Education

Éducation

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Note: All physician–patient interactions related in this paper are based on actual cases.

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Not all your patients are straight

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A young woman visits a family physician for the first time. During the course of a physical examination, the physician asks, "When was the last time you had sexual intercourse?"

"I've never had sexual intercourse," she replies.

"Never?"

"No."

"Do you have a boyfriend?"

"No."

"Well, don't worry. You will soon. Let's talk about birth control."

The physician finishes the discussion about contraception and writes in the chart "Not yet sexually active. Not in relationship. Contraception counselling given."

The patient never returns, but the next year goes to see another family physician for her physical. During the course of the examination, the physician asks, "Are you sexually active with men, women or both?"

"Yes," she replies, "with a woman. I'm a lesbian."

"Are you in a relationship?"

"Yes — for 8 years now. In fact, I wonder if my partner could come to see you, too? We're thinking about having children."

"Of course, I'd be delighted to meet her."

And so begins a long, healthy physician–patient relationship.

A physician is taking a history for a new patient. In response to a question posed by the physician, the woman answers, "I'm a lesbian."

The physician glances up, looks her over and counters, "No, you're not,"and then continues with the history.

An HIV-positive woman who identifies herself as a lesbian and who had been admitted to hospital previously for AIDS-related pneumonia goes to a new physician. After she relates her history, the physician declares, "I doubt that you are HIV positive. I think this whole thing is a trick."

The patient leaves feeling as though the physician has insinuated that she would get some benefit from having AIDS.[1]

Lesbians often receive inappropriate health care because their physicians make incorrect assumptions about them or are not aware of how to solicit relevant information from them. The above vignettes illustrate the single biggest problem that lesbians encounter when seeking medical care — invisibility. Society, including the medical profession, has historically ignored an entire population of women and thus rendered them "invisible." This invisibility compounds their vulnerability within a non-accepting medical system.

Lesbians encounter many kinds of invisibility. One is a lack of awareness by society at large and, as a consequence, by the medical profession, as illustrated in the first vignette. Another type of invisibility, more common than might be expected, arises from denial, as illustrated in the second and third vignettes. And then of course there is the invisibility that occurs when a woman is unwilling to identify herself to her physician as a lesbian. The reasons for this unwillingness can range

from fear of rejection or poor treatment by her physician to her own negative self-image and insecurity. Studies show that most lesbians want to disclose their sexual orientation to their family physicians but need to feel secure and safe to do so.[2]

The fear of disclosure is not based solely on emotional factors. Lesbians and gays may be the most victimized group in the US.[3] Hate crimes include enduring verbal abuse, threats, physical and sexual violence, property damage and murder. Violence is usually more severe if the woman is identified as being a lesbian. For example, lesbians in universities are assaulted twice as often as heterosexual women.[4] Violence is not inflicted only by strangers: in one study 25% of lesbians reported being a victim of a hate crime committed by a family member.[5] When women say they are afraid to disclose their sexual orientation, their fear is often based on a very unfortunate reality.

There are consequences to the invisibility of lesbians. A distrust of the medical system can lead people to seek alternative forms of health care — forms that they consider to be more inclusive. Invisibility can also lead to misdiagnosis or underdiagnosis, as will be illustrated in some of the vignettes to come.

The emotional health of lesbian patients is perhaps one of the largest consequences of invisibility. If a society does not validate an existence or a relationship, it is very difficult for individuals to do that self-validation in a vacuum. Lesbian culture and community is critical for healthy self-esteem. It is certainly easier and healthier for a person to be congruent in her life and not have to split off different aspects of her existence according to with whom she may be relating. Although there is no difference from the self-esteem between lesbians and heterosexual women,[6] it is often difficult for lesbians to act in accordance with their identity because of society's negative attitudes.[7]

One other very important consequence of invisibility is invisible families. Somehow, a chart notation of "decisions made re: management, friend present" does not carry the same weight as "decisions made re: management, wife (or husband) present." Our patients' support systems often go unnoticed and invalidated.

A woman comes running into the emergency ward.

"Excuse me, has Mary Smith been admitted? She was in a motorcycle accident."

"Are you family?" asks the nurse.

"Well, not really. We live together."

"I'm sorry, I can only give out information to family members."

"But we live together. Please, I must see her. We live together."

"Sorry, only family members are allowed to see her."

The woman sits in the waiting room until a new nurse comes on duty and then approaches the desk again.

"Excuse me, has Mary Smith been admitted?"

"Are you family?"

"Yes, I'm her aunt."

"Oh, she's in 34B. This way, please."

In this example, the woman gets to see her injured partner. This is a humiliating and worry-filled experience for the woman who was concerned about, and denied access to, her injured partner. After this incident, the patient's physician wrote a letter to the hospital board asking for a review of visiting policies in the emergency department and the intensive care unit (ICU). Physicians can ensure that the emergency department and ICUs of hospitals where they have admitting privileges is accepting of self-identified family members. They should also find out to whom their patients want medical information released. More people in same-sex relationships are giving powers of attorney to their partners to prevent just such an incident from occurring. People are family members if they say they are. Many lesbians are estranged from their biological families, so their families of choice become even more important to their well-being.

As discussed previously, lesbians are sometimes unwilling to divulge their sexual orientation in a medical setting because of the fear of being rejected or treated poorly. Not all women are willing or able to come out. Years ago, physicians tended to be unaware of the existence of a significant lesbian population or else assumed that their patients' sexual orientation was of no concern in providing good health care. Now that lesbian culture has become more mainstream, there is much greater awareness of lesbians and their need to be recognized. Recent data have suggested that between 3.6% and 6.9% of women describe themselves as lesbians,[8] although Kinsey and associates[9] found that 10% of the female population is lesbian. Therefore, a conservative estimate of the number of lesbians in Canada would be between 0.5 and 1.5 million. Unfortunately, the increased awareness has not been accompanied by a better understanding of how to provide good health care to the lesbian population. Studies published as recently as 1997 concluded that lesbians' experiences of discrimination on the basis of sexual orientation are so common that such discrimination has been deemed an obstacle to good health care.[10]

It has been well documented that lesbians have avoided the health care system because of their past discriminatory experiences.[11,12] Lesbians have been patronized, intimidated, ignored and subjected to unsuccessful attempts to render them heterosexual. They have endured inappropriate and invasive examinations and questioning.[13] Even when physicians have been supportive, they have sometimes been ill

informed or inadequately prepared to answer questions and manage the care of their lesbian patients.

The fact that lesbians have been shunned by the traditional health care system may be a major reason why lesbian culture has embraced complementary medicine. When a patient who has been seeing alternative healers does consult a physician, the physician should try to respect the process that sent her there and subsequently brought her back to the conventional health care system.

A young woman presents with lower abdominal pain and vaginal discharge. In taking her history, the physician asks, "Are you sexually active?"

"Yes," she replies, "sure am. I'm a lesbian."

The physician rethinks the differential diagnosis and moves pelvic inflammatory disease (PID) to the bottom of the list of possibilities.

The patient's symptoms worsen, and she eventually shows up in the emergency department.

"Are you sexually active?" asks the attending physician.

"Yes," she replies, "sure am. I'm a lesbian."

"Do you ever have sex with men?"

"Sure do. Just because I'm a lesbian doesn't mean I can't do boys!"

The physician puts PID back at the top of the differential diagnosis.

One of the biggest mistakes physicians make is confusing sexual identity with sexual behaviour. They are not the same. It is our behaviour that puts us at risk for illness, not our identities, unless we include hate crimes. Women can identify themselves as lesbians and not be sexually active, and other women can be sexually active solely with other women and not identify themselves as lesbians. Even when physicians are aware of the existence of lesbian culture, we need to keep in mind that it is not a rigid and undifferentiated culture, but rather one of extreme diversity. Lesbians are present in every facet of society, just as are heterosexual women.

A 72-year-old woman has been losing weight and not sleeping. She is tired all the time. During the course of a physical examination, the physician asks, "Do you live alone?"

"Yes," she sobs.

"What about your husband?"

"I've been divorced for over 40 years," she replies.

The physician does a complete examination, decides the woman is suffering from depression and prescribes antidepressants. The woman does not return.

She does, however, go to another physician, who asks, "Do you live alone?"

"Yes, I do," she sobs.

"Have you always lived alone?"

"No. My roommate lived with me for 37 years. She died just a few months ago."

"Were you very close to her?"

"Yes."

"You must miss her very much."

"Yes. I can't bear to live without her."

And so the physician sends the woman for the bereavement counselling she desperately needs.

Sometimes older lesbians don't use the same terms as younger ones; for some, it is not easy to say "lesbian," "dyke" or even "homosexual." Although this is changing as society changes, there are still many older women who are sexually active with other women and in long-term committed same-sex relationships who would not identify themselves as lesbians. When these women lose their partners, their loss is magnified by the fact that society does not recognize them as "widows" and they must mourn alone, or with a few friends, in silence. From the perspective of society, their status remains unchanged, although in fact their lives have been shattered.

The vignettes presented thus far are examples of how we, as physicians, need to broaden our conceptual beliefs. In the physician–patient interaction presented in the first vignette, the physician believed, as many do, that if the woman was not sexually active with men, then she was not sexually active. In the fifth vignette, the physician believed that if the patient was a lesbian, then she could not be sexually active with men. Older women can be and often are involved in meaningful relationships with partners of either sex, a fact that can easily be overlooked. Some older women with children and grandchildren identify themselves as lesbians and will need recognition and support from their physicians. Physicians should be aware of how ageism can creep into their thinking. These vignettes are all examples of how assumptions can adversely affect the well-being of others.

A 49-year-old woman has been in a relationship with another woman for 14 years. During her annual physical, she asks about her risks for cancer. In the course of the discussion, the physician says, "Well, you don't need a Pap test every year. Lesbians don't, you know."

The woman decides not to return to this physician. Instead, she goes to another physician to discuss cancer risks.

"Well," the new physician says, "there are certain risk factors for cervical cancer: having sex at a young age, having multiple sexual partners of either sex, a history of STDs, infections with human papillomavirus, smoking and, of course, abnormal Pap tests."

The physician goes on to say that cervical cancer, at least uncontrolled cervical cancer, is preventable, but only

if screening is done, and that all women should have regular Pap tests according to their medical history and other risk factors.

Later in the discussion, the patient mentions that she has heard that lesbians are at higher risk for breast cancer and asks why.

The physician describes the 3 main categories of risk factors: genetic, hormonal and external. Breast cancer in a primary relative, such as the mother or a sister, would put a woman at higher risk. Hormonal factors include number of years of menstrual cycling uninterrupted by childbirth, age of menarche less than 12 years, never having had children or having had children after the age of 30. External factors refer to dietary and environmental factors, alcohol intake, smoking and a history of radiation.

Some people believe, incorrectly, that lesbians don't have children as often as heterosexual women, that they are older when they do have their first child or that they don't have any children at all. Lesbians were thought to drink more alcohol than the general population, but that's because all early research was done in a bar context.[14] That lesbians drink more seems to be much less true now that they are less confined to bars as the only venues for expression of their culture. It is not being a lesbian that affects one's risks, but rather it is one's own personal behaviours and exposures that are important.

During the course of a medical visit, a woman says, "I am a lesbian just about to start a new relationship. Could you advise me about safe sex?"

The physician replies, "I just read an article in a medical journal that said that lesbians don't have real sex anyway. And lesbians don't get AIDS. Just be thankful you're a gay woman and not a gay man. But I'm glad you brought this up. What do lesbians do in bed anyway?"[12]

Upset, the woman leaves the office and goes to see another physician, inquiring again about safe sex.

"Good for you for asking," the physician responds. "Of course lesbians can get AIDS. It's the activities that you and your partner participate in that put you at risk."

"Look, we don't do drugs or sleep with men and neither of us has had a transfusion. I'm talking about regular things."

"Okay, but there are other ways women can become infected with HIV. Some women get it from donor insemination when screening has not been adequate. And don't forget occupational exposure — lab techs or other medical personnel could have an accident at work.

The first thing the two of you need to do is talk about past behaviour. That way you have some idea of potential risks. We do know that woman-to-woman sexual transmission of HIV is possible and has occurred.[1] Remember, some people don't always tell the truth, which is one of the risks if you don't know the person well. Talking about past behaviour with full risk assessment is a mandatory first step." (See Table 1 for a summary of safer-sex guidelines for lesbians.)

Just as it was once thought that women's health issues were the same as men's health issues (and therefore that the results of clinical trials involving men were applicable to women), it is now erroneously thought that lesbians' health issues are the same as women's health issues. What makes lesbian health a category is humanity's inability to rid itself of homophobia, racism, economic injustices, heterosexism and all the other "isms" and inequities that exist in our less-than-accepting society. There is no disease process that is specific to lesbians, yet the health care of lesbians is not equal to that of heterosexual women.[15–18] The reasons for this inequity range from blatant homophobia to naïve ignorance. The vignettes presented here illustrate that there are different ways of soliciting information from patients. How we, as physicians, interact with our patients helps define the quality of care we provide. Lesbians do not, as a group, have "different" diseases than heterosexual women; rather it is the nature of the physician–patient interac-

Table 1: Safer-sex points to remember for lesbians

Woman-to-woman sexual transmission of HIV is possible
HIV is spread through body fluids such as vaginal fluids and menstrual blood
HIV can be transmitted from body fluids to cuts on hands or mouth
Latex barriers protect against direct contact; dental dams (rinsed with water first) can be used, but condoms split lengthwise may be preferable; many women prefer household plastic wrap
Good latex gloves can provide a very effective barrier
Barriers should be used only once by one person, and a barrier should be used only on one side; some women put an "X" on one side so that the barrier does not get inadvertently turned around during sex play
Only water-based lubricants should be used with latex barriers or plastic wrap, because oil ruins the integrity of the barrier
Sex toys should be well cleaned after each use; they can also be covered with latex barriers (to clean, sex toys should be soaked in rubbing alcohol for 10 minutes and then rinsed with water, or washed in a mixture of 1 part bleach in 10 parts soapy water)
STDs such as human papillomavirus (HPV) and vaginitis can be transmitted by direct skin-to-skin contact
HPV and *Trichomonas* may be transmitted through fomites, such as shared towels
Women are more at risk during menses and when they have a yeast infection
After the risks have been assessed and if they are deemed to be very low, negative HIV tests should be recommended for both partners if they wish to engage in sexual activities without barriers
Risk status should be continually assessed, especially if circumstances change

tion that defines the quality of health care. The fear of being rendered invisible is a huge barrier to lesbians approaching a new health care provider. We, as physicians, need to ask ourselves what prevents us from asking the "right" questions — those that would allow patients to be comfortable being themselves. Is it simply naïveté, for which some education is needed and nothing more? Might it be bigotry or simply indifference? We need to recognize our prejudices and discomforts and either learn to overcome them or inform patients that their health care needs might be better met by another physician. Understanding and accepting differences do not necessarily imply approval. We do have the means available to educate ourselves so that we can be in an improved position to provide more appropriate and better health care to all our patients. Table 2 lists guidelines for providing good health care to lesbian patients.

Table 2: Guidelines for providing good health care to lesbians

Don't make assumptions
Remember that identity does not equal behaviour
Examine your own biases — how do they affect your patient interactions?
Remember that *how* you ask questions may be just as important as the questions themselves
If you can't support your patients' identity, refer them to someone who can
Don't contradict your patients when they make statements about themselves; avoid arguments
Roll with resistance, giving your patient time to integrate information and develop trust in you and the process
Educate yourself about issues relevant to good health care for lesbians
Involve your patients' significant others in decision-making and planning
Be aware of and display resources in your waiting room to let patients know you are approachable
Use inclusive language on all office forms and when talking with your patients
Ask your patients if there is something that you've missed asking about that they feel is important for you to know
Don't make assumptions

We lesbians want the same respectful and competent health care that everyone else wants. We, as physicians, have a responsibility to provide equitable health care to all. It is acceptable to ask questions and to be less than perfect in interactions with patients if our intent is to empathize and provide the best care that we are able. We can learn together in partnership with our patients and colleagues. We physicians need to increase our own awareness and broaden our conceptual beliefs in order to fulfill that role that has been entrusted to us as health care providers.

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Resources for lesbians and their doctors

Gay and Lesbian Medical Association
459 Fulton St., Suite 107
San Francisco CA 94102
tel 415 255-4547
www.glma.org/
An international organization of lesbian, gay, bisexual and transgendered (LGBT) physicians, medical students and their supporters. A huge source of information and support.

Journal of the Gay and Lesbian Medical Association
Subscription information:
Plenum Publishing Corp.
233 Spring St.
New York NY 10013
tel 212 620-8468
fax 212 807-1047
A multidisciplinary, peer-reviewed quarterly, devoted to the study of the health of the LGBT populations.

Lesbian Health Bibliography, compiled by Liza Rankow, PA-C, MHS
Ordering information:
Office of Gay and Lesbian Health Concerns
Bureau of HIV Program Services
New York City Department of Health
601–125 Worth St., Box 67
New York NY 10013
tel 212 788-4310
fax 212 788-5243
Originally published by the National Center for Lesbian Rights in January 1995. A 50-page booklet listing 798 references relevant to lesbian health issues.

Free your mind. The book for gay, lesbian, and bisexual youths — and their allies, by Ellen Bass and Kate Kaufman. New York: Harper Collins Publishers, Inc.; 1996. An excellent resource for young people and anyone who deals with them.

National Lesbian and Gay Health Association
1407 S St. NW
Washington DC 20009
tel 202 939-7880
This association has a publication list for relevant issues and is a good resource. Unfortunately, I know of no Canadian counterpart.

The Lesbian Health Book, edited by Jocelyn White, MD and Marissa C. Martinez. Seal Press, 1997.
Covers many aspects of lesbian health but is mainly anecdotal. One of its strongest features is the large number of resources listed in each section, for example, old lesbians, parenting, research and myriad others. Excellent for lesbian patients.

The Mary-Helen Mautner Project for Lesbians with Cancer
1707 L St. NW, Suite 1060
Washington DC 20036
tel 202 332-5536;
www.sirius.com/~edisol/mautner/index.html

Lesbian Mothers Support Society
630 4th Ave NE
Calgary AB T2E 0K1
tel 403 265-6433
www.lesbian.org/lesbian-moms/index.html

Lesbian Org, an online resource of information and links
www.lesbian.org/
This site leads to many other sites relevant to lesbian health. An excellent resource.

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