

Healthcare professionals' assumptions as barriers to LGBTI healthcare

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Abstract

Lesbian, gay, bisexual, trans and intersex people experience significant healthcare inequalities and barriers to healthcare services. Contextualised within six Member States of the European Union (EU), this paper discusses efforts to identify and explore the nature of barriers to healthcare as part of Health4LGBTI, a 2-year pilot project funded by the EU. Data were generated through focus groups and interviews with Lesbian, gay, bisexual, trans and intersex people and healthcare professionals and analysed using thematic analysis. Findings reveal that barriers to healthcare are underpinned by two related assumptions held by healthcare professionals: first, the assumption that patients are heterosexual, cisgender, and non-intersex by default; second, the assumption that lesbian, gay, bisexual, trans and intersex people do not experience significant problems (and therefore that their experience is mostly irrelevant for healthcare). On the other hand, it is notable that responding healthcare professionals were broadly 'LGBTI-friendly'. Thus, we argue that efforts to improve LGBTI healthcare should not be limited to engaging with healthcare professionals with negative views of LGBTI people. Rather, such efforts should also tackle these assumptions amongst LGBTI-friendly healthcare professionals.

Keywords: LGBTI, health inequalities, health providers, discrimination, European Union

Introduction

Despite extensive legislative shifts in the past two decades, lesbian, gay, bisexual, trans and intersex (LGBTI) people remain marginalised in Europe and internationally, leading to significant barriers in terms of accessing health and social care services (EC 2012; FRA 2015). Substantial evidence shows that discrimination impacts on LGBTI people's mental and physical health outcomes, resulting in significant health inequalities (Zeeman et al. 2017) and on their experiences of, and access to, healthcare systems (Williams 2015). For example, LGBTI people are at significantly higher risk of poor mental health compared to the general population, including a higher incidence of suicidal ideation, substance misuse, anxiety and deliberate self-harm (Bauer et al. 2015; Elliott et al. 2015; King et al. 2008; see also Haas et al. 2010; Meads, Carmona and Kelly 2012). Moreover, LGBTI people are more likely than the general population to report unfavourable experiences of healthcare including poor communication from health professionals and dissatisfaction with the treatment and care received (Bauer et al. 2014; Elliot et al. 2015; López, Generelo and Arroyo 2013; Lyons et al. 2015; Pennant, Bayliss & Meads 2009; Pinto, Côrte-Real, Ramos and Torres 2015; Thyen et al. 2014; Utamsingh et al. 2016).

Reducing health inequalities is a fundamental goal of public health research, policy, and practice in most European countries, and is regarded by the EU as being one of the most important public health challenges facing Member States (EC 2009, 2010, 2014). Despite this, in many European countries LGBTI people continue to experience inequalities in accessing health and social care services (EC 2012; FRA 2015). LGBTI people's health and their experiences of healthcare are affected by a range of social, structural and behavioural factors which together result in health needs that may not be met by existing health care services. Research suggests that medical curricula, nurse education and the training of healthcare professionals (healthcare professionals) across Europe rarely include adequate input about sexual orientation, gender identity and/or sex characteristics (e.g. Ellis et al., 2015; Rose, Ussher and Perz 2016; Sawning et al. 2017; Sherriff et al. 2011). Given the existence of health inequalities facing LGBTI people, and the unique challenges they experience, it is therefore important to understand the barriers to accessing health care within the EU and to consider how their healthcare needs can be better addressed. *Health4LGBTI*, a project funded by the European Parliament and managed by a European Partnership on behalf of the European Commission's Directorate-General Health and Food Safety, aimed to research the health inequalities experienced by LGBTI people; the barriers faced by health professionals when providing care to these groups; and subsequently to develop, test and validate a training package for healthcare professionals throughout the EU. Similar studies have taken place in North America but EU Member States have their own distinct healthcare systems, and LGBTI-related research and policymaking regarding Eastern European Member States in particular is often overlooked (Kulpa and Mizielinska 2016).

This paper uses data generated through a large scale, multi-site qualitative study as part of *Health4LGBTI*, with LGBTI people and healthcare professionals from Belgium, Bulgaria, Italy, Lithuania, Poland and the UK. Synthesising initial findings from the project's focus groups and interviews (McGlynn et al. 2017), we develop these further with additional primary data and analysis to explore how the assumptions about LGBTI people and their healthcare harboured by some healthcare professionals can present barriers to good healthcare and both (re)produce and reinforce health inequalities. Existing literature has noted elements of 'heterosexist' assumptions in a variety of healthcare areas. This previous work has focused on the identification of negative stereotypes of LGBTI people present among healthcare professionals at an individual level (Cant 2005; D'Augelli and Grossman 2001; Fallin-Bennett 2015; Fish 2006; Sharek et al. 2014). Further, prior research has mostly concerned healthcare professionals with an apparently negative or judgemental inclination towards

LGBTI people (CoE 2011; FRA 2013; Rawlings 2012), rather than positively-inclined healthcare professionals who may still feel that LGBTI status is not, or is no longer, relevant in healthcare.

In this paper we expand on this work in three new directions. First, we detail how the normative assumption that patients and/or clients are always heterosexual, cisgender and non-intersex by default, emerges in data from each of the 6 EU Member States studied. We then significantly expand on the existing evidence on healthcare professionals' assumptions by demonstrating that these are not limited to stereotypes and that they result in specific barriers to healthcare. We argue that these barriers are due to the repeated and pervasive nature of experiencing normative assumptions regarding sexual orientation, gender identity, and sex characteristics across the life course and throughout healthcare institutions. Second, we add a new element, not accounted for in the existing literature, by presenting analyses of conversations amongst healthcare professionals themselves, rather than just relying on the reports from LGBTI patients. Through this work we identify an additional, highly significant healthcare professional assumption – namely, that LGBTI people do not experience significant barriers to healthcare and that therefore LGBTI subjectivities¹ are mostly irrelevant to the proper provision of healthcare. We show this assumption, too, can be experienced as a healthcare barrier for LGBTI people.

In addition, while the Health4LGBTI focus groups were advertised across various groups of healthcare professionals, we surmised that participation would indicate interest in improving the equitable delivery of health care for LGBTI people. This was borne out in healthcare professional discussions and the lack of anti-LGBTI attitudes displayed. Therefore, findings regarding the two primary two assumptions are less about 'homophobic', 'biphobic', 'transphobic' or 'interphobic' healthcare professionals (although the data demonstrates that such attitudes do persist), than about how even broadly LGBTI-supportive healthcare professionals may be inadvertently reproducing barriers to healthcare for LGBTI people through these two assumptions. Therefore, healthcare professional training or development initiatives targeting discriminatory or bigoted healthcare professionals alone may not solve key issues that can cause significant barriers for LGBTI people.

Methods

Participants

103 participants were recruited for the focus groups and interviews, including both LGBTI participants (n=52) and healthcare professional participants (n=51). Some healthcare professionals identified as lesbian (n=2), gay (n=5), bisexual (n=5), and trans (n=3), although none identified as intersex. These healthcare professionals were not part of the LGBTI focus groups, but some (n=6) took part in separate individual interviews to capture their particular perspectives as LGBTI healthcare professionals. LGBTI participants were recruited by project partners and ILGA-Europe through purposive and opportunistic (snowball) sampling techniques, with the aim of recruiting samples which a) related to the local context, and b) included some representation of groups that typically experience additional marginalisation. LGBTI participants were eligible if they were a) a self-identified LGBTI individual, b) aged 18 or over, and c) sufficiently fluent in an official language of the host country to participate in a discussion about healthcare services and provide informed consent. Similarly, the healthcare professional sampling sought a diverse array of healthcare professionals including General Practitioners, nurses, mental health workers, midwives, social care staff and others.

Procedure

¹ By the term subjectivities we refer to a Foucaultian understanding of historically constituted senses of selfhood as LGBTI people (Kelly 2013).

12 focus groups ran from June 2016 to October 2016, with two in each of the six participating European Member States: Belgium, Bulgaria, Italy, Lithuania, Poland and the UK. Ethical approval was sought and obtained from each academic partner institution (the University of Brighton in the UK, the University of Verona in Italy, and the National Institute of Public Health - National Institute of Hygiene in Poland). The first focus group in each country comprised LGBTI individuals, and the second comprised healthcare professionals. Facilitators in each focus group guided participants through a semi-structured focus group schedule and conducted a small number of semi-structured interviews with selected focus group healthcare professionals who also identified as falling within the LGBTI abbreviation (N=6). These interviews used a version of the healthcare professional focus group schedule, adapted for use in a one-on-one format.

The focus group and interview schedules were developed through existing literature and the aims of the overarching *Health4LGBTI* project, and identical schedules were used in each country (with allowances for differences in translation). Key topics addressed by the schedules were experiences of health and social inequalities; examples of good practice; risks and resilience for LGBTI people; barriers for health/social professionals; and issues relating to communication and confidentiality. Although facilitators received training to support methodical homogeneity, they were free to deviate when other topics emerged as significant.

Focus groups and interviews lasted between 1 and 2 hours and were audio recorded, and subsequently transferred securely to the University of Brighton (UK) research team for transcription, translation, coding, and analysis. These translations were cross-checked by the facilitators. See McGlynn et al. 2017 for full details of the project's design and implementation, and the full demographic profile of our sample.

Data Analysis

Thematic analysis (Braun and Clark 2006) was used to explore the data generated through the focus groups and interviews. Two initial coding matrices were produced (one for the LGBTI focus groups, and another for the healthcare professional focus groups) with 21 key thematic codes based on the project's objectives, and reviews of the scientific and grey literature around LGBTI health inequalities (Zeeman et al. 2017). As both matrices were designed to address the project's aims as a whole these coding matrices were substantially similar, but incorporated differences according to their participants. For example, the LGBTI matrix included 'Patients Identifying Accessible healthcare professionals' and 'Withholding Sexual Orientation or Gender' as codes, while the healthcare professional matrix excluded these but included 'Forms, Bureaucracy and Admin' and 'Professional healthcare professional Training'.

New codes which emerged from the data were logged and added to the coding matrices, resulting in a final total of 34 distinct codes used in the wider data analysis. Repeated rounds of inductive and deductive analysis ensured that each code was explored with regard to emerging analytic themes. The full thematic analysis was carried out using the qualitative data analysis software NVivo Pro (Version 11). A detailed overview report of the analysis (including lists of codes and analytic themes) was sent to consortium partners for further discussion and input and finalised in agreement with the European Commission (see McGlynn et al. 2017). Direct quotes have been labelled using pseudonyms to ensure anonymity.

Findings

Two subthemes emerged based on the nature of the assumption. For each subtheme we present exemplar excerpts from the data along with analysis. Analysis of the first assumption - "Patients are

heterosexual, cisgender and non-intersex by default” (Section 3.1) - uses data from LGBTI respondents only and builds on existing literature identifying normative assumptions held by healthcare professionals. Specifically, we argue that facing these assumptions in healthcare setting is not a matter of isolated instances. Rather, it manifests as a healthcare barrier through their repeated and institutionally pervasive nature. Analysis of the second assumption – “Patients experience no significant problems due to sexual orientation, gender identity, and/or sex characteristics; and therefore, LGBTI subjectivity is mostly irrelevant for healthcare” (Section 3.2) – primarily uses data from non-LGBTI healthcare professionals, in distinction from the wider existing literature engaging with healthcare professional assumptions around gendered and sexual minorities. This assumption appears to be relatively unexplored in existing literature. In this section we also highlight that these healthcare professionals did not exhibit outright bigoted or discriminatory behaviour. Rather, we show that they are broadly LGBTI-supportive who may nevertheless unintentionally reproduce healthcare barriers for LGBTI people.

Assumption 1: Patients are heterosexual, cisgender, and non-intersex by default

In both LGBTI patients’ reported experiences and healthcare professionals’ own discussions across all six countries, one of the most common items of discussion was that healthcare professionals would assume patients were not LGBTI unless told otherwise. In both of the following quotes, LGBTI participants identified this particular assumption as a problem:

I demand from every doctor, every psychologist, every carer, that they have a minimum basic knowledge. And that starts by simply saying 'how's your partner' and when he starts talking to me about my wife then it's a fail from me.

(Romain, LGBTI person, Belgium)

I would like the doctors not to automatically assume I am heterosexual. I am sick of that. I have an experience with gynaecology from the labour ward. Every time they assume there is a father. Even if there isn't one, they still ask.

(Magda, LGBTI person, Poland)

Both of these quotes indicate that a near instinctive pre-judgement is being made regarding the sexual orientation (and, we could add, gender identity and sex characteristics) of patients by healthcare professionals – they ‘assume’ or ‘take it for granted’. In Romain’s case that even a well-intentioned slip, easily corrected by healthcare professionals, is still a ‘fail’. Magda’s comment (echoing those of other LGBTI people in all six countries) suggests that this is not a singular event but long-standing frustration or even weariness, evinced when she said, ‘I’m sick of that’ happening ‘every time’. Bringing this together with Romain’s implication of ‘every doctor, every psychologist, every carer’, we can begin to understand the long-standing and pervasive way in which this assumption of non-LGBTI subjectivity may be experienced by LGBTI people across the lifespan and throughout a multifarious healthcare system.

However, in another focus group, Giancarlo expanded this beyond the role of these individual healthcare professionals – doctors, psychologists, carers – to suggest that this assumption becomes a systemic or institutional issue:

By default, they somehow take it for granted that the person is cisgender and heterosexual. And then the user impacts with the protocol that does not recognise him and therefore the lack of recognition is institutional... It's the protocols often that I think represent a barrier.

(Giancarlo, LGBTI healthcare professional, Italy)

Here Giancarlo clearly recognised this assumption that ‘the person is cisgender and heterosexual’ as a barrier to healthcare. However, he connects a hypothetical individual healthcare professional to a lack of recognition throughout the entire healthcare institution. In this way, his comment suggests that while this assumption does manifest itself at the individual level – perhaps as a one-off meeting with an individual healthcare professional - it is not reducible to it. Other respondents also drew this link between individual assumptions and their prevalence throughout an entire institution:

Everything is so heterosexualised in the hospital, so everybody you’re with in the wards and everything, it’s just geared to heterosexual people, and so ... when you’re there long-term, that can become quite wearing... It’s just not geared up, really, hospitals or any of those services, for people who aren’t heterosexual, in the long term. And I think that becomes quite an issue, I think. So, for me it was my emotional wellbeing.

(Monica, LGBTI person, UK)

Monica’s statement builds on these assumptions of heterosexuality (and to this we could add cisgender and non-intersex) being not simply a one-off situation with a single healthcare professional. Rather, they become pervasive assumptions that (as Giancarlo argued) are spread throughout the healthcare system. Monica also moves beyond this idea of assumptions as merely a one-off situation by recognising a problem ‘in the long-term’. Taken together, then, these quotes from LGBTI participants demonstrate that the repeated (across time) and pervasive (across the healthcare institution) nature of this assumption was experienced as a particular issue. Another respondent from the UK, Josephine, discussed the potential impact of this long-term and institutional assumption:

It’s just too difficult to expect someone who has mental health issues to constantly explain to different areas. I can’t do it anymore without it impinging on my health, so I’ve just given up... If they have to explain to ten different people what’s wrong, over and over again, and then face different types of prejudices, depending on who you get, then they too might give up.

(Josephine, LGBTI person, UK)

In the quote from Josephine, we can see how an LGBTI person may experience the repeated and pervasive nature of this assumption in greater detail. For Josephine, lack of recognition through assumptions of heterosexuality, cisgenderness or non-intersexuality, was not merely a problem to get around (for example, by simply ‘coming out’ again and again). Rather, she described this as being ‘too difficult’ and said that consequently she has ‘given up’. This assumption has formed a barrier in the most solid sense then, as something that halted and prevented further progress or engagement.

Data from others LGBTI respondents built on this framing of the nature of this barrier, e.g. that being assumed to be heterosexual, cisgender and/or non-intersex made them feel that they must avoid healthcare services:

I have been present during my female partner’s medical consultations and when it comes to a gynaecological assessment they start with questions like: “Is it painful on intercourse?” etc. “You have to have a more active sexual life as otherwise this and this might happen” ... It’s not about discrimination, it’s more about the fact that at one point you feel like you’ve been given an ice-cold shower. So, you immediately feel like you can’t share anything with that doctor.

(Elena, LGBTI person, Bulgaria)

Elena's striking use of the phrase 'an ice-cold shower' conveys a sense of shock and 'freezing' in front of a healthcare professional. And again, she did not merely present this barrier as a difficulty to get around but emphasised the solidity of the barrier when she said, 'you *can't* share anything' (our emphasis).

While assumptions of individuals being non-LGBTI by default are well-documented in the literature (Cant 2005; D'Augelli and Grossman 2001; Fish 2006; Sharek et al. 2014; Ward and Schneider 2009), we have augmented this literature by showing that it is the long-standing and pervasive institutional nature of these assumptions that reproduces barriers between healthcare professionals and their LGBTI patients. This could result in poor communication (as demonstrated by Elena) and consequently less appropriate healthcare, or even (as in Josephine's case) not seeking healthcare in the first place. The normativities re/produced through this assumption impacted on LGBTI people's ability to be open with and to maintain good communication and relationships with their healthcare professionals – a status vital to the provision and receipt of good healthcare (Cant 2005; Baldwin et al. 2017; Bartholomaeus and Riggs 2018; Brach and Fraserirector 2000; Roter and Hall 2006; Stewart 1995; Utamsingh et al. 2016; see also Zeeman et al. 2017). Therefore, even well-intentioned and 'LGBTI-friendly' healthcare professionals (as in our sample) may reproduce barriers to healthcare via the assumption that patients are non-LGBTI unless explicitly told otherwise.

Assumption 2: LGBTI subjectivity is mostly irrelevant for healthcare

Historically, LGBTI subjectivities have been pathologically associated with disease, illness and risk-laden and 'deviant' behaviour (Weeks 2007). With the advance of LGBTI social and legal progress in Europe and beyond, there has been increasing recognition that LGBTI health inequalities stem instead from discrimination and pervasive normativities (Zeeman et al 2018). In the healthcare professional focus groups, a common belief presented was that discrimination, bigotry and barriers to healthcare have been (in Samir's words) 'nailed' for at least some LGBTI people. This was particularly common in the Belgium, Italy and UK focus groups. However, this belief emerged in each country, though sometimes with the qualifier that such progress was a recent development in Bulgaria, Lithuania, and Poland:

I believe that our nation has really taken a step forward and I don't believe that [LGBTI] people encounter major difficulties in... the hospitals.
(Vasilika, healthcare professional, Bulgaria)

I guess we're talking about trans because that seems the latest big thing, isn't it? We feel like we've nailed the sexuality type stuff but maybe that presents later once you get to the clinician and things.
(Samir, healthcare professional, UK)

We see that a lot [in care centres]. People go back into their closets. I think care providers underestimate it. They think it's not really a problem anymore.
(Mohamed, healthcare professional, Belgium)

While Samir framed trans issues as more notably recognised, both he, Vasilika and Mohamed suggested that healthcare professionals may believe issues of sexual orientation were a problem in the past but are not so 'anymore'. Indeed, Samir's use of the word 'nailed' conveys a particularly robust and final sense of completion, linked to wider popular assertions that LGB acceptance and

equality have been broadly 'achieved' particularly in Western Europe (Clements and Field 2014; Richardson and Monro 2012; Weeks 2007). This assumption of 'no significant problems' is hotly contested by the extensive and troubling accounts of healthcare experiences from the Health4LGBTI project's LGBTI focus groups and interviews, and from the wider literature (EC 2012; FRA 2015; Katz-Wise and Hyde 2012; López, Generelo and Arroyo 2013). The assumption that 'everything is OK now' for LGBTI people was held by healthcare professionals in both Eastern and Western Europe. In countries with an established legislative framework of rights for some LGBTI people (such as Belgium and the UK), a popular belief that inequalities for LGBTI people no longer exist, or are only insignificant, can prevail amongst LGBTI as well as non-LGBTI people (Walters 2014; Weeks 2007). Importantly, this belief relates to this assumption that 'everything is fine now' for LGBTI people despite evidence of significant inequalities in the wider literature (EC 2012; FRA 2015; Katz-Wise and Hyde 2012; López, Generelo and Arroyo 2013). Therefore, countries which are seen to be 'ahead' with regard to LGBTI equalities cannot be exempt from the need to train healthcare professionals in LGBTI issues, and healthcare professionals in such countries may actually struggle to recognise what it is that LGBTI people experience as barrier to healthcare (for example, see Semlyen, Ali and Flowers 2017). Although the assumption that 'everything is fine now' appeared more prominently in the Belgian, Italian, and British healthcare professional focus groups, discussions in the Bulgarian healthcare professional group were seen to develop a rationale underpinning it:

I work in a hospital; I have numerous encounters with [LGBTI] people. I have not been in a situation where these people weren't cared for exactly like any other patient in the hospital was cared for. Maybe a different attitude was present after the patient has left the hospital – there might be comments regarding what that patient was like... After all, the hospital is a humane place where it doesn't matter what you are like.
(Vasilika, healthcare professional, Bulgaria)

Vasilika relied on her own observations and experiences to identify issues for LGBTI patients and suggested that it is precisely *not* treating LGBTI patients as distinct from non-LGBTI patients which is a marker of success in this regard ('cared for exactly like any other patient'). This was perhaps a consequence of the assumption that there are no real problems for LGBTI patients, despite the data presented above. The assumption that LGBTI people simply being 'cared for exactly like any other patient' is sufficient was compounded when healthcare professionals in this focus group blamed LGBTI people for avoiding healthcare and subsequent poor health outcomes:

What I have personally observed, is that self-stigma is frequently seen as soon as they leave the hospital. These [LGBTI] children refuse to talk about this topic with their close friends and even with doctors who can provide help and support long-term. They refuse to talk about it with people who are highly intellectual and occupy professional positions... I can't fully analyse their actions.
(Dragomir, healthcare professional, Bulgaria)

This idea of 'self-stigma' was presented across other countries' healthcare professional focus groups. Participants suggested that LGBTI people's fears of discrimination were unfounded, and thus that LGBTI people were themselves contributing to their own marginalisation. LGBTI people's experiences as documented in this paper show that they did indeed fear discrimination and saw it as a barrier to healthcare (for further accounts see McGlynn et al. 2017, and Zeeman et al. 2017), but this fear was often justified (see Section 3.1) – a justification erased by this assumption of 'self-stigma'. Here self-

stigma was drawn upon due to the apparent incomprehensibility ('I can't fully analyse their actions') of LGBTI patients' lack of openness with healthcare professionals. Dragomir's belief that 'highly intellectual' people with 'professional positions' did not hold negative attitudes towards LGBTI people echoed Vasilika's assertion of hospitals as 'a humane place where it doesn't matter what you are like'. In both cases, healthcare professionals were framed as inherently above or beyond expressions of prejudice or bigotry – something we know from examples throughout this paper and in the wider literature (Baldwin et al. 2017; EC 2012; FRA 2015; Katz 2011; Katz-Wise and Hyde 2012), to be incorrect.

All of the healthcare professionals recruited to this study expressed an active interest in removing barriers to healthcare for LGBTI people. None expressed openly discriminatory or bigoted attitudes towards LGBTI people in the recorded focus groups. Yet the assumption we see these replicating in healthcare professionals quotes – that there are few significant issues remaining for LGBTI people in healthcare and that LGBTI people are thus to blame for lacking access and confidence – itself presents a barrier for LGBTI healthcare. This assumption also reveals a particular logic which builds on the first assumption, whereby if (1) patients are assumed to be heterosexual, cisgender, and non-intersex, this is acceptable because (2) there are no significant issues for LGBTI patients. This second element was then extended by participants, because healthcare professionals suggested that as a consequence of there being no significant issues then a patient's LGBTI subjectivity does not matter for most areas of healthcare. This perspective was one shared by other healthcare professionals in all countries, and identified amongst participants' colleagues:

I don't ask the question "What is your sexual orientation?" or "What are your problems and which group do you assign yourself to?" I can only hope that my patients' trust in me will allow them to share what their problems are.

(Stefan, healthcare professional, Bulgaria)

I do sometimes notice an attitude from certain care providers like "Do we really need to know about such a specific theme as transgender?"... Unfortunately, this is a theme that tends to fall by the wayside quite quickly I think as it isn't purely medical.

(Amandine, healthcare professional, Belgium)

Stefan's hoped-for trust was challenged by evidence demonstrating LGBTI people's widespread *lack* of trust from these focus groups and interviews as well as the wider health inequalities literature (CoE 2011; Elliot et al. 2015; Fish and Bewley 2010; Pennant, Bayliss and Meads 2009; see also reviews of individual EU Member States in Zeeman et al. 2017). A disciplinary categorisation often emerged in these discussions amongst healthcare professionals, whereby LGBTI subjectivity was seen as more or less relevant in different disciplines or areas of healthcare:

The most relevant field is psychiatry as in other medical fields sexual orientation is less relevant.

(Jonas, healthcare professional, Lithuania)

I don't think it's important for all the medical professions. For cardiologists, nephrologists this knowledge might not be useful. But for psychiatrists or dermatologists it is because they meet patients like that.

(Franciszka, healthcare professional, Poland)

With this abbreviation [LGBTI] we're talking about problems related to sex as an act and as an identity. These people might have orthopaedic problems, but it wouldn't come to them having to disclose their sexual preferences... Access to healthcare for them is in relation to sex and problems associated with it.

(Dragomir, healthcare professional, Bulgaria)

Jonas' and Franciszka's suggestion of psychiatry as 'the most relevant field' was echoed by numerous other healthcare professionals, and the other most frequently mentioned field was sexual health as indicated by Dragomir and Franciszka². Oncology was not one of these 'most relevant' fields, however significant issues emerged in one UK healthcare professional's discussion of the radiotherapy of a trans patient with cancer:

That was quite difficult because you had no training professionally on that. Is this a man? Is this a woman? How do they want us to treat them? It was really difficult for the patient as well... It was... not caring for himself as well as he might. He wasn't shaving but was there in a skirt and that was all a bit kind of, you know...

(Cathy, healthcare professional, UK)

The cancer treatment made this patient's transition particularly difficult, and the healthcare professional struggled to deal with trans issues, misgendering the patient and imposing responsibility for upholding binary gender conformity onto them. Although cancer is not an LGBTI-specific healthcare issue, there are issues associated with LGBTI people with cancer (Fish et al. 2016; Rose, Ussher and Perz 2016). The assumption that LGBTI people only have LGBTI-specific healthcare issues and not general healthcare needs may result in LGBTI-related education and training being seen as unnecessary in most healthcare fields. Yet a lack of LGBTI-related training in any field could create problems for healthcare professionals and worsen a patient's experiences. Indeed, for some patients this could be a life or death situation:

There was a transgender person admitted to A&E, he was undergoing the gender correction. Everyone panicked. They didn't know what to do with that patient. The doctors didn't know how to talk to him. It comes from lack of education during the medical studies. There is no education included as part of the medical university course. Everyone was scared to deal with that patient. They were looking for a volunteer. The patient attempted to commit suicide... We did not know how to act, what to say, what to ask. No one taught us.

(Tomasz, healthcare professional, Poland)

Tomasz's troubling account reminds us again that LGBTI subjectivity is not only relevant in particular areas of healthcare such as psychiatry. However, Tomasz also echoed the situation described by Cathy above, highlighting even more clearly that these issues stem not from the LGBTI person, but rather from healthcare professionals themselves who, confronted by the reality of an LGBTI person, struggle to cope and consequently impact negatively on that person's health. Crucially, he linked this to a lack of training during medical studies at university (see Fallin-Bennett 2015; Parameshwaran et al. 2016). This may be precisely where the assumption of the irrelevance of a patient's LGBTI status (outside of certain limited fields) may impact on what new healthcare professionals learn. Conversely, active sensitivity towards a patient's subjectivity as an LGBTI person can be experienced as beneficial (Cant 2005; Fish 2006) and as part of a recovery process:

² Note that in Poland sexual healthcare often falls within the field of dermatology.

I was in hospital and I was unable to communicate anything to do with my sexual orientation to the consultant who was seeing me. It just so happened that on this particular occasion another consultant was there, and this consultant was a psychiatrist, and he didn't make any assumptions about me, and so, as a result, he was able to understand what was wrong, because I was better able to talk to him. Because I had kept facing people who just kept making assumptions about who I was, over and over again... As a result, I actually improved and was discharged from hospital.

(Josephine, LGBTI person, UK)

Taken together, these excerpts demonstrate that the assumption of the irrelevance of a patient's LGBTI status creates serious problems not just for LGBTI people seeking healthcare, but also for healthcare professionals wishing to provide good healthcare to LGBTI people. Consequently, the assumption that LGBTI subjectivity is mostly irrelevant for healthcare must be tackled in training or initiatives for healthcare professionals to address barriers faced by LGBTI patients – including LGBTI-friendly healthcare professionals.

Study Limitations

This study was limited in terms of the number of countries included (n=6) and the number of participants in each (see Figures 1 and 2). Trans and intersex participants were also under-represented. The findings cannot be considered generalisable for all EU LGBTI experiences in healthcare or amongst healthcare professionals, although the overall sample size was relatively large for a focus group study (n=103) and the data and analyses offer clear and applicable insights. The assumptions focused on in this paper were not part of the focus group or interview schedules but instead emerged unprompted in participants' discussions during analysis. Therefore, an extended, more detailed discussion of these assumptions could not be captured. Future research is needed to identify ways in which these assumptions can be productively engaged with in a healthcare professional training context.

Conclusion

Research investigating health inequalities has identified an array of barriers to receiving good quality healthcare (or indeed any healthcare) for LGBTI people (Zeeman et al. 2017). The resulting scientific and grey literature details LGBTI people's ongoing experiences of denial of healthcare, legislative and policy-based inequalities, and openly prejudiced attitudes in EU healthcare services (EC 2012; FRA 2015). The data generated from the *Health4LGBTI* focus groups and interviews support and builds on the LGBTI health inequality literature in many areas (see McGlynn et al. 2017). However, one of the unique contributions to the literature of our data is with regard to healthcare professionals who do not consider themselves to be prejudiced towards LGBTI people, and who in fact have an expressed interest in improving healthcare for LGBTI people. Together, the project's stated aim during recruitment and the recorded data (in which no healthcare professionals voiced openly discriminatory or negative attitudes towards LGBTI people) indicate that the healthcare professional sample was indeed comprised of healthcare professionals interested in the equitable delivery of LGBTI healthcare. healthcare professionals who see themselves as non-discriminatory and who express some desire to assist LGBTI patients can nevertheless unknowingly maintain and reproduce LGBTI healthcare inequalities through widely held assumptions that: 1) patients are heterosexual, cisgender and non-intersex by default; and that 2) LGBTI patients do not experience significant problems and so LGBTI subjectivities are mostly or entirely irrelevant in healthcare provision.

Through our analysis of data gathered from focus groups and interviews in 6 EU Member States, we argue that both of these assumptions are flawed, and can actively contribute to the creation and maintenance of barriers to good healthcare for LGBTI people. The first assumption that *patients are heterosexual, cisgender, and non-intersex by default* was described by LGBTI people in the dataset as resulting in a lack of communication with healthcare professionals and the avoidance of healthcare. We augment existing research describing this in individual settings, by arguing that it results in barriers to healthcare though the long-standing (potentially throughout a patient's lifetime) and pervasive (throughout entire healthcare institutions) nature of the assumption. The second assumption that *LGBTI patients do not experience significant problems and therefore LGBTI subjectivity is irrelevant* is belied by an extensive health inequalities literature, as well as by the findings from the Health4LGBTI project's Comprehensive Scoping Review and focus groups/interviews on which this paper draws. This second assumption appears to have gone unremarked in the literature on healthcare professional assumptions to date (Cant 2005; D'Augelli and Grossman 2001; Fish 2006; Sharek et al. 2014; Zeeman et al. 2017), and yet emerged as a clear barrier to good LGBTI healthcare in our research. It may therefore contribute to ignorance around the issues which LGBTI people continue to experience in accessing healthcare. It was also clearly related in the data to a lack of training around LGBTI issues, and a belief that such training/awareness was not needed except in a limited set of medical fields (e.g. psychiatry and sexual health). Yet the focus groups uncovered examples where this lack of training led to serious and potentially life-threatening situations for LGBTI patients, and for considerable stress and anxiety for well-intentioned healthcare professionals.

In conclusion, our data suggests that to reduce healthcare inequalities for LGBTI people in the EU, it is not sufficient to tackle the beliefs and attitudes of openly discriminatory and bigoted healthcare professionals. Indeed, we suggest that such a focus on these 'bad apples' may actually mask how well-intentioned and ostensibly LGBTI-friendly healthcare professionals can inadvertently re/produce healthcare inequalities via their unchallenged assumptions. We recommend that future research explores how LGBTI-friendly people working in healthcare settings may inadvertently reproduce barriers to LGBTI-healthcare. Further work is also needed to understand how best to engage those who may consider themselves already fully educated, aware, or friendly regarding LGBTI people and issues. The Health4LGBTI modular training package (Amaddeo et al. 2018; see also Donisi et al. 2018) which we have developed was informed by these findings, but other healthcare professional training and staff development programmes designed to tackle LGBTI healthcare inequalities may benefit from addressing these assumptions, and from including even those healthcare professionals who believe that they would not need training in LGBTI issues. While our data and analyses remain specific to the EU Member State context, healthcare providers in other geographic settings may also benefit from such considerations.

Data Access Statement

Generation of the data used to support the findings of this study was funded by the European Commission. In accordance with EU data protection legislation, the authors' copies of this data have now been destroyed. Access to the anonymised dataset can be requested from the European Commission Data Protection Officer. See https://ec.europa.eu/info/departments/data-protection-officer_en for details.

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