Building Health Partnerships

Clinical rationale for sexual orientation monitoring

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A discussion of the evidence on existing health inequalities among lesbian, gay and bisexual communities and attitudes towards patient sexual orientation monitoring in a general practice setting among staff at South Manchester Clinical Commissioning Group.

The Lesbian & Gay Foundation
Ending Homophobia, Empowering People
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SOCIAL ENTERPRISE UK

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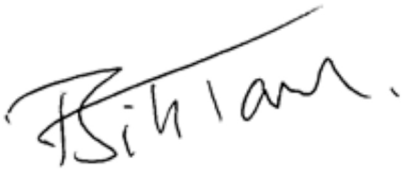
Foreword by South Manchester CCG Chair Dr Bill Tamkin

The advent of clinical commissioning groups has brought a new perspective to health care. Today, those who are responsible for how NHS resources are utilised, are clinicians seeing patients on a regular basis. South Manchester CCG has the responsibility of tailoring health care to more than 160,000 people. Dr Rogers' paper indicates that as a minimum 2,500 of these people and possibly nearer 8,000 will be from the lesbian, gay and bisexual (LGB) community. Apart from the obvious epidemiological significance, this paper clearly demonstrates the need for South Manchester CCG to reflect on its understanding of the needs of this community, both at a personal and organisational level. It challenges how we both commission health care and provide health care in south Manchester. It shows that simple things, from changing the language we use to the use of posters in the waiting room, can make seeking health care so much easier for the LGB community.

For clinical commissioners, this paper highlights the need for CCG's to develop real partnerships with the Voluntary Sector and has important lessons for us in tackling health inequalities in our community for the future. I am pleased that South Manchester CCG is at the forefront of tackling these inequalities for the LGB community.



Dr Bill Tamkin,
Chair of South Manchester Clinical Commissioning Group

Recommendations on a Page

- Have an awareness of health inequalities affecting LGB patients including smoking, alcohol use, drug use, mental health conditions, sexual health and social isolation in older adults.
- Clinicians to be aware of GMC guidance and promote equality and diversity in the workplace.
- Consider the role of equality and diversity lead in South Manchester CCG and attempt to gain national opinion of SOM in healthcare settings through liaison with professional and regulatory groups.
- Clinicians to have an awareness of the law surrounding SOM especially the Equality Act 2010 and the equality duty applicable to public sector organizations.
- To begin monitoring of sexual orientation of staff and patients in order to comply with the Equality Act 2010.
- To encourage practice participation in "Pride in Practice" to increase confidence and skills allowing effective communication with LGB patients surrounding sex and sexual orientation.
- To begin addressing patients in a "gender neutral" manner along with training in effective ways to discuss sexual orientation with patients.
- Respond positively to a patient's disclosure of their sexual orientation; challenge any inappropriate homophobic opinions of staff and patients.
- Display LGB inclusivity posters in waiting and consultation rooms in order to demonstrate a welcoming disclosure environment for LGB patients.
- For practices to have access to up to date information of available services for LGB patients
- To consult patient participation groups on implementation of SOM.
- The majority of clinicians would want sexual orientation to be monitored at new registration. However, they would want a standardised form, strict guidance on why the information is being collected, how it will be used and how patients' privacy will be protected.

Introduction

The World Health Organisation (WHO) defines health inequality as "differences in health status or in the distribution of health determinants between different population groups producing avoidable and unfair distributions resulting in health inequalities leading to inequity in health." [1]

The general health of British population has steadily improved over the last hundred years and life expectancy is at its highest on record.[2] The effects of socioeconomic variations on the health of our nation are well known and monitoring demographic data has enabled practitioners to improve service delivery to affected groups. Monitoring of ethnicity in one Primary Care Trust (PCT) identified that African-Caribbean and South Asian men were 40-70% more likely to suffer a stroke than the general population. Targeted service delivery in the healthcare system could reduce this inequality.[3]

Estimates of people identifying themselves as lesbian, gay or bisexual (LGB) can vary greatly. The Office of National Statistics (ONS) estimates that 1.5% of the UK population identify themselves as LGB.[4] However, a more accurate estimate is thought to be in the region of 5-7%,[5] with precise estimates difficult to quantify due to changing social trends and sexual identification.

Health inequalities are thought to exist for LGB patients and there is gathering evidence to support this hypothesis. Formal collection of sexual orientation data in healthcare settings would allow epidemiological analysis to investigate health inequalities and allow targeted campaigns to improve outcomes and the patient's experience of healthcare.

The introduction of The Equality Act 2010 brought a simplification of the law concerning equality introducing nine protected characteristics, including sexual orientation. This makes it unlawful to directly or indirectly discriminate against a person because of their sexual orientation, including within the public sector.

This paper was commissioned by SMCCG in partnership with The Lesbian & Gay Foundation (The LGF) and is part of Building Health Partnerships (BHP) which is a national programme funded by NHS England and delivered by a partnership of NAVCA (National Association for Voluntary and Community Action), Social Enterprise UK and IVAR (the Institute for Voluntary Action Research). It aims to examine the available evidence for health inequalities in the LGB population, to identify the current views of clinicians towards sexual orientation monitoring in general practice and make a clinical rationale for sexual orientation monitoring that is appropriate and acceptable to clinicians within SMCCG.

1 World Health Organisation: Health Impact Assessment: Glossary of terms used, WHO 2013, N.p., Web. 10.10.2013
2 Hicks, J. and Allen, G., A Century of Change: Trends in UK Statistics Since 1900. House of Commons Library: Social and General Statistics Section. London, 1999.
3 Hunt, R. and Cowan, K. Monitoring Sexual Orientation in the Health Sector. Department of Health and Stonewall. London. 2009
4 Office of National Statistics, Integrated Household Survey April 2011 to March 2012: Statistical Bulletin. London 2012
5 Department of Trade and Industry., Final Regulatory Impact Assessment: Civil Partnership Act 2004, UK Government, London. 2004

Current Evidence of Health Inequalities in the LGB Population

Data supporting health inequalities in the LGB population has been gathered through academic research and LGB organisations. The mainstay of evidence surrounds lifestyle choices including smoking, illicit drug and alcohol misuse, and mental and sexual health. However, there is limited evidence in other areas including cancer epidemiology, cardiovascular and respiratory disease and other conditions that are associated with the above-mentioned negative lifestyle choices. Here we examine the current evidence for health inequalities in the LGB population.

Smoking

The negative health effects of smoking have been extensively studied in the general population and increasingly publicised in recent years. The Government's "Smoke Free England" campaign,[6] along with legislative changes introduced by the Health Act 2006, restricted indoor smoking within public places and increased the minimum smoking age from 16 to 18. This legislation is thought to have decreased the number of admissions to hospital for heart attacks by 2.4% and decreased the overall amount that people smoke.[7] However, in 2012, the Office of National Statistics estimated that 20.9% of the UK population are still current smokers and 32.5% are ex-smokers.[8]

There are several surveys suggesting that smoking prevalence is greater in the LGB community, the majority being carried out by Stonewall[9 10] and The Gay Men's Sex Survey.[11] A summary of these surveys can be seen in table 1. A number of reasons for this increased incidence have been postulated including higher rates of mood and anxiety disorders, so-called minority stress resulting from social stigma, internalised negative stereotypes and external discrimination.[12]

Table 1. Summary of evidence for smoking incidence in the UK

	Gender	Year	Number of Participants	Percentage Smokers (%)
Background Incidence (Office of National Statistics)[8]	Mixed	2012	12620	20.9
Stonewall[10]	Male	2011	6861	25
Stonewall[9]	Female	2008	6000	66
The GMSS[11]	Male	2005	16426	30.9

A study of 1,633 LGB people in Colorado USA published in 2012 suggested that smoking cessation advice in clinical settings is unfavoured in preference of non-clinical access to evidence-based treatments.[13] Other studies including "The Last Drag", a six week LGB targeted smoking cessation scheme in San Francisco reported smoke free success rates of 60% by the end of the course and 36% sustaining this up to 6 months later.12 Similar success rates have been reported in the UK with LGB targeted cessation advice, providing an open environment allowing LGB people to discuss their triggers and social weaknesses in a "safe" way. This London based pilot study had 76% of participants smoke free at 7 weeks compared to the UK National average of 53%.[14]

6 HM Government., Smoke Free England Campaign: Everything You Need to Prepare For the New Smoke Free law On 1 July 2007. Department of Health, London. 2006.
7 Bauld, L., The Impact of Smoke Free Legislation in England. Department of Health, University of Bath, 2011.
8 Office of National Statistics. Opinions and lifestyle Survey, Smoking Habits Amongst Adults., London 2012
9 Hunt, R. and Fish, J. Prescription for Change: Lesbian and Women's Health Check 2008., Stonewall. London 2008
10 Guasp, A. Gay and Bisexual Men's Health Survey. Stonewall. London. 2011
11 Hickson, F et al. Consuming Passions: Findings from the United Kingdon Gay Men's Sex Survey 2005. Sigma Research and Terrence Higgins Trust. London. 2007
12 Eliason, M. J. et al, The Last Drag: An Evaluation of an LGBT Specific Smoking Intervention. Journal of Homosexuality. London. 2012
13 Levinson, A., et al. Smoking Cessation Treatment Preferences, intentions and Behaviours Among a Large Sample of Colorado Gay, Lesbian, Bisexual and Transgendered Smokers. Nicotine and Tobacco Research. Oxford Press. 2012
14 Harding, R., et al. Targeting Smoking Cessation to High Prevalence Communities: Outcomes from a Pilot intervention for Gay Men. BMC Public Health. Springer. 2004

Alcohol

Alcohol abuse and poor drinking habits are responsible for high rates of morbidity in the UK general population including liver disease, cardiovascular disease and poor mental health. In 2012, the ONS reported that 8,748 deaths resulted from alcohol abuse with males over 30 being most at risk.[15]

The Department of Health (DoH) estimates that the total cost to society of alcohol related issues was £21 Billion in 2012; with projected cost to the NHS management of liver disease alone to be £1 Billion per year by 2015.[16]

The DoH defines "binge drinking" as consuming more than 3 to 4 units of alcohol per day for males and 2 to 3 units for females.[15] In 2013, the ONS estimated that in the general population 23% of males and 18% of females consumed in excess of these guidelines on a weekly basis.[15]

Alcohol use in the LGB community has been quantified by several small studies including The LGF in partnership with the University of Central Lancashire[17] and Stonewall.[9 10] These are summarised in table 2.

Table 2. Summary of evidence for binge drinking in the LGB population

	Gender	Year	Number of Participants	Percentage Binge Drinkers (%)
Background Incidence (ONS)[15]	Male	2013		23
Background Incidence (ONS)[15]	Female	2013		18
Stonewall: Gay and Bisexual Men's Survey[10]	Male	2008	6861	42
Stonewall: Prescription for Change[9]	Female	2008	6000	25
The LGF: Part of the picture	Male	2011	4206	34
The LGF: Part of the picture	Female	2011	4206	29

This data suggests that rates of alcohol use in the LGB population are almost double that of the general population. It is possible that this is associated with higher rates of liver disease and other negative effects of alcohol use. However, due to lack of sexual orientation monitoring in healthcare there is currently no reliable evidence to support this.

The effect of alcohol cessation programmes is difficult to quantify. The DrinkAware Campaign report of 2012 claimed that 181,000 new patients enrolled for access to their support and services. In addition, the average change in alcohol use decreased from 5 to 3.9 units per day following their online intervention; which is still above the recommended intake for both men and women.[18]

In General Practice the avenues for referral to specialist alcohol services remains in the form of Community Alcohol Teams (CAT) and voluntary services such as Alcoholics Anonymous (AA), Addaction, Alcohol Concern and Turning Point. However, there is no formal alcohol counselling support options for LGB people available generally who may have different social cues for drinking including homophobia and biphobia, discrimination and minority stress.

15 Lifestyle Statistics and Health and Social Care Information Centre. Statistics on Alcohol, England 2013. Office of National Statistics. London. 2013
16 HM Government. The Government's Alcohol Strategy. Department of Health. London. 2012
17 Buffin, J. et al. Part of the Picture: Lesbian, Gay and Bisexual People's Alcohol and Drug Use in England 2009-2011. The National LGB Drug and Alcohol Database. Manchester. 2012
18 The DrinkAware Trust. Changing the Culture Around Alcohol: The Social Impact of DrinkAware's 2012 Campaigns. The DrinkAware Trust. London. 2012

Illicit drug use

The effect of illicit drug use on individuals, communities and their long-term effects on health are well documented.[19] The DoH estimates that there were 1,605 illicit drug related deaths in the UK in 2012.[20] The Crime Survey for England and Wales, carried out by the Home Office, collates data from a representative sample of 50,000 national households. It collects data on sexual orientation. In 2011/12 it estimated that in the general population 36.5% of 16-59 year olds had used illicit substances in their lifetime, 8.9% in the last year and 5.2% in the last month.[21]

In 2004, drug use was estimated to cost the Treasury £15.4 billion.[21] Due to a relatively small sample size the Crime Survey does not report annually on any correlation between drug use and sexual orientation. It publishes data every two years, the last being for the period 2009/10. It showed that this cohort is 3 times more likely to take illicit drugs and 5 times more likely to take stimulants. Furthermore LGB respondents were more likely to take illicit drugs regularly (32.8%) compared to heterosexual respondents (10%).[22]

In 2010 the UK Drug Policy Commission (UKPDC), a charity aiming to provide independent analysis of UK drug policy, carried out a review of available literature concerning the rate of drug use in minority groups, including the LGB population. They found that 75% of LGB people had taken drugs in their lifetime and between 30% and 50% had used them in the last year.[23]

The drug type commonly used in the LGB population is changing. Amyl Nitrate (poppers), LSD, Amphetamines (speed) and Cannabis (weed) are becoming less popular and Cocaine (coke), Ecstasy (E), Ketamine (Special K) and GHB (liquid ecstasy) use is increasing.[23]

The LGF and University of Central Lancashire Survey "Part of the picture" carried out between 2009-2011 found that 35% of LGB respondents had taken drugs within the last month and LGB people were 7 times more likely to take drugs in their lifetime compared to the general population.[17] This was echoed by Stonewall's Gay and Bisexual Men's Survey of 2011 with 51% of men taking drugs within the last year compared to 12% of men in the general population.[10]

The Terence Higgins Trust released a drugs awareness campaign in 2007 called "Drugfucked",24an interactive website designed to give information regarding currently used drugs in order to prepare the LGB community on their effects. They also offer the chance to ask questions to a drugs advisor through their online service and answers will be displayed online within a week. This provides the opportunity for interested LGB people to gain advice if needed. However, with current rates of illicit drug use high in this population, a more proactive approach by healthcare and voluntary organisations may be needed in order to provide more effective change and awareness. Sexual orientation monitoring by public and voluntary sectors would allow organisations to see who is accessing their services and target these populations as necessary.

Mental Health

Mental health conditions will affect 25% of the total UK population in the next year and approximately 400 per 100,000 will self-harm. These rates are the highest in Europe.[25]

In 2008 a systematic review published in BMC Public Health included data from 214,344 heterosexual individuals and 11,971 people who identified as LGB. The study compared the rates of depression and suicide in both groups and found that depression was 1.5 times more likely in the LGB population and self harm twice as likely as the heterosexual population.[26]

In 2011, the British Journal of Psychiatry published a paper setting out rates of mental illness in the UK population using the Adult Psychiatric Morbidity Survey. This survey of 7,403 households found doubled

19 The British Medical Association. Drugs of Dependence: The Role of Medical Professionals. Chapter 3: The Burden of Illicit Drug Use. BMA Board of Science Department. London. 2013
20 Office For National Statistics. Deaths Related to Drug Poisoning in England and Wales, 2012. UK National Statistics. 2013
21 Office for National Statistics. Drug Misuse Declared: Findings from the 2011/12 Crime Survey for England and Wales. 2nd Ed. London. 2012
22 Hoare, J. and Moon, D. Drug Misuse Declared: Findings from the 2009/10 British Crime Survey: England and Wales. Home Office Statistical Bulletin. London. 2010
23 Beddoes, D. et al. The Impact of Drugs on Different Minority Groups: A Review of the UK Literature. Part 2: Lesbian, Gay, Bisexual and Transgender (LGBT) Groups. The UK Drug Policy Commission. The Office for Public Management. London. 2010
24 The Terrence Higgins Trust Website."Drugfucked". http://www.drugfucked.tht.org.uk Last Accessed 29.10.2013
25 Halliwell, E. et al. The Fundamental Facts: The Latest Facts and Figures on Mental Health. The Mental Health Foundation. London. 2007
26 King, M. et al. A Systematic Review of Mental Disorder, Suicide and Deliberate Self Harm in Lesbian, Gay, and Bisexual People. BMC Psychiatry. 2008

rates of mental health disorders including depression, General Anxiety Disorder, psychosis, lifetime suicide and self harm attempts in people identifying as non-heterosexual.[27] Furthermore, the prevalence of these conditions was reflected in the use of GP consultations with non-heterosexual patients consulting on average 1.5 times more than heterosexuals.[27]

Sexual orientation monitoring in general practice and the mental health sector would gather evidence on whether the LGB population are accessing these services, whether targeted intervention would be beneficial in these groups and allow a comparison of outcomes between differing groups.

Cancer and Screening

The National Cancer Intelligence Network (NCIN) does not monitor sexual orientation of patients and we are therefore unable to draw firm conclusion in the UK.[28]

However, in the USA, 122,345 people completed the State of California Health Interview Survey in 2011 and the data used to investigate cancer diagnosis rates with respect to sexual orientation.[29] Gay men were twice as likely to be diagnosed with cancer in their lifetime and also received this diagnosis on average 10 years earlier than their heterosexual counterparts.[29] This increased rate in men was thought to be due to the incidence of HIV related anal cell carcinoma in San Francisco. The rate of cervical and uterine carcinoma amongst lesbians was also double that of heterosexual women.[29]

Anal cell carcinoma is a rare cancer with an incidence of 2 per 100,000 general population. This incidence is known to be increased in HIV negative men who have sex with men (MSM) to 40 per 100,000 population, increasing to 80 per 100,000 in HIV positive MSM population.[30] Due to this, the UK National Screening Committee (UKNSC) performed an external review to explore whether a national screening programme should be considered. The review concluded that more research was needed to ensure the benefit of a screening program was clear.[31] Sexual orientation monitoring in healthcare settings would possibly shed light on scenarios like this and highlight new health inequalities that require action.

Lesbian women are more likely to delay pregnancy (or never have a pregnancy), less likely to breast feed and less likely to attend for breast and cervical screening. They are also more likely to be obese, drink alcohol and smoke.[9] These risk factors are thought to place lesbian women at higher risk of breast and gynaecological cancers.[32] Historically, lesbian women were thought to be very low risk for cervical cancer leading to some clinicians incorrectly not recommending cervical screening for lesbians.[33] However, there is now an established link between the Human Papilloma Virus (HPV) and the development of cervical cancer, originally thought to be transmitted through heterosexual contact alone. A study published in the British Journal of General Practice in 2000 investigated the link between sexual orientation and smear results. HPV was found in both lesbians who have only ever had sex with women and lesbians previously having had sex with men. Thus suggesting that transmission of HPV occurs during both heterosexual and exclusively lesbian sexual activity.[34]

Sexual Health

The Health Protection Agency (HPA) collates annual data of all newly diagnosed Sexually Transmitted Infections (STIs) in the UK. The rate of new diagnoses in the general population rose by 5% in 2012 with 448,442 new infections. The rate of Chlamydia infection fell by 2% with 186,196 new diagnoses.[35] Sexual orientation is recorded during the Genitourinary Medicine (GUM) consultation allowing data to be processed by the HPA.

27 Chakraborty, A. et al. Mental Health of the Non-Heterosexual Population of England. British Journal of Psychiatry. 2011
28 National Cancer Intelligence Network Website. http://www.ncin.org.uk Part of Public Health England. Last Accessed 29.10.2013
29 Boehmer, U. et al. Cancer Survivorship and Sexual Orientation. Cancer. 2011
30 Fish, J. NHS Briefing 6: Gay Men's Health. Briefings for Health and Social Care Staff. The Department of Health.2007
31 Hocking, A. et al. Screening for Anal Cancer: External Review Against Programme Appraisal Criteria for the UK National Screening Committee. UK National Screening Committee. 2012
32 Cochran, S. et al. Cancer-Related Risk Indicators and Preventive Screening Behaviours Among Lesbian and Bisexual Women. American Journal of Public Health. 2001
33 Light, B. et al. Lesbian, Gay & Bisexual Women in the North West: a multi-method study of cervical screening attitudes, experiences and uptake. University of Salford and The Lesbian & Gay Foundation, 2011.
34 Bailey, J.V. et al. Lesbians and Cervical Screening. British Journal of General Practice. Oxford Press. 2000
35 Health Protection Report. Sexually Transmitted Infections and Chlamydia Screening in England, 2012. Public Health England. 2013

Gay men are thought to be at higher risk of STI's including, Chlamydia, Gonorrhoea, Syphilis, Hepatitis and Herpes with rates steadily climbing over the last 10 years.[36]

In 2012, MSM contributed to a large proportion of new infections, especially Syphilis (91%), Gonorrhoea (58%), genital warts (55%) and genital Herpes (38%).35 This data is summarised in Table 3.

Table 3. Rates of new STD diagnoses in 2012

Disease	Number of New Diagnoses Overall	Number of New Cases in MSM (Percentage of Total)
Syphilis	2978	2713 (91%)
Gonorrhoea	25,525	18,537 (58%)
Chlamydia	206,912	51,454 (25%)
Genital Herpes	32,021	12,259 (38%)
Genital Warts	73,893	40,392 (55%)

Lesbians have previously been thought not to be at risk of STIs. Medically, this is not the case. Even in lesbians who have only ever had sex with women Trichomonas vaginalis, genital herpes and genital warts have been diagnosed.[36]

HPA guidance is to offer HIV testing to all patients where HIV incidence is greater than 1 in 1000 population. Currently, Manchester has an incidence of 5 per 1000 and 32 per 1,000 in its MSM population. This is the highest in the country outside of London with 154 new diagnoses of HIV per year.[37]

The promotion of sexual health in the LGB population has come a long way in the last 10 years. Safe sex awareness campaigns are now commonplace in gay venues and saunas, with outreach sexual health clinics provided in LGB popular areas. This use of targeted campaigns would not have been possible without epidemiological evidence from the HPA demonstrating increased incidence of STI's in the LGB population.

Social Care Needs

We live in an ageing population with life expectancy steadily increasing. Studies have shown that older LGB people are twice as likely to be single, two and a half times more likely to live alone and four and a half times as likely to have no children to call on for help when needed.[38] Added to poor mobility and management of chronic medical conditions, this is likely to become a growing problem in the future that needs catering for.[39] There are emerging voluntary group projects that aim to address this problem.

AgeUK has set up an "Opening Doors" Project in London. It hosts regular activities allowing socialisation of the older age group and provides telephone advice and befriending services specific for older LGB Patients.[40] AgeUK have also produced guidance on how to deal with later life issues for LGB people including rights to benefits, tax, wills and tenancy rights.[41]

An awareness of sexual orientation in the older age group, along with the development of specific services to cater for this group will help reduce this burden. Building relationships between the voluntary and public sectors is becoming increasingly important and robust links with older LGB patients through residential homes, social services and specialist care groups will enable this unique group to be catered for.

36 Fish, J. NHS Briefing 10: Sexual Health: Briefings for Health and Social Care Staff. The Department of Health. 2007
37 Health Protection Agency. Evidence and Resources to Commission Expanded HIV Testing in Priority Medical Services in High Prevalence Areas. The Health Protection Agency. 2012
38 Age Concern. Issues Facing Older Lesbians, Gay Men and Bisexuals. Age Concern, The National Council on Ageing. London. 2002
39 Fish, J. NHS Briefing 4: Older Adults: Briefings for Health and Social Care Staff. The Department of Health. 2007
40 Age UK. Opening Doors. Website: http://www.openingdoorslondon.org.uk Last Accessed. 29.10.2013
41 AgeUK Publication. Lesbian, Gay, Bisexual or Transgender: Planning for Later Life: Money Matters. AgeUK. London. 2013

Professional and Regulatory Body Guidance

General practice is regulated by professional and regulatory bodies that produce guidance on best practice when interacting with colleagues and patients. However, there is no real guidance from either the GMC or RCGP specifically regarding the monitoring of sexual orientation in the community.

The General Medical Council (GMC), in conjunction with Stonewall, has produced a leaflet for LGB patients discussing the level of treatment they should expect from their Doctor.[42] In their advice to doctors they state:

"You must not unfairly discriminate against [patients] by allowing your personal views... about sexual orientation... to affect adversely your professional relationship with them or the treatment you provide or arrange."

"You must not express to your patients your personal beliefs, including political, religious or moral beliefs, in ways that exploit their vulnerability or that are likely to cause them distress."

The guidance provided in "Good Medical Practice" from the GMC comments on treatment of patients irrespective of their sexual orientation; in Domain 3 of the guidance:[43]

"Section 48: "You must treat patients fairly and with respect whatever their life choices and beliefs."

"Section 59: "You must not unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange...

The Royal College of General Practice (RCGP) does not have specific guidance around sexual orientation monitoring but does include guidance in its curriculum coverage for trainees under section 3.4: Promoting Equality and Valuing Diversity[44] which suggests General Practitioners:

"act in ways that recognise that people are different and do not discriminate against people because of those differences" and "act in ways compliant with employer law, disability discrimination legislation and best practice in recruitment [and] encourage others to do so.[44]

The Law and Sexual Orientation

Homosexuality, as a criminal offence, was introduced in the Criminal Law Amendment Act 1885, otherwise known as "the blackmailers charter". It introduced the ill-defined term "gross indecency", used in the court to bring charges for "buggery" or sexual acts between two males that could not be proven.[45]

It wasn't until 83 years later when the Sexual Offences Act 1967 was passed, that sexual acts between 2 men were partially decriminalised provided both males consented and had reached the age of 21.[46] The age of consent reduced to its current age of 16 in the year 2000.

In 2003 the Employment Equality Regulations came into force that protected LGB people from discrimination in the workplace based on their sexual orientation. A year later the Civil Partnership Act (2004) allowed relationships of same sex couples to be recognised in law and afforded many of the associated opposite sex marital rights to civil partners. This includes financial, health and social care as well as access and care of children. However, there are subtle differences between civil partnership and marriage. The practical difference relates to pension entitlements of a remaining partner following death (entitlement is usually reduced and provided for a limited period).[47] The Equality Act (2007) made it illegal for the public sector to discriminate on the basis of sexual orientation in the provision of goods and services, including the health sector.

The government passed the Equality Act in 2010 making it unlawful for public services, including the NHS to discriminate against protected characteristics.[48] Until 2010, law surrounding equality and diversity was

42 The General Medical Council and Stonewall. Protecting Patients: Your rights as Lesbian, Gay and Bisexual People. The General Medical Council. Manchester. 2007

43 The General Medical Council Website. Domain3: Communication Partnership and Teamwork. The General Medical Council Website, accessed 31.10.2013: www.gmc-uk.org/guidance/good_medical_practice/communication_partnership_teamwork.asp.
† This includes your views about a patient's or colleague's lifestyle, culture or their social or economic status, as well as the characteristics protected by legislation: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy or maternity, religion or belief, sex and sexual orientation."

44 RCGP Curriculum Statement 3.4: Promoting Equality and Valuing Diversity. Royal College of General Practitioners. London. 2007

45 David, H. On Queer Street: A social history of British Homosexuality 1895 - 1995. Harper Collins. London. 1997

46 HM Government. The Sexual Offences Act 1967. UK Parliament. 1967

47 Fairbairn, C. Same-Sex Marriages and Civil Partnerships. House of Commons Library. HM Government. London. 2012.

48 HM Government. The Equality Act 2010. London. 2010

complex with over 116 different legislations. The Equality Act 2010 consolidated the legislation for all these protected characteristics into one Act. These can be seen in Table 4.

The Equality Act also establishes the public sector Equality Duty which requires that public bodies should publish the data they have available on the protected characteristics of their workforce and their performance as service providers. There is no requirement to routinely collect this information but the act states that public bodies should be prepared to provide this data if requested.[49]

Table 4. Protected characteristics listed in The Equality Act 2010

Protected Characteristics listed in the Equality Act (2010)	
Age	Gender
Gender Reassignment	Disability
Race	Religion or belief
Sexual Orientation	Marriage and Civil Partnership
Sex	Pregnancy and Maternity

Barriers to Discussing Sexual Orientation in the Consultation

Research has shown that for a variety of reasons clinicians feel uncomfortable discussing issues surrounding sexual orientation with patients. Research also shows that patients want to talk about sexual orientation and prefer to talk to their GP above anyone else. However, patients also want their GP to initiate these conversations.[50]

This can lead to a consultation stalemate and patients may not receive appropriate advice specific for their needs. Here we identify common issues that present as barriers to clinicians discussing sexual health an orientation with patients.

In 2011, a literature review carried out at University College of Cork investigated reasons why clinicians felt uncomfortable talking about issues of sex and sexual orientation.[51] It collated evidence from 12 publications featuring discussions with General Practitioners and Practice Nurses.

Embarrassment was cited as a major factor and this seemed to arise from mismatches in doctor-patient demographics such as age and sexual orientation.[52]

Some clinicians reported lack of confidence and knowledge when dealing with issues of sexual health for LGB patients. At one end of the spectrum clinicians felt that sexual health did not form part of the remit for discussion in General Practice and that sexual health was a "specialty" in its own right. This belief was opposite however to Practice Nurses who felt that sexual health encompassed forming trust with patients and was therefore a valid part caring for LGB patients holistically.[51]

Clinicians reported avoiding the issue of sexual orientation for fear of offending patients. They felt that by getting a patients sexual orientation wrong or "catching the patient off-guard" they would be judged as being discriminatory.[51]

Communication with patients is becoming more challenging due to the dynamics of language surrounding sexual practices. Clinicians have encountered problems understanding the emergence of new sexual terminology and have avoided discussing LGB sexual health issues because of this.[51]

General Practice is becoming increasingly busy and workload shows no sign of reducing. Demand is increasing through the Quality Outcomes Framework (QoF), patient numbers, paperwork and referrals. Clinicians felt that by discussing sex and sexual orientation they would be led into a world akin to Pandora's Box resulting in lengthy discussions that they are ill equipped to manage.[51]

49 Creegan, C. and Keating, M. Improving Sexual Orientation Monitoring. Equality and Human Rights Commission. Manchester.
50 Krychmal, M and Kellogg, S. Sexual Health Fundamentals: Talking with patients About Sexuality and Sexual Health. Association of Reproductive Health Professionals. California. 2010
51 Stott, D.B. and Burgoyne, J. The Sexual Health of Lesbian, Gay, and Bisexual Patients in General Practice: a review of the literature on barriers to discussion and medical training programs. The undergraduate Awards. Dublin. 2011
52 Gott, M. et al. "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. Family Practice Vol. 21, No. 5 Oxford University Press. 2004

LGB Patients Experience of Healthcare

Research shows that LGB patients have faced discrimination when accessing healthcare and have actively avoided healthcare for fear of discrimination in clinical settings.[53] The LGF's annual GP patient experience online national survey asks the LGB population for their experiences of care in General Practice.[54] In 2013 there were 141 respondents in Greater Manchester.

29% (37) of respondents had not declared their sexual orientation to their GP and of those that did 5.5% received either a negative response to their disclosure or this was not acknowledged at all.

The Sigma Report is produced by the London School of Public Health and Tropical Medicine. It focuses on the social, behavioural and policy aspects of HIV and sexual health.[55] In its 2005 survey, 50% of respondents had not disclosed their sexuality to their GP and of those that hadn't, 39% had no intention of doing so for fear of the a homophobic response from their GP.[55]

The term "heterosexism" was first used in 1972 by Weinberg and defined as an ideological system that "denies, denigrates and stigmatises" any non-heterosexual "form of behaviour, relationships of community and to describe a belief system that positions "superiority of heterosexuality over homosexuality."[56] This phenomenon is commonplace in General Practice according to the GP patient experience survey carried out by The LGF with 34% of respondents claiming their GP had assumed that they were heterosexual.[54] Comments received from patients can be seen in box 1.

Box 1. Heterosexist comments perceived by patients during consultations

"It's quite simple really; he just assumed I was straight! Maybe I should have worn pink to the consultation... but I didn't see that on the paperwork! They're programmed to see a straight person, that's the problem."

"A receptionist at the GP was very confused when I asked if my partner and I could have our smear tests together. She eventually said "so your male partner wants a smear test?" I couldn't believe she had assumed that rather than that I might be gay. Another time I was questioned a lot about how I could be sure I wasn't pregnant if I don't use contraception."

"I'm in an opposite sex relationship so my GP assumed I was straight, which is pretty standard in the wider world I'm afraid (bi-invisibility)."

This is an important issue as heterosexualist comments could be construed as discriminatory by patients and therefore a contravention of the Equality Act 2010 and leads to a breakdown of rapport and trust between doctor and patient.

The level of homophobia in general practice is difficult to quantify and there are many factors, both clinician and patient dependant, which could account for this. However, 5% of GP patient experience survey respondents claimed to have experienced discrimination, homophobia or unfair treatment from their GP due to their sexual orientation. Comments from the GP experience survey can be found in box 2.[54]

Box 2. Discriminatory comments received by patients at their GP practices

"When I first went to register at the surgery, they told me they were full. My partner was already a patient there. When I pointed this out - we lived at the same address - they said this wasn't relevant. I knew that if we were a heterosexual couple living at the same address they would have allowed me to register. I contacted my MP [name] about this discrimination. He brought it up with them, and the Practice Manager then allowed me to register."

"When I had a urine problem I was told to go for STD test first because I was gay."

20% of LGB respondents felt their GP does not currently meet their needs as an LGB patient and 52% thought their GP could improve services offered for LGB patients.[54]

Therefore it would appear that there are relatively simple solutions that would improve patient rapport and care during these consultations.

53 Guasp, A. Lesbian, Gay and Bisexual People in Later Life. Stonewall Publication. London. 2011
54 Baldwin, D. Taking Pride in Practice: Lesbian, Gay and Bisexual Patient Experiences of their GP. The Lesbian and Gay Foundation. Manchester. 2012
55 Dodds, C. et al. It Makes Be Sick: Heterosexism, Homophobia and the Health of Gay Men and Bisexual Men. Sigma Research. London. 2005
56 Smith, I., et al. Homophobia to heterosexism: constructs in need of re-visitation. Gay and Lesbian Issues and Psychology Review. Australian Psychological Society. 2012

Current Opinion of South Manchester CCG Regarding Sexual Orientation Monitoring in General Practice

We invited staff from South Manchester CCG to give us their views regarding sexual orientation monitoring of patients. In order to gain an insight into the current opinion regarding sexual orientation monitoring in general practice we invited primary care physicians, nurses, practice managers and reception staff to complete an online questionnaire. The survey can be viewed in Appendix a. Those replying to the questionnaire were given the opportunity to discuss these issues in more detail through informal semi-structured face-to-face interviews. The results of this process are discussed here.

There were a total of 80 respondents to the survey from varying job roles within the CCG. These included practice managers (14), general practitioners (26), Nurses (11), GP trainees (4) and Reception staff (26). Of these 27 were from a practice that had achieved a "Pride in Practice" award, 24 had not received an award and 25 did not know. 10 of the respondents were from practices that already monitor sexual orientation of patients, 29 were thinking about it, 14 were not thinking about it and 24 did not know.

We asked whether sexual orientation was relevant to work carried out by the respondent. Data was gathered using a 5-point scale with 1 being not relevant at all and 5 being extremely relevant. These responses can be seen in table 5.

Table 5. Relevance of sexual orientation to work carried out by clinicians in SMCCG

Relevance	1 Not Relevant at all	2	3	4	5 Extremely Relevant
Number of Respondents	26	11	24	11	6

Breaking this down into role within the CCG we can see that relevance appears highest to GP trainees (4.0), Nurses (3.0) and GP's (3.0) and lowest to Practice Managers (2.4) and Reception Staff (2.0). This can be seen in table 6 below.

Table 6. Average relevance of sexual orientation by role

Role	Practice managers	General Practitioners	Nurses	GP Trainees	Reception Staff
Average Relevance	2.4	3.0	3.0	4.0	2.0

We asked whether there was ever a time that knowing a patient's sexual orientation had been relevant to their contact with them. 33 (41%) replied yes and 47 (59%) replied no. This can be broken down into role with highest relevance in General Practitioners (81%) and lowest in Practice Managers (7%). This can be seen in table 7.

Table 7. Has sexual orientation ever been relevant to your contact with a patient?

Role	Practice managers	General Practitioners	Nurses	GP Trainees	Reception Staff
Yes	7%	81%	66%	75%	11%
No	93%	19%	33%	25%	89%

We asked those responding "yes" what scenarios it was relevant in. These scenarios, along with the frequency of their reporting across the CCG can be seen in table 8.

Table 8. Scenarios where sexual orientation of patients was relevant to the consultation

Scenario	Percentage of Total Cases Mentioned
Sexual Health	48
Fertility and Contraception	17
Gynaecology	14
Mental Health	10
Relationships	7
Gender	3

We asked how comfortable staff was when discussing sexual orientation with patients. Again using a scale of 1 to 5 where 1 was not comfortable at all and 5 extremely comfortable. These results can be seen in table 9 and a breakdown by role in table 10.

Table 9. How comfortable are you discussing sexual orientation with patients?

Comfort Scale	1 Not confortable at all	2	3	4	5 Extremely Relevant
Number of Respondents	18	9	17	18	17

Table 10. Role specific comfort score

Role	Practice managers	General Practitioners	Nurses	GP Trainees	Reception Staff
Average Comfort Scale	2.9	3.6	4.2	3.5	2.9

We asked participants what would make them feel more comfortable discussing issues of sexual orientation with patients and responses are summarised below.

Finally we asked if practices would benefit from training in sexual orientation monitoring of patients. 61% thought that this would be a good idea and 39% thought this was not needed.

Face to Face interviews

Using semi-structured interviews we asked members of South Manchester CCG what their experience of sexual orientation monitoring was, how monitoring would affect patient and clinicians and how they can envisage the data being used. Some common themes occurred, which can be seen below.

Improving Communication and Understanding of Patients

"Having prior knowledge of a patients sexual orientation before a consultation is handy. I had a transgender patient the other day and I wouldn't have otherwise known beforehand. I was able to ensure the correct screening was necessary that otherwise may have been missed."
Practice Nurse

"I use neutral terms like partner and enquire who is at home with them, rather than assuming sexuality. We also use posters regarding smear tests and sexuality along with LGF posters, hopefully giving the message that "we don't care" about sexuality in the nicest sense."
GP

"The more information you have the more likely you are to cater for a patients needs."
GP

"Asking about sexual orientation is similar to asking diabetics about erectile dysfunction. I can almost see the a relief for patients that someone has asked them about a problem they did not want to bring up and they say "Thank God, someone has asked me."
Practice Nurse

"We need more research to see whether monitoring improves things or whether there are there other methods such as having posters on display. More people tell me their sexuality now having seen a poster and it's their choice to do that."
GP

"People may not answer this question because of the stigma surrounding sexuality. They might not be open about their sexuality or have ever discussed it with anybody. They may think its none of my business and may affect their working life."
Practice Nurse

Promotion of Awareness of issues affecting LGB Patients

"I feel like we don't do enough checking out [of sexual orientation] sometimes, and perhaps people are a little reluctant to say. Maybe normalising this through monitoring will help this."
GP

"As a health professional I would be anxious to know what we would be collecting the data for so that patients can be protected as well. I don't want to betray the trust of patients inadvertently."
Practice Nurse

"It wouldn't be relevant to every consultation. I can see that it is an absolute minefield really as some people would resent being asked and some would welcome it as it would give them the opportunity to talk about something that they haven't previously been able to talk about that is relevant to their health."
GP

"The thing is, I know that the LGF exists but I haven't got a number or a leaflet in front of me to give the patient and I need to know, before I ask the question of sexuality to a patient that I have the knowledge, skills and resources to deal with this if I needed it."
Practice Nurse

Epidemiological Benefits

"I hadn't thought about the wider epidemiological aspect of how useful the data may be but I suppose it would be useful."
GP

"Occasionally [sexual orientation] is handy to know. Such as, [discussing] Hepatitis B vaccinations and risky sexual habits. Then you obviously want to equip patients and make sure that they are covered and are safe. Monitoring would allow this population to be targeted."
Practice Nurse

Issues relating to how best to implement Sexual Orientation Monitoring

"We have got so much loss of continuity of care then the chances are that patients are going to meet a new doctor every time that they go and should it therefore be helpful for [sexual orientation] to be recorded in the notes?"
GP

"Asking sexual orientation at registration would be a good way of collecting the information as patients are beginning a new relationship with their new doctor. Obviously, this could not be a mandatory thing and would have to be optional."
GP

"For those people who don't feel comfortable asking and discussing sexuality with patients face to face maybe a registration form would be a good way to collect this information."
GP

"People have got the right to privacy and if they don't want to [disclose their sexuality] then that is their choice and we shouldn't put people under pressure to disclose something that they might not want to disclose."
GP

"Some people would not like to be asked because they would want to know what you are going to do with that information and they will worry about confidentiality. Although they may trust their doctor with information, they may not want their employer to know. Nice enough as it would be for people to be open, in the real world people aren't and are really reluctant to tell their employer and workmates."
GP

"As a general tick the box exercise I can understand people not wanting to answer, without a valid reason why they should answer it. I think it would be a bit easier if we explained why we wanted to know to patients."
Practice Nurse

"[A monitoring form] would have to be phrased in a way that could not be perceived as discriminatory and explain to patients how it would help their provision of healthcare."
GP

These comments give an excellent insight into the varying opinion of SOM in SMCCG. During the interviews it was apparent that the epidemiological aspect of SOM is not at the forefront of clinicians' minds. SOM would promote awareness of LGB issues in the community and prior knowledge of sexual orientation has its advantages for the consultation in some scenarios. Most clinicians are comfortable at discussing sexual orientation but some would prefer monitoring through a formal registration form. However, the common opinion is for SOM as long as it is clear to both patients and practitioners what the data is for and how it will be used whilst respecting patients' privacy.

Summary

There is mounting evidence for health inequalities in the LGB population. This evidence is most robust where sexual orientation is recorded in healthcare settings, such as in GUM clinics. Risky health behaviours such as smoking, alcohol use and illicit drug use are more common in LGB groups. Studies have also shown that this group prefers to receive advice and treatment in non-clinical settings.

The prevalence of mental health disorders in the UK is thought to be the highest in Europe. Rates of anxiety and depression are twice that of the non-LGB population and completed suicide 1.5 times greater.

Evidence also suggests that MSM are at greater risk of some cancers including anal cell carcinoma and Lesbian women from breast and cervical cancer. This is thought to be due to a combination of negative health behaviours such as obesity, smoking and alcohol consumption. Furthermore these groups are less likely to attend for cancer screening for a variety of reasons.

The older generation of LGB people are often overlooked and studies show that social isolation and poor social support is common in this group. An assessment of this issue in Manchester would be beneficial in order to assess the scale of impact of sexual orientation in the advancing age group.

Currently there is no professional or regulatory body guidance on how to instigate sexual orientation monitoring of patients in general practice. The GMC's "good medical practice" document suggests that Doctors do not discriminate against a patient based on their personal beliefs including sexual orientation. The RCGP in their curriculum to GP Trainees act in way that recognise that people are different and not to discriminate because of these differences.

The law regarding sexual orientation has changed. The Equality Act 2010 stipulates 12 protected characteristics including sexual orientation. It is unlawful to discriminate against a patient or colleague based on their sexual orientation. The equality duty 2010 also suggests monitoring sexual orientation of the workforce and be ready to supply such information in order to eliminate inequalities in the workforce.

Barriers to clinicians discussing issues surrounding sex and sexual orientation with patients are include embarrassment, fear of offending patients, lack of training, lack of resources to signpost patients and a perceived idea that issues surrounding SOM will be time consuming. These issues can be addressed if practices participated in training through "Pride in Practice", by having an awareness of services available to LGB patients in Manchester and addressing patients in a gender neutral way.

Studies have shown that the majority of LGB patients are happy with the care that they receive from their General Practitioner. However, between 30% and 50% of LGB patients had not disclosed their sexual orientation to their GP for a variety of reasons including fear of discrimination or receiving a negative response from their Doctor.

SMCCG reception staff felt that patient confidentiality was most important to them and that a private room was necessary to discuss issues of sexual orientation with patients. Practice nurses felt that they needed more training about why they were asking patients their sexual orientation and GP's would prefer sexual orientation monitoring to be mandatory at registration so that the information would be available if needed, rather than having to ask.

SMCCG clinicians are ready to implement sexual orientation of patients. However, clinicians want strict guidance including why the information is being collected, what it will be used for and how privacy of patients will be protected. SMCCG clinicians feel that this should also be clearly explained to patients at time of data collection through a statement on the data collection form. The most appropriate time to collect such data would be during a new registration at practices and the monitoring form should be standardised across the whole CCG, ideally nationally.