

## Guest editorial

# Critical issues in LGBT well-being

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It may seem odd to talk in terms of an issue being 'critical' when heterosexism is so old, so subtle, so functional, and so ingrained in health and social care settings as to be 'everyday'. I use it to allude to the position in which many diverse lesbian, gay, bisexual and transgender (LGBT) people, indeed any people who might be identified as 'queer', find themselves when they interact with service providers. Seeking something, and being vulnerable, at the same time as making one's sexual or gender identity known is a critical moment. There is no knowing quite what the outcome will be.

I also use the word 'critical' to describe the current framework for equalities organising. The current emphasis on 'local organising' threatens to radically undermine exploration of the experience of specific communities. Just as equalities legislation provides the leverage to enforce institutional changes across the board, particularly in healthcare, the voluntary sector, with its contacts, advocacy relationships and trust of communities, is taking a forceful economic hit. The same could be said for 'equalities work in progress' in public health, under the current health reforms.

And I use the word 'critical' to describe the dynamic in many of us who may feel and may indeed be utterly stable, yet are fundamentally supported by one critical factor, be it a partner, a home, work, or good health. This 'something' has taken up a position of such power in countering the pernicious impact of heterosexism that we do not recognise its importance. Moreover, we and others may be shocked at the devastation that can occur when it is removed, an issue that was alluded to in a study by Fenge and Hicks in a previous issue of this journal (Fenge and Hicks, 2011). Their research is critical for a number of reasons. Primarily, it demonstrates very clearly the enormous amount of change necessary for LGBT people to feel trust when interacting with services for older people. This 'fear/trust' paradigm is acute, and is constructed from a myriad of life experiences. The work necessary for providers of services to be able to convey a deep level of understanding, and to rebuild any kind of trusting relationship, is extensive. Given the low levels of empathy for the LGBT experience, it takes a rare professional to determine to do this, and to have the resilience and

sustainability to create such change across an organisation.

Yet creating an environment where both patient and clinician are comfortable, and equipped to have a rounded and healthy interaction, is probably a lot further off than older LGBT people themselves reaching a point of uncompromising comfort with whom they are. I was taken aback recently (and doing this work means that happens extremely rarely these days), when I happened upon a website giving guidance for health-care professionals working with 'gay and bisexual people'. The website referred to a 'list of things to talk about'. I reacted positively, naively expecting to see questions like 'Do you live with anybody?', 'Do you have children?' and 'Do you have a partner?' Basically, I was looking for ordinary everyday approaches to enable a patient to describe their life situation, questions including clues that the clinician has an open mind about what might follow. However, the list started with HIV, ended with domestic violence, and in between covered alcohol misuse, drug abuse, erectile dysfunction, smoking and depression. It is simply unimaginable that such a list of conversation points would be provided as guidance for GPs to raise with the average patient.

So why has this come about? This kind of guidance is the cul-de-sac in which we find ourselves when an issue has been afforded so little public and clinical attention. It is a situation that is exacerbated by research involving self-selecting populations of LGBT people rather than research studies conducted at the point of entry to services, or across completely random samples of LGBT and non-LGBT individuals. Even our research is marginalised. First of all, our participation in such work is directly related to factors such as our relationship with identity and 'outness'. Our participation depends upon our interactions with services, which are in turn related to our support and relationship frameworks, and it is a result of relationships with the Internet and information pathways. Factors such as these, no matter how much research is undertaken, and no matter how much people aspire to 'diversity', create a very specific, pathogenic result with a quite specific demographic. Vital as it is, in particular for 'proving need' (the all-essential element in funding),

creating more research, and persuasion, the danger is that the resulting provision, if any, responds solely to a profile of a community that manifests only need.

People who have managed to age knowing and understanding absolutely nothing about LGBT identity, other than that which is frankly silly, flippant or sensational, are introduced, through this research, to a community that is incredibly vulnerable, with a profile that in no way celebrates the robustness of our coping mechanisms and the fortitude of the support relationships that many among the communities have managed to engineer. And indeed we are vulnerable. It is simply a matter of degree and extremes. We are never just the 'ordinary everyday patient' with a heart condition, who also happens to be LGBT.

More importantly, none of the learning that is so fundamental for the development of these projects actually takes place in the service settings themselves. Providers of services remain acutely ignorant until they are presented with a list of all of the negative aspects of an experience, and as a consequence we have the list of 'ten things to discuss'. Hard as it may be, we should advocate for the critical need for creation of research samples at the point of entry to all services. The change dynamic that is needed is double-edged. LGBT communities do need to be inspired by positive and supportive messages, which could include a clear indication that a service is looking into how it responds to LGBT experiences. We need to be more confident, and we need to risk identifying ourselves in order to ensure a more rounded response. Nevertheless, many services are simply not safe. Whether it is the reported case of a lesbian who identifies her sexuality during the admission interview, and is then subject to whispered 'messages of wrath' during the night, or the gay doctor who does not identify his gender or sexual identity to his colleagues in the practice because of his observations of homophobic behaviour among staff, the changes to services that are required are extensive.

And the odd thing is that, despite legal changes, and increasing amounts of research that provide clear evidence of inequality, LGBT equality simply does not attract the heterosexual advocates that other issues do, and the heterosexual advocates that this work needs. The people who are working determinedly for change are almost exclusively LGBT individuals themselves, within services, and this is not always the most

productive dynamic. It seems that although some research may admonish LGBT communities for having fear where there is no immediate need, there is ample evidence that fear of prejudice by association is having an important influence. Many clinicians would not push an issue for fear of being *thought to be* LGBT.

Any practitioner or clinician who is reading this issue, who is in the least bit interested in an equal and diverse world, is invited to consider what could be done today in the environment in which they work. The 'seven degrees of separation' issue means that no one of us is that far from an LGBT relative. Just as we may have our family photograph on the wall where we work, why should we not have that of our niece's civil partnership, which happened to be the big Asian wedding of the year? And just as we have information about 'getting pregnant' that only refers to straight people, directly or by association, why should we not seek to develop this into something that works for parents per se? Creating better service responses for LGBT people requires a new kind of generalist education across the board, rather than in sidelined pockets.

The critical issue, which has been highlighted well in the research by Fenge and Hicks, is invisibility. Our lives continue to be invisibilised to such a degree that when we pop out it is often a shock to us all. This is the dynamic that needs to be reversed. *Coming out* one way or the other, LGBT or not, should be no surprise at all. When this is achieved, we will have moved some way towards creating environments in which experiences are valued, needs are at least explored, services are there for everybody, and differences are appreciated and celebrated.

#### REFERENCE

- Fenge LA and Hicks C (2011) Hidden lives: the importance of recognising the needs and experiences of older lesbians and gay men within healthcare practice. *Diversity in Health and Care* 8(3):147–54.

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Kairos in Soho (KiS) is an LGBT-registered charity and community development organisation. It has recently published the first edition of the *London LGBT Almanac* ([www.kairosinsoho.org.uk/almanac.asp](http://www.kairosinsoho.org.uk/almanac.asp)), which highlights the fragile economy, dynamic organising and diverse communities that participate in LGBT voluntary and community action in London.