

“Neither invisible nor abnormal!” Exploring the invisibility and pathologisation of LGBT people in the Greek National Health System.

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Abstract

This article presents findings from a research study aiming at exploring in-depth experiences of LGBT individuals and communities in the Greek Healthcare System. This was the first study of its kind in Greece. Data collected from interviews with LGBT groups and individuals, as well as doctors, suggest that homophobia and transphobia are profound factors of systematic exclusion and restriction from access to good quality health care. Our findings suggest that within the healthcare context, LGBT people are routinely invisibilised and/or pathologised. The authors emphasise on the urgent need for challenging chronic and institutionalised invisibility experienced by LGBT people as a necessary precondition of social equality and genuine universalism within the Greek Health System.

Key words

health inequalities, homophobia, LGBT, transphobia, queer research

Introduction

In recent years there has been a growing appreciation of the importance of socio economic conditions as crucial determinants of health and wellbeing (Wilkinson and Pickett, 2010, Schulz and Mullings, 2006). The evolving utilisation of social constructionist approaches in medicine, public health and epidemiology has allowed for a welcome, if not long overdue, focus on the effects of social inequality and class division (Wilkinson and Pickett, 2010, Graham, 2006). Within this context, attention has been given to research suggesting that homophobia and transphobia are major

environmental and social stressors that impact on the health and well-being of LGBT people disproportionately. A significant exposure to disease vulnerability, lack of health-related risk identification and restricted access to the health care system are the main contributing factors (Institute of Medicine, 2011, Potter et al., 2008, Wilton, 2000, O'Hanlan et al., 1997). Moreover, 'minority stress', the mental health consequences of stigmatization, and homophobic/transphobic bias result in poorer mental and physical health outcomes among the LGBT population (Dentato, 2012, Institute of Medicine, 2011, King et al., 2008, Herek et al., 2007, Meyer, 2003).

Despite the emergence of evidence confirming that LGBT people experience substantial health inequalities, sexual orientation and gender identity are still not fully considered as solid sociodemographic characteristics much of mainstream health research (Williams et al., 2013, Institute of Medicine, 2011). Consequently, LGBT people are either routinely ignored in health research or they are merely considered as part of a patient predominantly linked to HIV-related studies (Institute of Medicine, 2011, Price, 2011). Likewise, the prevalent male/female binary in epidemiological research allows little space for recognition of other gender identities and their subsequent diversity in health experience. Meads et al. (2012) and Fieland et al. (2007) argue that the broader invisibility of LGBT people and the limited health data referring to this community create institutional barriers which have led to a lack of investigation into sexual orientation as a social determinant of health. It also obscures the prioritisation of LGBT health in official policy reports and objectives.

Such erasure of LGBT communities from public health discourses and policies appears to be common even in countries that generally adopt a more progressive socio-legal context for the protection of LGBT people (MacDonnell and Daley, 2015, Mule, 2015, Daley, 2006). One could confidently assume that the situation is significantly worse in countries that retain intolerant and punitive policies towards the LGBT community. Research on the health experience of LGBT people in these contexts is very limited. Our research aims at addressing such gap by exploring the health experience of LGBT people in the context of the Greek National Health System. As such, our research is the first of its kind.

The Greek state has historically pursued an intolerant approach to LGBT civil and human rights issues. It is worth noting that, proposals for ensuring equality in civil partnerships became a law as late as in 2015 and only after

the country's conviction by the European Court of Human Rights (Vallianatos vs Greece on 7/11/2013). Legislation allowing trans individuals to affirm their desired gender from the age of 15 was only approved in October 2017 (right after the conclusion of the current research project).

Appreciation of broader social inequalities as a health determinant has been notoriously poor among the Greek NHS (Economou, 2012, Tountas et al., 2004). Research and literature on health inequalities in Greece has been equally sporadic and it has primarily focused on examining the relationship between specific socioeconomic groups and particular diseases (Tountas et al., 2004). Economou's (2010) extensive review on health inequalities in Greece has concluded that there is virtually no national research programs, policy reports or expert advice on this issue, whatsoever. Challenging such institutional and pervasive disregard for the critical links between social determinants, health inequalities and the experiences of minority groups, has been the main motivation for the current research. In particular, our research aims at exploring the complexity, diversity and challenges experienced by the LGBT community in their encounters with the Greek NHS.

LGBT health inequalities in the context of extreme austerity.

Crucial in exploring the experience of the LGBT community is the recognition of important social and health intersections. This research was conducted during a period of protracted recession which constituted what is commonly known as the "Greek Crisis". What started as a debt crisis in 2010 quickly escalated to a full blown bankruptcy which triggered a bailout from a troika of creditors; the IMF/ European Bank/ European Commission. The total rescue fund has been the largest ever (€288.7bn) provided to a single country by international creditors. However, the brutal bailout conditions, based on the "holy trinity" of neoliberalism (privatisation, austerity, liberalisation of markets) had adverse effects on the population and in particular the most vulnerable people in society (Ioakimidis and Teloni, 2013). Health Care has not been unaffected by the financial crisis and the subsequent reforms. On the contrary, international lenders have primarily focused on reforming Health and Social Care through the implementation of extraordinary cuts and rapid marketisation of services (Ifanti et al., 2013, Ioakimidis and Teloni, 2013, Kondilis et al., 2013).

Research on the effects of the economic crisis on the health care sector present a picture of "humanitarian catastrophe" (Kondilis et al., 2013, Kentikelenis et al., 2011). As the budget for public health services has been

reduced by more than 30% and means tested criteria abruptly restricted access to many vulnerable groups in society, thousands of patients have been reported to be seeking basic healthcare in charity based on makeshift 'Social Solidarity Clinics' (Ifanti et al., 2013, Kondilis et al., 2013, Kaitelidou and Kouli, 2012, Kalafati, 2012).

Despair, deprivation and disillusionment have provided fertile soil for extremist, far-right groups. In this context, minority groups have experienced further demonisation. The Racist Violence Recording Network (RVRN) recorded 273 incidents of racist violence only in 2015. LGBT individuals were the single most affected group of victims, targeted in 185 incidents.

It is precisely this extraordinary context that makes health and health care experiences of LGBT people a matter of priority. The chronic experience of institutionalized homophobia and transphobia, in conjunction with the impact of recent unprecedented austerity policies pose a direct threat to people's dignity, health and wellbeing.

Study design

The main research questions of the current study have focused on (1) How homophobia and transphobia are experienced by LGBT people in health care settings in Greece; (2) How do homophobia, transphobia and the sense of fear they trigger impact on the quality of health and healthcare services experienced by LGBT people (3) How do doctors experience and understand LGBT issues in clinical settings. Data were collected during the period between June 2014 and March 2015. A qualitative phenomenological research approach, underpinned this study. In particular, data collection involved 30 semi-structured interviews with LGBT individuals, 4 group interviews in which 16 LGBT activists participated, 10 semi-structured interviews with doctors, and 2 semi-structured interviews with key informants. The first key informant was a social anthropologist employed by an NGO working with immigrants and refugees. His contribution was crucial as he provided us with information for the health care needs of LGBT persons with refugee status and this information was in line with our purpose to further explore the interlocking oppressions (e.g. refugee status-sexuality-gender). The second key informant was a leading activist in the LGBT community and director of an association of people living with HIV. His contribution was essential in helping us understand some of the key issues affecting HIV-seropositive patients.

This approach generated rich data on issues related to the health care experiences of LGBT people from various health care settings including hospitals, health centres and private surgeries.

Our intention had been to immerse in the everyday conditions and contexts of the participants so as to engage with them and have insights into their every-day realities. The emphasis on the in-depth and holistic dimension of the study has been reflected on our choice to avoid 'one off' interviews and engage more systematically with participants. In this sense, the interviews were part of an evolving and on-going conversation rather than following a typical question/answer model. We considered that the restrictions of the inflexible "one off" interviewing model would hinder opportunities for follow up discussions in case participants wanted to provide additional information or suggest other potential contributors. Moreover, as one of our researchers has been active in the LGBT movement herself, during interviewing she could invite participants to reflect on shared experiences and observations. In this sense, our approach has blended phenomenological research approaches with elements of ethnographic interviewing. The two main factors shaping our research strategy were the sensitive nature of the topic and the hard-to-reach population. As Forsey (2010a) argues, ethnographic interviews are conducted with an ethnographic imaginary, aimed at revealing the cultural context of individual lives. In this view, casual conversation and formal interviews are part of what is "observed" in the field(Forsey, 2010b, Cohen and Rapport, 1995).

Our research design allowed detailed –often referred to as “thick”-descriptions of the ways that participants experienced homophobia and transphobia when dealing with health and health care related issues. This necessitated an interpretive approach to this study which gave priority to the reporting of participants' own meanings, understandings and interpretations of what constitutes homophobia and transphobia in the context of accessing health care.

Purposive sampling was employed in order to contact potential participants who self-identify as LGBT from within the LGBT community venues including LGBT organisations, LGBT events, lesbian and gay bars-cafes, web-based LGBT forums etc. All these methods have also been extensively used in order to recruit participants in LGBT studies (Meyer and Wilson, 2009, Fish, 2006).We combined this with snowball techniques and asked our initial contacts to nominate potential participants from among their social

networks. In turn, they too were asked to give further referrals from their own social networks (Bailey, 2007, Heckathorn, 2007).

For the group interviews, we invited LGBT organisations from both Athens and other regional/rural areas of Greece to participate as a group. The LGBT organisations who accepted our invitation for group participation also determined the places visited during field trips. This was a method we used in order to enhance the diversity of the sample as the voices of the LGBTs who live in regional/rural areas of Greece are hardly known even within the LGBT community of the capital. Although these field trips usually ranged from only 3 to 5 days, we enriched our data by participating in LGBT events, spending non-structured time with LGBT individuals, and conducting individual and group interviews.

Doctors who participated in this research were interviewed in their own private practice but all of them had prior or current experience in working at public hospitals. Also, all of them-with the exception of one bisexual cis woman-, were heterosexual cis men. The sensitivity of the topic and institutional barriers meant that the most effective way of recruiting doctors in this study was the utilisation of snowball technique.

Invisibility as a barrier in accessing health care

The primary and single most important finding of this study has been the exposure of the endemic LGBT invisibility within the Greek NHS and also the mapping of its extent, prevalence and consequences. Invisibility seems to be affecting every aspect of the health care experiences of LGBT participants. This was replicated in both the direct and indirect forms of discrimination that participants experienced in health care. Invisibility as a social phenomenon appeared to reproduce the same heterosexist and cissexist perceptions and practices that its own sustainability relies upon, analogous to the operation of self-powered dynamic systems.

Participants' own experiences within the health care system highlighted six main factors responsible for the creation and reinforcement of LGBT invisibility: a) the heterosexual and cissexual assumption, b) the unchallenged homophobic/transphobic language in health care settings, c) the idea that the health care needs of LGBTs are identical to those of

heterosexuals/cissexuals, d) the idea that the sexual orientation is irrelevant to patient health care/quality of services or located only in relation to some aspects of our health/body (for example sexual health) e) the individualistic perception of stigma, and f) depersonalized health care services.

Within such culture of silence and invisibility, many participants accepted they had felt completely powerless to discuss their health related concerns linked to their sexuality. In fact, many of them were forced to actively or passively conceal their sexual orientation/gender identity even when they knew that such behaviour included the risk of withholding crucial information about their medical condition. The culture of shared silence is reflected on Apostolos' words when explaining why he had not received appropriate information before and during a haemorrhoidectomy:

I asked some others who had the same surgery like me “what did doctors tell you about when you could have sex again?” Nobody had dared to ask [their doctors], I didn't ask either [...] Of course the doctor could mention this without waiting for such question. Butte doctor is also probably afraid to say something because someone could take this as an insult. This is a taboo issue(Apostolos, 28-year-old, gay man)

The heterosexual assumption, so prevalent in the Greek health care system, was routinely experienced by LGBT participants as a constant threat. It intensified participant's coming-out stress and reinforced their 'need' to self-surveillance. Moreover, the complete absence of positive signals towards LGBTs identified in health care settings, made participants comply with the heterosexual assumption in order to prevent explicit homophobic attitudes and ensure “the same”, yet not equal, treatment as heterosexuals. In short, many participants felt that avoiding discussing issues which could reveal their sexual orientation was a safer option than the risk of 'homophobia' that could be triggered after a possible coming out to the doctor. Crucially, such complicity created a “don't ask, don't tell” norm, as the majority of both the LGBT participants and doctors do not perceive invisibility as a form of discrimination or as a root cause of health inequalities.

Nevertheless, concerns among LGBT people about their own safety were found to be justified. Participants' highlighted that they were often exposed to homophobia or transphobia within the health system. Homophobic

language had been traumatic even when communicated by the hospital authorities/ doctors in the typical impersonal and generic way. The trauma of homophobic/transphobic language was devastating especially when it was experienced during medical examination which entailed voluntary physical immobilization or exposure. For example, Alex described how he reversed his decision to come out as gay man after he had received implicit signals of negativity and aggression towards homosexuality in a doctor's office including religious icons, nationalist and racist comments by the doctor:

My PSA test was bad so I needed to go to a urologist, [...] I wanted to come out, not for any other reason rather than to explain to him that since I am having passive sex then I have a rubbing cock in my prostate so I would like to know if this has any effect in a way [...] I got in his office and I saw all these saints and virgins in his walls and I thought "now, we are damned!" I have no reason to come out to every fascist [...] and I will also be fingered by him and he will notice that I am penetrated, so I said that the situation is not good at all. He kept repeating "as Greeks we are the best nation in the world", as opposed to "all these stinky foreigners" (Alex, 51years old, gay man)

Other signals of potential or actual hostility detected by LGBT patients included expressed religiosity of doctors, hate speech on racial minorities, sexist and nationalist comments resembling the terminology and discourse articulated by the Greek far right. Such a toxic combination of explicit or implicit aggression routinely resulted to overwhelming feelings of unsafety, discomfort and fear to disclose information on sexual orientation or gender identity. Avoiding or postponing medical appointments was the most common response to these experiences. In our research we came across several similar stories.

She [the dentist] was speaking out about men who were totally perverts and they cut their balls [...] and I was under oral sedation with my mouth open and I was thinking "why is she doing this? She has no empathy! Nothing!" [...] and now I am scared to visit her, one of my teeth hurts but I don't want to visit her, I postpone it (Jason, 18years old, Trans man).

Again, within a context of silence and invisibility incidents of this nature remain unrecorded and unchallenged. Doctors, who participated in this research did not deny that homophobic language is common in the health system. A common denominator in doctors' responses was that homophobic and transphobic comments could be somehow communicated more "discreetly". Indeed, using LGBT identities as a source of jokes or gossip appeared to be endemic in the organisational culture of health care settings. Although, all participants (patients and doctors alike) agreed that discriminatory jokes and comments were prevalent in the health system we did not hear of a single story of discriminatory language that had been challenged within the group of peers. Doctors who participated in our research seemed to be aware of the derogatory nature of "gay-jokes". However, reinforcing the heteronormative discourse, they suggested that those jokes were harmless as they were reproduced only discreetly and in the perceived absence of LGBT people. Most of the doctor respondents did not believe that these jokes could be harmful

One day a Trans woman came to the Accidents and Emergency Room because of a precordial episode. Of course, all of us laughed a lot at her but we only did so discreetly. So, that was ok! (Kosmas, 38years old, GP)

Similarly, one psychiatrist argued that derogatory language towards homosexuality or gender reassignment is a form of "inside harmless gossip" "not intending to offend the patient.

We still make a fuss and say "Ah! He is a homosexual", but it doesn't mean that we want to marginalize or to reject the patient. It is discussed as a gossip. Like when we say "he went out with her", "he made this or that"... I don't think this is done to reject someone (Lambro's, 56 years old, psychiatrist)

Tolerant attitudes towards homophobic/transphobic language were common among doctors despite the fact that this could result in a fear of disclosure and put LGBT patients at risk. When asked directly, most doctors equated such fear with internalised homophobia or transphobia. In this sense, they followed 'blame the victim' approach highlighting the patient's immaturity and lack of self-acceptance and self-respect. The prevalence of this idea was so widespread among doctors that rarely did believe that their attitudes could potentially influence the disclosure decisions of their LGBT patients or

their very sense of safety. Therefore, individualistic perceptions of stigma determined a context of structural indifference towards LGBT people. This created an environment of complicity and abandonment of any effort to ensure that the NHS provides a safe environment for LGBT people to disclose information relevant to their sexuality and gender identity.

Furthermore, within the norm of “don’t ask, don’t tell”, the experience of hospitalisation was often very traumatic for the LGBT participants as it entailed the stigmatisation and invalidation of their same-sex relationship. Pretending to not see the true nature of the relationship of an LGBT couple was the most common invalidating response from the part of the health personnel. LGBT participants argued that health professionals do not ask about the nature of the relationship but instead proceed to assume it as heterosexual (i.e. the patient is accompanied by a sibling or a friend). In fact, labelling partners as siblings appeared to be the most common “solution” to the problem visitation barriers. This was seen as a proactive approach towards allowing space for the couple to share the health crisis together and support each other. With a generalised absence of any written or transparent guidelines regarding visiting rights in Greek public hospitals, some LGBT participants adopted the same approach in order to maintain closeness to a hospitalised partner. As one participant said a health crisis “*is never a good time for a revolution*”

However, obtaining visitation rights under the condition of a “don’t ask, don’t tell” norm proved to be an insufficient strategy when a patient was in a critical condition or important health care decisions needed to be made. Tania, a 50year-old lesbian, described how she would come up with ways to manoeuvre through the system in order to ensure undisturbed access to the health care of her partner. Although she had initially registered herself as her partner’s sister, eventually she realized that this was not enough when her partner’s health deteriorated and had to be moved in the Intensive Care Unit (ICU).

I told him [the doctor] I was her sister but he still wouldn’t allow met see her... he eventually allowed me to enter the room but he then asked “doesn’t she have a family?”, and I said “it is me, I am her sister”. “No, I mean...” This is what was happening all the time, they kept asking “who are you?” I asked if someone can inform me about Rena’s condition “can I see the intensive care specialist?”, “Doesn’t she have a family?”, “Of course she has! I am her sister. “He said “no, I mean doesn’t she have her own family? Doesn’t she have a husband?” I replied “no” and he then allowed me in. But once

I got in the room I made it clear to them that I wasn't leaving under any circumstances - after that point I was no longer obligated to wait for their permission.

The dominant biomedical approach of health and disease appeared to reinforce the invisibility of LGBT people within health care by depersonalising the provided services through: a) the degradation of the role of the doctor patient relationship with regards to an appropriate diagnosis, treatment and health care environment, b) the detachment of people's health care issues/problems from their social realities and experiences, and c) the structural ignorance of the social dimensions of sexuality.

Lesbians and bisexual women described their annual gynaecological examination to be strictly limited to a typical Pap smear test. This was done during a rapid doctor visit, where the doctor-patient relationship was not a prerequisite. Within this invisibilising environment the dominant biomedical explanations worked to pathologise and further distort identities of LGBT people. This was evidenced by the accounts of many doctors. For instance, Thanos, a 45 year old endocrinologist, emphasised on the existence of two sexual categories -those of heterosexuality and homosexuality - a hypothesis that, in his view, could be proved if the gay community was not defensive towards the medical study of the causes of homosexuality. When asked whether such hypothesis would not apply to those who identified as bisexuals, he replied:

There are gays and there are straights. There are gays who are super sexually active, there are straights who are equally super sexually active. It is the same thing. There is a system on the brain which is the system of dopamine, the system of rewards. This system makes some people more prone to addictions. I believe that one part of people who are sexually super-active needs a lot of partners, and they become bisexuals because they are addicted to pleasure.

Preventive and primary health care in the context of invisibility and pathologisation of LGBT people

Our research suggests that penis-in-vagina intercourse appears to be the absolute norm of what is perceived as 'healthy' and 'normal' sex in the Greek health system. It is also the one type of sex that does not contravene gender

norms and the “natural” expressions of femininity and masculinity. Equally, gender was assumed to be managed exclusively by the rules of biology and could not be seen as fluid or different to the one assigned at birth. Consequently, LGBTs who depart from these norms are doomed to be perceived as abnormal, incomprehensible, inferior, lesser “women” or lesser “men”.

Our study did not only seek to map out and document these attitudes. It also demonstrated that the perceived “normality” created an important barrier for LGBT people to accessing appropriate healthcare. Our findings highlight impact of such pathologisation of LGBT people within health care. In particular : a) LGBT participants experienced high levels of discomfort when discussing issues regarding their sex life or their health concerns pertinent to their sexuality and/or trans identity, b) avoiding, postponing or opting-out of medical care due to prior experiences of homophobia or transphobia during physical examinations, d) embarrassment at being examined in their genitals as they feared that they would trigger homophobic/transphobic responses or because they feared that their sexuality would be revealed, e) uncertainty of trans participants in terms of entitlement to gender-specific examinations.

Lesbians, particularly those whose sexual practices did not involve penetration from penis-shaped sex toys, appeared to be considerably more reluctant to discuss openly about their sexual practices. For some of them the concept of penetration was so strictly related to the penis that even finger-in-vagina intercourse was not considered as either sex or penetration. Sexual practices such as oral sex, finger-to-vagina contact and genital-to-genital contact were also assumed to be safe in relation to STDs transmission. Moreover, lesbians who assumed that their hymen had remained unruptured were feeling compelled to identify as virgins because of the popular myth that virginity is only lost through penetration by a penis. Within the dominance of heterosexism in health care settings lesbians were assumed either as heterosexual or as (heterosexual) virgins. The feelings of shame for lesbians who were having sex exclusively with non-penetrative methods and their consequent pathologisation were even more intense. As the issue of virginity carried powerful emotionally and culturally charged stigmas, lesbians routinely self-identified as virgins and complied with these perceptions during preventive health care appointments. Doctors appeared to always protect the assumed virginity of lesbians and their assumed unruptured hymen from medical procedures such as the PAP smear but without discussing sexuality and sexual activity with patients. Mary, 41-year-old lesbian, described the enormous pressure and discomfort she felt in medical appointments as she could neither “come out” nor comfortably describe herself as a 41-year-old virgin.

I still cannot come out. And every time I went to the doctor... it is this word "virgin" that is very bad. Especially, after a certain age. I was feeling like a freak... it is difficult to even say this word, even if you are not a lesbian, it is difficult to say that you are at this age and you have never had.... So, I said this once to this particular doctor and I had an abdominal ultrasound, but it was liberating when I finally could have a smear test normally (Mary, 41 year-old, lesbian).

Gay men and their doctors also appeared to be in avoidance of speaking about anal sex. In one case this was explicitly verbalised by a psychiatrist who identified his own internalised homophobia specifically in relation to his difficulty of speaking about anal sex with gay patients. The uneasiness of all other doctors who participated in this research was expressed in implicit ways such as by lowering their voice, and/or by their nervous laughter. In another example, a GP projected his embarrassment of speaking about safe anal sex responded to the question in a 'humorous' tone: "*Aren't you embarrassed of asking these questions to all doctors? Or is that you only ask me these questions?*" Not surprisingly, the majority of gay men argued that medical examinations that necessitate physical exposure can easily become traumatic experiences:

A friend of mine visited an urologist at a hospital for a DRE, and during the examination the doctor asked "do you fuck?" Hey dude! I may not fuck! You know... he felt bad... he felt his internalized homophobia to be fired up. I may take the dick! If I tell you this what are you going to say? *What are you going to say?* As a doctor you must be ready for this, and you mustn't say that this is unnecessary information because you are a doctor and if you are good scientist this information is very relevant. As an urologist you have things to tell me about my prostate (Alex, 51 years old, gay man)

Among Trans participants, the examples of being treated in a transphobic manner by health care and mental health care providers seemed to be the norm. Such experiences included repeated and/or deliberate misgendering, insensitive and indiscreet questioning on transitioning and sex-related body parts, staring and facial expressions of disgust, verbal brutality and expression of transphobic ideas, harsh and rude behaviour, deprivation of support in hospitals, and direct denial of health care services. During the course of interviews with doctors, most of them admitted witnessing similar

transphobic incidences in their workplace and even acting out on their own transphobic ideas. Lucas, a 56 year old pathologist, was invited as part of this research to think about the possibility of encouraging a Trans woman to have preventive health care for prostate cancer. His response was one of the most transphobic recorded in this research:

...I can't go out and ask "who is a trans?" (He laughs), to ask him whether he has removed his prostate or not? (He laughs), he must come to me and say that he has prostate, since it is his gland and may be at risk of cancer... but has he ever thought about his prostate? (He laughs), he will probably think of other things, other things are in his mind [...] I can't ask a person "have you removed your prostate?", because if I ask this question I may be punched.

Not surprisingly, all Trans participants felt considerably vulnerable within the health care system and many of them were poorly informed about preventive healthcare. Melina a 29 year old Trans woman confirmed this when suggesting

Basically, I do not have a check-up very often. It has been a long time since I had a check-up. I don't know exactly... even on this issue I don't really know exactly what to do. I don't know to what specialist should I go... .. because of my nature I am not sure to whom should I go. So I guess just because I have a complete ignorance on this matter... you know, I am bit confused... normally, I must visit a gynaecologist. Look, I have completely neglected this issue, I've never had a check-up. To be honest I don't even know if I will have to tell the doctor that I had a sex reassignment surgery, I don't even know if they will be aware of this. What can I tell you? I don't know... this issue is a bit confusing. (Melina, 29 years old, Trans woman)

Identifying the urgent need for a proactive reform in Health Care settings

Our study has been the first to identify and explore LGBT people experiences in the Greek National Health System. This is particularly important in a context where public authorities have shown little interest in researching health inequalities, there is no full-scale system for the

appropriate reporting of racist, homophobic or transphobic violence or discrimination, and there is no policy for LGBT persons' protection against discrimination, or a national program to raise public awareness and combat negative stereotypes and prejudices (ECRI, 2015, Economic, 2012, Taunts et al., 2004).

As a result, homophobia and transphobia in Greece are often understood in narrow ways, usually linked exclusively to hate speech or homo/transphobic violence in public spaces. The purpose of this study has been to outline the processes through which these social structures appeared to act as barriers in accessing quality health care services for the LGBT participants. The study has documented the need for urgent policy intervention as the safety of LGBT people in Greece has been ignored for too long. Considerable delays in researching the experiences of LGBT people can be attributed to institutional barriers towards, avoidance of traditional social movements to deal with LGBT issues and the sense of powerlessness felt by the LGBT people itself when dealing with the stress health crises.

Drawing on what Ward and Win Stanley (2003) metaphorically called “the absent present” to characterize the oppressive power of silencing, we offer these findings to uncover the invisible aspects of homophobia and transphobia and prove that they are powerfully “present” through the many “absences”, silences and invisibilities of LGBT identities in the health care regime.

We are confident that the importance of this study goes beyond the confines of Greek society and it is of relevance to an international context. For the traumatic and oppressive experiences of many LGBT patients in Greece are certainly not unique. It is often the case that the unwillingness to deal with the broad and urgent healthcare experiences of LGBT people is hidden under the exclusive identification of this community with the HIV. Presenting this disease as the sole health concern associated with LGBT communities seems to be a dominant approach internationally. Moreover, medical protocols, best-selling medical textbooks and diagnostic codes at a global level still prioritise biomedical models almost unconditionally, justifying and perpetuating the implicit or explicit pathologisation of LGBT patients.

A theoretical reconceptualisation of the current models of health care delivery, in a way that they become much more inclusive and sensitive to the needs of this group, is of paramount importance. This of course presupposes the intervention of policy makers and the participation of professionals involved in public health promotion. Most importantly, the LGBT movement can and should play a significant role in reforming the Health Services in a genuinely inclusive way. As a contribution to this

reconceptualization process our analysis offers three points for consideration.

Firstly, we need to recognise that the societal forces of homophobia and transphobia are still in place and continue to shape health care services resulting in the pathologisation of LGBT people and the marginalisation of their health concerns. Clinical environments in which homophobic/transphobic language and interaction prevail create dynamics of exclusion that considerably impede LGBT access to health care. These factors also fuel patients' fear of disclosure and may even influence them to postpone, avoid, opt-out from the health care they need. Policy makers should take this into consideration in order to reform health care in a way that it ensures healing, safe and accessible clinical spaces for both LGBT patients and health professionals. It is therefore necessary to create monitoring mechanisms which would assess and analyse medical and epidemiological data linked to the LGBT community. Of course, this would require breaking with the narrative of 'invisibility' through the recognition of the specific medical/ prevention needs of the LGBT community. Inclusion of the LGBT community in the design, delivery and evaluation of health services and health education would be of paramount importance.

The development of inclusive environments in health care for LGBT people should be considered as an ongoing process which presupposes:

a) Mandatory and ongoing training for all health care professionals and staff on LGBT relevant information (e.g. the distinctions between sexual orientation and gender identity), affirmative practice and LGBT health issues. As with all patient populations, providing appropriate health care services to LGBT patients requires that health care professionals should be able to understand the cultural context of their patients' life, the issues around sexual and gender diversity and familiarity with the LGBT health needs. In addition, health professionals need to develop their ability to reflect upon personal attitudes that might prevent them from providing the kind of affirmative care that LGBT people need.

b) All involved in health policy and health care should start to utilize, adapt (if appropriate) and widely disseminate international literature and LGBT-focused clinical guidelines which have been developed to address cultural competence and promote good professional practice. There is a growing body of literature which enables health professionals to address important issues such as: the clinical rationale for monitoring sexual orientation, how to ask these questions in an appropriate way, trans-affirmative hospital policies/practices etc.

c) Specific protections, anti-discrimination policies for LGBT people and targeted initiatives to tackle homophobic and transphobic language and treatment within health care settings. Transparent policies are also required to allow patients to decide for themselves who may visit them or make medical decisions on their behalf, regardless of sexual orientation or gender identity.

d) Rejection of the dominant “neutral doctrine” and acknowledgement that within a heterosexist and cissexist world, there is a need for health care settings and health providers to convey affirming messages for LGBT populations. Visible signs may include posters with LGBT affirming messages, LGBT magazines, rainbow pins/flags/stickers etc. It should be acknowledged by all involved in health care that the ideas that are conveyed through language determine spaces of inclusion and exclusion.

e) All patients should have private and confidential time to talk with health providers.

f) The use of forms that include patients’ preferred names and pronouns, and the need for health information materials to be inclusive of the LGBT diversity.

g) Ongoing assessment of how health care is delivered. This could be achieved through the contribution of the LGBT community which should be encouraged to be actively involved in the design, delivery and evaluation of health services and health education.

Secondly, it is our contention that all of the above recommendations need to be informed by participatory and inclusive research. In fact, research should provide the platform for bringing together elements of learning, policy making and action into a meaningful approach that articulates and systematizes tools that promote good health and health care outcomes for oppressed populations. An overarching aim of this analysis has been to start removing the veil of “invisibilisation” and open up a genuine debate on the health inequalities of LGBT people in Greece.

Thirdly, the LGBT community in Greece can have a strong impact on the ways that minority health inequalities are currently understood both within the LGBT community and generally in society. For the LGBT movement, going forward would mean expanding the discussion on LGBT health inequalities beyond HIV issues, which although still crucial for the wellbeing of the LGBT community, it is not identical with the notion of LGBT health issues and inequalities.

Conclusion

Our research has focused on the health experiences of the LGBT community in the Greek health care system. The findings of our research suggest that within the healthcare context, LGBT people are routinely invisibilised and pathologised. Institutional homophobia is widespread in the Greek NHS and it manifests itself either through the systematic suppression of the health needs of the LGBT community or through the use of the moralistic rhetoric of “normality”. In either case, LGBT individuals feel isolated, fearful and they often internalise such oppressive language and practice. Furthermore, ignoring the specific health needs of the LGBT individuals not only creates an environment of oppression but it also puts their physical health at direct risk.

Our study does not explore the LGBT experience in isolation from the wider political and cultural contexts. The inadequacies of a chronically under-developed healthcare sector, further disrupted and undermined during the recession years, disproportionately affects the most vulnerable people in society regardless of sexual orientation. Even in the period prior to the recession, outsourcing services to the private sector and encouraging the expansion of the private healthcare provision had contributed to the creation of a two-tier system (Tountas et al, 2004). This meant that most working class patients, would primarily have access to inadequate health services in public hospitals while more affluent patients would be able to access the more responsive private sector. Indeed, a recent meta-analytical study on the effects of the current recessions suggests that “*since the onset of the Greek economic crisis, the efforts for reform have focused mainly on short-term effects by reducing expenditure, while the measures imposed seem to have potentially damaging long-term consequences for public health and healthcare.*” (Simou and Koutsogeorgou, 2014)

Inevitably, social inequalities and hierarchies also affect the LGBT community internally as the community itself is neither homogeneous nor immune from class- specific tensions. Therefore we need to avoid the reduction that working class LGBT patients, whose only option is public hospitals, share identical experiences with wealthier LGBT patients who can afford private and personalized healthcare. Nevertheless, our current research demonstrates that in a country where homophobia and LGBT invisibilisation are rife nearly all members of the LGBT community would expect to experience a range of uncomfortable, risky or potentially dangerous encounters within the Greek Health Care context (public or private). Therefore, a proactive Health Care reform that focuses on

identifying and tackling homophobia while facilitating genuine citizen/ patient participation is long overdue.

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