Affirmative care: The heart of general practice

Claire Denness

Throughout this Focus issue, the acronym LGBTQIA+ (lesbian, gay, bisexual, transgender, queer/questioning, intersex, aromantic/asexual, with the + representing other gender identities/sexualities that are part of the community) is often used, alongside other acronyms such as TGD (transgender and gender diverse). We acknowledge that the LGBTQIA+ acronym does not encompass all culturally specific gender identities and sexualities. We also acknowledge that the LGBTQIA+ community is diverse and heterogeneous, and that this heterogeneity and diversity is not always reflected in the statistics, data and research literature. We chose to call this Focus issue 'gender and sexual diversity' in recognition of this.

IT WAS OVER 40 YEARS AGO that the idea of a medical consultation as a meeting of experts was first proposed, challenging earlier, more paternalistic consultation models.[1] To this meeting, the doctor brings their expertise in diagnostic and management skills, and the patient brings their expertise in living with any illness they might have and its impacts on their life and family. And together the two experts forge a management plan – seams of medical expertise and patient expertise aligning, interlocking, weaving together.

Positioning and respecting patients as the experts in their lives is the thread running through this Focus issue on gender and sexual diversity. It underpins everything – why assumptions about sexuality or gender are harmful, why asking for chosen names and pronouns is important, why trauma-informed models of care matter.[2–5]

This issue also highlights some of the health disparities experienced by LGBTQIA+ people in Australia. We learn that less than 40% of TGD people with a cervix have ever had a cervical screening test.[3] We are encouraged to reflect on the minority stress model and how this may explain why three-quarters of lesbian, gay, bisexual and other (LGB+) people have been diagnosed with a mental health disorder, compared with 42% of non-LGB+ people.[2] We read that the majority of older TGD people have experienced suicidality or lost someone in their community to suicide – experiences that have profound effects on ageing, social connection and belonging.[5]

The reasons for these disparities, and the inequities driving them, are multifaceted and complex. But as I curated this Focus issue and reflected on these disparities, an article that *Australian Journal of General Practice* published last year resonated, somewhat uncomfortably, with me. It was an article that described how young TGD patients told us that sometimes *we* seem uncomfortable consulting with them.[6]

Yet there are glimmers of hope. When we return to the core strengths of general practice, we can begin to change these disparities. Russell explains that when we build supportive, affirmative relationships with LGBTQIA+ people, they experience less distress and less suicidality.[2] McNair and Wynne offer us insights into the resilience of LGBTQIA+ people, and the importance and power of peer support and positive community connections.[2,5]

And so this Focus issue takes those glimmers of hope and kindles them. Because affirmative care is what we do. It is our specialism, the lub-dub of our profession. For some patients, affirmative care might include the prescription of gender-affirming hormone therapy, but, more importantly, affirmative care is about positioning the patient as the expert in their life. It is about listening to them, learning from them, understanding them and reflecting. It is about knowing them, *really* knowing them, and shaping their care accordingly. And that is something we are very good at.

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