An evaluation of self-perceived knowledge, attitudes and behaviours of UK oncologists about LGBTQ+ patients with cancer

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ABSTRACT

Introduction Over one million people in the UK identify as LGBTQ+ (lesbian, gay, bisexual, transgender, queer or questioning). Research has shown that this population experience differing cancer risk factors compared with non-LGBTQ+ patients and persistent inequalities in cancer care. Literature concerning the knowledge of oncologists of this group’s healthcare needs is limited; our study aimed to evaluate knowledge, attitudes and behaviours of UK oncologists about LGBTQ+ patients.

Methods A 53-question survey was delivered via a secure online platform. Questions covered respondent demographics, knowledge, attitudes and behaviours with the majority of responses on a Likert scale. Oncologists were recruited via email from professional bodies and social media promotion. Informed consent was sought and responses fully anonymised. Multifactorial ordinal logistic regression and Fisher’s exact test were used to assess for interactions between demographics and responses with Holm–Bonferroni multiple testing correction.

Results 258 fully completed responses were received. Respondents had a median age of 43 years (range 28–69); 65% consultants and 35% registrars; 42% medical, and 54% clinical, oncologists. 84% felt comfortable treating LGBTQ+ patients but only 8% agreed that they were confident in their knowledge of specific LGBTQ+ patient healthcare needs. There were low rates of routine enquiry about sexual orientation (5%), gender identity (3%) and preferred pronouns (2%). 68% of oncologists felt LGBTQ+ healthcare needs should be a mandatory component of postgraduate training.

Conclusions This survey showed that UK oncologists feel comfortable treating LGBTQ+ patients but may fail to identify these patients in their clinic, making it more difficult to meet LGBTQ+ healthcare needs. There is self-awareness of deficits in knowledge of LGBTQ+ healthcare and a willingness to address this through postgraduate training. Educational resources collated and developed in accordance with this study would potentially improve the confidence of oncologists in treating LGBTQ+ patients and the cancer care these patients receive.

Key questions

What is already known about this subject?

► LGBTQ+ (lesbian, gay, bisexual, transgender, queer or questioning) patients are known to experience inequalities in cancer care.

► Studies from the USA have suggested that this may in part be attributable to a lack of knowledge among healthcare providers about the specific healthcare needs of this population.

What does this study add?

► We surveyed UK oncology specialists’ knowledge, attitudes and behaviours when treating LGBTQ+ patients, the first study of this kind in Europe.

► UK oncologists feel comfortable treating LGBTQ+ patients but lacked population-specific cancer knowledge.

► UK oncologists may fail to encourage disclosure of gender or sexual minority status in their clinic.

► UK oncologists feel ill-prepared for the cancer care needs of the LGBTQ+ population after completing current UK medical training curricula and would welcome further educational resources.

How might this impact on clinical practice?

► Greater awareness of the need for training around the specific needs of LGBTQ+ patients with cancer, and subsequent development of educational resources for healthcare providers, has the potential to improve treatment outcomes and quality of care for this patient group.

INTRODUCTION

LGBTQ+ stands for lesbian, gay, bisexual, transgender, queer or questioning but the acronym is used to encompass the broader population of sexual and gender minority individuals. The term transgender or trans is used to describe someone whose gender identity does not align with the sex they were assigned at birth. Those whose gender identity and sex assigned at birth do not align are described as being cisgender, and a number of other diverse identities exist. It is estimated that 5%–7% of the UK are LGB (lesbian, gay or bisexual) and approximately 0.5%–4.5% of adults identify as gender diverse.

To cite: Berner AM, Hughes DJ, Tharmalingam H, et al. An evaluation of self-perceived knowledge, attitudes and behaviours of UK oncologists about LGBTQ+ patients with cancer. ESMO Open 2020;5:e000906. doi:10.1136/esmoopen-2020-000906

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Despite progressive equality and diversity legislation, LGBTQ+ individuals worldwide continue to face discrimination when accessing healthcare. They experience higher incidence of a number of diseases as well as risk factors for ill health, a lack of visibility in healthcare research and provision, and frequent cis-heteronormative assumptions by healthcare providers may create a barrier to the patient/provider relationship, holistic care planning and support. Cancer care is an area of particular importance, with a number of cancer types having differing risk factors, incidence, screening and treatment considerations in the LGBTQ+ population. Although it is wrong to consider LGBTQ+ people as a homogeneous group, certain sexual and gender minority subpopulations have higher rates of obesity, smoking, alcohol consumption and blood-borne virus infection compared with the general population, putting them at higher risk of various cancer types. Meanwhile, sexual orientation and trans status recording in cancer incidence data continues to be poor.

There are inequalities in cancer screening, where lesbian and bisexual women, and trans people assigned female at birth, have lower rates of cervical cancer screening uptake. Gender-diverse patients in particular may require thoughtful planning of their oncology treatment, including possible changes to any gender affirming medications such as hormones, procedures and surgeries. For example, work by one Dutch group demonstrated that rates of breast cancer in both trans men and trans women were higher than those for cis men and lower than those for cis women, and this is modulated by factors including duration on cross-sex hormones and chest surgery. For these patients, it is important to discuss the risks and benefits of pausing or stopping hormones during investigation and treatment, weighing up the physiological and psychological effects. In addition, trans patients may experience degrees of dysphoria following the diagnosis of a cancer in an organ associated with their sex assigned at birth. Sexual function may also be poorer for LGBTQ+ patients following treatment, as for gay men with prostate cancer, which will be important treatment planning and consent.

Of note, there is also increasing evidence of the importance of sex assigned at birth as a marker of prognosis, adverse events and response to treatment in non-sex-related cancers. A recent European Society for Medical Oncology (ESMO) report recommended that ‘men and women with non-sex-related cancers should no longer be considered as subgroups, but as biologically distinct groups of patients’. This raises clinical questions for the treatment of trans patients, which need to be answered in order to provide optimal care. These include to what extent karyotype, hormones and behaviours govern the sex-related differences observed in such studies, how these studies should be interpreted for trans patients now, and how we involve these patients in research and study design now to improve their treatment in the future.

Further, the practice of oncology necessitates a particularly well-developed therapeutic relationship. Respect for a patient’s gender identity and sexual orientation, with correct use of pronouns, preferred terminology for body parts and understanding of their relationships are key to building rapport. A lack of recognition of same-sex relationships and carers is one of the most significant inequalities linked to the experiences of LGBTQ+ people affected by cancer.

The charity Cancer Research UK (CRUK) first published a policy statement recognising the need to better address cancer care for LGBTQ+ patients in 2008. In 2017, workforce development was one of the five areas of recommendations in a position statement from the American Society of Clinical Oncology (ASCO) on reducing cancer health disparities among sexual and gender minority populations. Similar directives have not yet been made by bodies responsible for oncology specialist training in the UK and Europe, and LGBTQ+ cancer care does not feature in the ESMO/ASCO Recommendations for Medical Oncology Training.

While there is growing UK-based literature exploring treatment of LGBTQ+ patients in cancer services from the patient perspective, there is a paucity of literature exploring how provider factors may be contributing to this. This study therefore was designed to assess knowledge, attitudes and behaviours of oncologists in the UK when treating LGBTQ+ patients with cancer, with a view to understanding the educational needs in this area, and how they might be addressed through policy and training.

**METHODS**

A 53-question survey was designed to assess self-perceived knowledge (n=23), attitudes (n=10) and behaviours (n=12) of oncologists when treating LGBTQ+ patients with cancer, and factors which may affect these, including demographics. Aside from questions on participant demographics, majority Likert scale responses were used.

Existing literature was used to shape the design of the study, as well as feedback received from a number of UK bodies responsible for the training of oncologists including Association of Cancer Physicians (ACP), Royal College of Radiologists (RCR) and Royal College of Physicians. In order to ensure questions pertinent to the LGBTQ+ patient with cancer experience were asked, patient feedback on our survey was sought via the CRUK Patient and Public Involvement Team.

The project was approved by UCL Research Ethics Committee (project ID: 15771/001) with formal endorsement from the RCR and ACP.

The survey was delivered via a secure online platform (Opio ProV.7.12, ObjectPlanet), informed consent was sought, and responses were fully anonymised.

The study aimed to recruit consultant and trainee (higher specialty), medical and clinical oncologists throughout the UK. Participants were invited by email invitation to all members of the ACP, via newsletter and
follow-up email to clinical oncology members of the RCR and via advertising on Twitter.

The survey remained open for 6 weeks from 9 October 2019 until 20 November 2019, during which time 263 responses were received. Results were analysed for the 258 participants who completed the survey. Over 10% of UK oncology specialty doctors participated.29

Results were presented as descriptive statistics. To assess interactions between key demographic and response subgroups, multifactorial ordinal logistic regression was utilised for Likert scale responses and Fisher’s exact test for categorical responses. Holm-Bonferroni multiple testing correction was applied, and all p values shown are adjusted. Statistical analysis was carried out using R V.3.6.3.

RESULTS

Demographics
Participants had a median age of 43 years (n=237; range 28–69) and the median number of years since medical school graduation was 19 (n=234; range 4–46). A higher proportion of respondents identified as female (58%) versus male (41%), with 1% preferring not to answer. About 98% stated their sex assigned at birth was the same as their gender identity. About 81% of participants identified as heterosexual with 14% identifying as LGBQ and 4% preferring not to say. With a similar ethnic breakdown to the current NHS workforce,30 75% identified as white versus 25% as black, Asian or minority ethnicity. Further demographics are shown in table 1.

Two thirds of respondents were consultants with the remainder higher specialist trainees. There was a fairly equal representation of both clinical and medical oncologists. A breakdown of respondents by specialty and grade is shown in table 1.

Knowledge
Overall, only 8% of participants felt confident (‘agree’ or ‘strongly agree’) in their knowledge of the unique healthcare needs of LGBTQ+ patients with cancer, while 75% felt they would benefit from further education on this (figure 1A). This is despite moderate levels of equality and diversity training and policy awareness (figure 1B, C).

Results showed that 3% and 5% of participants felt prepared for the needs of LGBTQ+ patients by their undergraduate and postgraduate training, respectively, with the majority agreeing that this should have been a mandatory curricula component (figure 1A). Oncologists who agreed that their undergraduate and/or postgraduate training provided them with an understanding of the healthcare needs of LGBTQ+ patients were more likely to say that they were confident in their knowledge of healthcare needs of LGBTQ+ patients (OR=9.5; 95% CI=3.4 to 26.2; p=0.0082).

Despite low levels of confidence and preparedness, 67% of all respondents felt confident in their ability to communicate effectively with LGBTQ+ patients with cancer (figure 1A).

Regarding knowledge of risk factors for cancer, only 24% of participants were in agreement (‘agree’ or ‘strongly agree’) that cancer risk differs in patients whose gender differs to the sex they were assigned at birth and

| Table 1 Demographics of respondents |
|-------------------------------------|
| N (%)                              |
| Gender identity                     |
| Female (including trans female)     | 149 (58) |
| Male (including trans male)         | 106 (41) |
| Non-binary                          | 0 (0)    |
| Prefer not to say                   | 3 (1)    |
| Gender identity same as sex assigned at birth |
| Yes                                 | 253 (98) |
| No                                  | 1 (1)    |
| Prefer not to say                   | 4 (1)    |
| Sexual orientation                  |
| Heterosexual                        | 212 (81) |
| Gay                                 | 18 (7)   |
| Lesbian                             | 5 (2)    |
| Bisexual                            | 9 (3)    |
| Pansexual                           | 2 (1)    |
| Asexual                             | 1 (1)    |
| Queer                               | 0 (0)    |
| Questioning                         | 0 (0)    |
| Other                               | 0 (0)    |
| Prefer not to say                   | 11 (4)   |
| Ethnicity                           |
| White                               | 193 (75) |
| Mixed                               | 9 (4)    |
| Asian/Indian                        | 42 (16)  |
| Black/African/Caribbean/Black British| 4 (2)   |
| Other ethnic group—Arab             | 3 (1)    |
| Prefer not to say                   | 7 (3)    |
| Grade                               |
| Consultant                          | 171 (66) |
| Higher specialty trainee (non-consultant specialist) | 86 (33) |
| Prefer not to say                   | 1 (1)    |
| Specialty                           |
| Clinical oncologist                 | 142 (55) |
| Medical oncologist                  | 111 (43) |
| Paediatric oncologist               | 3 (1)    |
| Endocrine oncologist                | 1 (1)    |
| Specialist nurse                    | 1 (1)    |

Percentages are rounded to the nearest whole number and so may not sum to 100%.

NHS, National Health Service.
26% agreed that it differs according to sexual orientation. However, 78% agreed that cancer risk differed depending on sexual practice.

Despite established evidence that cancer risk factors of obesity, tobacco smoking, excess alcohol intake and social drug use are higher in the LGBTQ+ populations, over a quarter of respondents responded ‘Don’t Know’, to each of these knowledge statements (figure 2B), with low numbers in agreement, particularly for obesity (6%). By contrast 59% agreed that bloodborne virus infection (including HIV, hepatitis B and C) were higher in LGBTQ+ populations, with only 15% responding ‘Don’t Know’. Interestingly, on multifactorial ordinal logistic regression, participants responding agree or strongly agree to this statement were also more likely to agree that ‘cancer risk differs with sexual practice’ (OR=4.2; 95% CI=2.3 to 7.6; p=1.4 × 10^4), and that there are higher smoking (OR=4.2; 95% CI=2.5 to 7.3; p=9.5 × 10^4), alcohol use (OR=4.2; 95% CI=2.5 to 7.3; p=1.3 × 10^4) and illicit drug use (OR=5.2; 95% CI=3.1 to 9.1; p=1.2 × 10^4) in the LGBTQ+ population.

Regarding access to healthcare, 48% and 57% of all respondents agreed it was impacted by sexual orientation and trans status, respectively. However, 41% were aware that cervical cancer screening uptake specifically was lower in LGBTQ+ patients, and 38% were unsure.

Finally, with regard to fertility, only 14% of respondents felt confident in counselling trans patients with cancer about fertility options and 51% of participants in knowing where to refer such a patient for fertility treatment. Knowledge of where to refer trans patients for fertility treatment was the only item which showed significant differences in responses for consultants versus trainees, with 53% of consultants knowing where to refer the patient versus only 30% of trainees (p=0.000157, figure 2C).

Attitudes

A majority of respondents (79%) felt that sensitive communication around gender identity had implications for the doctor–patient relationship, and over half (57%) felt that it was important to know a patient’s gender identity to better determine their healthcare needs. However, there was equipoise with regard to the referrer’s responsibility to provide both the sex assigned at birth and gender identity of a patient in their referral (figure 3A).

By contrast, only 29% of participants felt it was important to know a person’s sexual orientation to better determine their healthcare needs, with 75% feeling it was not the responsibility of a referring clinician to supply this information.

Eighty-four per cent of participants stated they felt comfortable treating LGBTQ+ patients, but concerningly, 3% stated that they were not comfortable; it is
unclear if this relates to their concerns over their lack of knowledge or training, or any level of prejudice. Five per cent of respondents did feel that LGBTQ+ patients were more difficult to treat, though reasons for this were not explored as part of this study.

Oncologists who agreed that they were comfortable in treating LGBTQ+ patients were significantly more likely to feel confident in their ability to communicate with them (OR=4.3; 95% CI=2.2 to 8.5; p=0.018).

Thirty-seven per cent of respondents felt confident to be listed as LGBTQ+ healthcare providers (‘agree’ or ‘strongly agree’), 16% did not feel confident (‘disagree’ or ‘strongly disagree’) and 37% gave neutral responses (‘neither agree or disagree’ or ‘don’t know’). No definition of ‘LGBTQ+ healthcare provider’ role was given. The free-text responses to this question were categorised into four main themes: (1) a lack of training to stay up-to-date with healthcare needs of this group; (2) a lack of clarity about what being a LGBTQ+ healthcare provider entailed; (3) a perception that LGBTQ+ patients did not present specific care issues compared with the general population; and (4) that these patients may be disadvantaged by putting their care solely into the hands of clinicians badged as LGBTQ+ specialists. Themes (1) and (3) were found throughout responses whereas theme (2) was expressed predominantly by those providing neutral or negative responses (disagree/strongly disagree). Theme (4) was expressed solely by those providing positive responses (agree/strongly agree).

Those who agreed that they were willing to be listed as an LGBTQ+ friendly provider were significantly more likely to agree that they were comfortable in treating LGBTQ+ patients (OR=6.8; 95% CI=3.7 to 12.7; p=6.9 × 10^{-7}). A greater knowledge of where to refer trans patients for fertility services was also noted in those willing to be listed as a LGBTQ+ friendly provider compared with those who were not (p=0.039).

**Behaviours**

There were stark differences in perceived clinician behaviours around gender identity versus sexual orientation. Fifty-nine per cent stated they never asked a patient’s gender identity and 64% never asked a patient’s preferred pronouns. Forty-three per cent acknowledged that they have ‘always’ or ‘often’ made assumptions about a patient’s gender identity, but 87% went on to state that they always or often assumed a patient was cisgender.
Figure 3  (A) Attitudes to communication and disclosure for gender-diverse patients. (B) Attitudes to communication and disclosure for LGB patients. (C) Comfort with treating LGBTQ+ patients. GP, general practitioner; LGBTQ+, lesbian, gay, bisexual, transgender, queer or questioning.
By contrast, only 16% ‘always’ or ‘often’ made assumptions about sexual orientation, though 33% then stated they ‘always’ or ‘often’ assumed a patient was heterosexual.

While rates of asking partner status and name of partner ‘always’ or ‘often’ were relatively high (72% and 53%, respectively), rates of asking about sexual orientation and partner gender were low (figure 4B, C). Rates of taking a sexual history were also low with 65% taking one ‘rarely’ or ‘never’. Though this may reflect its perceived relevance to the tumour type being treated, sexual problems are one of the most commonly reported negative consequences of treatment for a range of different tumour types.31

Further subgroup analyses
No significant differences were found when responses were grouped by: gender identity; experience; specialty (medical vs clinical oncology); time since medical school graduation (less than vs more than 10 years); and identifying as LGBTQ+ (yes or no). Significant differences were found for consultant versus higher specialist trainees, only when assessing knowledge of fertility referrals pathways as discussed.

DISCUSSION
To our knowledge, this study represents the first assessment of oncologist’s self-perceived knowledge, attitudes and behaviours regarding LGBTQ+ patients with cancer in a European country. With over 250 respondents, it assesses these domains for over 10% of the medical and clinical oncology specialist workforce in the UK and is the largest worldwide study of oncologist doctors in this area.

Three similar studies have been conducted in the USA investigating knowledge, attitudes and behaviours of oncologists when treating LGBTQ+ patients. Shetty and colleagues32 surveyed 108 oncology professionals including medical doctors and specialist nurses at a single institution. Banerjee et al collected responses from 1253 healthcare professionals at a comprehensive cancer centre, including 187 of which were physicians (including non-oncologists) and 828 nurses. Finally, Schabath et al administered a similar study to 149 oncologists in 45 cancer centres across the USA.

Despite the heterogeneous nature of these studies, and the differences in culture and training between the USA and the UK, there are many commonalities in the findings. Our study found a high level of comfort in treating LGBTQ+ patients at 84%, compared with 94% in Shetty et al.32 Schabath and colleagues35 separated comfort measurements for treating LGB and trans patients, which were 95.3% and 82.5%, respectively. These measurements likely vary due to previous experience of treating patients in these groups as well as prior education. High levels of comfort are reassuring, although discrimination or unconscious bias may persist. The NHS Rainbow Badge initiative34 has done much to highlight healthcare inequalities for LGBTQ+ patients by providing this information to staff of NHS Trusts that sign up to the scheme and this may improve the insight of some healthcare professionals. Still, only 5% of respondents in our study felt that LGBTQ+ patients were more difficult to treat compared with 17% in the study by Shetty and colleagues.32

Similarly, 75% of UK oncologist’s surveyed felt they would benefit from further education on LGBTQ+ patient needs regarding their cancer care, compared with 78% and 70.4% in the two USA studies mentioned.32 33

Our study went further, to determine where this education might be offered, and found that low levels were being offered in both the undergraduate and postgraduate curricula, respectively, with most UK oncologists reporting that it should be a mandatory component of both. Of note, a staggering 56% of respondents in our study strongly disagreed that their undergraduate training provided them with an understanding of the healthcare needs of LGBTQ+ patients.

Similar to work by Banerjee and colleagues,35 our specific knowledge questions on cancer risk factors received around 25% ‘don’t know’ or neutral responses, a figure that was even higher for some of the differing knowledge questions posed by Schabath et al32 such as the fact that LGBTQ+ have increased healthcare avoidance. In our study, the majority of respondents did know that there was an increased rate of bloodborne virus infection in the LGBTQ+ community, which fits with research that the undergraduate curriculum on LGBTQ+ healthcare mostly concerns sexual health and HIV, as does the amount of research funding this area receives.12 36 37

The fact that oncologists who were aware of this had greater knowledge of other factors affecting cancer risk, also suggests this is a basic piece of field knowledge which physicians may or may not build on during their training.

Work by Banerjee and colleagues35 also found that specific knowledge of LGBTQ+ healthcare predicted open communication behaviours by oncologists. Indeed, improved knowledge of reasons why it is important to know a patient’s gender identity and sexual orientation may result in a change in related attitudes and behaviours. Much of the failure to enquire about gender and sexual orientation in ours and other studies32,33 likely results from the mistaken belief that equality means treating all patients in the same way, something that is borne out in our own free-text question, as well as those in the Shetty study,32 or from a lack of knowledge on the differing risk factors or medical considerations. However, in addition, failure to identify LGBTQ+ patients in the clinic may impair the therapeutic relationship. In a study by Fish and colleagues,38 disclosure of sexual orientation by LGB patients with cancer allowed a level of authenticity for many patients and enabled the provision of more holistic care. Partners were an important salutogenic resource enabling disclosure and their involvement in subsequent decision-making improved patient satisfaction with treatment.
Figure 4  (A) Self-rated behaviours on gender identity and trans status monitoring. (B) Self-rated behaviours on sexual orientation monitoring. (C) Self-rated behaviours on patient partner status and support structure.
A willingness to provide appropriate healthcare for LGBTQ+ patients is seen in the fact that almost half of respondents would be confident to be listed as an LGBTQ+ healthcare provider. This statement was left intentionally broad, as in different settings it may be used to suggest everything from simply a guaranteed non-discriminatory approach to LGBTQ+ patients, to enhanced training on LGBTQ+ patient specialist services and/or greater experience with this population. The majority of respondents recognised that such a listing in the UK would require enhanced education which is important, given that in the USA there are many providers listed as ‘LGBTQ+ friendly’ lacking the necessary expertise.39

Importantly, our study highlighted almost no effect of specialty, experience, length of practice, gender or LGBTQ+ identity on the knowledge, attitudes and behaviours assessed. This indicates that universal improvement to LGBTQ+ specific education and training for UK oncologists is required. The authors felt that increased knowledge of fertility referral pathways by consultants is likely due to them having worked in the same locality for a longer period of time.

Limitations
Given recruitment to this study was disseminated via national specialty organisations and social media, we believe that it includes physicians from across the UK. However, we acknowledge that regional-level data were not collected, in the interests of maintaining anonymity.

This study is the first of its kind in Europe, and, although limited to the UK, its results are consistent with some of those observed in studies of oncology professionals in the USA,32 33 35 while also containing unique findings. However, in countries across Europe, there will be important differences in sociocultural factors, equality and diversity legislation and LGBTQ+ healthcare provision. We would therefore recommend that studies of this kind be undertaken across Europe, and indeed, worldwide.

The survey was disseminated via Twitter to ensure non-members of professional bodies (ACP and RCR) were provided the opportunity to participate. All respondents were asked to confirm their specialty status during the informed consent process and responses that did not include specialty confirmation were not included in the analysis.

This study was limited to specialist doctors in oncology; however, we acknowledge that cancer care requires expert input from a multiprofessional team and subsequent studies should also include other specialties involved in the cancer pathway (eg, surgeons), allied healthcare professionals working in oncology (eg, cancer specialist nurses, pharmacists and radiographers) and non-clinical staff helping to coordinate care in inpatient, outpatient and community settings. The expected level of training of a multiprofessional audience will of course vary but it may be possible to develop common educational resources for these varied groups. Surveying specialist doctors and introducing appropriate educational interventions will enable this group to lead by example.

Although some of the attitudes and behaviours surveyed could be representative of underlying discrimination, as identified in similar studies,33 30 we did not evaluate this as part of this study. We acknowledge that both direct and indirect discrimination continue to persist in the clinical environment.7 8 39 However, the purpose of this study was to determine where education could improve LGBTQ+ cancer care in particular, and it is hoped that better understanding of the inequalities faced by this population may reduce discrimination. This of course needs to be complemented with equality and diversity and unconscious bias training to tackle the underlying beliefs and assumptions linked to discrimination. There may also be sociocultural factors at play in this and our study lacked the geographic data to look at differences between oncologists treating patients in rural versus urban settings, or with populations of differing socioeconomic status. We also acknowledge the greater levels of healthcare inequality and discrimination that may be faced by a trans person of colour or who has a disability, and that we have not examined knowledge of the importance of intersectionality healthcare40 in this study. Further studies on this topic are warranted, but are beyond the scope of this work.

Our study did not address particular issues in cancer care for patients with disorders of sexual differentiation and or identifying as intersex. We acknowledge that studies addressing healthcare inequalities for this population are also warranted.

Recommendations
Findings of this and other studies show that further education for oncologists on the cancer care needs of LGBTQ+ patients is both desired and necessary to end the health inequalities faced by this diverse group of patients. The authors therefore make several recommendations regarding the future direction of education in this area in the UK.

First, any oncology-specific training should be set in the context of improved teaching on LGBTQ+ health in UK undergraduate medical curricula, similar to work that has already been piloted in the UK.41 42

Second, awareness of LGBTQ+ care needs in oncology should be incorporated into the postgraduate curricula for medical and clinical oncology. This need not be a bespoke module, but may be done when considering important population-specific knowledge for these patients under the relevant curriculum areas, such as cancer screening and sex and relationships after cancer. An example of this in practice, is the inclusion of two LGBTQ+ oncology cases in the ACP’s forthcoming publication on Cancer and Fertility.43 44

While the Royal College of General Practitioners, UK, have developed bespoke modules on LGBTQ+ general practice topics in a similar format,45 a differing approach in oncology might be to build an online repository of existing available educational material, supplemented by
some specially designed UK-specific content. This would also enable oncologists to be directed to a wealth of resources for LGBTQ+ patients that have been produced by charities.26 46 47 Many of these have been coproduced with LGBTQ+ patients, which would also allow lived experience to be heard. Such a repository should also be accessible to other healthcare professionals working in oncology, as well as to patients themselves.

Finally, the level of education and training in LGBTQ+ cancer care needs is only as good as the research from which it is derived. High-quality health research in this field requires healthcare organisations, registries and trials internationally to collect data on sexual orientation and gender identity status, in order to detect differing cancer risks and outcomes in these populations. It also requires support from cancer charities, funding bodies and the Royal Colleges to research topics specific to LGBTQ+ cancer care needs, within which patients are involved from study conception. In particular, the evidence base for non-transition-related medical care for trans patients is lacking, and must be included and encouraged to participate in clinical trials.

Progress in clinician education and research has the potential to greatly reduce the healthcare inequalities experienced by the LGBTQ+ people accessing cancer care in the UK and beyond.

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Acknowledgements We would like to thank the CRUK Patient and Public Involvement team for their assistance with contacting patient representatives to review our survey, as well as the patients themselves for taking the time to provide such useful feedback. We would like to thank the Association of Cancer Physicians, UK and the Royal College of Radiologists, UK for their support, including endorsement and promotion of the survey. We also thank our colleagues at UCL Research Department of Medical Education and the Royal College of Physicians, London, UK for their support and intellectual input.

Contributors AMB and DJH developed the concept of the study. AMB, DJH, DS, BH and TB developed the questionnaire. AMB, DH and HT assisted in participant recruitment. AMB and DH analysed the data. AMB, DJH, DS, BH, HT and SB were involved in results interpretation. AMB and DJH wrote the original draft of the manuscript. All authors reviewed and edited the manuscript. The corresponding author attests that all listed authors meet authorship criteria and that no others were involved in results interpretation. AMB and DH are the guarantors.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests AMB reports personal fees from Pfizer Oncology, outside the submitted work. SB reports grants and personal fees from Astrazeneca/MSD, grants and personal fees from GSK/Tesaro, personal fees from Closov, personal fees from Immunogen, personal fees from Mersana, personal fees from Roche, personal fees from Aymen, personal fees from Seattle Genetics, personal fees from Gennab and personal fees from Merck Sereno, outside the submitted work.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. Deidentified participant data are available upon request from Dr Alison May Berner—ORCID ID 0000-0002-1132-0275. Reuse is permitted where aggregate data will advance research in this field, for example internation or cross-specialty studies of this kind.

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