Improving urological care for the LGBT+ community

Nigel Borley

Health-care inequality exists in marginalized groups such as the LGBT+ community. Having been involved in setting up a urological service to connect with this community, I reflect on how health-care organizations must prioritize the unmet needs of this group in order to strive for equality.

LGBT+ (people from sexual and gender minorities): the acronym keeps evolving. Referring to non-heterosexual persons as gay has been accepted for some time, at least in the majority of upper-income countries. The word gay stands for Good As You, and was adopted by the community around the time of the New York Stonewall Riots in 1969 in defiance of the persecution being suffered. Those people who were 'outside of the normal' supported each other and fought together to fight injustice, although their individual circumstances of being 'outside of the normal' varied.

The gay rights movement grew, became more generally accepted, and gained hard-won rights and freedoms. During this time, the disparate elements of the movement sought to find their own identities and voices. Thus, each group felt they could 'come out of the shadows' and set out their different positions, difficulties and needs, be it social, legal, economic or health related.

Health care works best when it is accessible by all; the success of COVID-19 immunizations (where they were widely available) in hopefully halting a pandemic has illustrated that concept. However, barriers to health-care access might be more than economical or geographical; they could be due to stigma felt by service users preventing use of the service or ignorance on the part of service providers to provide a service that is relevant and helpful.

Consequently, if we want to (and we need to) encourage health-care service use in all patients, we get a 'greater bang for our buck' when we can make the greatest intervention in those who need our services the most but paradoxically are the least likely to use a service. For example, the entrance of the Genitourinary Medicine (GUM) department is located away from the main hospital entrance, or even on a separate site, for a reason: to reduce embarrassment or shame and to encourage attendance. In addition, one of the reasons doctors tend to specialize in a specific area is so we can more readily identify the knock-on or corollary effects of a condition that will affect a patient or those around them. Identifying these effects not only helps the person with the condition, but helps their family and friends, who

will ultimately support the patient in continuing their journey. Reassurance of the 'worried well' is important, but engaging the person who would not normally come to seek help, who has a symptomatic or a transmissible disease that we can prevent the spread of, is where we can provide the most benefit. The concern we have is if someone with a problem does not know who to get professional advice and help from, they could instead turn to online forums and chat rooms, with disastrous results. Helping these patients is when we fully fulfil our roles as educators, confidants and portals to appropriate care.

In my experience, when thought and consideration for health-care service users in marginalized communities has been done well, it can lead to hugely beneficial results. Soho is a bohemian and diverse area of central London long associated with an immigrant population, those on the edge of society and subsequently an area for sex workers and those people who have historically felt the need for somewhere to come out of the margins to find like-minded people. The logical questions for setting up a new urological health-care service in London were: Who most needed our service; who were the least likely to use our service? The answer was: the same people. Where could we find these people? The answer was: Soho.

I therefore organized a regular urology clinic in a GUM unit that was built in the heart of the red-light area of Soho. If you have a product no one is willing to make the effort to try, make it as accessible as possible: somewhere to 'pop into on the way home'. The GUM clinic was successful, a single clinic diagnosing one out of every nine new HIV infections in the country. It also helped to make people unafraid of visiting by advertising specialized clinics, such as for those people who are transgender or who are sex workers. After initial acute needs are met, in a clinic such as this it usually does not take long for pent-up anxieties and problems to come flooding out if someone previously thought they were going to be dismissed (or even chastised) by a health-care worker. Unsurprisingly, urology was one of the specialities that people were referred onto the most.

Practice Plus Group Urology,
Royal South Hants Hospital,
Southampton, UK.
e-mail: ncborley@gmail.com
<https://doi.org/10.1038/s41585-021-00484-y>

Notably, by having the urology clinic within the Soho GUM clinic, it reduced the number of people who did not follow through with their onward referral.

Importantly, not every LGBT+ person needs a helping hand to get what they need. Members of the community are as articulate and proactive as anyone else and can navigate their way through a health-care system. However, if someone with a problem has felt different since they were born, then they have a condition that means they could be ill (for the patient, that illness further suggests they are 'different'), and on top of that the issue is with their genitals (which they might already perceive to be 'different'), that means 'different' to the power of three. Regrettably, additional historical personal issues could push that power even higher. Fundamentally, one can insert into that mindset any marginalized community who might perceive themselves as 'different'; thus, leading to personal embarrassment, distrust of health-care professionals, lack of engagement with services and consequent health-care inequality.

So here is my call to action, and it is called the 20:80 rule. Many of us have heard the widely used management term '80:20': design a service to meet 80% of users' needs and that is your model to take care of enough of the demand. By inference, I have always assumed that the remaining 20% of users are forgotten or left to fend for themselves. However, this is health care, it should not work like that; if we miss someone, that should be one too many. Thus, if you realize a section of the clientele who would use your service is not accessing better health care, and I do not mean just LGBT+, I mean any group feeling marginalized, be the champion for them and ask how you can get them to come forwards. The 80% will very probably come whatever; the 20% is who you have to encourage. Achieving gains on the 20% will drive your organization forwards by increasing the numbers using your service and will strive towards health-care equality in marginalized groups.

Competing interests

The author declares no competing interests.