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# Seeking open minded doctors

## How women who identify as bisexual, queer or lesbian seek quality health care

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### BACKGROUND

Bisexual, queer and lesbian women experience higher rates of discrimination, trauma and abuse and are at higher risk for adverse health outcomes than heterosexual women in the same populations. This research investigated the strategies these women use to maximise the quality of health care they receive.

### METHODS

Semi-structured interviews with 47 self identified bisexual, queer and lesbian women. Predominant themes were correlated with findings by other researchers.

### RESULTS

These women sought skilled practitioners who responded positively or neutrally to their sexuality. Some did not disclose their sexuality even where it seemed relevant, or preferred finding an accepting practitioner to ensuring continuity of care. Additional strategies for obtaining quality care included: 'coming out', selecting practitioners carefully, and educating practitioners about sexuality.

### DISCUSSION

Like those in other countries, Australian bisexual, queer, and lesbian women do not assume that health practitioners will accept their sexuality. They seek to avoid hostility by locating sympathetic practitioners. General practitioners can signal their willingness to provide quality services to these patients by relatively simple methods.

**Bisexual, queer and lesbian women experience higher rates of discrimination, trauma and abuse and are at higher risk for adverse health outcomes than heterosexual women in the same populations.**

Victimisation is prevalent.<sup>1,2</sup> Stress, depression, anxiety and self harm are more frequently reported by lesbians than their heterosexual counterparts,<sup>2,3</sup> while bisexual women are at greater risk of discrimination,<sup>4</sup> sexual coercion,<sup>5</sup> and mental health problems<sup>3</sup> than either heterosexual women or lesbians. Bisexual and lesbian women also experience difficulty accessing health care<sup>6-8</sup> and have lower participation rates in preventive health programs.<sup>9</sup>

While their health risks are well documented, less is known about the how these women go about obtaining health care. Our findings were part of a larger research project investigating wellbeing among bisexual and lesbian women and their strategies for thriving. This qualitative study extends knowledge about how women in these relatively hidden populations engage with health providers.

### Methods

Purposive sampling was used to locate key informants. Participants were recruited through bisexual and lesbian

organisations, email networks, and women's health and queer health conferences. Volunteers were invited to share their views on how to thrive. Forty-seven women were interviewed in person or by telephone using a semi-structured interview format focusing on strategies for thriving and support for wellbeing. Women aged 20–71 years were recruited from five Australian states. Fourteen were eligible for a health care or pension card. Twenty-seven identified as lesbian, 16 as bisexual, and four rejected either label and preferred the term 'queer'.

The interviews were transcribed and coded thematically. All text relating to health care was analysed. Four themes predominated: positive interactions with health care providers; negative interactions with health practitioners; disclosing sexuality to health care providers; and how to find a good practitioner. Parallels are drawn with the findings of other research, which has investigated interactions between bisexual or lesbian women and health care providers.

### Findings

When asked 'What makes you thrive?' and 'Where do you get support for yourself as a bisexual (or lesbian) woman?' none of the participants nominated health practitioners. On prompting with 'Have any health

providers been helpful?' some respondents described supportive experiences. Others gave accounts of aversive experiences in which they had a hostile response or had been mistaken for heterosexuals (or, in the case of the bisexual women, mistaken for lesbians).

These women did not assume that every health practitioner would accept their sexuality. They sought quality care by locating sympathetic practitioners or services through friends and community networks, consulting several practitioners or setting criteria for the care they would accept.

### Features of a good service

Practitioners who were open minded or friendly toward people of different sexual orientations were valued by both bisexual and lesbian women. In addition to a positive or neutral response to sexuality, therapeutic skill was appreciated and respected. One bisexual woman said, 'I love my doctor... I trust his judgment, but that's like less... about being bisexual and more that... his skills as a doctor are really good. Like when I burnt out last year he recognised I was suffering from depression more than I, and was able to help me with that.'

Lesbians appreciated general practitioners who acknowledged their lesbianism, took care to understand their problem and addressed any reservations they had about suggested treatments. One said, 'She considers me, or the lesbian aspects of my health, as though they were normal. When she looks up research she always says, 'Well, you know, there's not anyone who's ever said that they were lesbian or gay in the research, and therefore this is the heterosexual finding, and how does that relate to you?'

Bisexual women described the need to confront assumptions of both lifelong heterosexuality and homosexuality. They sought queer friendly practitioners even if their current partner was male. One said, 'Whether I'm with a man or a woman, I want my health care professional to be supportive of whatever choice I made.'

### Finding a 'good' practitioner

Acceptance of sexuality was a primary consideration when choosing a practitioner. For some, being treated in a neutral fashion rather than with overt hostility was sufficient. They referred

to their practitioner's 'nonjudgmental', 'open minded' or 'affirming' approach. This contrasted with aversive experiences where practitioners had expressed hostility or condemnation or had been 'judgmental' or 'unsupportive.'

Referral from trusted sources was a central strategy used to find a nondiscriminatory practitioner. They sought referrals from friends or women's services, or chose practitioners associated with the queer community. One lesbian health worker told us, 'I often get asked do I know of either a lesbian friendly health practice or a lesbian in health practice, so it's clearly something that matters to people.'

Several had set criteria for selecting a health practitioner. One lesbian had interviewed many psychologists before choosing one she believed had the appropriate attitude and skills, and a bisexual woman told us, 'I make it clear that I'm not monogamous pretty early on, and if the doctor had seemed to have had a problem with it I would have not gone back.'

### Choices about disclosure

Having located a sympathetic practitioner there were a range of opinions on whether disclosing

sexual orientation was necessary or useful. Some women made a policy of 'coming out'. One lesbian said, '... make it my business to tell them first, rather than wait and pussyfoot around.' Others felt that disclosure was unnecessary or irrelevant.

Several bisexual women implied that raising sexuality was risky unless it was clearly relevant. Some had chosen to avoid disclosure in order to protect their wellbeing. One had noted her gynaecologist's assumptions about sex and number of partners and chosen not to contradict them, but she remained unsure of their relevance to her care. Some bisexual women preferred sexual health services believing them to be queer friendly, sex positive and understanding of casual sex by comparison with their usual practitioner. 'They're really open... they focus more on behaviour than identity... it's nice to have that recognition that not everyone is straight.' Others used sexual health services specifically to avoid confiding in or confronting the assumptions of their usual practitioner. One said, 'I knew that would be an okay place, rather than spring it on my GP' and another, 'I went to the [STI] clinic... it was free... and there's not a big furore and big explanation like with your GP'

**Table 1. How GPs can contribute to the wellbeing of bisexual and lesbian patients**

- State your clinic's policy of nondiscrimination and confidentiality clearly
- Make the waiting room welcoming with posters and information directed to bisexual and lesbian women
- Use gender neutral language on intake forms and give choice in documenting next of kin and relationships
- Encourage patients to disclose their sexual identity, orientation and behaviour by asking about opposite sex and same sex partners
- Reflect your patients use of language and self identification. If in doubt, ask what terms they prefer
- If a female patient identifies a female partner, do not assume that she has never had a male sexual partner or been pregnant
- Recognise the impact of discrimination on health and the link between being 'in the closet', high risk behaviours and poor health outcomes
- Develop a referral network for lesbian and bisexual women. The same referral you give to your heterosexual patients may not be helpful

**Table 2. Resources**

- Gay and Lesbian Health Victoria – [www.glhv.org.au/](http://www.glhv.org.au/)
- GP focused information on health care needs of lesbian, bisexual and same sex attracted women from an Australian perspective – [www.dialog.unimelb.edu.au](http://www.dialog.unimelb.edu.au)
- The Lesbian Health Research Centre provides information for lesbians 'Your health, communicating with your doctor' – [www.lesbianhealthinfo.org/your\\_health/](http://www.lesbianhealthinfo.org/your_health/)
- The Gay and Lesbian Medical Association (USA) guidelines for creating a safe clinical environment for lesbian, gay, bisexual, transgender and intersex (LGBTI) clients – [www.gлма.org](http://www.gлма.org)

Sexual health services were unanimously endorsed by the bisexual women who had used them. They appreciated having their sexual identity and the sex and/or number of their partners treated as 'unremarkable'. One described her delight in finding 'bisexual' offered as an option on a registration form, 'It felt really good that I was even asked. And I felt quite strong to have ticked... 'bisexual'... it probably was the first time I'd ever encountered it.'

Some lesbians attended different doctors for different issues. One told us, 'I see a straight, lesbian friendly GP at a clinic for my female stuff, my gynaecological stuff really, and... emotional stuff, and I see the gay guy for physical ailments.'

Sometimes disclosure had no impact on health care interactions, on other occasions there had been positive responses. One lesbian told us, '[the palliative care team] were completely lovely. They greeted me like a long lost friend and they included my partner.'

Three women reported that disclosure had resulted in better care. One believed that discussing her gynaecological problems had become easier, while disclosure had enabled two others to seek referral to sympathetic psychiatrists. Others withheld information and wondered afterward what impact this had on their care, 'I went to the emergency ward... I was experiencing chest pain and had no idea what caused it... I really should have mentioned that I bind my breasts. I wasn't sure how significant it would be... I was too embarrassed or frightened of what his reaction would be, so I never told him.'

### Other strategies for getting good care

Some women had decided on educating their chosen practitioner, but stressed that this required a high level of personal confidence, 'Because I am confident and okay about my sexuality, I'm okay about telling [my GP] everything that I need to tell him... somebody who was frightened that the doctor would judge them and hasn't got so much self esteem may not be able to tell the doctor everything they need to be telling him to be able to make a good diagnosis.'

Several women had participated in training programs for health practitioners. They hoped that more practitioners would understand diversity, be inclusive and not assume that everyone is heterosexual in the future.

## Discussion

Confidence in the validity of this report is supported by parallel findings by other researchers. Research conducted in the United Kingdom found that only 40% of lesbians revealed their sexual orientation to their GPs,<sup>10</sup> while Bailey et al<sup>11</sup> noted that lesbians and bisexual women in Canada experienced significant costs associated both with revealing and concealing their sexuality. A large study based in England and Wales found that high proportions of bisexual women and lesbians reported negative or mixed reactions when disclosing sexuality to mental health professionals<sup>12</sup> while bisexual and lesbian women interviewed by Eliason and Schope<sup>13</sup> in the United States looked for signs of acceptance in the health care setting before disclosing their sexual orientation, but rarely found any.

The reservations of these patients are mirrored by GPs. In a qualitative study of 22 GPs in Sheffield, Hinchcliff<sup>14</sup> found that they perceived barriers to discussing sexual health with patients who were not heterosexual. The GPs felt ill equipped and suggested that they would be assisted by a better awareness of gay lifestyles. Some of the women we interviewed had set about educating practitioners, either through training institutions or by talking to their own practitioner. Their advocacy parallels growing calls for improved training about sexual and gender diversity for health care providers.<sup>2</sup>

We recruited confident and articulate members of relatively hidden communities. While interviews with other bisexual and lesbian women would yield different stories, we believe that the range of strategies reported here corresponds to the range employed by bisexual, queer and lesbian women seeking health care generally.

Bisexual women chose to disclose their sexual identity only when they felt it was necessary, relevant and safe. Their decisions have clear implications for continuity of care. They had decided that the reaction they feared from their practitioner was a greater risk to wellbeing than discontinuous care or care based on incomplete information.

Many patients have secrets and some wonder whether their doctor would disapprove of them. For bisexual, queer and lesbian women the prospect of judgment and disapproval are highly aversive because these responses represent a rejection of who they are – their core sense of

self. To engage with these at risk patients, health practitioners need to take active steps to indicate their openness to disclosure about sexuality.

### What can GPs do?

Letting patients know that they can expect to be treated with respect and dignity is not difficult. General practitioners wishing to signal their willingness to provide high quality care to bisexual, queer and lesbian women may consider the practice tips provided in *Table 1*, or obtain advice from sexual health services (*Table 2*).

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