Exploring the individual experiences of LGBT+ patients with their General Practitioners: An interview-based study

Abstract

Introduction. LGBT+ individuals may face prejudice in many aspects of life, including primary healthcare. General Practitioners' (GPs) (called Family Practitioners/Doctors in some countries) are usually the first port of call for health-related issues, so their attitudes and behaviours can influence patient outcomes, as well as predict future access to services.

Methods. This study aimed to explore the individual experiences of LGBT+ patients with their GPs. LGBT+ participants were recruited through the (anonymised for review) and social media. Semi-structured interviews were conducted remotely through Microsoft Teams between June and July 2021. The interviews were analysed using thematic analysis.

Results. Six participants included one non-binary person, two lesbians, and three gay men. The participants reported mixed experiences, including recognition and support from GPs, but also judgement, prejudice, and dismissal. Experiences had a great impact on patient disclosure, treatment outcomes, and future service access.

Conclusions. There is a need for the development and implementation of more inclusiveness training for General Practitioners to support them to address the distinct needs of LGBT+ service users.

Policy implications. Culture change should be driven by a top-down policy within health services supporting GPs to better understand non-heteronormative experiences in their clinical practice, an example of which could be systematic (i.e., nation-wide) implementation of sexual rights policies.

Keywords: LGBT+, General Practitioner, Family doctor, Primary health care, Qualitative research

Introduction

Over the past few decades, society as a whole has become more aware and accepting of individuals identifying as LGBT+ (lesbian, gay, bisexual, transgender, and other identities) (Flores, 2019). Originally included under the umbrella term '*LGBT'*, several acronyms have been used over time to refer to this community, which encompasses a diverse range of identities pertaining to sexual orientation, romantic attraction, and gender identity. This article will use the umbrella term *LGBT+* to refer to individuals who are not heterosexual (heterosexual being a person who is romantically and sexually attracted to persons of the opposite sex or gender) or cisgender (cisgender being a person whose gender identity and expression corresponds with their birth sex).

LGBT+ rights and awareness have been improved through legislative changes (e.g., Gender Recognition Act 2004; Marriage [Same Sex Couples] Act 2013; Sexual Offences Act 1967), as well as advocacy efforts and portrayal in the media. As a result, public knowledge and acceptance of LGBT+ individuals have improved (Payne, 2013). Nonetheless, society in general remains widely heteronormative (assuming that heterosexuality - being sexually attracted solely to people of a different sex - is the preferred or normal mode of sexual orientation) and cis normative (assuming that cisgender - gender identity that match the person's sex - is the norm (Logie et al., 2018). This perpetuates a double standard making society prejudiced toward LGBT+ identities and experiences and exposing LGBT+ individuals to the risk of discrimination, which can be blatant, such as bullying and hate crimes, or more subtle and implicit. In the latter case, LGBT+ individuals can face prejudice and stigma in many aspects of life, such as in education (Ng et al., 2017) at work (McFadden & Crowley-Henry, 2018), and on social media (Abreu & Kenny, 2018). One setting where such experiences can also be harmful is healthcare. Research found that healthcare settings may display heteronormative and cisnormative values (Davy & Siriwardena, 2012; Mkhize & Maharaj, 2020), such as by recording only patients' biological sex and not gender identity (Dolan et al., 2020), potentially neglecting transgender identities.

The first healthcare professionals that the general public visit for a range of medical matters are general practitioners (GPs), also known as Family Practitioners/Doctors in some countries. Research suggests that GPs' attitudes and knowledge around LGBT+ individuals and their medical needs are very variable. For instance, LGBT+ patients have reported having to educate GPs on LGBT+ matters, or that GPs are uncomfortable discussing topics such as lesbians' sexual health (Hinchliff et al., 2005; Willis et al., 2020). Such incidents could be due to systematic pitfalls, such as lack of standardised training (Taylor et al., 2018) and/or to GPs' own negative personal opinions toward patients' LGBT identities.

As well as medical consequences, anticipated or actual discrimination by GPs could seriously impact LGBT+ patients' mental health. In general, discrimination has been found to predict increased risk of self-harm and suicide in various minority groups, such as black adults (Brook et al., 2020) and individuals with lower incomes (Rehman et al., 2020), justifying concern for the mental health of LGBT+ patients who experience discrimination by GPs. LGBT+ individuals have been found to have a higher baseline risk of mental health issues than the general population (Russell & Fish, 2016; Yarns et al., 2016), making any discrimination by GPs particularly threatening, as it could potentially discourage access to further health care and support.

While previous research has explored healthcare professionals' approaches to LGBT+ patients, these studies often focus on medical settings other than general practice, such as radiography (Bolderston & Ralph, 2016) and end-of-life care (Makita et al., 2020). Given that GP are the first port of call for health-related consultations, more research is needed in this area. This study aimed to explore LGBT+ individuals' experiences of interacting with GPs, as well as their thoughts of how GPs' attitudes and behaviours to LGBT+ patients can improve.

The research questions were:

1. What are LGBT+ individuals' experiences of interacting with GPs?
2. What are some positive and negative impacts of such interactions?

3. What improvements do participants feel could be made in GPs' interactions with LGBT+ patients?

Methods

Design

This study employed a qualitative methodology to explore LGBT+ participants' experiences of interacting with GPs. It abides by the consolidated criteria for reporting qualitative research (COREQ).[22]

Sample

Participant inclusion criteria:

1. 18+ years old.
2. Identifies as any identity or identities under the LGBT+ umbrella, such as gay, bisexual, transgender, non-binary, or asexual.
3. Has recent (i.e., no more than one year before recruitment) experience of visiting a GP. Ideally, the GP was aware of the participant's LGBT+ identity, in order to gauge GPs' responses to these identities.

Participants were recruited through advertisement by an LGBT+ organisation and via social media between June and July 2021. Recruitment was facilitated by the York LGBT Forum. The York LGBT Forum was chosen due to an established collaboration with the research team. The first author (SW) designed a poster to be advertised by the organisation, and on relevant social media platforms (e.g., LinkedIn) to maximise recruitment. Individuals

interested in participating contacted SW to receive more information about the study and to consent to take part, if interested and eligible. Ethical approval for the study was given by the Research Ethics Committee of (anonymised for review).

Procedure

Due to COVID-19 restrictions, all participants were interviewed remotely through Microsoft Teams, though the option to be interviewed over the phone was also offered. Interviews were audio-recorded using a password-protected phone which did not upload to any file sharing software such as the Cloud. At the start of each video call, the participant was recorded verbally reaffirming their consent to take part in the study. Next, demographic information, including age, gender, and sexuality, was collected from participants.

An interview schedule (Appendix A) was developed to explore participants' experiences with GPs, impacts of these experiences, and participants' ideas for how interactions could improve. The interview schedule was developed through consideration of key issues within LGBT+ healthcare, as informed through literature-based research. This schedule was used flexibly to guide conversation while allowing exploration of new topics emerging during the interviews.

Data Analysis

Interviews were transcribed verbatim by the first author from the audio recordings. Transcripts were analysed using inductive thematic analysis (Braun & Clarke, 2006), to allow for evidence to emerge from the data. The first author (SW) annotated transcripts to identify individual codes, such as 'GP addressed non-binary participant as their correct name' and 'participant was worried their identity would not be taken seriously'. Once all six transcripts were coded, SW created mind maps to identify common themes to which codes could be allocated. Potential themes were then reviewed, and sub-themes were identified through discussion with the second author (CDL). A codebook was then developed (Table 1) by SW, which summarises themes and sub-themes identified through the coding process.

Table 1. *Codebook summarising themes and sub-themes*

Theme	Sub-theme	Definition	Example of quotes
1. Patient experiences		Participant experiences of appointments with general practitioners	
	1a. Positive experiences	Appointments that were positive for participants and features that made them positive	*They just treat you like a human being … it isn't about sexuality or anything like that. It is just 'Yes, you've got a problem, we need to sort it'.*
	1b. Negative experiences	Appointments that were negative for participants and features that made them negative	*He just completely and utterly ignored me (…) I might as well have been talking to a brick wall.*
2. Outcomes of appointments		Impact of appointments pertaining to treatment uptake, physical and mental health, and future service access	
	2a. Impact on treatment outcome	Response to treatment for the medical concern for which the appointment was booked	Receiving helpful treatment following challenges: *(It was) really validating (but) that's kind of just what you should expect from a GP."*
	2b. Impact on mental health	Impact on mental health, emotions, and overall feelings following positive and negative GP appointments	*If that GP had (ignored) me (when their mental health was less stable), I wouldn't have probably gone back to another GP … I would've stayed at home so … it would've been even worse*
	2c. Impact on future service access	How participants responded or feel they would respond to certain interactions with GPs, e.g., to confront negative GP responses, to return to the	Feelings about returning to the GP to discuss gender identity: *I would not expect any good experiences.*

		practice, and what they expect of future appointments	
3. Improvements to GP attitudes and behaviours		Changes discussed by participants which can improve how LGBT+ individuals are attended to in GP appointments	*Training should be done (…) around communication*; *When you are dealing with (…) patients, you probably need to be more tactful*

Results

Six participants were included in this study: three gay men, two lesbians, and one non-binary person. Ages ranged from 21 to 77 (mean age = 36 years, SD = 19.62 years). Five participants were white; one was British African-Caribbean (See *Table 2* for participant characteristics). Each interview lasted between 17 and 33 minutes (mean = 27 minutes).

Three main themes were identified, of which one had two sub-themes, and one had three sub-themes (*see Table 1*). Findings are discussed here.

Table 2. Participants' demographic characteristics

Participant ID	Gender identity and pronouns	Sexuality	Age	Ethnicity
P1	Non-binary, they/them	Attracted to women	37	White British
P2	Cisgender male, he/him	Gay	39	White European
P3	Cisgender female, she/her	Lesbian	21	White British
P4	Cisgender male, he/him	Gay	23	British African-Caribbean
P5	Cisgender female, she/her (considering exploring gender identity)	Lesbian	21	White British
P6	Cisgender male, he/him	Gay	77	White British

Theme 1: Patient experiences

All participants had attended at least one appointment during which the GP had been aware of their LGBT+ identity. Most participants had experienced variation in how GPs responded to their identity. This theme discusses some positive and negative experiences of participants' interactions with GPs.

All participants had some positive interactions with GPs. Following several negative experiences while attempting to discuss exploring their gender identity with GPs, P1 (non-binary, 37 years old) recalled a positive interaction during a telephone appointment with a GP:

> It was the first time the doctor actually phoned up, called me (preferred name), and they used 'they' and 'them' pronouns … they went 'Hi, is (preferred name) there?' and I'm thinking 'Who's this?'; (the GP said) 'The GP' and I went 'Oh…okay!'

P1 continued "I was bouncing off the roof, I got quite excited", showing how validating the acknowledgement of one's LGBT+ identity can be. P1 explains this experience was "the only positive" recent interaction they have had when discussing their gender with a GP, making this experience all the more valuable.

While acknowledgement of LGBT+ identity is valuable to some participants, such as P1, on the other hand, P6, a 77-year-old gay man, stated he sees interactions with GPs as positive when they treat him the same as everyone else. Of the GP practice where he has been registered for 19 years, he said "They just treat you like a human being … it isn't about sexuality or anything like that. It is just 'Yes, you've got a problem, we need to sort it.'" While P6 reports having some negative experiences during the 1970s, he noted that GPs have become more understanding of his sexuality over time, stating that he and his late partner "have had more positive experiences than negative experiences … especially since the mid-'80s."

P4, a 23-year-old gay man, also felt that equal treatment is a key feature of positive interactions with GPs, recalling a recent appointment he arranged due to anxiety, partly related to coming to terms with his sexuality:

> I was telling (the GP) how I think it's also kind of related to my sexuality … I feel like people are judging me … I thought that was triggering my anxiety. (The GP was) very supportive. I never felt, like, berated or … negatively judged.

Participants also faced negative interactions with GPs, including instances where their identities were misunderstood, stereotyped, or ignored. P5, a 21-year-old lesbian, commented on her concerns around the perceived variation in GPs' knowledge of LGBT+ matters: "It really feels like, 'Has this particular GP done a kind of course on how to deal with LGBT people, or not?' … It really feels very individual." Lack of adequate knowledge risks patients encountering negative experiences while accessing GP services. For example, P2, a 39-year-old gay man, explained that he was assumed to have AIDS when he presented to the GP with a virus, despite having regularly tested negative for HIV:

> I was very sick for a while … I had lost a lot of weight, so I was very thin and also pale … (the GP saw) on the clinical history that I was gay, so he thought that I could have HIV, or … no, actually, AIDS … That was very disappointing, to be honest.

P2 also recalled an experience during which a GP appeared to stereotype same-sex intercourse as inherently risky: "She (the GP) said something like 'Well, you shouldn't be checking (for HIV) so often if you were not engaging in these types of risky behaviours.'" As well as stereotyping gay men, this comment could also be interpreted as victim-blaming, a process which blames individuals for their negative experiences, such as contracting HIV. P2 explained he viewed this comment as "prejudicial," as the GP appeared to make this statement based on personal beliefs "instead of using statistics" to appropriately discuss risk of sexually transmitted infections with P2.

Additional negative experiences include GPs being unaware of patients' identities, even if stated in patient notes. P5, a 21-year-old lesbian, stated "I did put down 'lesbian', and since then, even though I've had fair few appointments, they don't look (at her notes). They really don't look." P5 stated this leads to her "coming out during the appointments over and over and over again," which she would "rather not do." P4 reported a similar view:

> I feel like GPs don't really look at your notes … if it was in my notes, about my sexuality, I don't think they would even know … most of the time I go to the GP … I feel like I'm just another patient on the conveyor belt.

Further comments relate to GPs openly ignoring participants' identities. P5 described one interaction during which a GP directly challenged her identity:

> (The GP) was asking me if I was sexually active, and it was the first time I'd said to anyone in the GP service 'Well, yes, but not with a man.' And even though I'd said that she continued questioning me about … if I'd ever actually been with a guy … I was (thinking) 'Okay, you just don't believe me … and also you've kind of completely ignored what I've just said to you (regarding the medical matter of the appointment).'

P1 (37 years old) made a similar comment, recalling that when they initially tried to discuss their gender identity with a GP, "he just completely and utterly ignored me … I might as well have been talking to a brick wall." Additionally, P6 (gay man, 77 years old) recalled negative experiences with one particular GP in the 1970s: "We had a male GP when (partner) and I first got together … he was really very sort of short and very dismissive … of talking about sexual issues."

Overall, participants reported variation in interactions, such as between individual GPs or over time periods. Some positive features of participants' interactions with GPs included acknowledgement of an LGBT+ identity when appropriate, while also treating patients equally

regardless of gender or sexual orientation. Negative experiences involved GPs being unaware or deliberately dismissive of participants' identities, which could exacerbate existing concerns.

Theme 2: Outcomes of GP appointments

This theme outlines how interactions with GPs affected patients in various ways, including in their treatment uptake, mental health, and future service access.

GPs' lack of awareness of LGBT+ issues could negatively impact patients' treatment outcomes. P1 stated that they currently take a contraceptive pill to halt their periods in order to alleviate gender dysphoria, the negative feelings associated with discord between one's physical appearance and gender identity. However, P1 explained that they were introduced to this treatment option by their therapist rather than a GP, stating "it wasn't actually a doctor that mentioned (the pill)" and that they "wouldn't have even thought about" taking the pill if their therapist had not brought it to their attention. This suggests that GPs P1 had visited were unaware of such treatments for gender dysphoria, and that they may not be knowledgeable on other areas of LGBT+ health.

However, not all LGBT+ patients will seek the same treatment, and the reasons for this should be acknowledged. For example, P5 (21 years old) experienced frustration at repeated recommendations to take the contraceptive pill to treat painful menstrual cramps. This was because, as a lesbian, P5 did not require the pill to prevent pregnancy, and she also felt it was not guaranteed to improve her menstrual cramps, meaning its benefits were limited. She stated:

> Every single time it's been 'Well, just go on birth control,' and I'm like 'Er, I don't really want to go on birth control. Have you got any other options for me?' You know, bearing in mind I don't really have any other benefits to that.

P5 stated she felt that many medical treatments are tailored to the needs of “cis (cisgender) white men (and) at a push, cis white women”, meaning that the opinions and needs of LGBT+ patients are often neglected, leading to incorrect assumptions like those experienced by P5. However, P5 stated a GP recently performed blood tests on her and she has been prescribed iron tablets to help treat her symptoms. While happy about this outcome, P5 felt frustrated that this alternative option had not been recommended by previous GPs, saying “(it was) was really validating (but) that’s kind of just what you should expect from a GP.” Therefore, despite some positive medical outcomes, participants’ statements suggest that GPs may lack knowledge of unique medical needs of LGBT+ patients, presenting barriers to exploring treatment options.

Interactions with GPs also had emotional impacts for many participants. P1 explained how feeling “validated”, such as when a GP recently used their correct name, can encourage them to “open up” and have a more productive conversation and better appointment outcomes. In contrast, P1 stated that GPs previously dismissing their gender identity “upset me because it’s took me a long time to actually realise I didn’t want to transition into male, but I definitely knew I wasn’t female.” Additionally, P2 (gay man, 39 years old) stated that he found being stereotyped by GPs “scary”, explaining that the possibility of a GP’s knowledge around LGBT+ topics being “compromised” made him question other aspects of their skills, such as their medical knowledge. Additionally, P3 (lesbian, 21 years old), while not having experienced direct prejudice from a GP, stated that such experiences “wouldn’t make me feel very safe.” Therefore, negative interactions with GPs could lead LGBT+ patients to feel judged, isolated, anxious, or unsafe. This could jeopardise patients’ pursuit of medical attention and treatment, presenting long-term risks.

Such emotional impacts could be further exacerbated by the fact that some participants had limited support networks. For instance, participants 3, 4, and 5 all stated they would not turn to family to discuss encountering prejudicial or unknowledgeable GPs, with P5 (lesbian, 21 years old) stating “I do talk to my partner, and really, before (meeting her partner), I didn’t

talk to anyone about it, which isn't easy." Therefore, experiencing prejudice by GPs can result in distress or fear in LGBT+ patients, which may be exacerbated if they do not have sufficient sources of support with reporting negative experiences or navigating challenges.

As well as negative emotional reactions, participants also discussed actions that they would or would not take following appointments. Firstly, several participants were uncertain of how they would respond to negative GP behaviours, such as whether they would confront or report prejudice. P4 stated "Most people would say you should report it but I'm not sure if I would report it or not … because of my anxiety." Meanwhile, P6 (77 years old) stated that, while he would not want to visit his previously dismissive GP now, he felt that he would now be confident enough to confront the GP's behaviour: "If I had to go and see him (now), he'd have to be put right about certain things and he'd be told in no uncertain terms to improve his approach". However, P6 states he has gained confidence as he's aged, meaning younger LGBT+ patients may be less likely to confront or report prejudicial GPs, making them more at risk of its impacts:

> Interviewer: So, do you think that you've grown in confidence over the years and like you feel like you'd confront (negative GP responses) now, but maybe in the past would you have been less likely to?
>
> P6: Yes. Definitely. Yes.

P1 stated that they may not have returned to the GP at all if they had been in a poor mental state when facing previous negative experiences:

> Luckily, I was not in a bad position with my mental health (when a GP ignored them), but if that GP had done that to me (when their mental health was less stable), I wouldn't have probably gone back to another GP … I would've stayed at home, so … it would've been even worse (P1)

Despite their recent positive experiences, P1 stated they still “expect” GPs and receptionists to use their incorrect name and pronouns, saying they have had to “accept that it is like that at the GP and it’s not going to change any time soon.” This comment suggests that GPs’ lack of awareness of LGBT+ issues is seen as a common and ongoing challenge by some patients. Indeed, P1 stated “We (LGBT+ individuals) as a community have issues all the time (when accessing healthcare)”.

In a similar vein, P5 stated she is considering exploring her gender identity, but explained she “would not expect any good (experiences)” if she were to discuss this with a GP. She added “I don’t think that’s something I’d ever feel comfortable talking about with a GP.” P5 also voiced her concerns regarding her and her girlfriend’s plans to pursue fertility treatment in the future. Given her previous experiences of having her sexuality questioned by GPs, P5 worries how she and her partner will be treated as a lesbian couple in that situation. P5 explained she is “already extremely nervous for … if me and my partner go down any pregnancy kind of thing (fertility treatment), that is terrifying … thinking about dealing with the GPs … that is really scary.” Therefore, LGBT+ patients may anticipate negative experiences with GPs, which could dissuade them from seeking GP services in the future.

Furthermore, P3 (lesbian, 21 years old) stated that, while she has not experienced direct homophobia from GPs, she would “change practice” if this occurred, saying “I think any practice that keeps a GP like that wouldn’t be one that I’d want to stay at.” This experience would likely be distressing and could delay treatment for patients who leave a GP practice due to discrimination, perhaps exacerbating existing conditions.

Overall, participants were impacted by interactions with GPs in a number of ways, including with regards to treatment, mental health, and future expectations around service access.

Theme 3: Improvements to GP attitudes and behaviours

This theme discusses participants' views of how interactions between GPs and LGBT+ patients can improve. Participants also raised the point that while standardised changes may be made, patients' individual preferences should still be acknowledged.

Participants stated that they believed GPs' interactions with LGBT+ patients would benefit from training to improve knowledge and communication around gender and sexuality. P1 stated "It's just the GP being aware that to overcome a barrier in somebody is just asking the question 'Have you got a preferred name?' (or) 'Do you want some information on gender identity and sexuality?'" Additionally, P2 acknowledged a need for training "around communication," and asserted that some GPs "probably need to be more tactful" when discussing matters of sexuality with patients, such as HIV testing. P6 expanded on such views by asserting a need for training "for the practice as a whole," including receptionists, who P6 said are "key in all of this, because that's the first point of contact." Therefore, there appears to be a consensus among participants for the need for improvement in GPs' communication and literacy around LGBT+ topics.

As well as discussion around standardised improvements, some participants also emphasised the need for respect of individual patient preferences. These may include whether patients prefer to receive care from a male or female GP. For example, P6 (77 years old) recalled that when his late partner was in hospital being treated for dementia, he was assumed to prefer a female carer, as a heterosexual man may do. P6's partner was in fact more comfortable with male carers, a preference which was not explored at the beginning of his stay. P6 linked this experience to general practice, stating that all healthcare professionals, including GPs, should consider and respect such preferences in order to facilitate patient comfort. P6 also recommended that GPs ask questions such as "'Are you a member of the LGBT community?'" in order to encourage open communication and to explore preferences specific to LGBT+ patients.

P5 also discussed possible preferences of LGBT+ patients when interacting with GPs. She suggested that patients may prefer to visit a GP who is themselves a member of the LGBT+ community, or who holds specialist knowledge in LGBT+ matters, especially if visiting for a matter related to their LGBT+ identity. P5 said “One thing I think would be really great is … if you could request possibly in some instances to see an LGBT GP … like, not for a cough, but maybe for lesbian pregnancy [laughs].” Such accommodations could help patients feel more at ease and better understood in interactions with GPs, benefitting patient outcomes.

Therefore, overall, participants mostly feel that standardised training for GPs and open communication could greatly improve their interactions with LGBT+ patients. However, participants also note that individual preferences should be explored and fulfilled where possible, to maintain a holistic, patient-centred approach to LGBT+ healthcare.

Discussion

Despite recent progress in equality and inclusivity in society, the continued prejudice toward members of the LGBT+ community in settings such as healthcare warrants further research into their experiences. The current study aimed to explore experiences of LGBT+ individuals’ interactions with GPs, as the first point of contact for many medical matters. Six individual semi-structured interviews highlighted various participant experiences and impacts of interactions with GPs over time and across settings. Participants also discussed their own ideas for how interactions between GPs and LGBT+ patients could be improved. Findings and their implications are discussed.

Participants reported variation in GPs’ knowledge of LGBT+ identities, reflecting findings in other medical settings, such as nursing (Carabez et al., 2015) and mental health (Rutherford et al., 2012). Variation in GP knowledge holds unique risks for LGBT+ patients, as patients may be apprehensive as to whether future GPs will be aware and accepting of their identity, or whether they may experience discrimination.

Regarding positive experiences, in line with findings by Sharek et al (2014), being respected in their identities by GPs made participants feel that they received equitable treatment. Such experiences helped participants feel that their needs were met, and that GPs were not fazed by their identities. Given the panoply of benefits associated with accepting LGBT+ individuals across settings (e.g., Greytak et al., 2013; Longarino, 2019; Ryan et al., 2010), acceptance by GPs can be expected to greatly benefit many patient outcomes. Indeed, several participants stated that feeling comfortable with a GP contributed to them being forthcoming with information, which in turn benefitted treatment outcomes.

Meanwhile, participants recalled that GPs judging or questioning their identities caused feelings of fear, frustration, and isolation, similar to findings from Luvuno et al. (2019). Such negative experiences held various consequences for participants, impacting treatment outcomes, mental health, and future service access. LGBT+ individuals are at a higher risk of mental health issues (Russell & Fish, 2016; Yarns et al., 2016), meaning discrimination by GPs could increase the likelihood of outcomes like self-withdrawal, self-harm, and suicide. These experiences could also discourage patients from accessing GP services in the future, meaning insufficient attention to various medical and mental health concerns. This highlights the cruciality of GPs' attitudes toward LGBT+ patients.

Reported variation in GP responses to LGBT+ patients may be due to lack of sufficient training in healthcare. Participants felt that standardised training for GPs around LGBT+ matters would benefit patient experiences. Such training could educate on LGBT+ identities and associated medical and mental health considerations. Communication training could also improve GPs' confidence in discussing topics around gender and sexuality. Poteat et al. (2013) found that medical professionals often do not feel confident in their knowledge of LGBT+ matters, particularly in interactions with transgender patients. As a result, some professionals were found to stigmatise transgender patients in order to compensate for their own lack of knowledge and to reinforce the power imbalance between professional and patient. This could be one explanation for experiences of dismissal and prejudice by GPs reported by participants

in this study. In such cases, training to improve LGBT+ knowledge and communication is valuable. Training around LGBT+ matters has been shown to improve knowledge in groups such as medical students (Wahlen et al., 2020), so it is expected that to be effective for GPs as well. However, training alone may not be sufficient to improve attitudes and responses, as GPs' personal views of LGBT+ individuals may still influence their treatment of patients (Di Lorito et., 2021). As such, additional challenges must be addressed to improve interactions, including a need for culture change. Culture change could be driven by a top-down agenda within health services supporting GPs to better address the needs of non-heteronormative patients in their clinical practice. At the organisational level, greater inclusivity could be promoted through welcoming language/imagery in promotional materials, building partnerships with LGBT organisations, or even hiring staff who identify as LGBT or have experience of working within an equality and inclusion framework (Fredriksen-Goldsen et al., 2018). To further support equality and inclusion in healthcare services, changes in policy may be required too. For example, systematic (i.e., nation-wide) implementation of a sexual rights policy (see e.g., the sexual rights policy for the elderly implemented in the Riverdale Care Home - Dessel & Ramirez, 2013), would support staff to understand issues around sexuality and relationships of older LGBT+ service users (Barrett & Hinchliff, 2017).

This study has several strengths. Participants were from a range of background and demographics, and they represented various LGBT+ identities, contributing a variety of experiences. While exploration of one specific group within the LGBT+ community may have contributed more detailed data to the specific needs of one subgroup from the LGBT+ community, interviewing the broader group will contribute initial evidence that is much needed in this area. This study also has some limitations. The main one is that it involved a small sample and therefore results should be interpreted with caution as they are not generalisable to the LGBT+ community. Conducting interviews via video call could have affected rapport and limited the researcher's observation of participants' body language, for instance. However, participants' comfort due to participating from an environment of their choice could

have counteracted any challenges arising from online interviewing. In any case, all interviews began with ‘small talk’ in order to build initial rapport and make participants comfortable.

This study has some implications for future research. Findings of this study contribute to a relatively new area of research. Future research could expand on these findings in a number of ways. Firstly, surveys could be employed to gain a broader view of LGBT+ patients’ experiences with GPs. Research could also focus on specific identities within the LGBT+ community, such as transgender or intersex individuals, to gain understanding of whether and how various LGBT+ groups are treated differently by GPs. GPs themselves could also be recruited to give feedback on their standard of knowledge and ways to improve this

Conclusions

The current study highlighted various experiences and impacts of LGBT+ patients’ interactions with GPs and has contributed some understanding of how experiences can improve. Participants’ recommended improvements emphasise a need for the development and implementation of culture-sensitive training for General Practitioners, which should be accompanied by an organizational agenda supporting more inclusive approaches.

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