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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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