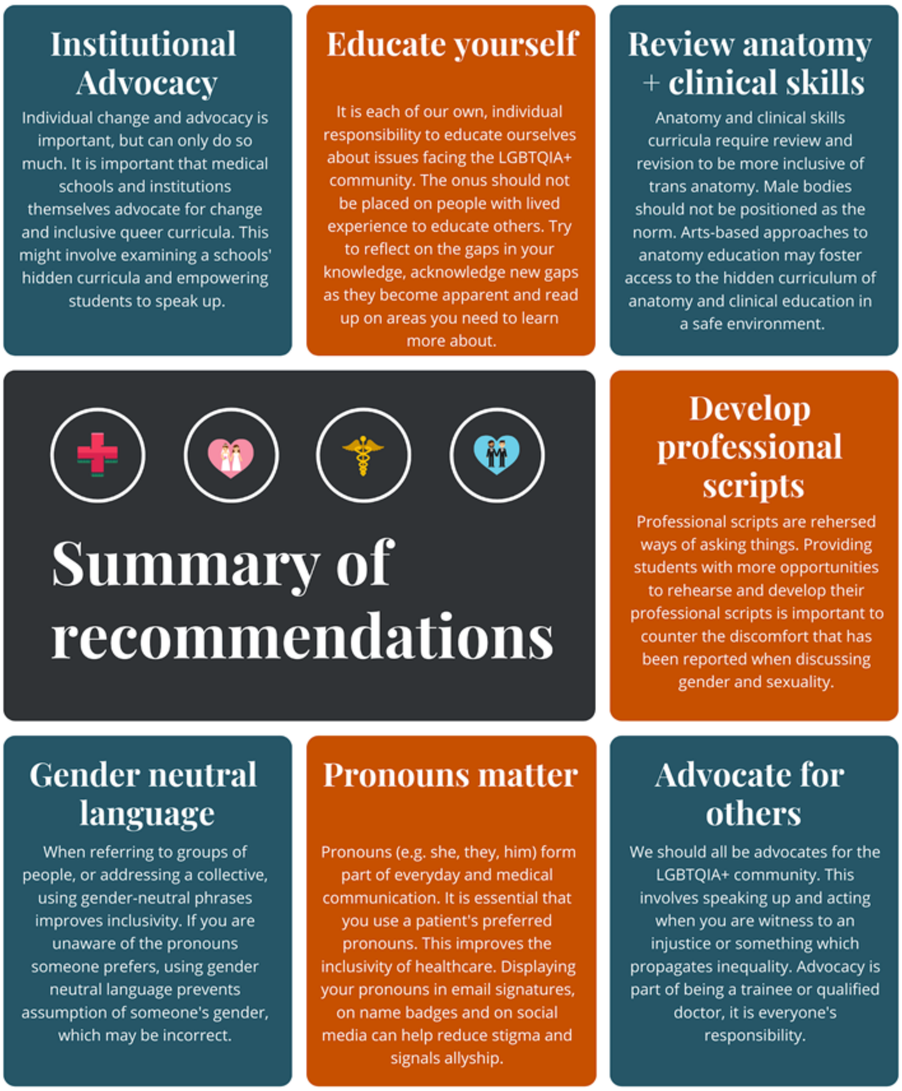
The integrated recommendations of this article have been summarised in an infographic, provided as Figure 1. This infographic highlights the key messages of this discussion article, and we hope will be used by institutions, educators and students to support the inclusion of queer curricula in medical education.

CONCLUSION

Through this discussion, it is hoped that queer curricula will receive more prominence within medical education. By taking a proactive approach, investing the time to educate the future clinical workforce, the queer lexicon will no longer be dismissed as alphabet soup. Through such education, there is an opportunity to bring about positive change in the experiences of LGBTQIA+ students and patients, reducing stigmatisation and improving health outcomes for these frequently marginalised groups. Further, creating a culture centred upon education and advocacy ensures that the burden does not fall to those with lived experiences to educate others. Health curricula need to evolve to represent the diversification of society.

Figure 1

Recommendations for institutions, educators and students to support the inclusion of inclusive queer curricula in medical education.



Institutional Advocacy

Individual change and advocacy is important, but can only do so much. It is important that medical schools and institutions themselves advocate for change and inclusive queer curricula. This might involve examining a schools' hidden curricula and empowering students to speak up.

Educate yourself

It is each of our own, individual responsibility to educate ourselves about issues facing the LGBTQIA+ community. The onus should not be placed on people with lived experience to educate others. Try to reflect on the gaps in your knowledge, acknowledge new gaps as they become apparent and read up on areas you need to learn more about.

Review anatomy + clinical skills

Anatomy and clinical skills curricula require review and revision to be more inclusive of trans anatomy. Male bodies should not be positioned as the norm. Arts-based approaches to anatomy education may foster access to the hidden curriculum of anatomy and clinical education in a safe environment.

Summary of recommendations

Develop professional scripts

Professional scripts are rehersed ways of asking things. Providing students with more opportunities to rehearse and develop their professional scripts is important to counter the discomfort that has been reported when discussing gender and sexuality.

Gender neutral language

When referring to groups of people, or addressing a collective, using gender-neutral phrases improves inclusivity. If you are unaware of the pronouns someone prefers, using gender neutral language prevents assumption of someone's gender, which may be incorrect.

Pronouns matter

Pronouns (e.g. she, they, him) form part of everyday and medical communication. It is essential that you use a patient's preferred pronouns. This improves the inclusivity of healthcare. Displaying your pronouns in email signatures, on name badges and on social media can help reduce stigma and signals allyship.

Advocate for others

We should all be advocates for the LGBTQIA+ community. This involves speaking up and acting when you are witness to an injustice or something which propagates inequality. Advocacy is part of being a trainee or qualified doctor, it is everyone's responsibility.

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Discussion

Facilitation of sexual and gender identity disclosure and improved healthcare for LGBTQ+ patients: current processes, shortcomings, and recommendations for change

DISCUSSION

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ABSTRACT

Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ+) people are at increased risk of physical and mental health problems compared to their heterosexual and cisgender counterparts. There are significant barriers to both accessing and maintaining healthcare for LGBTQ+ people. General practitioners (GPs), being the first point of access to healthcare in the UK, should therefore have knowledge of their patients' sexual and gender identity. Safe disclosure of sexual and gender identity should be facilitated within healthcare services to ensure LGBTQ+ people can receive appropriate healthcare. Currently, GPs and other healthcare professionals may not adequately facilitate disclosure of patients' sexual and gender identity because they believe it is irrelevant or they feel unequipped. Moreover, heterosexist behaviours from GPs and worries of experiencing discrimination may reduce the likelihood of sexual identity disclosure in patients. This discussion starter aims to discuss the current processes and shortcomings within the UK healthcare system to demonstrate that disclosure is not adequately facilitated. Evidence-based recommendations for improved practice are provided, focusing on practitioner training and the primary care environment, whilst building upon the recently launched NHS initiatives such as Pride in Practice. Current efforts to facilitate the needs of LGBTQ+ people must be prioritised and extended in order to end the current healthcare inequalities faced by this community.

The problem

Lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ+) is an umbrella term that refers to sexual (e.g. lesbian, gay, bisexual, queer) and gender minority (e.g. transgender, nonbinary, genderqueer) populations. (1)

Increasing numbers of people self-identify as LGBTQ+ with around 3-5% of the general UK population and 10% of 14-19-year-olds identifying as gay, bisexual, or other. (2, 3) These people are at increased risk of experiencing physical and mental health problems versus their cisgender heterosexual counterparts, but their specific healthcare needs remain underserved.

LGBTQ+ people are more likely than heterosexual people to experience mental health difficulties, with higher rates of psychological distress, anxiety, and depression, as well as greater engagement in deliberate self-harm and suicide. (4-8) There is evidence that this is linked to the experiences of heterosexist discrimination, social rejection, lack of social support, and systemic exclusion from healthcare services that permeate the everyday and lifetime experiences of this population. (7, 9, 10) Experiences of heterosexism are exclusive to the LGBTQ+ population and have been found to be the strongest individual predictor of distress among them. (9)

Heterosexism is discrimination or prejudice against LGBTQ+ people, with the assumption that heterosexuality and cisgender identify is normative, and the expectation of gender and sexual conformity. (9)

As a possible response to this increased psychological distress, LGBTQ+ individuals are also more likely to engage in risk behaviours, such as substance misuse, smoking, and sexual risk behaviours than their heterosexual counterparts. (1, 6, 8) This, in turn, may contribute to poorer overall physical health within this population. LGBTQ+ people are at greater risk of poor sexual health, and various life-limiting physical health problems, including diabetes, heart disease, and a range of cancers. (1, 6)

Existing inequalities experienced by LGBTQ+ people can be perpetuated and exacerbated by discriminatory experiences within the healthcare system and in interactions with healthcare professionals. LGBTQ+ people may not receive the same quality of healthcare as members of the heterosexual population, as their specific needs are less likely to be adequately recognised or treated. There appear to be specific barriers to LGBTQ+ individuals accessing and maintaining adequate healthcare: 8% of respondents to the UK National LGBT Survey (4) had tried and failed to access mental health care despite significant levels of distress. LGBTQ+ persons have been found not to access healthcare services regularly, if at all, compared to their age-matched heterosexual counterparts. (11) This evidence underlines the importance of prioritising the healthcare needs of members of the LGBTQ+ community in UK healthcare settings.

The first step in adequately meeting the needs of the LGBTQ+ population is to facilitate disclosure of sexual and gender identity within healthcare services.

As patients in the LGBTQ+ community have higher health risks, knowledge of sexual identity can be valuable in understanding patients' concerns within the consultation and providing LGBTQ+ specific healthcare. (6, 12) For instance, when consulting sexual health, pregnancy, mental health, and problems stemming from discrimination, sexual identity would be pertinent to assessments, treatments, preventative measures, and specialist referral. (13) Disclosing sexual identity could also be an important part of forming positive GP-patient relationships. (14)

In this article, discussion of current processes and shortcomings within the UK healthcare system demonstrate that disclosure is not adequately facilitated, and evidence-based recommendations for improved practice are provided. In particular, we will focus on disclosure within general practitioner (GP) consultations, whereby both the practitioner themselves and the environment in which the consultation takes place can contribute to an atmosphere in which LGBTQ+ people feel safe to disclose if they wish to. We recognise that a wide range of healthcare professionals and auxiliary staff members work together within GP surgeries, and therefore many of the recommendations that are made within this discussion may be relevant to other healthcare professionals in primary care.

Health care needs vary not only between heterosexual or cisgendered people and LGBTQ+ people, but also within the LGBTQ+ population. For instance, transgender people are most likely to attempt or die by suicide within this LGBTQ+ population. (6, 15-17) Experiences intersect even further with other identities; for instance gay and bisexual Black men may experience greater depression symptoms, experiences of physical assault, issues around sexuality nondisclosure, and polydrug use versus gay and bisexual White men. (16) Thus well-informed, person-centred and sensitive care is extremely important to address health inequalities.

Current Processes and Shortcomings

GPs are the first point of access to healthcare in the UK, so they are a well-placed target for intervention. 1.3 million GP consultations take place daily, and GPs aim to take a holistic approach by assessing and looking after the 'whole person'. (13) Despite this, two-thirds of cisgender bisexual and one-third of gay/lesbian people have never discussed their sexual and gender identity with medical staff. (4, 18) Within the LGBTQ+ umbrella, bisexual people are less likely to disclose than other members of the LGBTQ+ population and people from ethnic minorities are less likely to disclose than their White counterparts. (1, 6, 7)

In general, GPs and other healthcare professionals do not facilitate disclosure by inquiring about patients' sexual and gender identity. Within NHS services, only 5% of people who disclosed their sexual and gender identity to their GPs did so after being directly asked by them. (12) GPs often avoid inquiring, either because they believe it is irrelevant, they aim to "treat everyone equally" and not to be offensive, or they feel unequipped to address the patient's sexual and gender identity. (18) Therefore, patients are burdened with creating a safe space to disclose within consultations. (12, 19)

"GPs are often the first point of contact for anyone with a physical or mental health problem and patients can be at their most anxious. Looking after the whole person - the physical, emotional, social, spiritual, cultural and economic aspects through patient-centred approaches - is a vital part of any GP's role." (13)

GPs themselves recognise that NHS services are not sensitive to the needs of the LGBTQ+ population, and report feeling reluctant to ask about or record sexual or gender identity of patients. (5) Linked to this, GPs do not feel they receive enough LGBTQ+-specific training and that the LGBTQ+-specific issues covered within mandatory diversity training is insufficient.

This lack of education and skills is prevalent even at the baseline of medical school training. A survey study found that 84.9% of a sample of medical students in the UK reported a lack of LGBTQ+-specific training. (20) Interviews with medical students suggested that awareness of health inequalities and LGBTQ+-specific issues, such as gender dysphoria, was limited. (21) This limitation in medical training may result in a lack of skills that are vital for working with LGBTQ+ groups and may lead to further shortcomings in postgraduate education, such as within GP training.

In addition to GPs not facilitating disclosure, they can form a barrier with heterosexist behaviour. Heteronormative assumptions often communicated by GPs regarding contraception and sexual health may make it less likely for people to initiate disclosure themselves. (6)

Some LGBTQ+ people do not believe disclosure is necessary and are therefore less likely to do so. (6, 12, 22) However, in a recent systematic review of sexual identity disclosure, Brooks et al. (6) identified that some people do not disclose because of a fear of potential negative consequences. Concerns around confidentiality and sexual identity information being documented in medical records can form a barrier for some individuals. (6, 12) Other people fear the potential negative personal reactions from the healthcare professionals, and approximately 8% of cisgender LGBT people reported fearing that disclosing their sexual identity could harm the quality and experience of healthcare. (4) These worries around and reluctance to disclose can lead to people concealing sexuality-related health issues or even delaying help seeking. (18, 23) However, there is evidence demonstrating the positive impact of successful, respectful, and affirmative disclosure. One sample of Lesbian women reported being more likely to report issues related to sexual and gender identity, such as experiencing discrimination, sexual health problems, and wishing to become a parent, after such successful disclosure. (18) Given that disclosure can facilitate more specific and sensitive healthcare, GPs should strive to provide a safe space in which LGBTQ+ people can speak openly about their sexual identity if they wish to.

In response to health inequalities experienced by the LGBTQ+ community, a number of initiatives are already in place. NHS England have guidelines indicating that healthcare professionals should ask about sexual orientation at face to face interactions with an option to decline an answer if this information is not already within the patient's medical records. (24) However, there remain significant issues around disclosure of sexual and gender identity which will be explored now. Further, the NHS has recently launched Pride in Practice. (25) Pride in Practice provides support services for patients and healthcare providers to voice LGBTQ+ related concerns within the practice. The initiative also offers advice on social prescribing and specialist services, as well as co-producing research with LGBTQ+ stakeholders, and increasing access to training. Additionally, waiting room resources for an inclusive environment are provided. Since its launch in 2016, the initiative has had a large positive impact: 87% of the services that the initiative has reached has implemented sexual and gender identity monitoring and 60% has started trans status monitoring. (26) There is also evidence of increased patient satisfaction and disclosure of gender/sexuality as detailed in the LGBT foundation's patient survey, but further impact is yet to be assessed. The Royal College of GPs (27) has also launched a resource, which provides GPs with access to online LGBT+-specific training. However, this training is optional and takes only 20 minutes to complete. Therefore, it is unlikely to adequately address the current problem.

The evidence presented within this article highlights that the impact of these initiatives may still fall short of what is required to tackle the existing health inequalities faced by LGBTQ+ populations.

The Solution

Training

A vital first step in ensuring facilitation of disclosure and adequate treatment of LGBTQ+ people is to provide all healthcare professionals, including medical students and GPs, with the appropriate training to discuss LGBTQ+ issues. This should begin in medical school and continue throughout practice.

1. **LGBTQ+-specific training needs to be practical**. Students and GPs must be LGBTQ+-sensitive, having both an understanding and experience of treating health issues in LGBTQ+ patients. (28) In order to improve healthcare providers' confidence and competence when approaching and holding conversations about sexual and gender identity, training should include a practical element. This practical training could consist of conversations and/or role-play consultations with LGBTQ+ stakeholders, making sure that LGBTQ+ voices are accurately represented. With adequate training, healthcare providers can improve the sensitivity of their responses to patients' experience and avoid unhelpful reactions, such as embarrassment, which may be perceived as homophobia. (29) This may reduce anxiety and stress in LGBTQ+ patients and foster an environment where patients feel safe and heard, rather than feel discriminated against. (30)
2. **Language is important.** Within training, the importance of

correct language use and its impact should be recognised and focused on. The use of inappropriate language, whether intentional or unintentional, may be harmful and reduce access to health services in LGBTQ+ patients.(14) Students and GPs should use terminology that empowers patients in contributing to shared decision making and should have an understanding of why certain terms are or are not appropriate. For example, "sexual identity/orientation" should be used rather than "sexual preference" as preference suggests choice. (14) In this way, healthcare providers can foster positive and trusting provider-patient relationships, which is a vital first step in ensuring patient engagement with healthcare services and providing optimal care based on patients' individual needs. (14)

3. **Training needs to be iterative, up-to-date, and person-focused.** It is possible that training can become irrelevant and something of a tick-box exercise for healthcare providers. There are several possible solutions to this problem, including, but not limited to the following:
    - LGBTQ+ voices should play a leading role in the co-design, co-production, and coordination of training sessions. This will ensure that students and GPs understand the spectrum of identities, experiences, and unique health needs of this heterogeneous group (14) and can appropriately respond to them.
    - Training sessions should be continually reviewed and developed, as language and specific needs of the LGBTQ+ community evolve. Regular evaluation and feedback from LGBTQ+ patients and stakeholders can be used to inform the continuous development of relevant training sessions. This will allow current and future healthcare providers to understand that incorporating gender and sexual diversity within practice is a reflexive and continuous process.
    - The effectiveness of training sessions should be evaluated continually. Healthcare providers should be assessed on competencies around being empathetic, non-judgemental, caring, an active listener, and employing open-ended questions. (28, 30)

Environment

The healthcare provider is one very important component of a patient's experience, but the environment in which a patient interacts with their GP can also play an important role. Therefore, it is crucial to create environments in which LGBTQ+ patients feel accepted and safe to discuss their sexual and gender identity and related health issues.

1. **Environmental facilitation of disclosure, continuity of care, and feedback.** Disclosing one's sexual or gender identity to one's GP directly is one avenue for disclosure, but it would be helpful if more avenues were available. For example, GP registration forms which inquire about sexual identity can facilitate disclosure and would be welcomed by many LGBTQ+ patients. (6, 23) These forms should also use an inclusive range of gender pronouns and open text options, allowing patients to communicate aspects of their identities that are important to them. (14, 28). Visual signposts could also be used as a means of improving access to complaint systems which may promote a sense of safety and accountability. In line with the Sexual and Gender Identity Monitoring Information Standard, (31) GPs are currently being guided to competently monitor sexual identity and trans status. Keeping record within electronic systems means that patients do not have to unnecessarily disclose every time they access health services, reducing stress and ensuring continuity of care. However, practitioners should also be conscious of the fluidity of sexual identity; and it will be important for electronic systems to allow for changes in patients' identities over time. (14)

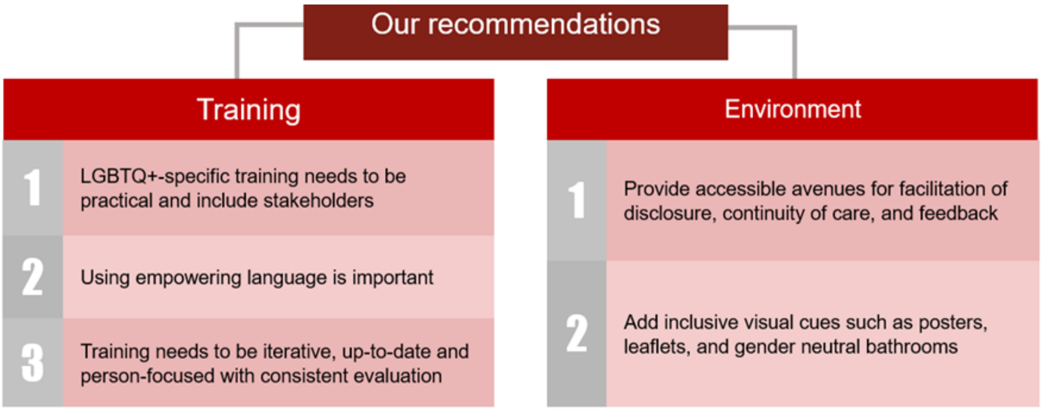

Figure 1

Summary of recommendation

2.

2. **Inclusive visual environments** Aspects of patients' physical environment can facilitate disclosure, such as using inclusive language and displaying LGBTQ+-friendly leaflets and posters within the primary care environment. (6) Posters that are already being rolled out by initiatives like Pride in Practice should avoid portraying heteronormative messages, such as only depicting heterosexual relationships; posters should include LGBTQ+ families and people too. Other forms of visual language like leaflets and resources in waiting rooms should include affirmative information on LGBTQ+ health. This may improve awareness of LGBTQ+-specific health needs (28) and facilitate referrals to LGBTQ+-specific services and support, like support groups. (29) Primary care centres could also be made more accessible by providing inclusive facilities, such as having gender neutral signs on bathrooms. (30)

CONCLUSION

There is a lot of fear surrounding sexual and gender identity disclosure which may not be adequately addressed by healthcare systems, despite disclosure having the potential to impact the quality of healthcare received by LGBTQ+ individuals. Healthcare providers and the surrounding systems need to acknowledge this and ensure factors are in place to facilitate sexual and gender identity disclosure. (28) Research in the area has highlighted this problem, and recent clinical initiatives, such as Pride in Practice, have demonstrated positive change. However, further positive impact could be made at the front-line of healthcare through sufficiently training GPs to be sensitive to the needs of LGBTQ+ people and creating environments which are inclusive and foster a sense of safety. Recommendations extend to a range of healthcare providers, with the aim of maintaining safe and inclusive patient-provider relationships throughout the healthcare system. Current efforts to facilitate the needs of LGBTQ+ people must be prioritised and extended in order to end the current healthcare inequalities faced by this community.

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Discussion

Is biomedicine compatible with contemporary understandings of queerness?

DISCUSSION

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ABSTRACT

Medicine is widely considered a site of social power, one that influences, and is influenced by, social and cultural norms. As such, medicine is deeply intertwined with societal powers and has complex patriarchal roots, with a history of oppression and underserving marginalised communities. This is compounded by the rise of biomedicalisation in the nineteenth century, which centres the empirical scientific method, further steering medicine from its foundations in social responsibility.

The development of queer theory, on the back of feminist work since the 1960s, has shifted cultural views on gender, sexuality, and human identity far from the pathologising models of queerness suggested by modern biomedicine. As these radical theories have developed, biomedical understandings of identity have expanded into the biopsychosocial model. However, it is uncertain whether biomedicine as a discipline will be able to fully integrate wider queer theory, due to a limiting language and framework based on patriarchal and empirical foundations. It is critical that the ideologies currently pervasive throughout medical schools accurately reflect contemporary thought on gender and sexuality.

This article calls for a radical analysis of the frameworks for understanding gender and sexuality that exist within biomedicine. Contemporary understandings of queer theory, and how that applies to the human body and good health, must be integrated in the education of medical students.

INTRODUCTION

Since its establishment, medicine has been a site of social power, shifting through its evolution to reflect the cultural and social ideals of the time. The reference points for ideal health standards, formed through medicine's development, have long been dictated by the contours of societal power, or patriarchy. Historically, bodies not deemed to be of value by patriarchal ideals have been left marginalised and oppressed. The othering of these bodies has been further compounded through the biomedicalization of health, beginning in the nineteenth century. (1) First appearing in medical dictionaries in 1923, biomedicine refers to "clinical medicine based on the principles of physiology and biochemistry", (2) and its gain in popularity represents a shift from a public health-based medicine to one focused on empirical science. The biomedical focus on viewing the human body through a biological and anatomical lens has led to the pathologizing of bodies and the creation of harmful binaries that are, to this day, prevalent throughout biomedicine.

With a chequered history of centring and protecting the white, able, cis-gendered, and heterosexual body, biomedicine has long considered some bodies 'normal', whilst pathologizing those that fall outside of these categories. (3, 4) Since the 1970s, theories of gender and sexuality have transcended the normal/pathological binary found within biomedicine, exposing a gap in medical understanding in relation to the treatment of queer bodies. (5) In response, the biopsychosocial model (6-10) aims to expand understandings of good health to consider the social and psychological aspects of a patient's experience. However, biomedicine has been slow to implement this contemporary understanding of health. In practice, those acute medical and surgical specialties holding greatest economic and political power have shown limited acceptance, with only general practice and psychiatry demonstrating a more holistic approach. (11)

The role of the healthcare provider lies in the definition of good health. Building on the biopsychosocial model, current definitions dictate a body that is not only free of pathological illness or disease, but also enjoys complete physical, mental and social wellbeing. (12) Despite this, current methods of medical knowledge production, as well as the frameworks used to create the biopsychosocial model, remain with a legacy of pathologizing queerness with discrete biomedical categories for patient identity. It is therefore unclear whether contemporary theories of queerness are compatible with Western medicine and its understanding of human identity.

This article will consider the historical biomedicalization of queer bodies, contemporary theories of gender and sexuality and the limitations of the biopsychosocial model in relation to preparing medical students to engage with queer communities. It is the contention of this article that the biopsychosocial model for good health is unable to offer queer patients care that aligns with contemporary queer theory. Queer communities are overburdened with poorer health outcomes due to a health system unable to serve them. (13) Radical change is needed to keep pace with contemporary theories of queerness, and to ensure medicine is fit to serve all.

The biomedical and biopsychosocial models of health and disease

An understanding of the origins and production of medical knowledge is fundamental if medical students are to situate themselves within the shifting landscape of contemporary theories of health. This includes an awareness of how the frames of reference through which we view our patients have evolved, and for whose benefit.

Prior to the nineteenth century development of biomedicine, the body was viewed as a whole, and treatment of disease was based on sacred and spiritual beliefs applied to the body, mind, and soul. (14) This model held true until the post-Renaissance period, when invention of current day medical tools, such as the microscope, stethoscope, and anaesthesia led to a proliferation of discoveries due to anatomical exploration. (15, 16)

The work of René Descartes is widely attributed to have resulted in the shift to a dualistic ontological view of the body, or the existence of mind and body as separate entities. (17) Viewing the body as a biological organism, and thus reducible to its constituent components, allows for the recreation of an ideal standard of good health; a standard in which disease is viewed as a deviation from the norm, to be rectified by medical intervention. This model for good health has evolved with societal changes, reflecting shifts in power and maintaining the white, able, cis-gendered and heterosexual body as the standard of normality and wellbeing. (18) The production of this ideal standard within biomedical discourse may serve to uphold patriarchal systems, whilst inevitably maintaining social oppression. By reducing a body experiencing ill health to a set of noncontextualized and quantified deviances from cultural norms, the nuance and humanity of the individual are lost. (19)

Traditional views of ill health in terms of deviance from a biological norm allow for no consideration of the psychological, environmental, and social factors that influence the experience of ill health. The biopsychosocial model, introduced by Engel between 1960 and 1980, (6-10) attempts to allow for the consideration of these wider factors. Despite this, it is argued that a model grounded in empirical diagnosis, prioritising the pursuit of causative agents of disease rather than centring the experience of the patient, is not a sufficient tool for either the clinician or the healthcare system. (20) The dividing up of medical knowledge into the empirical and perceivable creates a distancing of medicine from health, in search of an objective normality. (18) It is arguable that the inherent social power found in medicine, gained through nurturing the bodies that allow patriarchy to prosper, may have created a vulnerability to cultural and politicised influences that have shifted focus away from the social responsibility at medicine's foundations.

Whilst reinforcing and reproducing heterosexual hegemony, these medical standards have had damaging implications on patient care for those without white, able, cis-gendered male bodies. Inequalities can be seen widely in clinical encounters, where pain thresholds and patient credibility are questioned, and treatments drawing on cis-gendered and male-centred research may be used inappropriately. (21) Disparities in health outcomes are reported widely between cis-gendered men and women, with a higher rate of undiagnosed illness and negative experiences with healthcare providers amongst cis-gendered women. (22) Further research is urgently needed on the health disparities found in all LGBTQ+ patient groups.

Historical biomedicalization of gender and sexuality

In response to the societal promotion of a heteronormative health ideal, the pathologizing of those partaking in non-conforming gendered or sexualised behaviours followed. As of 1953 these were officially diagnosable in the Diagnostic and Statistical Manual of Mental Disorders (DSM). (23)

Homosexuality was a diagnosable condition until 1973, when it was removed from the DSM-II due to theories of immaturity, (24, 25) and normal variation, (26, 27) outcompeting those of a pathological basis for sexuality deviance. Medical theories of homosexuality have mapped closely to the wider language of binaries and reductionist views of the body. These theories are rarely separated from those of gender, with theories spanning the nineteenth to twenty-first centuries drawing on cultural concepts of inherent qualities of cis-gendered men and women. (5) Essentialist gender beliefs have led cultural notions that individuals not performing expected sexual behaviours may possess traits of the other sex, rarely deviating from the male/female binary. (28)

Following the removal of homosexuality from the DSM-II in 1973, a new diagnosis of 'sexual orientation disturbance' described homosexuality as an illness only if the person was 'disturbed by, in conflict with, or wished to change their sexual orientation'. (28) This was again altered in the release of DSM-III, with a diagnosis of 'ego dystonic homosexuality', and entirely removed in 1987. Gender variances have been listed as pathological conditions since 1980, when 'gender identity disorder' entered the DSM-III. (29) The pathologizing of gender variance in children and adults has been widely condemned as perpetuating stigma and traumas experienced by transgender individuals. (30) In 2013, following the publication of the DSM-V, the diagnosis of 'gender identity disorder' was removed in place of 'gender dysphoria', a diagnosis used to describe experiences of distress within gender-variant populations. (31) However, this new diagnosis may raise questions as to whether the vagueness of the diagnostic criteria limits their clinical applications, whilst maintaining stigma around gender variance. Furthermore, since the introduction of gendered pathologies in the DSM, wider discourse around the efficacy and purpose of such diagnoses holds that complete removal of gendered pathologies is the only way to take proactive steps towards reducing stigma experienced by gender-variant communities. (32)

Contemporary understandings of gender and sexuality

Historically, models of good health have been produced and reinforced through biomedicine and patriarchal power systems. This has been resisted by second wave feminist groups since the 1970s. Health activists have suggested the biomedical model imposes passivity, ignorance, and disempowerment on patients, thereby distinctly lacking feminist principles. During the 1970s and the following decades, a focus was placed upon feminist medicine. This centred prevention over cure, and the patient's social and interpersonal experiences as part of health management. (19)

Without the burdens of a prescriptive and pathologizing model of knowledge production, and on the back of decades of health and feminist activism, the social sciences have been at the frontier of sexuality and gender theory. (33) Rejecting the medical notion of inherent differences between cis-gendered men and women, the late 1980s saw the introduction of concepts of gender performativity (34) and social constructionism, (35) two foundational theories in contemporary gender studies that present gender as a product of intrapersonal, interpersonal, institutional and society-wide relations. (36) A social model of gender and sexuality is reflected in current definitions of health, as defined by the World Health Organisation as 'complete physical, mental and social well-being and not merely the absence of disease or infirmity'. (12) This holistic view of health harks back to pre-biomedical models of wellbeing, with the body containing an interconnection of components that can only be considered in the context of the whole. (17)

Can current models of health serve queer communities?

Despite progressive cultural shifts towards a more conceptual model of sexuality and gender, biomedicine appears slow to adapt, with limited evolution of the biopsychosocial model since its introduction. It has been suggested that this may be due to patterns of homosociality, or the relationships between cis-gendered men that act to propagate patriarchal systems and, reproduce medical traditions that resist radical change. (37) A study in Sweden in 2011 sought to investigate the views of cis-gendered male medical faculty members on the implementation of gender issues into medical education. The study reports ambivalent attitudes of the participants, who acknowledged gender as a determinant of health and the existence of inequalities, however ultimately considered gender to be 'important… but of low status'. Pertinently, gender education was viewed as a poor use of time and space, as well as considered to be unscientific. (37) The findings of this study draw close parallels to wider notions of the empirical and patriarchal origins and interests of biomedicine, seeking to centre and maintain dominance of the white, able, cis-gendered and heterosexual male.

Despite efforts by medical institutions to incorporate current LGBTQ+ health issues into medical curricula, (38, 39) this often falls short of the requirements of patients, leaving clinicians feeling inadequately prepared to support LGBTQ+ communities. In addition, studies have shown hidden curricula (that which is learnt inadvertently or passively during education) within medical schools that act to propagate compulsory heteronormative notions in its students, reinforcing homophobic stereotypes about queer patients. (40) The biases taught through medical education are pervasive, with a review of healthcare professional' views towards LGBTQ+

patients reporting approximately half of first-year medical students to express explicit negative attitudes towards lesbian and gay patients, and over 80% of students exhibiting implicit biases towards the same groups. (41)

It follows, then, that current attempts to include LGBTQ+-related health matters in medical education may be falling short of the needs of those communities, not only by creating clinicians ill-equipped to treat patients, but also exhibiting implicit and explicit biases. (41) Medical curricula have been shown to produce and reproduce sexual stigma and compulsory heteronormativity in both medical and hidden curricula. (42) Further, medical curricula have been shown to render specific sexual behaviours as natural and unremarkable, with others as excluded from this normality. (40) Considering these shortfalls, it therefore may be necessary to take more radical change when addressing the limits of medical education in relation to LGBTQ+ health.

A key question in rethinking LGBTQ+ health education is whether it is sufficient to treat these health needs as a discrete, peripheral learning opportunity, as health in relation to gender, sexuality and identity is experienced by all patients. Educating medical students to identify and treat patients only when they are deemed to have deviated from a heterosexual, cis-gendered normality may serve only to other and alienate patients, leading to a lack of engagement, failure to disclose health matters and, ultimately, inferior health outcomes.

It is critical that healthcare providers fully appreciate the significance of sexuality and gender to a patient, particularly when presenting in the clinical setting and seeking support as they experience ill health. (43, 44) In the clinical space, patients are often reduced to their diagnosable biological state. However outside of this space the patient exists in social and cultural spheres, where their identity and wellbeing are intimately linked. When patients feel that this part of themselves is not compatible with biomedicine, perhaps even disregarded by the clinician, they may feel forced to seek care from alternative providers. (19)

Alternative medicine (AM) is often sought out by patients due to increased time with care providers, (22) and by those seeking a clinical relationship that acknowledges and incorporates the patient's social realities into health management. (19) The use of AM may reflect the patient's resistance to the biomedical frame, whereby patients experience a loss of autonomy and humanity at the hands of a profession seeking to reinforce patriarchal power structures. (22) AM is widely considered within biomedicine to be effective only as far as placebo limits allow. (45) Therefore, it may be in the best interest of the patient to ensure that biomedical health providers are not enforcing unnecessary barriers to accessing care, for patients who are seeking only to be treated as a sum of more than their biomedical symptoms.

While the identification of at-risk groups is crucial in supporting specific communities and managing disease, the ideologies cultivated through medical curricula, hidden curricula and cultural discourse must be considered and carefully navigated. (46) Medical school can be considered a transformative site of professional socialisation, (42) where models for conceptualising gender, sexuality and identity may challenge or even supersede original understandings. Therefore, we must be intentional in ensuring that we produce healthcare professionals who are aware of and sensitive to the identity of their patients and actively create healthcare spaces that are safe for currently underserved communities.

Given modern theories of gender and sexuality as a transient set of experiences, expressions and behaviours, biomedicine appears to fall short in its ability to either define or incorporate contemporary queer theory. The requirement to fulfil discrete categories in diagnostic criteria to engage with treatment may place biomedicine at a distinct disadvantage when attempting to offer care to a community whose bodies fall outside of those categories. Careful consideration should be made as to how current and future medical professionals are educated, ensuring the language and frameworks applied to patient care are inclusive of, and accessible to, communities that exist outside of traditional medical narratives. Radical rethinking of the binaries applied to medical diagnoses and the pathologizing of the human experience are needed if care is to be truly patient-centred.

CONCLUSION

The biomedical and biopsychosocial models of healthcare were constructed on patriarchal ideals of physical, social and cultural standards. As sociological understandings of human identity develop, particularly in relation to sexuality and gender, biomedicine may not be equipped to incorporate contemporary queer theories into its frameworks of care. With distinct disparities in health outcomes between queer and non-queer communities, medical professionals, educators and students must rethink the ideologies that are being taught and are entering the clinical space, if biomedicine is to remain a model of healthcare that is viable for the future.

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Discussion

The importance of near-peer mentorship for LGBTQ+ medical students

DISCUSSION

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ABSTRACT

Navigating medical school can be especially challenging for LGBTQ+ medical students. LGBTQ+ medical students may face unique barriers and struggles in personal and professional development because the LGBTQ+ identity is often unrecognized or unacknowledged within medicine. Currently, there is not enough support for LGBTQ+ medical students. One emerging resource to navigate transitioning through medical training is near-peer mentorship. A near-peer mentor is a peer who is at least one year senior to a mentee in the same level of educational training and provides guidance on career development and psychosocial growth. Given the generally small number of LGBTQ+ medical students at each institution, near-peer mentorship would have to happen at both a local level and through social media. In this article, we explore the barriers that LGBTQ+ medical students face, the importance of near-peer mentoring, and examples of potential mentorship programming.

INTRODUCTION

Navigating medical school is incredibly challenging. Many students move away from their communities of support to pursue a medical education. Beyond the loss of a local support network, LGBTQ+ students may face uncertainty about the receptivity or safety of their new area. (1) The intensive course schedule makes maintaining personal relationships difficult and may lead to feelings of isolation. (2–4) The academic rigor of medical education is a substantial increase from the requirements of many secondary, undergraduate, and post-baccalaureate programs. Students must learn and retain a broader range of scientific and clinical content in greater depth than expected in the pursuit of a secondary or undergraduate degree. (4,5) Beyond the coursework, students are learning new technologies, study skills, and testing modalities. (4,5) Many students find that their previous study habits are insufficient or not well-matched to the content. (4) Additionally, the pursuit of medicine necessitates significant professional and personal growth, especially during the transition from the pre-clinical to clinical curriculum. LGBTQ+ students may struggle to find support because their identity is unrecognized or unacknowledged within medical education and practice. (6)

One emerging resource to navigate transitioning into medicine is a near-peer mentor. A near-peer mentor is a peer who is at least one year senior to a mentee in the same level of educational training. (7) In this relationship, the near-peer mentor provides guidance such as career development, psychosocial growth, and role modelling. (8) Given the similar stages of training, this relationship allows for social support that can help ease the transition into and through higher education. (9) Higher education, including STEM programs and medicine, have incorporated near-peer mentorship programs through both formalized programming, such as courses where senior students teach younger students skills, and informal programming, which includes having time set aside for regular meetings to discuss the transition into higher education. (10–12) LGBTQ+ medical students are faced with unique challenges stemming from the stigmatization and oppression of their identity, separation or estrangement from families, the lasting impact of the AIDS epidemic of the 1980s and 1990s, and the lack of adequate resources devoted to improving their success. (13–15) Due to the growing research on the importance and usefulness of near-peer mentorship in navigating life challenges, medical education programs should focus on developing such programs to include and centre the experiences of LGBTQ+ medical students. (16,17)

Background and Significance

Peer mentorship has the potential to alleviate LGBTQ+ medical students' fear of identity-based discrimination. In conjunction with academic stressors, LGBTQ+ medical students must navigate being out in personal and professional settings that have been historically discriminatory. (13,14,18,19) LGBTQ+ students may even limit where they apply to medical school out of fear of discrimination. Students moving to a new location for medical school are challenged with the additional stress of assessing their safety while learning their new environment. Because a persons' level of outness may affect their clinical evaluations and safety, LGBTQ+ medical students must continue this assessment process throughout their training as they change learning environments within their clinical years. (20) Having increased worry about discrimination contributes to burnout and can worsen mental health outcomes. (4,21–23) Near-peer mentorship can help alleviate this stress for newer cohorts of medical students. This mentorship provides a means for older students to pass on critical knowledge that can help younger students better navigate medical school and know who to contact for support. (25) Having a near-peer mentor with a shared understanding and experience of these settings can therefore create a relationship in which a younger student can feel safe, prepared, and understood. (24) Such guidance can also be achieved electronically, as evidenced by the creation of OUTlists, which list LGBTQ+ faculty at different institutions for student and faculty access. Social media and video sharing platforms like Twitter can also connect LGBTQ+ medical students to peers and mentors, as well as create forums for students to receive advice on handling discrimination. (29) Such resources help younger students to feel supported, navigate medical and academic spaces, and decide how to live authentically. (13,26–28)

The current scarcity of LGBTQ+ mentorship opportunities stem from the impact of the AIDS epidemic of the 1980s and early 1990s. The AIDS epidemic caused a disproportionate and significant loss of an entire generation of LGBTQ+ individuals and contributed to the societal stigmatization of LGBTQ+ people, even in healthcare. (30) The epidemic created a restricted definition of "LGBTQ+ Healthcare" by disproportionately emphasizing HIV-related and sexual health over other LGBTQ+ health concerns. This narrow definition compartmentalized both LGBTQ+ health and health professionals, as it created a precedent about the type of medical issues that gay physicians should experience and pursue. (15) Although research could be one method of restoring attention to the true diversity of LGBTQ+ health, LGBTQ+ populations are still underrepresented because studies on health disparities do not assess sexual and gender identity data. (24,31,32) Alternatively, mentorship from near-peers could provide current LGBTQ+ medical students with the opportunity to reverse and challenge this definition of LGBTQ+ health and the specialty precedence that arose during the AIDS epidemic. Being able to witness older LGBTQ+ students pursue different specialties would allow future LGBTQ+ students to see themselves represented in a variety of fields, which might increase their incidence of applying to different specialties. This shift could assist in creating a more diverse medical field, thereby reducing the bias and discrimination that LGBTQ+ patients encounter and improving the academic productivity of LGBTQ+ individuals in a variety of specialties. (13,19,24,33) Although mentorships between older LGBTQ+ medical practitioners and medical students may offer similar benefits, the temporal relationship between older peers and younger mentees would provide mentees with a better representation of the current state of medical practice. Additionally, because the compartmentalization of LGBTQ+ health is based in historical perceptions and experiences, mentorship relationships with older LGBTQ+ practitioners may reinforce these beliefs rather than challenge them. LGBTQ+ medical students should be able to pursue any specialty or career path that they want and one way to contribute to this is through their mentorship, guidance, and support. (24,34)

Currently, there is still not enough support for LGBTQ+ medical students. This lack of support can be seen across medicine, including in the lack of data regarding how many medical students or faculty identify as part of the LGBTQ+ community, the paucity of pathways available to support LGBTQ+ research outside of the context of HIV or sexual health, and the absence of adequate education regarding LGBTQ+ healthcare both in the US and the UK. (24,35,36) Not all specialties have groups that support LGBTQ+ individuals, which contributes to the contemporary exclusion of LGBTQ+ individuals from certain medical environments. This dearth of protection and representation has led to the perpetuation of a cycle wherein LGBTQ+ medical students avoid certain, often more competitive, specialties that they perceive as being less inclusive. This phenomenon is especially present in surgical specialties and subspecialties, as noted by the 2016 British Medical Association and Association of LGBTQ+ Doctors and Dentists (GLADD) survey. In this survey, one-third of respondents reported that they chose their specialty based on relative LGB friendliness. Additionally, 33 respondents reported that they had changed specialties due to discriminatory experiences. (19,34) Although there is no data on current LGBTQ+ provider prevalence in each specialty, data on the perception of inclusion has remained fairly constant over 20 years. Specialties such as Paediatrics, Internal Medicine, Family (General) Practice, and Psychiatry are considered the most supportive specialties, and surgical specialties the least supportive. (34) Barriers such as absent faculty support or knowledge, lack of funding, and fear of long-term academic repercussions to engaging in LGBTQ-specific research further prevent LGBTQ+ medical students from pursuing diverse interests in medicine. The previously discussed stigmatization of LGBTQ+ individuals and narrow definition of LGBTQ+ health also pigeonholes trainees into avoiding certain types of research and causes academic institutions and faculty to view LGBTQ+ research as inferior to other topics. (24,26) Although these barriers cannot be fixed by near-peer mentorship alone, near-peer mentorship allows access to more diverse experiences by expanding both the mentor and the mentee's personal and professional networks. The social networks gained through mentorship may be protective against the feelings of isolation that LGBTQ+ medical students encounter in academic settings.

Near-Peer Mentorship Programming

Given the generally small number of LGBTQ+ students at each institution, organizing near-peer mentorship programming for LGBTQ+ students would have to occur at the local level as well as the regional or national level. On a local level, student organizations like the Medical Student Pride Alliance (MSPA), the first national LGBTQ+ student group in the US, or the GLADD Student section in the UK could use their national connections to bolster local LGBTQ+ medical student groups. This assistance would come in the form of mentorship training that gives mentors the tools to support and discuss being an LGBTQ+ medical student in their community. Such training would provide LGBTQ+ medical student group leaders with the skills to develop safe spaces and maintain rewarding mentor-mentee relationships.

Training mentors and mentees is an important part of developing a fruitful mentorship. This training should cover how to be an effective mentor, how to be an effective mentee, and how to form and maintain a gratifying relationship. Being an effective mentor includes being honest, responsive, motivating, and available. Part of being an effective mentee includes helping drive the relationship, maintaining honesty, and being proactive about areas of need. In terms of maintaining a mentorship, there are four phases: initiation, where the relationship commences and expectations are set; cultivation, where both sides grow; separation, where both sides have gained satisfaction from the relationship and the completion of desired objectives; and redefinition, where the hierarchy is removed and the near-peer transitions to a peer. (37) For a near-peer relationship, these stages can mirror the timeline of training (i.e. both being in medical school). In addition to network expansion, mentorship can provide the mentor with personal fulfilment for having given back to the LGBTQ+ community and assistance in developing scalable leadership and mentorship skills for their later career. Additionally, mentees may gain a sense of community and empowerment, especially if the mentorship is developed on a local level. For example, local LGBTQ+ medical student groups could personalize the training they provide to their mentors to cover the specific resources in their area and the known concerns of their peers, advising on topics applicable to all medical students, along with providing training to ensure a safe and healthy mentorship relationship and maintaining appropriate boundaries.

A near-peer mentorship program could be accomplished by adapting components of existing faculty-to-medical student mentorship models. (38) A traditional group model is one such design, wherein a senior student mentors a group of younger students. Another is the tiered or vertical model, where a senior student mentors a junior student who would then be expected to serve as a mentor for an even younger student in their training program. In these mentorship arrangements, mentors and mentees could meet in both 1-on-1 session and groups, which would allow for personal guidance and insight based on different level of experiences. Multiple styles of mentorship could be set up at each individual institution; however, given the small number of LGBTQ+ medical students at each institution, these models could also be used in virtual groups and on social media and video sharing platforms to further bring students together.

Social Media and Video Sharing Platforms

Social media is an important way of connecting students to near peer mentors on a regional or national level. Social media platforms provide LGBTQ+ students access to resources, peers, and faculty that may not be available locally. The duration of near peer mentorship on these platforms can be both short and long-term. The responsive nature of social media allows mentors to rapidly address questions or social concerns that arise through chats, webinars, hashtags, or threads. Longer-term mentorship may occur through one-on-one conversations, within groups, or as part of ongoing programming such as weekly chats or journal clubs.

For example, MSPA has put on exemplary events in support of LGBTQ+ medical student and pre-medical student mentorship. These online events included a panel on applying to medical school as an LGBTQ+ pre-medical student, a discussion on applying to residency as an LGBTQ+ medical student, and an LGBTQ+ student research symposium. During these events, junior medical and pre-medical students often had questions about how to navigate applying to school while fearing discrimination, maintaining professionalism in clinical settings that felt exclusionary, and reporting experiences of discrimination. These events provided insight into the general lack of support LGBTQ+ students experience in medical education and how, through virtual events, LGBTQ+ medical students can start developing the tools they need to support themselves and their peers. These relationships can serve as a source of guidance, role-modelling, and safety that will allow LGBTQ+ medical students to grow and develop in both their personal and professional identities.

With the growth of video sharing platforms over the last year, as well as the continuing growth of social media, there has been an increase in opportunities to connect with peers from different institutions and across the globe. Now, opportunities that had not been as common previously, such as having social events with other institutions over secure video platforms like Zoom, may allow LGBTQ+ medical students to meet each other and develop relationships that can evolve into near-peer mentorships without the fear of being "outed" to their larger communities. Medical students can also establish networks on social media platforms, as has already been demonstrated through the Facebook groups "LGBTQIA+ Medical Students" and "LGBTQ Premedical & Medical Students". In these groups, students in different years of training have been able to share advice, advertise events and resources, and connect with each other based on common experiences and goals.

Institutional Change

Although mentorship alleviates some of the barriers that LGBTQ+ students face, mentorship alone will not resolve the broader issues of stigma, discrimination, harassment, and bias. Systemic changes to improve and support LGBTQ+ medical students are still needed and will take time. For any mentorship programming to occur, LGBTQ+ medical students need to feel safe to develop peer relationships. (6) One place to start would be for medical institutions to create an environment that is welcoming to LGBTQ+ medical students. Part of creating a safe environment for LGBTQ+ medical students includes supporting the formation of LGBTQ+ medical student groups at institutions; hosting trainings to recognize and prevent LGBTQ+ discrimination; and educating students, faculty, staff, clinicians on the barriers and disparities that LGBTQ+ persons experience. In addition to working to prevent explicit discrimination, institutions should also give financial support to LGBTQ+ medical student groups that would allow these groups to attend conferences and connect with a larger network of LGBTQ+ medical students and clinicians. By creating an environment in which LGBTQ+ medical students feel supported and protected, programs can naturally foster the formation of mentor-like relations.

CONCLUSION

There are numerous barriers and anxieties that LGBTQ+ medical students may experience as they navigate training. However, there are also many opportunities and theoretical models for improving the support and success of LGBTQ+ medical students. One growing and promising solution is the development of near-peer mentorship. In the US, we have witnessed a growth in LGBTQ+ medical student networking through both social media and national programming, as has been utilized by MSPA. Over the next several years, MSPA hopes to use the models and theoretical principals explored in this article to create guides and resources that better connect local LGBTQ+ medical student groups with each other and with established mentorship practices. Hopefully, with some of these tips and suggestions, LGBTQ+ students in the UK can also work to connect and support each other through medical school.

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Discussion

Social barriers to pre-exposure prophylaxis uptake within sexual and gender minorities in the UK

DISCUSSION

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ABSTRACT

Background: Pre-exposure prophylaxis (PrEP) is a biomedical tool taken by HIV-negative individuals to prevent HIV transmission. (1) HIV prevalence is disproportionately high for transwomen and Afro-Caribbean men who have sex with men (ACMSM). (2, 3) This suggests that maximising PrEP uptake could be fundamental in curbing HIV prevalence, thus social barriers inhibiting its uptake warrant a deep understanding. The aim of this critical inquiry is to develop an understanding of PrEP social barriers faced by ACMSM and transwomen in the United Kingdom (UK).

Methods: The following databases were used for this critical inquiry: JSTOR, PubMed, and Web of Science. Out of the 30 studies identified as potentially relevant, 10 studies were included in the review.

Results: PrEP social barriers identified include: stigma, insufficient awareness, non-adherence, and suboptimal patient-provider relationships. (4-12) Social situations can lead to fear of PrEP stigma, deterring ACMSM from PrEP uptake. (4) A homophobic upbringing and racism could shield these individuals from PrEP awareness and adherence. Insufficient PrEP awareness, transphobia and the all-consuming oppression transwomen face may reduce PrEP access for transwomen. (9) Intersectionality could explain the heightened PrEP social barriers faced by transwomen and ACMSM. (4, 9, 10, 13)

Conclusion: Social barriers to PrEP uptake are enhanced amongst ACMSM and transwomen due to intersectionality. Continued training on intersectionality and sexual and gender minorities (SGM) health are essential for enhancing patient-PrEP provider relationship, and reducing discrimination from sexual health services. (14) Incorporation of SGM sexual health in sex education may alleviate the PrEP stigma ACMSM and transwomen face. Increasing policy representation of transwomen may

INTRODUCTION

Sexual and gender minorities (SGM) are a group of people who embody a variety of sexual orientations and genders (Figure 1). (15) SGM have faced historical challenges, including but not limited to the AIDS epidemic and infringements of their civil rights. (1) These widespread social issues continue to be a burden for SGM and contribute to health inequalities. The socio-economic inequalities they suffer from lead to restricted health care access, under-representation in policies, social isolation, and has also been attributed to a heightened risk of contracting COVID-19. (1)

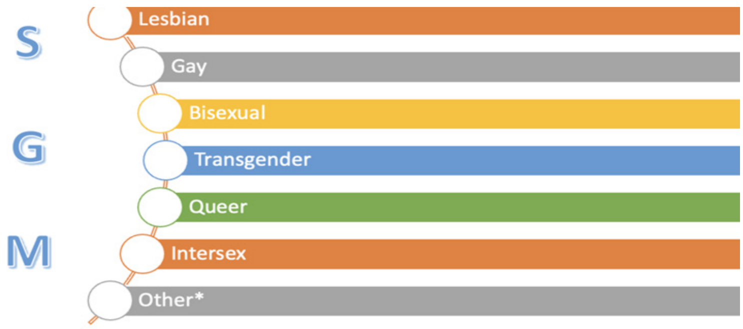


Figure 1: *Adapted from Blondeel et al. (15)*
*Other includes queer, asexual, men who have sex with men, questioning, two-spirit, gender variant.

Pre-exposure prophylaxis (PrEP) is an effective oral drug combination used by HIV-negative people to prevent HIV contraction. (17) As well as its biomedical potential, it can have psychosocial benefits like sexual liberation. NHS England was the last NHS system in Great Britain to commission PrEP (Figure 2). (18) Before its widespread commissioning in England, PrEP was only accessible via the IMPACT trial or if privately funded. (18) However, the trial did not sufficiently consider high-risk groups (sex workers, transwomen, and Afro-Caribbean men who have sex with men (ACMSM)) in their study demographics, raising issues on equitable access to PrEP for minorities. (19)

Health inequalities disproportionately affect transwomen and ACMSM. (1, 2, 20, 21) Coupled with high prevalence of depression and anxiety, the World Health Organization (WHO) reported that transwomen are 49 times more likely to have HIV than the non-transwomen population. (2) Despite this, there is a lack of awareness of PrEP amongst transwomen. (9, 10) According to the National AIDS Trust, the proportion of Black Africans and Caribbeans having late HIV diagnoses were 52% and 40% respectively, yet they only receive 28.7% and 2.8% of HIV specialist care in the United Kingdom (UK) respectively. (3)

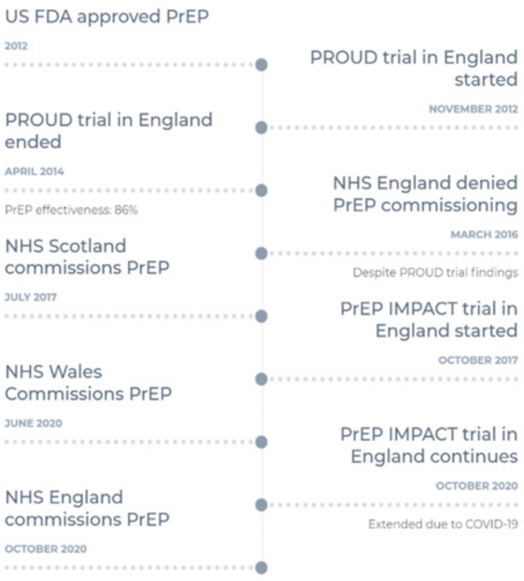


Figure 2: *Adapted from Terrence Higgins Trust (18)*

Social barriers to PrEP uptake continue to be an omnipresent challenge in the UK. (4, 5, 10-12, 22) A non-exhaustive list of barriers include stigma, non-adherence, lack of risk perception, insufficient awareness, and a suboptimal patient-provider relationship. These barriers can co-exist and have different weightings for various groups within SGM. (4, 10, 22) Poor PrEP uptake can increase HIV transmission, worsening its prevalence amongst SGM. (23) This threatens WHO's efforts of ending HIV transmission by 2030. (2) The lack of improvement in HIV prevalence amongst SGM will continue to fuel HIV stigma as the social aftermath of the AIDS epidemic prevails to this day. (1)

PrEP gap is a term given to the difference between the proportion of MSM on PrEP and the proportion of MSM who would likely take PrEP if given access. (24) In a survey to MSM across 50 countries in Europe and Central Asia, the EMIS-2017 report found the PrEP gap in the UK to be 20%. (25) Another finding was that 96.5% of HIV-negative MSM in Europe and Central Asia had never heard of PrEP (N=112939). In 2019, HIV transmission in MSM still made up nearly half of the national mode of transmission in the UK, while 84% of trans people accessing HIV care were transwomen. (3) The EMIS-2017 report findings (25) and HIV transmission statistic in the UK (3) necessitate holistic approaches in tackling barriers to PrEP uptake. Breaking social barriers through challenging social behaviours and expectations is thought to have been successful in controlling HIV transmission in the United States (US). (26) It is therefore fundamental to identify social barriers to PrEP uptake in the UK.

RESULTS

PrEP stigma

PrEP stigma refers to prejudice against those taking PrEP, for example associating it with being promiscuous or HIV-positive. (4, 13) After the IMPACT trial in England, Turner et al. found a statistically significant 4.6% rise in STI rates (N=3407), through a retrospective study amongst MSM. (27) Hildebrandt et al. conducted a nationwide survey (N=738) looking at the effects of HIV lifestyle stigma on public perceptions of PrEP funding. (11) The mean level of support for PrEP public funding in the lifestyle stigma group (those who are reminded of lifestyle factors associated with contracting HIV) is 3.73 (N=105), whereas the control group had a mean level support of 3.86 (N=115). When compared to each other, no statistical difference was found (p=0.38).

Witzel et al. investigated PrEP barriers amongst Black MSM Londoners and discovered that some participants refuse PrEP as they do not want to fulfil stereotypes. (4) One participant highlighted the stigma against Black MSM that they are "promiscuous and dominating". Nakasone et al. conducted semi-structured interviews to assess PrEP attitudes of Afro-Caribbean transwomen, and established PrEP stigma to be a heavier burden for them, (10) consistent with Witzel et al. (4) Two respondents were fearful towards institutional stigma and racism when accessing sexual health services (SHS) (N=21). This is in addition to their worry about people finding out they are on PrEP and associating this with having HIV. Rael et al., who conducted focus groups to amass attitudes to PrEP use, had similar findings for transwomen in the US (N=18). (13) A transwomen sex worker described an experience of a client confronting her about her PrEP medication, demonstrating the stigma associated with PrEP use. She mentioned that PrEP use could deter her clients, and be destructive to her career.

PrEP adherence

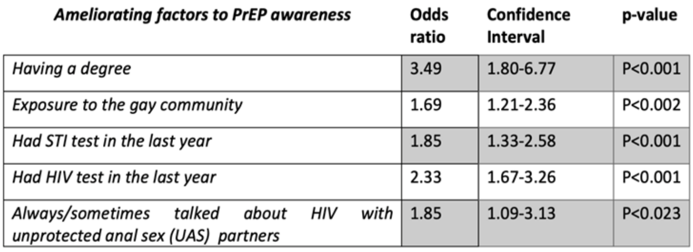
Young et al. discussed PrEP acceptance amongst MSM and African communities in Scotland. (22) PrEP stigma determines the level of PrEP adherence of participants. "Fear of being caught on PrEP" may lead to PrEP non-adherence. The lack of privacy, and a sudden change in environment when taking PrEP can intensify this fear. Furthermore, a disruption to their daily routine may lead to forgetting PrEP intake. An example of this is visiting families for holidays or changes in a work schedule. Meanwhile, third parties have been found to be beneficial for PrEP adherence if they are aware that a participant is on PrEP. (6) Grov et al.'s participants conducted semi-structured interviews to identify strategies used by MSM to maintain PrEP adherence, and 13% of participants (N=103) reported that third parties, who are aware and supportive of them taking PrEP, can give them daily reminders for PrEP use.
A multivariable analysis used by Mannheimer et al. identified factors affecting PrEP adherence amongst MSM (7) and showed disparities in PrEP adherence between White MSM and AC-MSM. When compared against each other, the odds ratio for PrEP adherence was 0.29 (CI: 0.13-0.66, p<0.0033), showing that White MSM had better PrEP adherence. Even after adjusting for other factors linked to PrEP adherence, results remain statistically significant.

Studies looking at PrEP adherence amongst transwomen reveal additional challenges. (9) In the US, trans-specific factors affecting PrEP acceptability were studied by Sevelius et al. through focus groups and individual interviews. They found that transwomen had a lower power to negotiate PrEP. A respondent described the limited selection they have for dating so when it comes to sex, they are more likely to be submissive to their partners and engage in riskier sexual activities. Ultimately, this may explain their struggle to take PrEP regularly.

Owens et al. conducted a qualitative study investigating PrEP adherence determinants amongst MSM. (8) All respondents (N=34) believed that quality of PrEP information given by providers affects adherence. Some thought that an in-depth instruction on PrEP use increased PrEP adherence for them, as opposed to being given an "abrupt instruction" to take it daily. Others believed that having a good and long relationship with providers has aided PrEP adherence. Similarly, Sevelius et al. established that transwomen found PrEP access easier from trans-informed providers due to reduced PrEP stigma. (9) In contrast, others were deterred from PrEP access due to transphobia from other patients in SHS, as well as providers.

PrEP awareness

Frankis et al. conducted a study to understand PrEP awareness amongst Scottish MSM. (12) Their findings supported the EMIS-2017 report; (25) 33% of participants were unaware of PrEP (N=690). (12) To evaluate factors affecting PrEP awareness, they used a bivariate regression analysis to display the factors enhancing PrEP awareness (Table 1).



Ameliorating factors to PrEP awareness	Odds ratio	Confidence Interval	p-value
Having a degree	3.49	1.80-6.77	P<0.001
Exposure to the gay community	1.69	1.21-2.36	P<0.002
Had STI test in the last year	1.85	1.33-2.58	P<0.001
Had HIV test in the last year	2.33	1.67-3.26	P<0.001
Always/sometimes talked about HIV with unprotected anal sex (UAS) partners	1.85	1.09-3.13	P<0.023

Table 1: *Adapted from Frankis et al. (12)*

The ameliorating factor, 'always/sometimes talked about HIV with unprotected anal sex partners', has significantly increased PrEP awareness. From Table 1, regular engagement with SHS increased PrEP awareness. Nonetheless, PrEP awareness may not necessarily be positively correlated with PrEP use, as Frankis et al. found (OR=1.03, CI: 0.74-1.42, p<0.873). (12) This was consistent with Walsh et al. who claimed that there is little evidence for the association between PrEP awareness and PrEP use. (29) Furthermore, Nakasone et al. supports this claim for transwomen. (10)

PrEP awareness is particularly low in ACMSM. (4, 10, 22, 29) Witzel et al. found that Black MSM struggle to have conversations about SGM sexual health with their families. (4) Not only that, Black MSM reported experiences of offline and online racism amongst SGM communities. Racial isolation was explored by Nakasone et al., where they discovered that Black transwomen in Glasgow struggle to access sexual health support from the White-dominated community. (10) Conversely, transwomen in London found it comfortable to access support from an ethnically diverse community. However, the main finding was most respondents were unaware of PrEP campaigns. Those who were PrEP-aware mentioned that it would help if PrEP campaigns were inclusive of BAME role models and transwomen, consistent with another study. (13)

Sevelius et al. found that only one transwoman knew about PrEP (N=30). (9) Respondents believed that differences in awareness is due to poor self-eligibility, lack of trans-inclusive PrEP activism, and PrEP threatening their femininity. They viewed PrEP to be exclusively for white gay men who are safe, and financially stable in life. Many felt they did not fit these criteria, leading to lower PrEP uptake. Nearly all of the participants highly valued femininity and perceived the intake of a 'masculine' product to demean their identity, making PrEP access uncomfortable and challenging for them. Regarding trans-inclusive PrEP campaigns, participants felt that transwomen are "an addendum" to MSM representation and believed they should have more representation.

DISCUSSION

Results show that transwomen and ACMSM may face stronger social barriers to PrEP uptake than other SGM groups. (4-10, 12) The rise in STI rates after the IMPACT trial (27) may strengthen public perception that PrEP encourages promiscuity. This may deter SGM from accessing PrEP, to prevent enacted PrEP stigma on top of other SGM discrimination. Although there is evidence showing positive attitudes towards PrEP funding, (11) further studies are required to support this finding. It is necessary to break associations between PrEP use and 'having HIV', and this can be done through general public education. PrEP non-adherence amongst ACMSM (7) may demonstrate how health inequalities affect PrEP use. For instance, they may have a more demanding occupation (30) meaning they de-prioritise PrEP adherence.

One may assume that intersectionality, a term describing the interlinked nature of social categorisations, may account for the reinforced social barriers ACMSM face. (4) The interactive effects of religion and ethnicity may affect the PrEP awareness of ACMSM. Belonging to a homophobic family may explain the insufficient PrEP awareness due to lack of conversation on MSM sex. (4) Another possible effect of this is intensifying internalised homophobia. This may explain PrEP non-adherence, as those who conceal their SGM identity from friends and families may find it more challenging to take PrEP in private. (5) PrEP non-adherence, due to lack of privacy at home, may worsen amidst COVID-19 restrictions. It may benefit individuals if PrEP was taken less frequently and away from home. Studies could look at the possibility of administering a single dose PrEP injection in a clinical setting. (29) Finally, SGM familial acceptance may influence PrEP adherence as support from third parties may benefit them through PrEP adherence reminders. (6)

A further effect of intersectionality is exemplified through transwomen. (10) Afro-Caribbean transwomen in London were more comfortable accessing sexual health support from peers than Glasgow counterparts. This could be due to fear of transphobia (8), and the differences in ethnic diversity of the two cities. Intersectionality suggests that being racially excluded in society, coupled with experiences of transphobia may both contribute to a weaker social network which may lead to insufficient PrEP awareness, and therefore not being able to access it.

A good patient-provider relationship has the potential to boost PrEP adherence. (8, 9) SGM may be too anxious to consult with a new provider due to PrEP stigma, and fear of disapproval after 'coming out' again. Transwomen may have additional struggles of dealing with transphobia from providers, and other patients. It can be suggested that MSM and transwomen may benefit from consulting with a familiar health care professional.
Those who talked about HIV with their UAS partners had greater PrEP awareness. (12) This may be due to having a mutual understanding of safe sex practices resulting in the empowerment of autonomy. The lower power status of transwomen results in a reduced ability to negotiate safe sex. (9) This may demonstrate that transwomen are disproportionately affected by insufficient PrEP awareness due to the impacts of social oppression. Another reason is that transwomen are more vulnerable to domestic violence, (20) meaning their lack of sexual health autonomy may be exacerbated. Increased PrEP awareness alone may not aid uptake as various studies found no link between increased PrEP awareness and increased PrEP use. (10, 12, 31) This suggests that even if SGM are PrEP aware, aforementioned social barriers may be more influential, and confounding this association; further studies are required to confirm this assumption. Risk perception of individuals to HIV could influence the weak link between the two variables.

Insufficient PrEP awareness amongst transwomen is explained by preconceived ideas that PrEP is only for MSM. (9) Transwomen being 'an addendum' to gay and cis-women-specific PrEP campaigns may contribute to this misapprehension. The motivations for this may include lack of understanding of trans-specific health needs, lack of societal trans-visibility, and under-estimating the risk of transwomen to HIV. Overall, this under-representation may explain the insufficient data available on transwomen health issues, (1) meaning that identifying the needs of transwomen across the nation may be difficult. Campaigns must also encourage transwomen to access support if suffering from domestic violence. (9)

This may also combat the lower power of transwomen to negotiate safe sex.

Strengths and limitations

All studies reviewed were conducted from 2012 onwards after the approval of PrEP (18). A notable critique for studies are their applicability to ACMSM and transwomen. Excluding studies specifically looking at ACMSM, 50% (N=103) and 94% (N=33) of participants recruited by Grov et al. and Young et al. were white, respectively (5, 6). This suggests that claims regarding PrEP adherence may be weaker for ACMSM, creating uncertainties on whether they face the challenges of privacy and support network, or lackthereof on PrEP adherence. Oppositely, Mannheimer et al. recruited 10% white MSM (N=176) in the USA, (7) meaning the representative claim of black MSM having a lower PrEP adherence, compared to their white counterparts, may be transferrable to the UK.

The use of focus groups and individual interviews by Sevelius et al. (9) ensures the expression of personal opinions, dissimilar to the sole reliance on focus groups by Young et al. (5) and Rael et al., (13) which may have lead to opinions being swayed by more dominating participants. However, Sevelius et al. conducted their study in the US; (9) and British transwomen may have face different challenges with PrEP adherence. Both Nakasone et al. and Witzel et al. are the first to conduct their research in the UK (4,10) so finding consistent studies to support PrEP social barriers for Afro-Caribbean SGM was difficult. This means the finding's reproducibility cannot yet be confirmed. Furthermore, Nakasone et al. recruited participants through SHS (10) so participants may be more PrEP aware, and accepting of PrEP. This suggests overestimation of claims, posing an issue on the representativeness of results to other transwomen in the UK.

CONCLUSION

This review aimed to deepen understanding of social barriers to PrEP uptake amongst SGM, in particular transwomen and ACMSM. ACMSM may find PrEP stigma a greater social barrier to PrEP uptake due to the racial stereotypes they wish to avoid being associated with. (4) This may lead to individuals abstaining from PrEP use to avoid the consequences of PrEP stigma. PrEP campaigns encouraging safe sexual liberation could build confidence in PrEP uptake amongst MSM. This is particularly pivotal for ACMSM and transwomen who are under-represented in existing PrEP campaigns. (9,10,13)

Intersectionality has aided the understanding of the PrEP social barriers faced by ACMSM. (4, 5, 10) Exposure to homophobia, racism and internalised homophobia may intensify PrEP stigma, insufficient PrEP awareness, and PrEP non-adherence. Discrimination against SGM may be curbed by integrating SGM sexual health, and SGM acceptance in heterosexual-focussed sex education delivered at schools. Ultimately, education aim to reduce PrEP stigma, and boost PrEP uptake amongst ACMSM.

Transwomen continue to suffer from insufficient PrEP awareness and PrEP non-adherence despite being at higher risk of HIV. (9, 13) Their continued experiences of social oppression (20) could explain these strengthened social barriers to PrEP uptake. Alleviating the social oppression of transwomen through governmental policies may lead to increased PrEP uptake. Discrimination from SHS and PrEP providers may form a combined barrier to PrEP uptake for transwomen and ACMSM. (8, 9) An in-depth instruction of PrEP use by familiar providers may benefit PrEP adherence for transwomen patients. Providers, as well as future providers, could benefit from continued awareness of SGM-specific health needs. Awareness of intersectionality and its effects on ACMSM and transwomen patients could better prepare providers for consultations.

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APPENDIX A

METHODOLOGY
REPORTING TEMPLATE

Criteria	For example…
Databases searched	JSTOR, PubMed, Web of Science
Search criteria	‘Pre-exposure prophylaxis’ OR ‘HIV prevention tool’ AND ‘Stigma’ OR ‘Awareness’ OR ‘Adherence’ OR ‘patient-provider relationship’ OR ‘transwomen’ OR ‘Black, Asian, Minority Ethnic’ OR ‘Afro-Caribbean men who have sex with men’
Inclusion criteria	Studies conducted from 2012; studies conducted on transwomen; studies conducted on Afro-Caribbean MSM; studies conducted in the UK and USA;
Exclusion criteria	Studies conducted on heterosexual men and women; studies conducted on biomedical barriers; studies not written in English
Number of journal articles identified from databases	85
Number of abstracts screened and identified as potentially relevant	30
Number of journal articles included in the review	10

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Discussion

Trans-formational? Why we need to do better for trans young people in the UK

DISCUSSION

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ABSTRACT

Gender diversity and issues facing transgender people are poorly covered in the medical curriculum, yet these patients will face higher rates of mental health issues, violence, stigma and discrimination than many others. Unfortunately, the continuing global pandemic has only served to further entrench the discrimination and inequalities faced by trans people in the UK, particularly trans people of colour, those with disabilities and young people. This paper seeks to provide an overview of who trans people are in the UK and to outline key issues facing this community. It will consider in further detail the context of transphobia in the UK, including the government's reluctance to meaningfully reform the Gender Recognition Act and the specific challenges facing trans young people accessing healthcare. It argues we need to take a human rights approach to trans issues and move away from a medical model which seeks to define gender diversity as pathology. Only if we better understand our trans patients can we better meet their health needs and help to challenge entrenched structures of discrimination.

INTRODUCTION

Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
Article 24, UN Convention on the Rights of the Child (1)

It is undeniable that the COVID-19 pandemic and associated lockdowns have been detrimental to the lives of children and young people in the UK. They have faced and continue to face huge upheavals in their daily lives, including increasing social isolation, loss of routine, disruption to education and examinations, not to mention the impact of seeing loved ones unwell and in hospital. The mental health charity Young Minds commissioned a survey of young people in the summer of 2020 which showed 80% felt their mental health was worse as a result of the pandemic, with 87% saying they had felt lonely and isolated. (2)

Unfortunately, we know that LGBTQ+ people are much more likely to have mental health issues than their peers; there is extensive evidence suggesting they are more likely to suffer from depression, engage in self-harm and to attempt suicide. (3) There is also evidence to suggest that trans youth especially suffer from significant mental health issues, facing stigma, discrimination, bullying, harassment, physical and sexual abuse and family rejection on a daily basis. (4) Stonewall's trans report found that 41% of those questioned had experienced a hate crime because of their gender identity, with a quarter facing domestic abuse from a partner and 12% having been physically attacked by a colleague in the last year. (5) We further know that trans people of colour (TPOC) and those with disabilities face additional structural prejudice and discrimination, including greater health disparities. (6) It does not seem unreasonable to conclude, therefore, that the pandemic is likely to have disproportionately affected trans people and young trans people especially, with an even greater impact for TPOC and those with disabilities.

Yet are we as doctors and future doctors sufficiently prepared to be able to help those patients who have been disproportionately affected by COVID-19? Unfortunately, the issues facing trans and gender diverse people are poorly covered in the medical curriculum, if at all. Given the huge range of challenges trans people face as set out above, it is incumbent on us to both better understand and advocate for these patients. This paper will seek to set out who trans people are, the context of transphobia in the UK and some of the specific issues facing trans young people, including current arrangements for the provision of gender identity related healthcare and a significant recent High Court judgment (Bell v Tavistock).

Who are trans and gender diverse people?

Trans and gender diverse people are those who do not identify with the gender assigned to them at birth, in contrast to cisgender or cis people who do identify with the gender assigned to them at birth. Trans people are an extremely diverse group, just like the rest of the LGBTQ+ community. For ease, the term trans will now be used as umbrella term to capture the wide range of trans and gender diverse identities. This not only includes binary transgender identities, such as someone assigned female at birth who is male, but a range of non-binary identities such as genderfluid, genderqueer or non-binary; in fact, a growing number of young people identify with non-binary identities. (7) There are no reliable figures on the prevalence of trans people and the reasons for this are multifaceted; non-binary identities are not formally recognised and many trans people are unwilling or frightened to identify as trans, which is understandable given the high risk of discrimination and even transphobic violence they may face. Again, this is compounded for many TPOC for a number of reasons, including the fact that their religious and ethnic communities are often one and the same. Trans visibility, while limited, is still overwhelmingly white, meaning many TPOC may be unwilling or unable to identify with this group. (8) However, one relatively recent meta-analytical study reported a prevalence of trans people of 4.6 in 100,000 and we know referrals to gender identity services are growing significantly year on year. (9) The decision to include gender identity in this year's Census may provide more accurate data but still of course relies on trans people feeling able to respond truthfully. Whilst trans identities are represented in the LGBTQ+ umbrella, it should be noted that gender identity is distinct from sexuality and trans people may be straight, gay, bisexual or have other sexualities.

Some, but not all, trans people will experience gender dysphoria defined in the DSM-5 as "a marked incongruence between one's experienced/expressed gender and their assigned gender". (10) There is a long history of pathologising the transgender experience; indeed, it is still listed as a psychiatric disorder in the aforementioned DSM-5 and was only depathologised as part of the ICD-11 in 2019. (11) The US Society for Adolescent Health and Medicine (SAHM) in its position paper on trans young people makes clear that gender diversity is a normal phenomenon, and that the DSM-5 is sometimes inappropriately used to categorise trans identities as a mental health disorder "rather than pathologising the state of distress that may be experienced" resulting from gender incongruence and societal stigma. (4)

Transphobia in the UK

It is not possible to write an article about trans experience in the UK without acknowledging the pervasive transphobia which permeates everyday life for trans people as well as media reporting and academia. A Parliamentary Select Committee report from 2016 acknowledged the concerning fact that "discrimination is a part of daily life for trans people", with witness evidence detailing "harrowing" accounts of violence. (12) The head of Ofcom, Dame Melanie Dawes, recently acknowledged that the BBC's practice of giving voice to transphobic views when reporting on trans issues was 'extremely inappropriate'. (13) Whilst attitudes towards trans people may be changing for the better, the most recent British Social Attitudes survey notes that whilst people are keen not to be seen as transphobic, only a third of respondents agreed that prejudice against trans people is always wrong. (14) Those with intersecting identities face additional discrimination, such as structural racism and ableism. The 2015 US Trans Survey found trans people of colour experience "deeper and broader patterns of discrimination" than their white counterparts and were much more likely to be living in poverty. Similarly, those with disabilities faced higher rates of economic instability and mistreatment. (15) Crucially this also affects access to healthcare, with people of colour and trans people experiencing more discrimination than the general population. What little research exists on this topic suggests those who are both experience even higher rates of discrimination. (16)

Many rightly see this is a human rights issue; Suess Schwend discusses the various and extensive human rights violations faced by trans people as a result of the Western medical model which psychopathologises gender identities that differ from the gender assigned at birth and argues for the recognition of gender diversity as a human right. (14) Clearly, a society which pathologizes gender diversity and sees trans identities as 'abnormal' versus the 'norm' of cisgender expression (what we might describe as 'cis-normativity') is not going to make it easy for trans people to live as their authentic selves.

It might be argued that the latest casualty of transphobia in the UK is the proposed reform of the Gender Recognition Act 2004 (GRA) with the publication of the long-awaited government response to the consultation in September 2020. This was met with great disappointment from many, particularly around the decision to not proceed with reforms to some of the onerous medical requirements of the process. This is despite the government's own analysis showing that 64% of respondents to the consultation (of which there were over 100,000) said there should not be a requirement of a diagnosis of gender dysphoria to access healthcare. 80% of respondents supported the removal of the requirement for a medical report (18), a position also supported by the British Medical Association (BMA). (19) Human rights organisations released a joint statement expressing their "huge disappointment" that the government had failed to "de-medicalise the process to recognise gender and bring the law in line with human rights standards". (20) Notably this brings England and Wales out of step with other countries with successful systems supporting self-identification, including Ireland, Denmark and Norway. (21) As this is a devolved issue in Scotland, we may see a different approach to legal recognition of gender there when the Scottish Government takes forward its proposals later this year.

Trans children & young people

Developmentally speaking, most children begin to have some understanding of gender between 18 and 24 months of age, with recognition of gender constancy (that is understanding of gender as a "permanent characteristic") from between 3 and 5 years. (7) Diamond highlights, however, that the cognitive and neurological changes relating to perceptions of gender in children are fundamentally contextualised by a society which holds a rigidly binary perspective on gender. Therefore, children consequently develop heightened attention to gender and adopt society's view of its binary nature. (7) The strength with which binary genders are entrenched in society perhaps goes some way to explain the vitriol of some arguing against under 18s being able to access any type of gender-related healthcare, with many transphobic commentators denying the existence of trans children altogether.

If the issues around access to healthcare for trans adults is controversial and complex, it would be fair to say that this is even more hotly debated for trans young people. In England and Wales, specialist care for those up to age 18 is provided by the Gender Identity Development Service (GIDS) based at the Tavistock & Portman NHS Trust in London. This is a specialised service coordinated by NHS England as per the Service Specification which sets out the deliverables of the service. (22) While it is difficult to clearly define the numbers of trans young people, and indeed the incidence and prevalence of gender dysphoria within this group, it is clear that numbers are increasing; referrals to GIDS in 2018 totalled 2,519 from 97 in 2009. (23)

The GIDS, which has been operating for over 20 years, comprises a psychosocial assessment period usually lasting a minimum of 6 months, during which the young person's development, gender identification and related feelings, behavioural and emotional issues including mental health and sexuality, are explored. In some cases, patients may be referred to paediatric endocrinology for consideration of puberty suspension with gonadotrophin-releasing hormone analogues (GnRHa) i.e., 'puberty blockers' (PBs) (24). The purpose of this treatment is that the young person is better able to reflect on their gender identity without the traumatic experience of puberty in a gender they do not identify with. As highlighted by Butler et al, the use of PBs is "only considered when the risks of non-intervention are considered the worse option in the patient's best interest". (9) Giordano emphasises the importance of recognising that the consequences being weighed up should "include longer-term physical, psychological and relational/social results of treatment versus non-treatment … not just the potential risk and benefits of medications". (25) Some patients subsequently go on to take cross-sex hormones once over age of 16 as an appropriate and necessary treatment option; this is of great concern to critics and is a position very much reflected in the Bell v Tavistock judgment. (23)

Media reporting on this issue is often inaccurate and frequently conflates puberty blockers with cross-sex hormone treatment which is categorically not available on the NHS for those under 16 - the age at which people are considered to be competent to make autonomous medical decisions. Contrary to the often sensationalist headlines on the issue, healthcare for trans young people is highly regulated and extremely difficult to access in the UK, with patients facing huge waiting times from a minimum of 18 months up to 4 years for a first appointment, despite waiting list targets of 18 weeks. This leaves many feeling it necessary to access private sector healthcare. Indeed, the public interest not-for-profit organisation Good Law Project recently announced their intention to take the Government to court on this issue arguing it is acting unlawfully in consistently failing to meet the 18 week waiting time targets whilst also neglecting to put in place any alternative provision. (26) In January 2021 the Care Quality Commission issued a damning report on the GIDS service calling on them to improve waiting lists – they found there were over 4,600 young people on the waiting list, with many waiting over two years for a first appointment. (27)

In January 2020, NHS England announced an independent review of puberty suppressants and cross sex hormones by an expert group chaired by Dr Hilary Cass, a former president of the Royal College of Paediatrics & Child Health, which is ongoing at the time of writing . (23) However, the review is likely to be influenced by the significant High Court ruling on 1 December 2020 in Bell v Tavistock. (23) The case involved a judicial review of the process used by the GIDS service when granting PB treatment to under 18s. The claimant's case was that all children and young people under the age of 18 are incapable of giving informed consent for PBs. The court concluded that it was "highly unlikely" a child under 13 and "doubtful" a child of 14 or 15 could meaningfully consent to PBs, while recognising the legal position that those 16 and over can consent to treatment. Whereas in other clinical situations where a child cannot consent to a treatment parental consent would be sought, this is not considered appropriate; a position underlined as part of the GIDS service specification. (22) In March 2021, however, the Good Law Project succeeded in another legal challenge to a High Court decision, confirming parents could consent in their child's stead. (28) Whilst there is an appeal against Bell v Tavistock commencing in June this year, the initial ruling represents a further curtailment of the ability of trans young people to access what is for many life-saving healthcare. Amnesty International and Liberty UK issued a joint statement on their "disappointment" with the ruling, describing it not only as a restriction of healthcare but also a move which fundamentally limits both bodily autonomy and a young person's right to self-determination. (29) As a direct result of the ruling, NHS England amended their service specification for GIDS effectively preventing access to puberty blockers for those under 16 without a court order. (30,31) Mermaids, a charity providing help and support to trans young people and their families, described already seeing "a hugely-distressed response from hundreds of trans young people". (32) The ruling is clearly taking a toll on the mental health and wellbeing of this community.

CONCLUSION

LGBTQ+ communities, especially young people, people of colour and those with disabilities, have been especially vulnerable to the effects of a pandemic which has worsened many pre-existing inequalities and structural discrimination. On a backdrop of widespread transphobia in the UK, where trans people are at daily risk of prejudice, stigma and violence, we have seen a further rolling back of their human rights as the Government fails to de-medicalise the process of legal gender recognition and neglects to provide appropriate access to life-saving medical treatments. But what can we do as current and future medical professionals? As a start, we can treat our trans patients with dignity and respect, with the fundamental recognition of trans rights as human rights. Simple steps like using someone's correct pronouns can make a big difference to our therapeutic relationships, as can listening to trans young people about their needs rather than making generalised assumptions about what is in their best interests. Trans people exist and have a right to do so; it is our duty as doctors to ensure that we do better for them all.

Figure 1: *Bell v Tavistock*

***Bell & Anor v The Tavistock And Portman NHS Foundation Trust* [2020] EWHC 3274 (Bell v Tavistock)**
Bell v Tavistock is a case brought against the Tavistock and Portman NHS Trust by a previous patient of the GIDS service who had received puberty-blockers, went on to take cross-sex hormones and had subsequently de-transitioned as an adult. The second claimant is a mother of a 15-year-old with a background of autism and mental health issues diagnosed with gender dysphoria; this patient has not been referred to GIDS but the mother is concerned that they might be.
The claimant's case was that all those under 18 are not competent to give informed consent to the administration of puberty-blockers on the basis that they cannot understand and weigh-up the potential long-term consequences of the treatment. Whilst the ruling did not fully accept the claimant's position, recognising those aged 16 and over as able to meaningfully consent to PBs, they did however find it 'highly unlikely' a child aged 13 or under and 'doubtful' those aged 14 or 15 could meaningfully consent. This means 14 and 15 year olds would likely have to seek a court order and this would also sometimes apply to those over 16 if deemed necessary by their clinicians. NHS England immediately updated their service specification to state "patients under 16 years must not be referred by … [GIDS] to paediatric endocrinology clinics for puberty blockers unless a 'best interests' order has been made by the Court for the individual in question". (1)
Another troubling aspect of the ruling is that the court found that informed consent for PBs should also consider the consequences of hormone therapy treatment which patients may or may not go on to access. Prof Meg Talbot notes this may represent a 'new legal principle' and is likely to be explored in the appeal. (2) The ruling further implies that provision of information alone may not be significant to enable a child to meaningfully consent to PBs, a conclusion that potentially has significant implications for *Gillick* competence in other areas.
It should be noted that one of the allowed interveners in the case was Transgender Trend, a transphobic pressure group that is described as providing "evidence-based resources for parents and schools" but who argue that transgender children do not exist. Organisations supportive of trans children and families were not permitted to intervene. Gendered Intelligence's blog noted "the judgment seems to come from a place where a transition of any kind is a last resort, something highly medicalised and highly stigmatised", making the important point that trans children are not inherently vulnerable but rather are continually damaged by a systemically transphobic society. (3)
In January 2021, Tavistock & Portman NHS Trust was granted permission to appeal against the ruling and the Good Law Project filed an intervention supporting the appeal, supported by a number of NGOs (Stonewall, Endocrine Society, Gendered Intelligence and Brook). The appeal will begin in June 2021.
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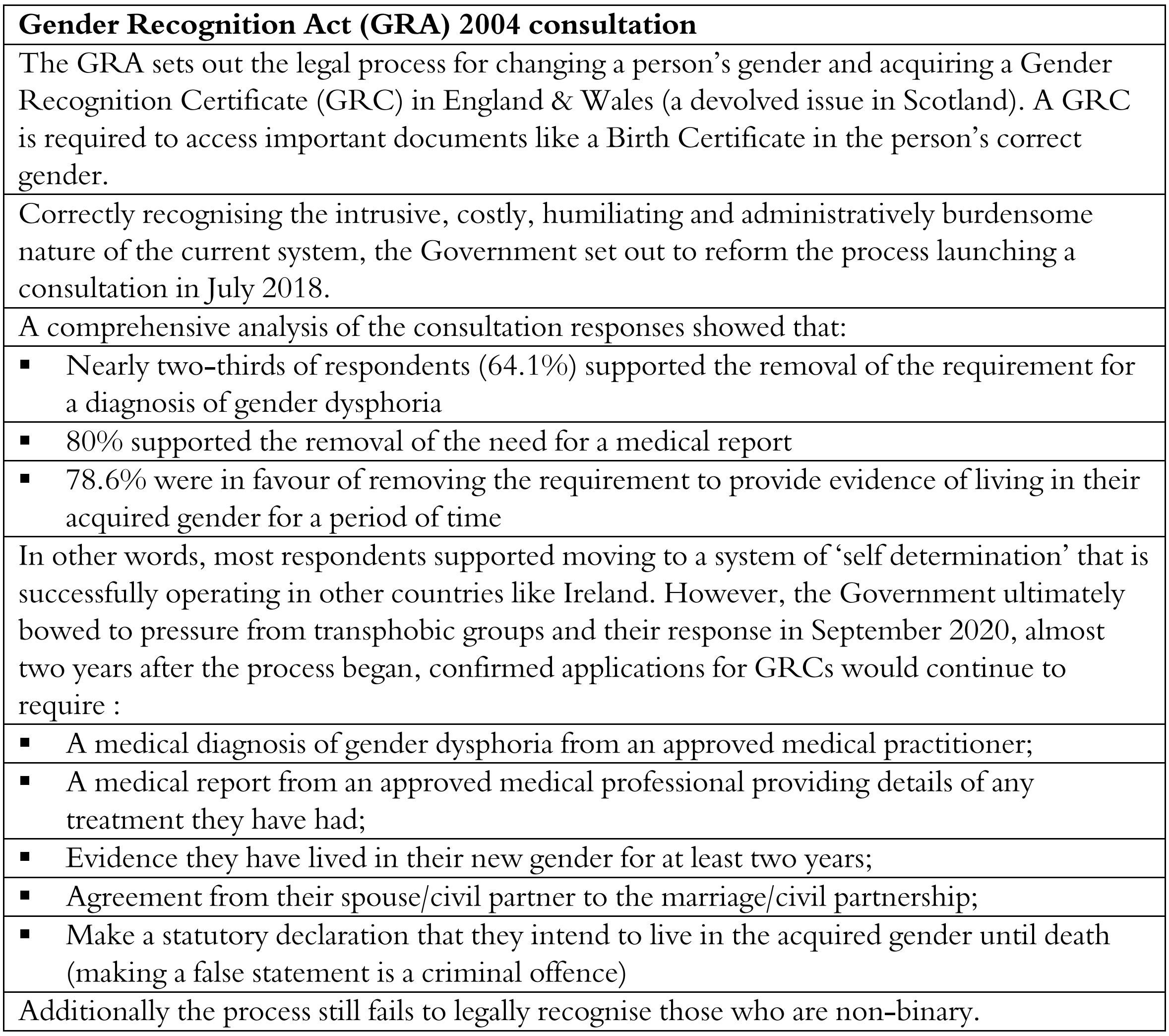
Figure 2: *Gender Recognition Act*



Gender Recognition Act (GRA) 2004 consultation
The GRA sets out the legal process for changing a person's gender and acquiring a Gender Recognition Certificate (GRC) in England & Wales (a devolved issue in Scotland). A GRC is required to access important documents like a Birth Certificate in the person's correct gender.
Correctly recognising the intrusive, costly, humiliating and administratively burdensome nature of the current system, the Government set out to reform the process launching a consultation in July 2018.
A comprehensive analysis of the consultation responses showed that:
▪ Nearly two-thirds of respondents (64.1%) supported the removal of the requirement for a diagnosis of gender dysphoria
▪ 80% supported the removal of the need for a medical report
▪ 78.6% were in favour of removing the requirement to provide evidence of living in their acquired gender for a period of time
In other words, most respondents supported moving to a system of 'self determination' that is successfully operating in other countries like Ireland. However, the Government ultimately bowed to pressure from transphobic groups and their response in September 2020, almost two years after the process began, confirmed applications for GRCs would continue to require :
▪ A medical diagnosis of gender dysphoria from an approved medical practitioner;
▪ A medical report from an approved medical professional providing details of any treatment they have had;
▪ Evidence they have lived in their new gender for at least two years;
▪ Agreement from their spouse/civil partner to the marriage/civil partnership;
▪ Make a statutory declaration that they intend to live in the acquired gender until death (making a false statement is a criminal offence)
Additionally the process still fails to legally recognise those who are non-binary.

Figure 3: *Actions you can take*

Actions you can take

- Speak to some trans people! Find out about some of the issues facing them and their experiences, particularly those with intersecting identities. Speak up against transphobia, racism and ableism
- Educate yourself on the issues facing trans people, especially in relation to access to healthcare, by reading the resources above and by following trans organisations and people on social media
- Read some books by trans writers such as Trans Power by Juno Roche and Unicorn by Amrou Al-Kadhi (aka Glamrou)
- Learn about non-binary people – the BBC Sounds podcast NB: my non-binary life is a good place to start
- Find out whether your medical school explicitly covers trans issues (including key pieces of legislation like the Gender Recognition Act) in the curriculum; if not, ask them why not!
- Consider displaying your pronouns on your social media accounts, work name badge and email signatures
- Donate to trans organisations and fundraisers such as We Exist's Trans Healthcare Fund https://www.weexist.co.uk/
- Consider supporting the Good Law Project's trans rights fund https://goodlawproject.org/case/nhs-duty-young-people/
- Join the Rainbow badge scheme through your own NHS Trust or via GLADD (The Association of LGBTQ+ Doctors and Dentists)

Figure 4: *Further reading*

Further reading:

- TransActualUK https://www.transactual.org.uk/ - organisation founded and run by British trans people
- Mermaids https://mermaidsuk.org.uk/ - charity supporting trans children
- All About Trans https://www.allabouttrans.org.uk/ - project positively changing how the media understands and portrays trans people
- Gendered Intelligence http://genderedintelligence.co.uk/ - charity that exists to increase understandings of gender diversity and improve trans people's quality of life
- Gender Identity Research & Education Society (GIRES) https://www.gires.org.uk/ - UK-wide organisation working to improve the lives of trans and gender diverse people of all ages
- Inclusivity – Supporting BAME Trans People https://www.gires.org.uk/inclusivity-supporting-bame-trans-people/ - guide on issues facing TPOC and how to best support them
- Non Binary wiki https://nonbinary.wiki/wiki/Main_Page - wiki dedicated to non-binary identities
- World Professional Association for Transgender Health https://www.wpath.org/

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Discussion

The Rainbow NHS Badge

DISCUSSION

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ABSTRACT

The Rainbow NHS Badge began as a conversation amongst friends and has grown into a project spreading through the NHS. It is something I am massively proud to have been a part of, and one I have learnt a lot from in doing. This article is a review of why it was created, what it stands for, and the challenges ahead.

BACKGROUND

The Rainbow NHS Badge began as a conversation amongst friends and has grown into a project spreading through the NHS. It is something that I am massively proud to have been a part of, and one I have learnt a lot from in doing … there are definitely some things I would do differently if I was starting from scratch now!

The original idea was simple: a strong visual symbol to say to LGBTQ+ people accessing NHS healthcare that:
"I am a good person to talk to about LGBTQ+ issues, and I will do my best to help you if you need it."

In the two years since the project was launched, we've heard so many stories from people wearing the badge about how it has helped to start conversations, including some where LGBTQ+ people came out to someone for the first time in their lives, that otherwise might not have happened.

Combining the NHS logo with the six-striped Pride flag, both strong visual symbols with a huge amount of history and meaning behind them, the badges are intended to send a signal to anyone who sees them that the wearer is someone who is aware of the health issues and challenges LGBTQ+ people can face in the NHS, but also that they will then act as an advocate for that person if needed.

In late 2017, the badges started out as a guerrilla project, with 300 prototype badges created and distributed to people working in the NHS across the whole UK, generating a lot of discussion on social media. Those wearing the badges said that they had an almost immediate impact, as people started to see and comment on them, which gave us the impetus to develop the project further.

Why are rainbow badges, or lanyards, needed in the NHS at all?

Making sure LGBTQ+ people can safely access healthcare is important, because healthcare outcomes in general are often worse for LGBTQ+ people. (1) NHS staff are often not aware that LGBTQ+ people can have specific health requirements or can be dismissive of them.(1)

Poorer health outcomes are particularly evident in terms of mental health, with LGBTQ+ people in general having significantly higher rates of anxiety, depression, self-harm and attempted suicide than the population in general; this risk rises higher for particular groups, including trans people, and LGBT+ people who are Black or from an ethnic minority. (1)

Data from Stonewall demonstrates one in seven LGBTQ+ people in the UK would be wary of seeking NHS care because they would be concerned they would experience discrimination. Looking specifically at attitudes towards LGBTQ+ patients and colleagues by NHS staff, despite a quarter of a century of improving social and legal attitudes towards LGBTQ+ people in the UK, Stonewall demonstrated that significant negative ideas and opinions about LGBTQ+ people persist amongst NHS staff. Almost a quarter of LGBTQ+ people report experiencing or witnessing NHS staff making negative remarks about LGBTQ+ people, and one in eight report experiencing discrimination as a result of their sexuality or gender identity. (1)

We knew that a badge alone was never going to be the solution to these problems by itself, but we hoped that it could be part of that solution. We knew the badges had to have substance behind them, so we developed the model for the badges into a pilot at Evelina London Children's Hospital, which launched in October 2018. This emphasised that choosing to wear a badge was a choice, with a responsibility involved in wearing it, and that staff who chose to do so had to have an understanding of why a project like this was needed. Staff are asked to sign a pledge affirming this, indicating they understand the importance of being someone an LGBTQ+ person can be confident they can trust.

The response to the pilot was hugely positive, from staff, patients and families. In February 2019, we launched the project across the whole NHS, offering a toolkit to other Trusts and NHS organisations who wanted to launch the project, with an emphasis that this should be ideally led by local Equality, Diversity and Inclusion teams, to integrate it into each Trust's own pre-existing approaches to supporting LGBTQ+ patients.

Even though we knew from the early response to the project how popular an idea it could be, we have been overwhelmed by the scale of the enthusiastic demand for the badges. In the last two years, the project has been launched by an overwhelming majority of NHS Trusts in England (70% at the time of writing in October 2020), as well as a significant number of other NHS organisations and GP practices. Similar projects are being looked at in the other UK nations.

Huge numbers of people have chosen to pledge to wear a badge, the majority of them staff members who are not themselves LGBTQ+. The next phase of the project will concentrate on making sure that the principles behind the project are maintained, and then look to build further on the project's success, particularly looking at how allies can continue to help support LGBTQ+ people, and what Trusts can do beyond just having staff wear a badge to tackle the huge issues we know still exist. That work will be done as the project integrates with the NHS England LGBTQ+ Advisor's office, with an ambitious plan for 2021 that you will hopefully be hearing about soon.

There are still many challenges

2020 saw the Pride flag being co-opted as part of a more general "thank you NHS rainbow" during the coronavirus pandemic's first wave, meaning that LGBTQ+ people started to doubt its presence as a sign of understanding, inclusion and safety for them. While the rainbow has long been a positive symbol of hope in the face of adversity, the Pride flag is a symbol which represents strength, solidarity, protest, pride and safety for LGBTQ+ people. Where the Pride flag has been appropriated to be used in a more generic and general way, we have a responsibility to emphasise that using the Pride flag needs to come with a meaningful commitment to supporting LGBTQ+ people and rights. While there is plenty of room for the rainbow and the Pride flag to co-exist within the NHS, making the distinction between them is vital.

Although there have been significant improvements for LGBTQ+ people's rights as a whole over the last 40 years, trans people's rights in particular continue to need to be advocated and fought for, against a backdrop of increasingly toxic social and media rhetoric in the UK about trans people, often rooted in ignorance and bigotry.

And, across the world, we are reminded both that there are members of the LGBTQ+ family who are yet to achieve rights that will keep them safe from harm but also that rights once won can be rolled back, emphasised for example by the terrifying introduction in Poland of "LGBTQ+-free zones", or the nomination to the US Supreme Court of a Justice who has supported anti-LGBTQ+ groups advocating for a rollback of laws protecting LGBTQ+ people.

Wearing a rainbow NHS badge by itself doesn't solve all of the problems that LGBTQ+ people still face, within the NHS, in the UK, and across the world. What it hopefully does to is send a strong signal to LGBTQ+ people that whatever they are going through, there are people who will stand with them, who will understand their needs, who will advocate for them when they cannot do it alone, who will educate in the face of ignorance, and up with them against prejudice and bigotry.

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Education

Health inequalities among LGBTQ+ communities

EDUCATION

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ABSTRACT

Summary

The article aims to provide an overall, introductory understanding of the health inequalities faced by Lesbian, Gay, Bisexual, Transgender, Queer plus (LGBTQ+) people in the United Kingdom. It is well documented that LGBTQ+ people have poorer health outcomes than their cisgender, heterosexual counterparts. The mental and physical health inequalities within this community are discussed, along with associated lifestyle factors. The different health issues faced by each group within the LGBTQ+ community are also considered.

Relevance

In their future careers, medical students will encounter patients who identify as LGBTQ+. It is therefore important that future doctors understand some of the issues faced by the LGBTQ+ community to treat patients with compassion and understanding.

Take Home Messages

There are major health inequalities among the LGBTQ+ community and LGBTQ+ people continually face negativity and discrimination within healthcare settings. While grouped as a single entity, LGBTQ+ is made up of many separate groups, each with their own distinct needs and specific health issues. Many LGBTQ+ charities are available to support individuals with physical and mental health needs. It is important that healthcare providers are too aware of the services that are available.

INTRODUCTION

Literature demonstrates that lesbian, gay, bisexual, transgender and queer (LGBTQ+) people face health inequalities in relation to health status, access to care, experience of care, and behavioural risks to health. (1-3) Inequalities in health status relate to both mental and physical conditions and individual groups within the LGBTQ+ community experience differing health status inequalities. (2, 3) In their future careers, medical students will likely care for LGBTQ+ people as patients; a basic knowledge of the disproportionate health issues affecting LGBTQ+ people is therefore essential. This article aims to provide an overview of the health inequalities faced by LGBTQ+ people in the United Kingdom (UK). Reasons for these inequalities will also be discussed.

Firstly, it is important to understand the meaning of the term 'LGBTQ+', an umbrella term which, amongst others, accounts for sexual minorities (lesbian, gay and bisexual individuals), and gender minorities (transgender (trans) and non-binary individuals). Not all identities within the LGBTQ+ community will be discussed here. In line with the available literature, this article will focus mainly on the health inequalities faced by lesbian, gay, bisexual and transgender individuals. Many of health issues mentioned will also relate to queer+ individuals or other LGBTQ+ groups but there is little to no evidence specific to these communities.

MENTAL HEALTH

It is well documented that there is a higher prevalence of mental health issues amongst LGBTQ+ individuals than the general population. (2) Certain groups within the LGBTQ+ umbrella also show differing prevalence of various conditions, with the reasons behind them varying. (2-6) In 2018, Stonewall (a UK based charity who campaign and lobby for the rights of LGBTQ+ people) produced a health report from a survey of more than 5,000 LGBT people across England, Scotland and Wales. (3) The report found that over half of LGBT individuals had experienced anxiety (61%) and depression (52%) in the previous year, with over 70% of non-binary and trans respondents reporting anxiety and depression. Of LGBT people aged 18-24, 13% reported that they had attempted to take their own life in the previous year, with 12% of trans and 11% non-binary people reporting to have attempted suicide compared to the 2% of non-trans LGB people. Half of respondents aged 18-24 reported having thoughts about taking their own life and 48% had self-harmed in the previous year. Again, there was a higher frequency of trans (35%) and non-binary people (41%) reporting they had self-harmed in the previous year than cisgender LGB (14%). For comparison, a recent report on self-harm found a rate of just 6% in the general population. (4) Numerous studies highlight the higher levels of anxiety, depression and self-harm/suicide amongst LGBTQ+ people compared to heterosexual cisgender counterparts, but as shown there also are significant differences between LGBTQ+ groups. (2, 5) Multiple factors contribute to the mental health issues faced by LGBTQ+ people but often reported are society's heteronormativity and the effects of minority stress, victimisation, discrimination and stigma. (6) Society perpetuates the norm of cisgender heterosexuality and so deviation from this norm can result in experiences of discrimination and prejudice. These issues result in enhanced stress which combined with other factors can result in the development of mental health conditions or exacerbate pre-existing conditions. (6)

A recent review of eating disorders and disordered eating amongst LGBT adults and adolescents found these groups were at greater risk than the general population, identifying a heightened risk among gay men, bisexuals and trans people, with mixed results for lesbian adults and adolescents. (7) Although a previous study comparing lesbian adolescents to their heterosexual peers identified a greater prevalence of purging behaviours and focus on reducing weight among the lesbian cohort (8). Eating disorders and disordered eating can be prominent among gay males due to the cultural pressures within the community to fit certain body type categories. (7) Gay men are predicted to represent 5% of the male population but the National Eating Disorders Association report gay men account for 42% of males who have eating disorders. (9) Although underrepresented in research, growing evidence shows trans and non-binary individuals experience a combination of body dissatisfaction and eating disorders, with the latter often in response to the former. (8) Factors suggested to contribute to the development of eating disorders for LGBT people include increased stress through experiences of stigma and violence but also cultural ideals within the LGBTQ+ community, such as the need to be 'thin' and 'fit' to be viewed as attractive. (7, 8)

For substance use disorders, evidence is limited. While many studies have identified heightened levels of substance use/abuse among LGBT groups along with high risk factors for developing a disorder, very few have examined substance disorders specifically. (2, 10-15) A systematic review and meta-analysis of LGB mental health found the rate of alcohol and other substance dependence was 1.5 times higher amongst LGB individuals compared with heterosexuals, with lesbian and bisexual women particularly at risk of substance dependence. (12) There is limited data from the UK about substance use disorders, but existing evidence indicates that gay and bisexual men have double the rate of alcohol dependence compared to heterosexual men. (10) Globally, research into substance use disorders in trans and non-binary individuals is minimal. Without research directly examining substance use disorders among LGBTQ+ people, the picture will remain unclear with little evidence to support the development of health interventions. Many reports of inequalities do suggest that support for substance use needs to be tailored to LGBTQ+ communities to improve uptake and recovery. (2-3, 10) One of the major issues with recovering from substance use disorders for LGBTQ+ people is that it can result in a feeling of isolation from their communities, for instance, individuals may feel uneasy attending LGBTQ+ pubs/clubs if they have ceased alcohol consumption. (15) Therefore, rehabilitation programmes specifically for members of the LGBTQ+ community can provide a connection to their community without risking their sobriety. Additionally, the rising number of alcohol-free LGBTQ+ venues is aiding in allowing community connections to be maintained.

Particular communities are reported to be at heightened risk – specifically, Black, Asian and minority ethnic LGBT people, disabled LGBT people, and those from lower income households. (3, 7) Trans and non-binary groups experience higher rates of multiple mental health disorders (3, 8, 10) and within LGB, bisexuals tend to report higher levels of anxiety, depression and suicidality. (2, 3, 10) It is vital to understand that the difficulties an individual experiences being LGBTQ+ are in addition to everyday stresses such as finances, employment, and relationships. As caregivers, it is important to be cautious of phrasing to avoid inferring that an individual's mental health issues are due to a person being LGBTQ+ which is still reported as a reason for avoidance of healthcare by LGBTQ+ individuals. (1) It is well recognised that mental health services within the NHS are overstretched and the COVID-19 pandemic will have added extreme pressures to the system. Although not a replacement for formal mental health services, patients on a waiting list can be directed to charities such as Mind or Stonewall who can provide support for LGBTQ+ people until the appropriate services are available.

PHYSICAL HEALTH

While disparities in mental health may be more widely recognised, LGBTQ+ people also experience significant physical health inequalities. (2, 6, 10) These inequalities vary depending on the age, gender and income of the individual (as among the general population), as well as between LGBT groups. For example, gay and bisexual males have been found to present more frequently with liver, kidney and long-term gastro-intestinal problems, potentially linked to high levels of alcohol consumption. (6, 10) Some evidence also suggests a higher rate of diagnosis of prostate cancer within this group but not all findings support this conclusion. (6, 16, 17) The potential for heightened risk has resulted in some physicians/ researchers calling for targeted screening services for gay and bisexual men, as early identification would provide better outcomes. (6) The symptoms of prostate cancer and impact on sexual intimacy have also been found to be more profound among gay and bisexual men due to the nature of sexual encounters. (6) An increased incidence of spinal problems, arthritis and chronic fatigue syndrome has also been reported amongst gay men. (5, 6) Lesbians and bisexual women too have been identified to suffer from higher rates of certain conditions, including significantly higher rates of polycystic ovary syndrome in lesbians compared to the general population of females (80% vs 32%) (6) Some evidence also points to a higher risk of breast, ovarian and cervical cancers in lesbians and bisexual women due to shared risk factors including not having children or having children later in life and various lifestyle factors (6), but this is not conclusive. One factor suggested to heighten risk of cancer within this cohort is low uptake of cervical screening, due to misconceptions around the need for screening (2).

The general health of trans and non-binary people is under researched, with one report identifying no reliable large-scale data to identify differences in the physical health of these groups. (10) With unknowns around the long-term impacts of cross-sex hormone therapy. The NHS identifies common risks and side effects, including thrombosis gallstones, weight gain, dyslipidaemia, increased liver enzymes, polycythaemia and hair loss. (18) Therefore, it recommended that anyone undergoing cross-sex hormone therapy should be closely monitored by their physician throughout treatment. There may also be metabolic risks associated with hormone treatment, with a Belgian case-control study reporting an increased prevalence of type 2 diabetes among both trans men and women compared to cisgender controls. (19) Without large-scale data it is difficult to understand the reasons for this or offer effective intervention. Cancers relating to gender-affirming hormone therapy are rare but still worth considering, with some early research suggesting carcinomas of the breast and prostate in trans women and cancers of the breast, ovaries, cervix and vagina in trans men. (20) As cancers can still occur in the reproductive organs of trans men and women, it is important that the screening of these organs is suggested by doctors. The administration of unregulated hormones and injectable silicone can also pose a risk to health due to poor quality products and potential needle-sharing, risking transmission of blood-borne infections. (21) In 2020, there was a 25% increase in transphobic assaults from the previous year (22). Increasing numbers of violent attacks on trans people could also lead to enhanced health needs. (10).

LIFESTYLE

The poorer physical and mental health outcomes for LGBTQ+ people can be partly attributed to certain lifestyle factors or behaviours that may be more prevalent amongst these groups. Evidence from the UK suggests that rates of alcohol use, substance use and risky sexual behaviours are higher amongst all LGBTQ+ groups than the general population. (2, 3, 10-14) These behaviours tend to vary by age, with younger LGBTQ+ people more likely to illicit substances, whereas older individuals are more likely to drink alcohol daily. (3) In the UK, excessive alcohol use are reported higher among LGB groups than trans and non-binary individuals. (3) A stronger connection to the LGBTQ+ community such as attending LGBTQ+ venues and events has been associated with greater consumption of alcohol. (11) LGBTQ+ venues are typically pubs and clubs, with fewer alcohol-free spaces; therefore, when socialising in a safe community setting, LGBTQ+ individuals will often find themselves in an environment focused on the distribution of alcohol. Community organisations are working to promote alcohol-free venues and events. (3) Evidence from recent population-level data in the UK shows recreational drug use is higher amongst LGBT groups than cisgender heterosexuals, with highest levels identified amongst gay and bisexual men (14). Compared with heterosexual counterparts, LGB individuals showed significantly higher rates of cannabis use (four times higher), as well as cocaine, ecstasy, hallucinogens, amphetamines, tranquillisers, ketamine and amyl nitrite. (14) Minimal evidence is available relating to the use of illicit drugs amongst trans individuals in the UK. New drugs and novel psychoactive substances are often introduced early into LGBTQ+ clubs, resulting in the community becoming 'early adopters' of substances and facing the related health issues. (14) High rates of substance use have been linked to minority stress, with alcohol and illicit drugs suggested to be used as a coping mechanism to deal with negative experiences. (10-11, 15) Substance use can be a cause of mental health distress as well as a by-product of poor mental health. (2, 10) With regard to smoking, previous research identified higher rates amongst LGBT groups, but recent findings suggest rates are similar to that of the general population. (3, 10)

When it comes to sexual health within the LGBTQ+ community, research tends to focus on gay and bisexual men, with less attention paid to trans individuals and non-trans lesbian and bisexual women. (10, 23) The focus on gay and bisexual men is largely due to the HIV/AIDS crisis but in recent years HIV has moved from being a deadly disease to a chronic one. The introduction of antiretroviral therapy, post-exposure prophylaxis and pre-exposure prophylaxis have resulted in reduced transmission of HIV amongst gay and bisexual men and trans women (GBTW). (2, 5) However, recent research shows condom use has been reducing year on year, with infections such as chlamydia, gonorrhoea and syphilis rising among GBTW. (5) Testing for all sexually transmitted infections is important to control levels of infection. Another issue for GBTW is the rising popularity of chemsex parties. Chemsex (see definition in Table 1) poses risks not only of substance-related health issues but potentially enables the spread of HIV and other sexually transmitted infections. (23) Currently only a minority of gay and bisexual men use drugs and engage in chemsex parties but data shows it is rising and may become a serious issue (14, 23). Specific men who have sex with men clinics and the recent introduction of postal testing for STIs have improved detection among these groups and should be promoted as rates of infection continue to rise. Interestingly, the various lockdown and social distancing measures in the UK may break chains of transmission of various infections. In conjunction with the introduction of postal testing across the UK, a drop in infections may be seen in the future. Lesbians, bisexual women and trans men (LBWTM) have their own specific sexual health needs which are often overlooked. Research suggests they are less likely than heterosexual women to be screened for STIs or to have a cervical smear, leaving them at greater risk of cervical cancer and complications of STIs. (10) Lesbian and bisexual women also report a lack of visibility of their sexual health needs compared to other groups within the LGBT community. (24) The exchange of bodily fluids and sharing of sex toys can spread infections between two women so it is important that LBWTM are informed about regular testing when engaging in sexual contact with new partners.

ISSUES IN HEALTHCARE

Under the Equality Act 2010, all healthcare services have a legal duty to treat all LGBTQ+ people fairly and without discrimination. LGBTQ+ groups are often found to avoid accessing healthcare or disclosing important information. (3) The fear of discrimination and stigmatisation as a result of disclosing one's sexual orientation or gender identity can increase stress and delay treatment, contributing to poorer outcomes. (2, 10) For example, evidence identifies that lesbians may not seek screening for breast cancer due perceived stressors associated with mistrust of the healthcare system. (25) Trans people regularly report difficulties talking to their GPs about health issues due to a lack of knowledge and awareness from practitioners. (26) Despite increasing 'LGBT friendly' services, many LGBTQ+ individuals still have negative experiences in healthcare, encountering homophobia and heteronormative attitudes. (2, 10) Stonewall's report identified experiences of unequal treatment, inappropriate curiosity (especially towards trans and lesbian groups), being outed without their consent and witnessing discrimination of LGBT people by healthcare staff. (3) These negative experiences erode trust in healthcare systems, contributing to negative health outcomes for LGBTQ+ people. The NHS Long Term Plan commits to ending health inequalities for LGBT people within a decade. (27) Regardless of future career disciplines in medicine, it is important that all doctors and healthcare staff are sensitive to the needs of patients. It is also important to directly address any negative attitudes and behaviours towards the LGBTQ+ community by healthcare staff and that staff are equipped with the training to identify and challenge discrimination where it exists. Discrimination endures when those who should act turn a blind eye.

CONCLUSION

Research identifies numerous health inequalities among LGBTQ+ communities. The LGBTQ+ community is not homogeneous and different groups have unique healthcare needs. There are major mental and physical health issues facing the LGBTQ+ community, all of which can be exacerbated by the heightened levels of drugs and alcohol use and risky sexual behaviours. Disappointingly, health inequalities are compounded the avoidance of healthcare due to of homophobia, heteronormativity and discrimination. As future doctors it is important that medical students actively try to understand all patients, including those who are LGBTQ+. LGBTQ+ people face the same everyday health issues as cisgender heterosexuals but bear the additional burden of being stigmatised and made to feel different by society. By understanding of some of the health issues that LGBTQ+ people face, students will be better placed to treat all patients with the compassion and understanding they deserve.

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Education

"Baby, you were born this way": LGBTQI+ discrimination in communication between healthcare provider and patient

EDUCATION

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ABSTRACT

Summary

In multiple healthcare situations, LGBTQI+ people still receive inadequate care due to their sexual orientation and/or gender identity. This is in part a result of a gap in knowledge and skills concerning inclusive communication with LGBTQI+ patients. Patients often feel discriminated against by their healthcare provider. Discrimination can occur both directly due to heterosexism or indirectly and unintended due to heteronormative microaggressions. These microaggressions mostly occur during communication between the LGBTQI+ patient and their healthcare provider.

Relevance

Most healthcare providers are not aware they display heteronormative microaggressions, making it hard to challenge this habit. This is problematic, because LGBTQI+ patients can be discouraged from disclosing their sexual orientation and/or gender identity, or choose to withhold information that might affect their health. Communication training and increasing awareness can reduce the withholding of important information, resulting in a more fulfilling provider-patient relationship and more adequate care overall. However, an individual approach will not suffice to tackle this problem once and for all, as most of these microaggressions are supported by a heteronormative society. The problem is rooted in our healthcare system as well as education and institutions, and as such a holistic and systems approach to a solution is needed.

Take Home Messages

To improve communication with LGBTQI+ patients, it is important that healthcare providers receive adequate communication training. This is crucial even in the early stages of medical education and the inclusion of this topic in the medical student curriculum would achieve particular impact. Nonetheless, changes at a wider level are required to solve the problem of microaggressions and heterosexism in healthcare communication.

INTRODUCTION

The challenges that members of the LGBTQI+ community face in their daily lives have a direct impact on their health. Due to their sexual orientation (SO) and/or gender identity (GI), they are confronted with adverse situations such as discrimination, stigmatisation, bullying and harassment. One example of systematic discrimination was the pathologizing of homosexuality within the DSM-I/DSMII, leading to a medicalisation of this SO. (1) Another example is the ICD-10, where transgender identity was labelled as a mental and behavioural disorder. The ICD-11 provides the definition of gender incongruence, taking a more nuanced individual stance on the matter. (2) Facing such discriminatory issues elicits negative emotions and leads to a higher prevalence of a number of mental issues in all ages compared to cisgender heterosexuals . (3) To illustrate, a nationwide study in the US evaluating the sexual behaviour in youth found the prevalence of suicide attempts at 20% in LGB youth compared to 6% in self-identified heterosexual peers. (3) Also, elderly LGBTQI+ people concealing their sexual identity are at increased risk of depression due to the heterosexual approach to care. (4) People belonging to the LGBTQI+ community experiencing indirect and/or direct discrimination are placed in a situation of distress. Identifying factors that are associated with mental burdens increases understanding of LGBTQI+ people and the assistance they may require.

As illustrated above, LGBTQI+ people have a higher prevalence of mental health issues compared to cisgender heterosexuals. As a consequence, substance abuse is seen in LGBTQI+ people to cope with stressors like discrimination, stigmatisation and prejudice. According to the National Survey on Drug Use and Health (2015), LGBTQI+ people are using more than twice the quantity of addictive substances such as tobacco, alcohol and other drugs compared to cisgender heterosexuals within the US. (5) Furthermore, within the LGBTQI+ community there are different health issues depending on SO/GI. For example, gay men are reported to have a higher risk of contracting HIV and other STIs than their cisgender heterosexual peers. (6) On the contrary, lesbian and bisexual women are wrongly believed to have lower risk of STIs than their cisgender heterosexual counterparts. This results in receiving fewer preventive interventions and tests for STIs. (7) Overall, LGBTQI+ people have a wide range of health disparities which are not reflected in cisgender heterosexual care, leading to neglect of their needs.

Identifying Mechanism of Systematic LGBTQI+ Discriminationt

As a result of negative views towards their SO/GI, LGBTQI+ people can experience "minority stress", referring to the tension and pressure felt by a marginalised group due to deviation from the accepted norm which can lead to conflict with a dominant group. (8) This is especially accentuated in immigrant populations, creating a "double stigma" which is reflected in poor mental health and a lack of family support. (9) Additionally, the expectation of stigma increases vigilance within the LGBTQI+ community and instigates a constant guard of the self-concept. (8) For example, institutional discrimination based on policies unsupportive of same-sex marriage leads to mistrust of public figures and discomfort disclosing SO/GI.

A predominant source of minority stress is heteronormativity, which influences stereotypes of LGBTQI+ people. Heteronormativity signifies that the norm is the binary male/female perception where heterosexuality is deemed as the normal and sometimes only SO. (10, 11) Closely related to heteronormativity is heterosexism. Heterosexism can be defined as discrimination that ignores non-heterosexual behaviours and identities. (10, 11) For example, stating "lesbian surgeon" or "gay nurse" is a form of heterosexist communication because heterosexuality as a SO is never emphasised. Furthermore, heterosexism is translated into gender stereotypes, like "masculine lesbians" or "feminine gays". (10) Such a view is deemed problematic as it poses LGBTQI+ people as "the other group" and not as equals of heterosexuals. (10) Stereotypical views are a particularly troubling source of bias during the sexual history of a LGBTQI+ patient where a healthcare provider (HCP) may assume that a GI is "male" when the patient is gender dysphoric, for instance. The influence of heteronormative expectations on stereotypes can create implicit bias by a healthcare professional and discrimination against a LGBTQI+ person.

Besides direct discriminations, indirect microaggressions are prevalent in healthcare. Sue D.W (2010) defines microaggressions as "brief and commonplace daily verbal, behavioural, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual-orientation, and religious slights and insults to the target person or group". (12, 13) When these microaggressions occur towards LGBTQI+ members, they follow a heteronormative scheme. (11) The organisation of the consultation room, the decoration and folders could be examples of how microaggressions are expressed through the environment. (14) Systematic microaggressions are often perceived as institutional and are expressed mostly through regulations and policies as illustrated above. (14) Referring to the partner of a male patient as "wife" without knowing whether the patient is heterosexual is an example of a communication microaggression. Another is the presumption that certain STIs are linked to patients SO/GI. (14) These can generate the feeling in patients that their HCP could be biased, might give them improper care or mistreat them because of their SO/GI. (12) Therefore, the fear of heterosexist microaggressions is influential in the disclosure of the SO/GI by LGBTQI+ people within the healthcare setting and could lead to a poor patient-provider relationship.

Communication Affecting Disclosure

HCPs can be uncomfortable during sexual history taking. (25) When enquiring about SO/GI, this may be due to fear of insulting LGBTQI+ patients and (15) possibly resulting in the patient not wanting to disclose information. Only 30% of LGBTQI+ adults in the US avoid disclosing their SO/GI to their HCP, indicating that there are several factors influencing a patient's decision. (16) For instance, in a study conducted by Rossman et al. (2017), young adults' motives to disclose or withhold their SO/GI found that the most common reason for non-disclosure is a lack of inquiry from the HCP. (17) 74% of LGBTQI+ patients say that asking about SO is pivotal and 82% of LGBTQI+ patients think it is important to ask about GI. (17) This explains why the other 70% of LGBTQI+ adults do disclose their SO/GI. Other factors that influence the willingness of patients to disclose are the relevance of the information to the medical care, the patient-provider relationship and the concerns of LGBTQI+ patients about a potential negative reaction from their HCP. (18)

Negative reactions by HCPs deter patients from disclosing their SO/GI again and may result in, for instance, anxiety. (19) These reactions include signs that show lack of knowledge about LGBTQI+ experiences, sexual practices, etc. Even graver, denying a patient’s SO or addressing them by non-preferred pronouns have been reported. (20) It can even go as far as refusal of treatment. In the study by Rossman et al. (2017), it was clear that LGBTQI+ young adults anticipated these inadequate reactions and had low expectations of their HCP overall. (17)

On the other hand, there are various behavioural traits and actions that are considered positive and encouraging by LGBTQI+ patients. A few of these are:

- The use of general terms: The terms “partner” or “significant other” are preferred over “husband” and “wife”, because they are more inclusive and less stereotypic. (21)
- The use of open communication and direct questioning: Asking directly about SO/GI gives the patient a chance to talk about disclosure. Even questions about specific topics can create such an opportunity. For example, think of talking about birth control with lesbian patients. (22)
- Staying calm and positive: It is considered positive when HCPs keep calm when talking about disclosure as LGBTQI+ patients may already be stressed enough on their own. LGBTQI+ patients also prefer their HCP to stay positive but realistic. (23)
- Disclosure of the SO/GI of the HCP: if the HCPs themselves are a member of the LGBTQI+ community, talking about it can help to create a safe space for their patient. Interviews with LGBTQI+ patients demonstrate that hearing about their HCP being a member of their own community helps them to feel accepted and understood. (23)

Strategies to Move Forward

Multiple strategies can be implemented to facilitate inclusive communication between HCPs and LGBTQI+ patients. The first is the inclusion of communication training in healthcare students’ curricula and further education programmes for HCPs.
Hayes et al. (2015) found that HCPs feel less comfortable discussing intimate practices and determining the sexual history of LGBTQI+ patients in comparison to other patients. In this study, inadequate training is reported as the main reason for this discomfort. (25) The authors calculated that 20% of HCPs have never received training in taking LGBTQI+ patients’ sexual history. Of those that did receive training, 33% felt it was insufficient. (25)

Communication training for HCPs is thus essential to achieve a thorough, inclusive, and sensitive sexual history. The benefits of such training were demonstrated by a study conducted at the University of New Mexico School of Medicine, (26) in which the comfort of medical students in their clerkship year when discussing sexual health with LGBTQI+ members was assessed before and after taking a course. After the course, “students felt significantly more comfortable discussing sex overall and discussing sex with patients of a different SO/GI than their own.” (26) Notably, when asked about their knowledge involving men who have sex with men and women who have sex with women many students reported this as insufficient before the session when compared to the knowledge they had after the session. Moreover, the students gained insight into which vocabulary was most appropriate to use towards members of the LGBTQI+ community. (26)

Although training HCPs in good communication is crucial to root out discrimination, it does not suffice. Good communication may provide a buffer against limited amounts of discrimination in healthcare, but this effect disappears when the amount of discrimination increases. It is not only important that HCPs are trained and aware of their communication, but also that the healthcare environment is inclusive and accessible for LGBTQI+ patients. (19)

Diversity training aims to address people’s biases and can educate HCPs about the varied resources available to them. Unfortunately, heteronormative microaggressions as mentioned above are frequently invisible to people who use them. When HCPs believe firmly that they give equal treatment to all their patients they are often unable to realise the microaggressions involved in their communication. (14) Boysen and Vogel (2008) found that diversity training does not help HCPs improve their implicit biases. (29) This is unfortunate, given that these particular biases are the ones that contribute to most microaggressions in the first place. Furthermore, diversity training focussing on interpersonal communication may not address environmental and systemic microaggressions embedded in our healthcare systems. (14) These can only be overcome by addressing the bigger problems of institutional discrimination. Hospitals can apply different interventions for this purpose, such as providing scripts for a structured approach to a patient, consisting of common questions and behavioural cues that demonstrate respect. Furthermore, by representing all SOs and GIs in their activities and media they can create a more inclusive healthcare environment.

(14) In conclusion, inclusive healthcare for LGBTQI+ patients can only be achieved by qualitative training to address conscious bias and communication errors in combination with institutional and environmental changes to prevent unconscious bias.

Another striking problem and therefore entry point for strategies is the lack of evidence-based guidelines. Interventions to improve the care of LGBTQI+ people, if any, are often based on findings of small observational studies that have not been reproduced in other settings. Research should focus on the value of different communication strategies and the effect of diversity training for HCPs on the experiences of LGBTQI+ patients. The role of heteronormative (micro)aggressions and the most effective ways to address them needs thorough investigation. (14) This information is of great importance in producing evidence-based guidelines for HCPs and changes to the healthcare environment at an institutional level.

The differences between the inclusion criteria of different LGBTQI+ studies is also remarkable as many studies do not include every SO/GI of the LGBTQI+ spectrum, which makes it difficult to compare one study with another. The transgender and non-binary population are often not included in study protocols, while simultaneously being affected by the highest amounts of discrimination and ignorance. Accurate multicentred studies focusing on this group of the LGBTQI+ community must be performed to expand current understanding. (28)

CONCLUSION

Unfortunately, there is still a major gap in knowledge and skills concerning inclusive communication with LGBTQI+ patients in healthcare situations. Often HCPs themselves are not aware of displaying heteronormative microaggressions. With all the different forms these can take, it is not surprising that they are frequently encountered in healthcare settings and, for most LGBTQI+ patients, are part of their average healthcare experience. This contributes to the fear of bias these patients might have as a result of disclosing their SO/GI to their HCP. Even though many microaggressions are unintentional and most HCPs do not intend to cause any harm, patients are afraid that biased HCPs might give improper care or mistreat them because of their SO/GI.

The challenge is to overcome different kinds of microaggressions that often have their roots in institutional discrimination. A brief training session will not suffice to fix heteronormative schemes that have been developing during the HCPs life through constant exposure to a discriminating society. As they have a complex social origin, they cannot be solved by intervention at an individual level. Therefore, there is great need for institutional changes around the culture of patient-provider communication. The incorporation of intensive communication training in every HCP’s curriculum is a crucial first step towards achieving inclusive and holistic healthcare communication, but other strategies tackling environmental and institutional microaggressions are needed as well.

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Reflections

Village boy moves to London

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In the Freshers' week magazine handed out in 1994 at a large London medical school (you can Google me to find out which one), all the clubs and societies on offer were listed in alphabetical order.

Under G it said: "Gay and Lesbian: Put on your tightest white T-shirt, darkest blue jeans, head to Soho – You'll know what to do". Well, as an 18-year-old from a tiny hamlet in rural Lancashire, I had absolutely no idea what 'to do' was or what that meant. Subconsciously, they made an implicit statement to any LGBT+ student saying – 'whatever you want – you won't find it here.' The support provided for young LGBT+ students in the mid 90s was scarce at best and non-existent at worst; tangible in the fact that the "B, T and +" elements of the LGBT+ community had not been recognised by the editors of the Freshers' booklet; made invisible, side-lined, without even acknowledging their existence. Day one, week one. How would you feel?

Less than 25 years ago things were very different. London as an 18-year-old man, mildly confused as to where his sexuality quite sat, was a daunting and foreboding place in trying to discover who you were. I knew of one out gay man, in a medical school of 1500 students. Fear of discrimination was everywhere. Would you be 'outed' against your will, marginalised, ostracised, actively not given opportunity? Section 28 of the Local Government Act 1988 was in force throughout my school years. It had been enacted when I was 12 and finally made redundant three weeks before my graduation in 2000 (superseded by the Learning and Skills act). These 210 words supressed conversation about being gay, not just about gay sex, because teachers were so afraid of discussing homosexuality for fear of punishment by law. This situation impacted the entirety of my senior school and college years.

I was not the only one affected by this law – all of my friends, gay or straight, were impacted too. My straight friends were prevented from learning about different relationships by the government, prohibited from learning about others who might be different to them. LGBT+ students were unable to raise their thoughts or feelings to teachers. Teachers were even fearful of discussing 'gay bullying' for falling foul of the regulations. Its damning phrases stated that schools "shall not intentionally promote homosexuality or publish material with the intention of promoting homosexuality" or "promote the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship". (1) This was a deliberate drive by the state to alienate and force invisibility upon LGBT+ students. How many LGBT+ children and young adults were drove into silence? How many children suffered mental health issues, eating disorders, depression, and all the other effects of discrimination that exist? No one will know. Section 28 constituted a malignant and pernicious intervention by the state and society to mis-educate its young in diversity and inclusion.

Section 28 wasn't formally taken off the statue books for another three years, a redundant clause in a forgotten act. Yet, when it went, quite literally struck off, I felt an overwhelming sense of joy. It was single the most devastating act of Parliament on my life and almost certainly a contributing factor to me coming out at 23. Further legislation on any sort of discriminatory issue has to, must, be squashed at its very inception. No community, sexuality, race, gender or creed must ever suffer the same treatment. Its supporters claimed Section 28 would 'protect' children – what it did was rob me of my early adulthood.

I met my boyfriend, now partner of over 20 years, in the fourth year of medical school introduced by mutual friend. My flatmates knew about my sexuality, eventually, by the virtue that we all lived together rather than by active choice. Yet it wasn't until results day in June 2000, at the college bar, after pretty much six solid hours spent consuming cheap lager interspersed with champagne, that we kissed in public for the first time outside of a gay bar. In the middle of the dance floor. And apparently, according to close and valued friends, for longer than was strictly necessary to show our feelings for each other!

Since that day I have made an active choice - not to be silenced anymore. Not by outright activism but by quietly plodding on with my day. Talking about my husband and family openly as the totally normal thing that it is. Discussing our two children's love and affection for us, as well as the occasional temper tantrum! Having a picture of the four of us proudly displayed in my office for all visitors to see. Not the "pretended family relationship" feared by the proponents of Section 28; the actual family relationship and reality of our life, with all its frank normalness: School runs, dog walks, play dates, and birthday parties.

One recent visitor to my office caused me to reflect on my own prejudices, however. A young female doctor wanted to discuss a scan request and after a few minutes, on the conclusion of our conversation, her comment "I love that picture of your family, Dr Topping" took me by some surprise. On reflection later, was I surprised because the young doctor wore a hijab (my own prejudice laid bare) or was it that she was comfortable talking about a different family relationship, perhaps because she herself had been taught about different families at school? Was it that she was brought up understanding acceptance and tolerance of different family groups? The most junior doctors today, and readers of this journal, being of school age post-abolishment of Section 28 is surely partially responsible.

As a lead for a medical school at my hospital site I feel privileged to be able to support LGBT+ students who study with us. I hope that I am the role model to them that I never had. I am proud to be able to give reassurances that there are those who are just like them. That we have good consultant jobs, are in positions of leadership and student welfare, have families, are open about who we are and share our lives without the fear of discrimination. Times have changed, thank goodness, and I am proud to be an inspiration to my LGBT+ and straight students alike.
Finally, I would ask you to put yourself into that 18-year-old boys' shoes. Day one, week one. How would you have felt? What advice could you give to a colleague in a similar situation? How could you support that friend? Our duty as a doctor is to "Never discriminate unfairly against patients or colleagues." (2) I reflect that today, as I look at a list of names of the chest X-rays waiting to be reported, they all have different diagnoses, pneumonia, heart failure, cancer etc. But each one does not say LGBT+ or straight; it says human, and, believe me, we all look the same.

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Reflections

Should I come out at work?

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"How was your weekend?"
"Good, my partner and I went for a nice walk."
"Oh, is he a doctor too?"

This is a topic of conversation that comes up regularly in polite small talk at work. Yet, I am increasingly second-guessing how best to respond to the latter question.

A year ago, I would have just corrected the other person without thinking and moved on. In my previous rotations, being a lesbian had never been an issue. People might have been a little surprised when they found out that my partner was a woman, but they were never unkind. Perhaps, this was my experience because I was working in a large tertiary hospital in a big city, with a really diverse population of staff.

However, at the beginning of 2020 I moved to a smaller, more rural district hospital. Before I had a chance to 'come out' to my colleagues, I had several experiences where people expressed their negative opinions about LGBTQ+ people in passing conversation. For example, one registrar told me that she had walked past a Pride parade when on holiday with her family, and that she had to escape quickly as she felt that "the gays and the lesbians are a bad influence on children". Following this a consultant told me that he had stopped listening to a well-known singer because he had come out as gay. When I tried to talk to a couple of other junior doctors about how this made me feel, their immediate reaction was to defend the people who had made these statements – for example, commenting that "they aren't from this generation" or "maybe they didn't mean it like that". I felt like these remarks normalised my colleague's behaviour and trivialised my concerns. I wasn't aware of any other openly LGBTQ+ staff members that I could talk to for advice, or about what their experiences were of working in my new environment. These might seem like trivial remarks, but it made me feel like I couldn't be myself at work. I didn't realise how often my partner came up in conversation until I was actively trying to cover it up. I couldn't talk about who I live with, or what I did at the weekend, or who I was spending my time with. It meant that I couldn't bond with my colleagues in the same way that everyone else could, and I probably came across as cold and aloof. I worried that if I opened up to people that they wouldn't respect me or might ridicule me behind my back. It made me question my relationship with colleagues in previous jobs – did others share poor opinions of LGBTQ+ people and they just didn't say it to my face because they already knew I was a lesbian?

One good thing did come from that job. A couple of months after I left, one of the other doctors found out that I was queer, and messaged me to say that they were also in a same-sex relationship. They also didn't feel like they could tell anyone from that workplace and wanted to talk to someone about coming out and what they were going through. It felt really nice that they were able to talk to me. It made me think that maybe by being courageous and being more open about my sexuality at work, it might provide others with an opportunity to do the same. I must admit this thought did fill me with anxiety. As a minority, queer people often feel an obligation to take on the burden of trying to make the workplace a safe place. Having to 'out' myself at work in order to try and create this, could feel unsafe and open me to discrimination.

Since then, I have moved to a new workplace. I would like to say that I have left these unpleasant experiences behind me, but I am definitely a lot more guarded than I once was. Should I come out at work? I suppose the answer that I have come to is 'yes' – but only if I feel it is safe to do so.

In my current rotation I have been open about my life with a few colleagues who seem to be open-minded and with whom I work on a very regular basis. Sometimes I take opportunities to gauge their opinions first. For example, there was a news story on the TV in the staff room last week about LGBTQ+ military veterans reclaiming the medals they had been stripped of, so I asked a colleague what they thought about this. With people who I don't know as well I tend to be purposefully vaguer if asked questions that might reveal that I am queer. For me it is a balance between the harm of potentially being subject to discrimination at work, but also the emotional harm caused by trying to hide who I am, and the harm caused to the LGBTQ+ staff population as a whole when there is a culture that erases us in the workplace.

This experience has taught me that representation matters – if my colleague and I were able to see other LGBTQ+ staff in our workplace being openly out, confident, and still able to go about their daily jobs, we might have felt empowered to do so too. By taking small steps to be more honest about who I am, hopefully I can make a difference, and promote an environment where people feel safe to be who they are without judgement. To other queer doctors and medical students who feel similar anxieties about coming out at work, I would advise 'testing the waters' with colleagues first – gauging people's opinions about LGBTQ+ topics is a useful tool to decide if they are someone you want to open up to. This should, however, not solely be the burden of queer people alone. I would encourage non-LGBTQ+ people within the NHS to show their allyship. This could be by challenging hurtful statements, listening to colleagues who feel oppressed by their work environment, and validating their concerns, being kind if a colleague comes out to you, or simply wearing a pride lanyard or a name badge with your pronouns to identify yourself as someone safe to talk to. Finally, I would also encourage organisations to actively seek the opinions of LGBTQ+ staff on what it is like to work there, and what can be done to improve things – staff may not come forward on their own for fear of reprisal or that they will not be taken seriously.

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Reflections

Queerness and professional identity formation

REFLECTIONS

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Clinical medical education should help us transform from someone with knowledge about medicine to a practicing doctor. Medical school should help us navigate this transformation of identity, merging it with our other identities in a consonant way. But is this process different for medical students who identify as LGBTQ+? Can an understanding of queerness be helpful? We reflected on our experiences at medical school thus far through the lens of professional identity formation.

The current dominant view defines professionalism as a set of behaviours; a role that is performed with outcomes that can be assessed. (1) An example of this framework would be the General Medical Council's Outcomes for Graduates, a document labelling the requirements for newly qualified doctors in the UK. (2) A second framework of professionalism is professional identity formation (PIF), where students are socialised into a community of doctors. (3) This view suggests clinical education to be a process of enculturation; whereby students should gradually acquire the accepted ideals of clinicians, over time thinking, acting, and feeling like professionals. (1) We find PIF to be a more helpful and accurate description of how we are shaped into clinicians.

The use of the word queer in this essay is purposeful. We view the interaction of sexual orientation and queerness in the same way we view the difference between professionalism as behaviours and professional identity. The term 'sexual orientation' was first used in the 1970s, then implying a definitive quality about someone and the relation of gender to sexual object choice. (4) Queerness more closely resembles the nonsexual meanings of the word 'orientation' – encompassing feelings, beliefs, and attitudes. Beyond a set of behaviours, queer identity brings with it practices, aspirations, and social locations. (4) We want to use the term 'queerness' to counter the model of sexual orientation as risk behaviours, which we often see in medical education. We feel that this can lead to harmful learning through the hidden curriculum; a term used to describe implicit messages we receive about norms and values, which can be inferred from the behaviour of individual role models, such as lecturers and consultants, or from processes and structures. (5) Alongside this, lies the null curriculum, the conspicuously untaught content, to be interpreted as unimportant. (5) We recall that mentions of LGBTQ+ people in an educational context have nearly always been as a risk factor for disease or as a diagnostic "clue" in problem-based learning sessions. From this, students can learn that their only interactions with LGBTQ+ people will be as a consequence of their risk behaviours. Moreover, the absence of varied queer representation suggests that future professional encounters with LGBTQ+ people not focusing on risk behaviours will be negligible and, ultimately, unimportant.

Of course, the hidden curriculum communicates more surrounding identity: not only the identity of others but of ours as soon-to-be doctors. The standard for understanding patients' identities in our medical education is cultural competence. This aims to produce practitioners who consider and value the worldviews of themselves and others. Cultural competence education has been criticised for treating the doctor as an unproblematic and neutral centre (or 'null point') in relation to which the identities of "others" can be arranged. (6) If we accept this criticism, students could logically infer that practitioners are separate from the "others". This defines not just who our "normal" patients are, but who a "normal" doctor is – white, Western, heterosexual, cisgender, middle-aged, and a first-language English speaker. This implicitly communicates that we are different from the professionals who define the community. Furthermore, the enacted teaching of cultural competence disproportionately focusses on cross-cultural communication – this being the measurable, desired endpoint. The implications of accepting doctors as a 'null point' and drawing focus on communication skills inadvertently contradicts the formal aims of cultural competence by neglecting to provide us, as students, with suitable tools for evaluating our own worldviews.

The enculturation process, within the PIF framework, involves internalisation of the core values and 'worldview' of the profession. To do that successfully, we must first evaluate our own worldviews – a challenge in itself – and determine whether the perceived values of the profession are congruent with our own. Costello, a leading sociologist on professional identity, suggests that integrating professional and personal identities can be harder for some due to identity dissonance – the incongruence between one's own multiple identities. Further, students with identity dissonance could be more likely to develop coping mechanisms such as "role playing" in professional situations. (7) Adapting to professional appearance could be one such example. Anna feels they perform traditional interpretations of femininity (such as wearing dresses and make-up) much more in a ward environment than they do in their personal life to balance having ultra-short hair. Whilst on placement, Sam dresses more masculine and wears more muted colours. Anna is concerned about the reception from seniors, whereas Sam feels they need to present within the traditional gender expression of "men" to meet what patients would expect from a doctor.

Ultimately, incongruence of identities can cause such discomfort that an individual no longer wills to become a member of their prospective professional community. During their time at medical school, the simultaneous but divergent growth of Sam's personal and professional identities has led to questioning of both. On several occasions, this has motivated thoughts to drop out of medical school, thereby resolving the tension caused by the emergent (and optional) professional identity. Anna has also experienced difficulties in the process of socialisation into the future profession. Below is a story from their colorectal placement.

I was observing a colorectal list and waiting for the next patient, coming in for exploration of rectum under anaesthesia. While the patient was moved and positioned onto the table, the consultant gestured me and the other medical students towards him. "He claims he has pain due to haemorrhoids, but I don't buy that", the consultant said to us. "He's gay and practises anal sex." He appeared pleased when the other two medical students started giggling. I felt uncomfortable and confused. This was treated as an acceptable 'joke' by the clinicians and students present but did not fall within my definition of professional behaviour.

To us, forming a professional identity feels like a "chicken and egg" scenario. Do we copy behaviour we see examples of until we form an identity as a 'professional', or do we have an idea of the kind of doctors we want to become first, and therefore behave in a way to fulfil our standards? According to PIF, having positive role models and exposure to doctors with qualities that resemble our own is crucial to our professional development (1). There are queer doctors out there, but there is also immense pressure to fit within the frame of what a 'professional' looks, dresses or acts like. We feel the prescriptive nature of both frameworks discussed may contribute to our experience of this pressure. Yet importantly, we also self-categorise who we are not, (8) and construct identities by noting differences. We feel like Anna's experience illustrates how there will always be professionals whose values appear to contradict our own. By seeing few role models resembling ourselves in the clinical world, maybe we need to lean more into thinking about what kind of doctors we want to be, rather than mirroring the behaviour of those already out there.

To make this enculturation process easier for queer medical students, how do we change a culture? Ideally, values congruent with our own would be communicated by the wider institutions we are a part of. Medical schools should be intentional about widening the view of what a doctor is. In the case of queer medical students, they should incorporate better LGBTQ+ content in their curricula – moving away from the harmful behaviourist framework. Medical schools should stop relying on advocacy from student groups or individual faculty members with a stakeholder interest, but instead hire education consultants with experience of these issues. Seniors should be held accountable by their peers, rather than a culture of fear of challenging explicit and implicit trans- and homophobia. However, we do not see this shifting soon. Meanwhile, maybe small acts of resistance, or secondary adjustments, (9) can be a safe way to chip away at existing culture. We can assess our personal levels of comfort and present more visibly queer in clinical environments. We can make it a point to ask patients about their pronouns at the start of our interactions. e can practice respectfully challenging views of peers, clinicians and patients.

Although queer medical students might struggle more with some aspects of PIF, it still has its merits. The PIF framework seems more able to consider multiple, complex identities through focus on the integration of individuals and communities. Queerness can entail a better understanding of identity as a concept, as queer people must understand themselves in relation to heteronormativity. Some of this thinking may be transferrable to thinking about our professional identities. Hopefully in the future, with a wider view of who a doctor is, more students can see themselves as part of the professional community

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Reflections

Trans ally, always: my commitment to patients, colleagues, and the community

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Over the past few years, I have become ever more aware of the need for trans allies to be visible and proactive in society. I believe that this is particularly pertinent within healthcare. However, it would be remiss of me to not acknowledge the limits of my allyship, and the importance of intersectionality. Although I am a bisexual woman, I am cisgender, white, and able-bodied, so cannot compare my experiences to those of people with disabilities, transgender people, and people of colour. Nor can I truly understand how the intersecting facets of such identities impact on peoples' lives and experiences of healthcare. (1, 2) What I can do, though, is reflect on how these people need me to optimise my allyship; I can use my privilege to uplift their voices and encourage others in healthcare to be passionate allies, too. As a patient, I have experienced the breakdown of a therapeutic relationship with a doctor because of my sexuality; for me, this was simply a minor inconvenience. The health disparities and discrimination in healthcare settings that my trans friends, colleagues and patients often experience, though, can have dire consequences. (3)

Since starting medical school, my circle of beautiful LGBTQ+ friends has widened; therefore, so too has my understanding, appreciation, and defence of trans identities. A series of fortunate events have allowed me to shadow inspiring gender clinicians and GPs with a special interest in the area, as well as attend a trans healthcare conference and local social groups. However, these were facilitated independently, as opposed to being part of the curriculum. I am extremely grateful for the generosity of the trans individuals that I have met for sharing their often-harrowing experiences in healthcare with me. My commitment to being a trans ally in my personal life has evolved into a professional aspiration to care and advocate for trans patients to the best of my ability, a view which a great many clinicians share. While healthcare students and professionals have a responsibility to strive to provide the very best care for all patients, this is especially important when caring for patients from marginalised groups, who are frequently discriminated against. We should be far beyond a situation where trans people need to create and share a list of local GPs to trust and to avoid, as some individuals in my local area have resorted to.

There have been many studies which have explored trans people's experiences in healthcare. While these experiences have not been universally poor, common and concerning findings include healthcare professionals persistently misgendering or 'dead-naming' trans patients, and acting as gatekeepers to them receiving gender-affirming care. (4) This is compounded by the vulnerability that trans patients can feel when navigating a deeply cisnormative and gendered healthcare system. (5) Furthermore, the burden of teaching healthcare professionals about trans health is often placed on the shoulders of patients during their own appointments, (4) resulting in them needing to take on the role of an educator at a time when they are seeking help. Anecdotally, I have met trans patients that feel deeply frustrated and infantilised because it is not uncommon for their every presenting complaint to be related back to the 'psychological impact of being transgender', or the physiological effects of any hormone therapy. This is akin to the concept of diagnostic overshadowing, and research suggests that it is commonly experienced by trans people. (6)

Ben Vincent PhD is the non-binary author of 'Transgender Health: A Practitioner's Guide to Binary and Non-Binary Trans Patient Care', an insightful and easily-digested book that I believe should be a mainstay of all clinicians' bookshelves. (7) A particularly useful section explores how someone's trans status, or the specifics of their transition, may or may not be relevant to their care, specialty by specialty; this would be a useful reference point for clinicians who are not gender specialists but have some trans patients. I shared this book with others, and it was later included on the reading list for some equality and diversity teaching at my medical school. Sadly, infrequent and standalone equality and diversity sessions can be seen to exemplify the 'othering' of trans people and their healthcare, and I fear that these small pockets of teaching may suggest to students that such knowledge is unimportant, or for interest only, or to tick a box.

In my view, a culture change within medical curricula is needed for any widespread improvement in gender-affirming medical care to be seen. At present, some qualified doctors may describe their lack of knowledge as a barrier to providing optimal care for trans patients, (8) but the next generations of clinicians must be sufficiently educated and empowered to meet the needs of the gender-diverse patient population that they will care for. Current undergraduate and postgraduate teaching will likely feature basic content about gender identity and pronouns; perhaps a communication skills simulation will include a gender non-conforming patient. (9) But when the rest of the medical curriculum is cisnormative and adherent to a binary view of gender, it is easy for students to view patients according to these fixed categories perpetuated in the vast majority of their teaching. As a result of this, many students will likely assume that any patient in front of them is cisgender and has certain pronouns and anatomy.

To help address these assumptions, instead of describing 'the male reproductive system', educators could use anatomical language and include caveats about transgender, non-binary and intersex individuals that may have these organs, as well as many cisgender men. It may be more accurate to say 'people that menstruate', or 'those with a prostate', seeing as gendered generalisations may not apply to cisgender people either. If we move towards using consistently inclusive vocabulary in medical education from day one, this will become second nature for students. As these students qualify to become healthcare professionals, their patients, transgender or not, would likely receive more specific and considered care. Such changes may mean our gender diverse colleagues find it easier to be their true selves at work, which will only be of benefit to trans or questioning patients. Why should it not become the norm to check a patient's name, date of birth, and pronouns? Everybody has them!

Medical competence and affirming communication, in every area of medicine, are the cornerstones of healthcare for trans people, but I believe that visible allyship should be, too. Students and doctors could display a trans or progress pride flag on their lanyard or in their consulting room. If safe for them to do so, they could include their pronouns next to their name, such as on their email signature. Other acts of allyship could include advocating for the use of inclusive language around screening programmes, and for gender-neutral toilet facilities in healthcare environments. Many of my trans friends, and patients that I have met, have described the positive impact of being in a visibly inclusive healthcare environment; they feel seen. However, it is vital that this allyship persists when trans people are not in the room, such as by correcting oneself or others when someone's incorrect pronouns or former name are used. Superficial, performative 'allyship' is self-serving and harmful to the trans community: we as cisgender allies need to prove that we care with tangible actions, especially when we are part of a healthcare system which trans people are often distrustful of. It is imperative that small signs of allyship are purely a foundation upon which a commitment to excellence in caring for trans people is built. Indeed, the mere existence of the need for healthcare professionals to display their allyship may be illustrative of the pervasive lack of support for trans people in our healthcare system; unless support is clearly displayed, people may assume that is not there.

No matter if we, as future clinicians, rarely care for trans patients or become gender specialists, we and our educators have a responsibility to demand and create positive change; I believe that medical schools are perfectly placed to be drivers of this. As individuals, we may not be able to shorten gender clinic waiting times, (10) but we can each take steps to show our allyship, increase our knowledge, and improve the experiences of trans individuals in healthcare; it is the very least that our patients, colleagues, and the trans community deserve.

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