

Access to inflammatory bowel disease healthcare for patients with LGBTQI+ identities

AUTHORS

Lesley Dibley

Faculty of Education, Health, and Human Sciences | Institute for Lifecourse Development
University of Greenwich
London, United Kingdom

Mel Duffy

School of Nursing, Psychotherapy and Community Health
Dublin City University
Dublin 9, Ireland

CORRESPONDING AUTHOR

Professor Lesley Dibley

University of Greenwich
Health Sciences Building
Avery Hill Campus
Avery Hill Road
Eltham
London
SE9 2UG

L.B.Dibley@Greenwich.ac.uk

Access to healthcare for people with sexual and/or gender minority identities has, historically, been challenging^{1,2}. Discrimination, homophobia, and a culture of heteronormativity within health care services can obstruct communication, negatively affect care delivery, and lead to poorer health outcomes for members of the community.

The Equality Act (2010)³ made it unlawful for any association [in this case the NHS] to *'discriminate against or victimise its members, associates, and guests, also its prospective*

members, associates, and guests' because of nine protected characteristics including gender re-assignment and sexual orientation. The Act heralded a slow, but discernible sea-change in social attitude, but legislation does not by itself change attitudes – education does. Visibility of and engagement with marginalised groups and a willingness to listen and learn is what facilitates change, by enabling people to understand that marginalised others are not so different from themselves⁴.

Yet whilst we may observe a widening tolerance, acceptance and allyship with sexual and gender identity minority groups in broader society, how can we be supportive in clinical practice, and specifically, in colorectal practice with patients with Inflammatory Bowel Disease (IBD)?

There is minimal evidence specifically addressing LGBTQI+ in IBD services^{5,6,7} reflecting an implicit assumption in most studies on sex and/or sexuality in IBD that participants were, and patients are, heterosexual. Yet gay and lesbian patients with IBD have reported concerns around receiving healthcare, including feeling they were treated differently because of their identity to the point that some would rather avoid the stress and not seek (even essential) hospital care⁵. Schenker et al⁶ highlight the importance of knowing the medical and surgical histories of transgender and gender nonconforming (TGNC) individuals, since there may be interplay between gender-affirming therapy and IBD medications, and gender-affirming construction of the neovagina using colonic or ileal tissue and IBD flares. They provide clinical guidance in three domains: medications, anatomy, and mental health (a known challenge amongst IBD patients⁸ that can be compounded in LGBTQI+ patients), and state that the ability to provide safe, effective care to TGNC (and by extension, LGBTQI+) individuals relies on patients feeling safe enough to share their gender identity.

Clinical care of IBD requires sensitive discussion, exploration, and often intrusive investigation of areas of the body that are usually only revealed to intimate partners. Whilst sexual identities are not purely driven by sexual activity, certain IBD treatment options – such as removal of the rectal stump following total colectomy, or creation of an ileo-anal pouch - may have a significant impact on any who engage in anal sex⁷. Any woman with vulval Crohn's⁹ is likely to face intimate challenges - regardless of identity – and this is how clinicians should be thinking for ALL patients – not that the stump removal, pouch creation

or vulval Crohn's won't be an identity problem – but that it might, and it needs addressing – and to address it competently, the patient's sexual and/or gender identity needs to be known⁷. The world has moved on since the 2014 study with gay and lesbian patients⁵; the range of gender and sexual identities is much broader than male, female, straight, and includes lesbian, gay, bisexual, transgender, intersex, gender fluid, non-binary, genderqueer. Clinicians need to be cognisant of these terms¹⁰ and of the diversity of individuals who can present themselves in practice, but how to create opportunity for patients to tell you who they are?

The starting point in providing culturally competent care for those with sexual and/or gender minority identities is to create an environment of openness that indicates to all IBD patients that the clinical space is open and welcoming^{6,7,10}. The only way the clinician can know that the IBD patient before them owns a sexual and/or gender minority identity, is if that patient 'comes out' to them. This process, of 'coming out' is ongoing - it moves from initially being an important personal affirmation of identity, to a repeated need – in numerous settings - to share that identity to try to avoid heteronormative assumptions, and in healthcare, to increase the likelihood that care will be provided that is sensitive to the individual's need. Coming out is aided by the provision of verbal and visual clues that invite the IBD patient to reveal their identity.

Verbal clues

For a first meeting, introduce yourself and invite the patient to do the same. Using gender neutral language sends a message that you are receptive to a wide range of possible responses – but be prepared to repeat the questions in later appointments – patients with historically discriminated identities need to feel they can trust you; it may take a while for them to open up, especially if they have had traumatic past experiences in healthcare.

Asking the patient how they would like to be addressed gives them opportunity to use their preferred pronouns and gives a clue to their identity. When asking about next of kin, make no assumptions ... *Do you have a partner? What is their name? Who do you live with?*

If the patient arrives in your consulting room with a companion, ask who the companion is: *And who is with you today? Is there anything else about you that I need to know, to help me understand your needs?* Of course, the digital or paper-based documentation then needs to

be able to record the patient's responses accurately, to avoid unnecessary repetition of questions, and/or omissions in care.

Visual clues

Humans are very good at interpreting visual clues - symbols that often very simply represent a complicated, detailed concept. LGBTQI+ patients will likely assess the diversity competence of their environment more positively when they see, for example, gender neutral bathrooms and LGBTQI+ pamphlets/posters⁶, any of the many rainbow-themed flags, including the LGBTQI+ ally flag and symbols representing LGBTQI+ support groups on documentation¹⁰, and clinical staff wearing the same as lanyards or badges.

When a person chooses to 'come out', they are facilitating their need for 'self-affirmation, validation and acceptance by others' resulting in their visibility. In any healthcare setting, including colorectal / gastroenterological services, coming out can result in the provision of properly individualised health care; the essential building of trusting relationships with health care practitioners can only happen if practitioners are aware that others exist outside the heteronormative realm¹¹.

Author contributions: Dibley wrote the original draft, and later reviewed and edited; Duffy reviewed and edited the original and revised draft. Both authors contributed equally.

Funding source: none, for this commentary piece.

COI: The authors declared no conflicts of interest.

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