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Special Healthcare Services for Lgbt Cancer Patients

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ABSTRACT

In the UK, a concern of prejudice, as well as a lack of gender identity and sexual orientation documentation, implies that LGBT persons mostly hidden to health-care providers. One of a review was carried out to examine primary literature on the psychological support requirements of LGBT cancer patients when receive treatment and after. Important findings: Key topics that have been mentioned include the negative impact on mental health, health care professional education and the absence of inclusive support groups, the pervasiveness of discriminatory practices within healthcare services. The research demonstrates how LGBT cancer patients are being failed by healthcare professionals in terms of psychological support, resulting in unmet requirements. There are some suggestions use to guarantee an LGBT inclusive atmosphere in cancer care, as well as the development of support programmes for LGBT people with cancer. Practical connotation: LGBT wellness and awareness education should be offered for HCP personnel. The registration and tracking of gender identity and sexual orientation is critical to ensuring that LGBT persons are not 'invisible' in cancer, radiation, and continued studies. LGBT cancer groups and services should be established, since information from the study indicated that LGBT individuals are actively seeking these services.

KEYWORDS: LGBT; Psychosocial; Supportive care; Cancer; Oncology; Healthcare

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1. Introduction

In global, there are 5.6% of adults had been identity as LGBT [1]. For example, In the United Kingdom, 3.6 million individuals identify as LGBT, accounting for 5 percentage of the overall population [2,3]. The unique wellbeing requirements of bisexual, gay, lesbian and (LGBT) persons vary from those of heterosexual people, and many feel that medical care do not meet their needs [4,5]. Sexual preference and gender expression (SOGI) data are not regularly gathered, and some transgender persons may be hesitant to 'come out' for fear of prejudice, causing them to forego healthcare treatments [6]. Minority pressure is the stress and shame of living in a community where institutional racism, disempowerment, and homophobia continue to have an impact on the person, as well as has been connected to physical health issues or an increase in cigarettes, drinking, and drug use [7]; however, research on the topic is restricted [8]. According to a study, persons who identify as homosexual or lesbian are more likely to smoke [9,10]; Roberts *et al.*reported that 45.7 percent of LGBT people polled smoke every day and 22.7 percent smoked sometimes [11]. According to the Equality and Human Rights Commission, LGBT individuals are 1.5 times more prone to abuse alcohol and other drugs [12]. These living part raise the risk of future malignancies that are avoidable [13].

One among cancer diagnoses are made in adults over the age of 65; hence, these patients would have lived at a period when being LGBT was not according to rules or was considered as a psychological disorder [14]. Approximately 55 percentage of LGBT patients have encountered misconceptions about SOGI inside the National Health Service (NHS), and a 25% of health care professionals (HCP) have heard co-workers make unpleasant remarks about LGBT persons. [15,16]. This bias may prevent a person from revealing SOGI for worry of not obtaining proper treatment from HCPs [17]. Many medical services are geared on cisgender, heterosexual individuals and may reject LGBT individuals. It has also been observed that mental health issues are more widespread in the LGBT population, with severe depression being 1.5 times as prevalent [18]. If LGBT persons are now struggling with mental issues, a cancer diagnosis may exacerbate their situation. Mehnert discovered that 52% of respondents had clinically relevant levels of distress as a result of cancer, however the research did not inquire about SOGI [19]. Because some LGBT persons may have inadequate family help, the requirement for proper care within the NHS may be increased [20].

2. Method

A comprehensive literature analysis was done to examine existing studies for LGBT cancer sufferers and the society's special support requirements. The first search was carried out in January 2018, and it will be redone in May 2020 for publicity.

2.1 Exclusion and inclusion criteria

To guarantee that the most current data was gathered, evidence ranging from 2000 to the current day was collected. This includes key legal developments enacted when early 21st - Equality at Work Rights, the Civil Partnership Act 2004, and the removal of Section 28 of the Local Government Act. The materials used were complete transcript, qualitative and quantitative, primary research and published in English. Sources were

rejected if they did not mention LGBT in their purpose or participation, were not cancer-related, did not have a psychosocial emphasis, were not participant, or were conversation articles.

2.2 Search strategy

Medline and PubMed were utilised to discover literature since they are two of the biggest databases of healthcare and medical research. The Medical Subject Heading (MeSH) tool was utilised to help locate key phrases and extend search queries, and then AND/OR qualifier tools were employed. The search phrases reported (**Table 1**) were broad enough to include all LGBT studies, psychological and supportive care, and cancer and oncology.

Table 1. Search terms

LGBT	Cancer	Support
Lesbian	Oncology	Supportive Care
Gay	Cancer- Care	Survivorship
Bisexual	Radiotherapy	Psychological
Transgender		Psychosocial
Sexual orientation		
Gender identifies		
Gender non-confirming		

2.3 Study selection

One researcher examined the records, deleting duplication and according to the qualifying criteria. The data were first checked by name, then by description, and lastly by complete text. The outcomes were documented on a PRISMA flowchart (**Figure 1**). To assess the research quality, three key appraisal techniques have been used: the Critical Appraisal Skills Programme (CASP) for qualitative research, the Effective Public Health Practice Project (EPHPP) for quantitative studies, and the Specialist Unit for Review Evidence (SURE) for cross-sectional research findings [21,22].

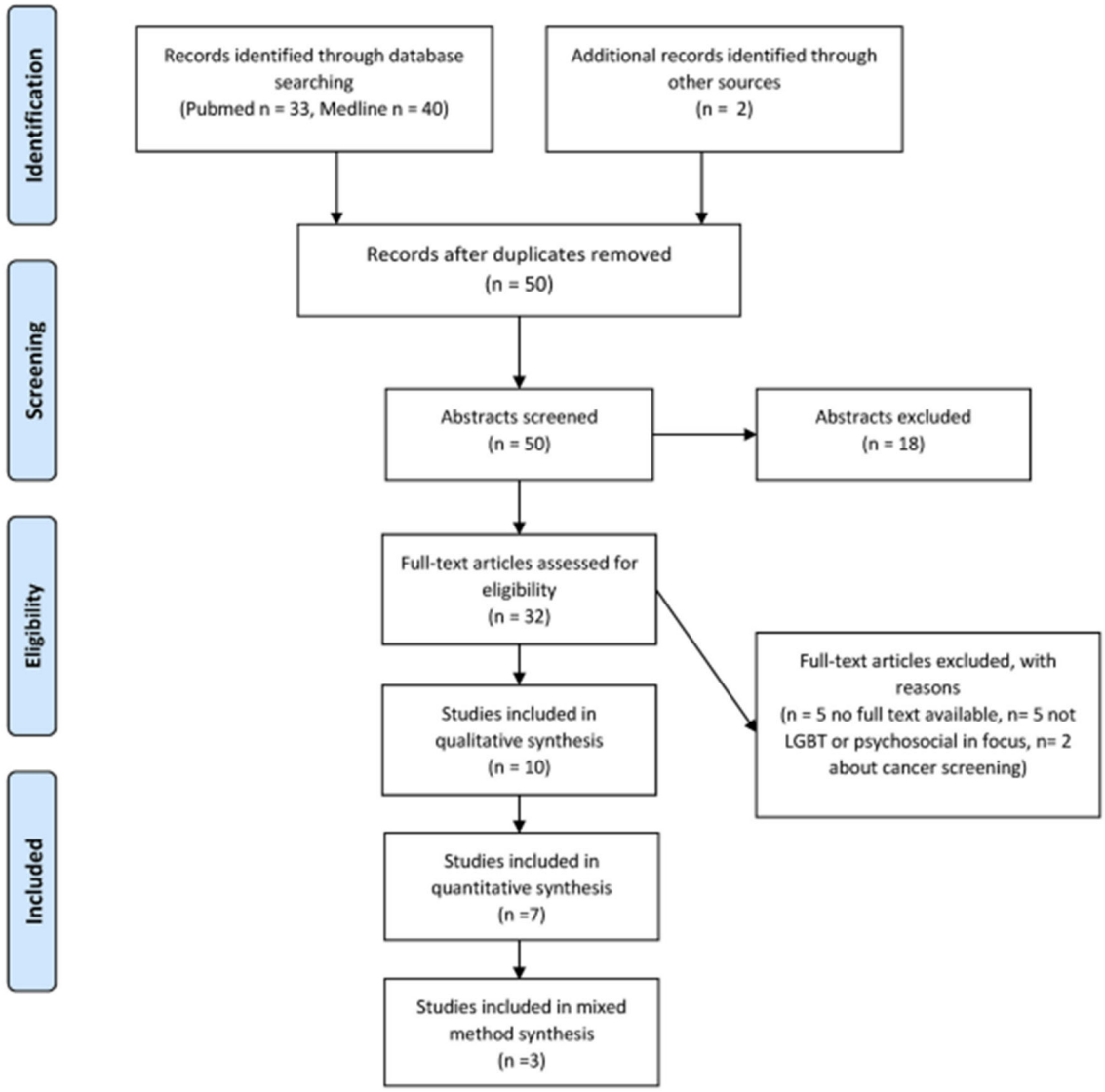

Figure 1: Prisma Flow Chart

2.4 Content and thematic analysis

Another researcher produced motifs by classifying the material and looking for significant terms and expressions that were repeating and most prominent throughout the findings. These phrases were then expanded upon to form themes.

3. Results

The search yielded twenty studies as a result [23,24]. Ten of the investigations were qualitative, seven were quantitative, and three were mixed methods. Based on the techniques of the investigation, assessment methods were employed to evaluate the quality of each study. Because there was no research that covered any LGBT persons, all of the trials included in the critical analysis were utilised in the findings. The most of those who took part were white cisgender homosexual men and lesbian cisgender women. Only two of the

research looked at transgender and sexually nonconforming people [25]. One study focused on radiation, whereas the others were all about "cancer services" or oncology in general [26]. The following are the primary issues highlighted: HCP awareness and training, the detrimental effect on psychological health, the absence of LGBT inclusive support networks and tools, the frequency of prejudice within healthcare services, and the revelation or non-disclosure of SOGI.

3.1 Health care professional's knowledge and education

The findings show that a scarce of awareness and knowledge of the LGBT population, as well as the special requirements of the LGBT community, led to discomfort and mistrust in health care services. Research respondents experienced a lack of dignity and respect from HCPs when they were rejected or removed from non-traditional support systems [27]. Assumptions, confusion, and mis-gendering may all have an influence on the patient outcomes, as well as some persons may feel 'pushed back into the shadows'.

Patients reported more unmet needs in survival when HCPs were unfamiliar with LGBT health. 40 In the Banerjee *et al.* (2018) survey, just 4.6 percent of HCPs properly answered all LGBT health questions [28]. But, since this was predicated with one medical centre in the US, it may just represent one centre's education. Unmet needs in sexual side effects and treatment were identified by gay cisgender guys. People thought they couldn't speak to HCPs about it since it was a "taboo" issue, thus they didn't know who to contact on where to go and for answers [29]. Shetty *et al.* (2016) discovered that 36% of HCPs in the USA want further knowledge on LGBT health issues [30]. Transgender and gender genderqueer cancer sufferers reported distinct support requirements and cancer experiences than LGB patients. According to Taylor and Bryson (2016), there is a dearth of HCP awareness and comprehension about the confluence between cancer care and gender affirming treatment [31]. A gap in knowledge the influence of cancer on gender affirming treatments, such as hormonal therapy, makes it difficult for patients to make educated maintain or enhance.

3.2 Negative impact on mental health

According to the research, LGBT cancer patients are more prone to have symptoms of depression and post-traumatic stress disorder [32,33]. Nevertheless, according to Boehmer *et al.* (2012), there is no substantial link among sexuality and cancer diagnosis following poor brain health issue, although LGBT prejudice has an influence on overall fitness [34]. Participants reported sense of loneliness and the influence on friendships [35,36]. Brown and McElroy (2018) and Fish and Williamson (2018) discovered that participants were unhappy in mainstream peer support, felt isolated, and had encountered heterosexist behaviour [37].

The effect on body image has been documented in homosexual cisgender males [38,39]. The impact on sexual identity and homosexual identity was noted, as well as the importance of physical beauty in gay culture. Some transgender and non-gender bending people saw the extreme surgery as a positive and appreciated the freedom it provided [40]. Some, meanwhile, thought this forced them to adhere to gender and become a binary gender by default. According to the most of client research participants, there is a shortage of psychological care for patient understanding [41].

3.3 Lacking LGBT inclusive support teams and materials

There were different emotions regarding mainstream support organisations. Six of the research showed that individuals were hesitant discussing their sexual health. Cancer non-specific groups were much more accessible because there was less emphasis on looks and much more emphasis on psychiatric symptoms. Patients desire to be able to talk openly about their safe sex and illness without feeling judged [42]. Because some support organisations were unfriendly to LGBT patients, people sought LGBT assistance elsewhere. The findings of all research revealed that, while a customised program is not required, an LGBT non-cancer location specific help group would be advantageous. Homosexual cisgender males had no access to gay cancer support groups unless they travelled a cross country, resulting in isolation and loneliness [43]. There were no services or cancer help available for transgender & gender nonconforming patients. Similarly, lesbian cisgender female patients reported feeling uneasy in breast cancer support networks, with an emphasis on conventional gender norms of being a "girly girl," "pink and fluffy."

On several cancer support site, LGBT persons have seen homophobic conduct and remarks. A mainstream online safety net fell well short of helping lesbian breast cancer sufferers, focusing mostly on looks and the necessity for ‘pleasing spouses’. This was fascinating since individuals were ignorant, they were just being investigated because the forum was on a social platform, providing a much truer view owing to reduced participant prejudice.

3.4 Prevalence of discrimination within healthcare services

Whenever LGBT persons consult healthcare practitioners, heterosexism is a major concern. According to one survey, 27 percent of HCPs presumed heterosexuality. Heterosexism and heteronormative behaviour may have an influence on the respect and permitted among HCPs and patients, as well as foster an 'expected dread of discriminating,' either done knowingly or unconsciously. Since they are neither can be honest and themselves, 26 LGBT patients may feel "driven back into the closet." Recognizing same-sex partners & different support systems is critical for obtaining effective treatment. According to Hulbert William. *et al.* (2017), a substantial percentage of LGB patients who did not have relatives or personal friends participating in therapy, and a large percentage of bisexual patients describe having handled as a number of health conditions [44].

Carr (2018) said that healthcare providers should have explicit signs and banners declaring that all types of prejudice are not accepted. Despite the fact that homosexuality is a common motif in the book, just one participant made a formal complaint. Clients perceived certain HCPs to be extremely homosexual or to have erroneous or inappropriate beliefs about human sexuality. Kamen *et al.* (2019) observed intersectionality in patients who experienced not just homophobia, and also sexism, xenophobia, and age discrimination. This was also the perspective of transgender and gender nonconforming patients, where it is unknown how specific characteristics of their social position, such as race, sexuality, and gender, affected their situations.

3.5 Disclosure or non-disclosure of sexual orientation and gender identity

Only 26% of HCPs gathered sexuality data, whereas another research found that only 8percent of the total of individuals had sexuality on medical forms and 1% had gender identification [45]. Concern of a negative response or prejudice prevents some patients from revealing SOGI [46]. Patients, on the other hand, thought that being 'out' to HCPs was essential sometimes not meaningful. Fish and Williamson (2018) note that sexuality may not always be important to healthcare, particularly in emergency treatment, but individuals also thought they received substandard treatment because they were unable to communicate openly with HCPs. Another respondent said that it was critical when asking questions about treatment, such as anal sex following colon operation or pelvic radiation. Disclosure possibilities should be made evident on paperwork and hospital systems.

4. Discussion

The Health and Social Care Act 2012 and the Equality Act 2010 impose an obligation of care on health professionals in the United Kingdom to treat all persons reasonably and equitably. HCPs are not needed to modify their religious or moral convictions in order to give good care to LGBT persons, but it is critical to serve each individual, decency, and outstanding care.

There are materials available that can help health professionals and HCPs understand LGBT inequalities in health and how to run an ensuring that the best. Several LGBT health materials are available through Stonewall and Macmillan [47]. These materials include pertinent data concerning LGBT patients' perspectives, gaps in concerning data supply, and how healthcare practitioners may improve practise. The LGBT Foundation is collaborating with Macmillan to provide training days for HCPs and volunteers on LGBT cancer-specific concerns like increased sadness. According to the LGBT Public Health Outcomes Framework Companion paper, cancer treatment providers should be aware staff education on LGBT concerns, particularly adverts that incorporate LGBT descriptive language [48].

One here in four LGBT persons have been subjected to excessive inquiry from HCPs due to a lack of knowledge, one in eight have had uneven treatment from HCPs as a consequence of becoming LGBT, and one in seven forgo treatment due to fear of prejudice [49]. Transgender and non-binary persons have found oneself in the position of 'expert patient,' needing to teach HCPs about issues that are unrelated to their treatment [50]. Upon entering a new health system, LGBT persons may search for LGBT-friendly signs, pamphlets, and guidelines to help that they are accepted and secure. Putting a rainbow flag on medical facilities proactively shows the customer that LGBTQ people are embraced, but this is inadequate on its own [51]. Employing neutral terminology rather than gendered vocabulary, such as "partner," "they/them" pronouns, and "person," reduces heteronormative preconceptions.

It is suggested that poor mental health before to cancer contributes to subsequent poor mental health [52]. 52 percent of LGBT persons have suffered depression, and 46 percent of trans* people have voiced suicide ideation, with these numbers increasing after a cancer diagnosis. [53], 37 While exploring for LGBT-specific

support networks and services to aid with these psychological concerns, clients discovered that there were very few accessible. As a result, web sites data are regarded critical. F-T-F and internet support groups should give a secure area for individuals who have had similar circumstances to share their feelings, situations, and worries, and it has been shown that utilising them concurrently offers the most benefit [54,55]. The findings, nevertheless, indicate that they are not diverse and exhibit heteronormative or homophobic views. According to ACCESSCare, there is no need for "bespoke" treatments for LGBT patients, but rather for HCPs to think differently in order to promote equality in patient-centred care [56]. It has been discovered that giving access to medically led and peer-led support groups improves psychological efficiency, coping abilities, standard of living, family contacts, and cancer awareness. Thru the cancer route, support networks, such as a spouse, parents, and friends, have been demonstrated to be useful in providing help and support [57]. LGBT persons may have 'non-traditional' support systems that should be involved if the person so desires, and it is thought that this can assist with the psychological strain that cancer can have.

Currently, SOGI data is not routinely collected; the absence of this critical data collection implies that LGBT persons are often 'invisible' on the National Cancer Registry. Watching and documenting will close gaps in service delivery when LGBT persons have previously been neglected or thought to be straight. According to the LGBT Public Health Outcomes Framework Companion document, which is endorsed by Clinical Commissioning Groups and NHS England, a service user's SOGI should be gathered and tracked, and this information should be utilised to improve services. Including gender and sex identification on forms sends a powerful message to transgender persons that they are welcomed and secure to be themselves. Despite previous legislative and policy improvements aimed at improving psychosocial support, LGBT individuals continue to face inequality and exclusion in healthcare.

5. Recommendations

The review's findings clearly reveal an unawareness and incomprehension of the LGBT population and its wellbeing. Incorporating LGBT knowledge and health education into HCP trainings, such as radiography BSc programmes, would address this issue. Moreover, knowledge in Health care and cancer is critical in knowing how we can prevent future unmet needs. While gathering data from patients, SOGI monitor should be incorporated. This might be utilised in radiation on treatment plans systems including Mosaiq and Aria. Healthcare professionals should give service users the option to divulge SOGI in compliance with the sexual orientation monitoring basic information. By adding this data, companies are able to demonstrate equitable access, have a better knowledge of the effect of health-care outcomes, and help determine health hazards for LGBT persons.

Textual content and tools should be more accessible, such as billboards featuring same-sex marriage, neutral gender material, and references to LGBT health. LGBT cancer support systems must be formed since research shows that people are actively seeking this resource. These will be connected with good causes and local LGBT organisations to advertise the service and point them in the direction of services that meet their requirements. Future research for LGBT cancer patients is required in order to enhance patient care, cancer

rates, and to guarantee LGBT patients are represented fairly in research. Several of the studies had difficulty recruiting volunteers and relied on marketing, snowballing, and "word-of-mouth." Organizations should consider ways to increase study enrolment and incorporate SOGI in clinical populations so that it is included in research results.

6. Limitations

Thirteen of the 20 investigations were done in the U.S, which is a constraint since health systems, laws, and objectives vary; hence, the findings are not always typical of the UK population. Nevertheless, LGBT persons face comparable stigmatisation in the USA And the UK according to research conducted in both nations.

In the study investigations, there was a shortage of transgender and gendered genderqueer participation. Only two of the research focused exclusively on gender and transgender nonconforming individuals. Transgender and non-binary persons may have different health requirements than LGBT students, including ongoing gender transition therapy, being improper, being unable to use a chosen name, and fear that HCPs would dismiss gender identity. A number of additional articles including Stonewall, Macmillan Seeing Persons as People, and the ACCESSCare research indicate areas where HCPs fail transgender and non-binary people.

Only one research was entirely focused on radiation, hence it was seldom cited in the evidence. As a result, scientific proof suggestions cannot be applied correctly to radiation. Nonetheless, underlying challenges in oncology and general healthcare, like the incidence of prejudice and SOGI documentation, will have an influence on radiation departments. More study is required to determine if or whether radiation has a special impact on LGBT persons, such as survivability and adverse reactions treatment, and aimed to making LGBT more obvious in radiotherapy. Furthermore, since the research evaluation was undertaken by a scholar, theme analyses and coding are susceptible to biasness. Several scholars should pass codes and discuss issues in future evaluations until an agreement is reached. This would boost the study's validity and safeguard it from potential error.

7. Conclusion

The review's findings reveal inadequacies in healthcare services of HCP education and LGBT patients' unmet psychological needs. This review is a first step toward expanding diversity in oncology and radiation and addressing the challenges LGBT people have while accessing services, including providing additional LGBT cancer backing services in the form of support networks and information. More study in radiation is needed to effectively serve LGBT people on their cancer experience.

Conflict of Interest

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