Quality of relationships between Ohio lesbian, gay and bisexuals and their healthcare providers: issues of communication

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Quality of Relationships between Ohio Lesbian, Gay and Bisexuals and their Healthcare Providers: Issues of Communication

Kaitlyn M. Hogan

The University of Toledo

2010
Dedication

I want to thank and dedicate my research and continued success to my family and friends for all of their immeasurable support. I would not have been able to complete this program without their help. I dedicate my hard work to my family for being my strong backbone, to my fiancé who put up with many my breakdowns, to my friends who showed me how to have fun during my lowest of lows, and lastly to Zoloft for maintaining what little sanity I had left. I am truly blessed to have all of these great people (and substances) in my life who believed in me even when others did not. Thank you all for being who you are, you mean more to me than words could ever convey.
Acknowledgements

I would like to take time to thank and acknowledge my advisor, Jolene Miller, MLS. I truly enjoyed working with her as an advisor. Without her thoughtful input, infinite wisdom and endless resources this project would not have gotten itself off the ground and running. She is truly a woman of inspiration; she gives every student her undivided attention, holds several positions within the University of Toledo and does an incredible job at all of them. It was truly an honor to have worked with Jolene on this project and I could not have done it without her.
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Introduction

Physician assistants and other medical practitioners take an oath to “do no harm,” but what if the harm is the result of ignorance on the part of the practitioner? Practitioners are causing harm by failing to adequately gather information about their patients, especially those from the lesbian, gay and bisexual (LGB) communities. The National Survey of Sexual Health and Behavior have estimated in 2010 between the ages of 14 and 94, up to 7% of women and 8% of men identify as gay, lesbian or bisexual (Herbenick et al., 2010), and up to 9% of men have engaged in same-gender sexual activity (Carrol, 2009), and 15% of men by the age 50 have had at least one oral sex encounter with another man (Herbenick et al.). As sexual minorities, lesbian, gay and bisexuals’ unique needs are commonly overlooked in today’s American society.

“Heterosexual until proven otherwise” was the mindset of healthcare systems in the recent past; this may be a contributing factor for lesbian, gay and bisexual individuals to be cautious about revealing their sexual orientation to healthcare providers (McNair, 2003; Rondahl, Innala, & Carlsson, 2006; Westerstahl & Bjorkelund, 2003; Williams-Barnard, Mendoza, & Shippee-Rice, 2001). Some healthcare providers and patients question the necessity of sharing such personal information, and others plead ignorance when it comes to identifying patients within the wide spectrum of sexual behaviors (Westerstahl & Bjorkelund, 2003). To quote Dr. M. Jocelyn Elders, former U.S. Surgeon General, “In order for physicians, nurses, pharmacists and other healthcare professionals to provide sexual health information to their patients, they must first have the understanding of what the sexual behaviors are in the community and how they are manifested. They must understand that humans are sexual beings from birth to death” (Elders, 2010).
Literature Review

Healthcare Needs of LGBs

A great deal of the healthcare of lesbians, gay men and bisexuals reflect the same standards of care for all men and women, but there are unique needs both physically and mentally that are important to identify (Gay and Lesbian Medical Association & LGBT Health Experts, 2001). The decision to come out or not can be a source for psychological stress. Coming out is often perceived as a risk, but choosing not to come out also can be as harmful, as illustrated in an interview with a college-aged lesbian, “Being in the closet is really unhealthy. Living that secretive life is so stressful. I was in the closet for 5 year [...] I hated that I would be called a lesbian. [...] It was very difficult, dealing with guilt, with not understanding yourself, not accepting yourself, living this lie” (Williams-Barnard et al., 2001, p. 132). Lehmann et al. (1998) found 49% of lesbian and bisexual women surveyed claimed to have been seriously or clinically depressed in the past; 27% also reporting suicide attempts. While Lehmann and colleagues surveyed women through a college lesbian association in West Virginia (median age of 23), another study found that lesbian and bisexual women over the age of 50 are more likely to display symptoms of depression than heterosexual women of the same age using the short form of the Center for Epidemiological Studies Depression Scale (Valanis et al., 2000). It was reported that 11.1% of 90,578 of the heterosexual women, 15.4% of the 704 bisexual women, and 31.5% of the 573 lesbians surveyed had some symptoms of depression (Valanis et al.). The Urban Men’s Health Study of depression in men who have sex with men found that of the 2,678 men surveyed, 17% had major depressive disorder (Mills et al., 2004). Depression is a major health issue in the general population regardless of orientation. In 2009, the Office of
Applied Science from the Substance Abuse and Mental Health Services Administration reported 6.4 percent of adults had at least one major depressive episode in the past year and of the adults with one major depressive episode in the past year had higher rates of illicit drug use (27.2%) than those without major depressive episodes (13%) (Substance Abuse and Mental Health Services Administration). A 2010 study done of Chicago men who have sex with men and indications of drug use are more likely to engaged in risky sexual behaviors placing them at a higher risk for HIV and other STDs (Mackesy-Amiti, Fendrich, & Johnson).

Lesbians and bisexual women are about twice as likely as heterosexual women to report having used illicit drugs in the past 30 days. This was reported by Koh et al. (2000), comparing lesbian and bisexual women to heterosexual women using odds ratios adjusted for age, race, education, household income, number of sexual partners in the past 12 months, and the number of sexual partners in their lifetime. These findings correlated with the higher rates of depression found among those same populations in comparison to their heterosexual equivalent. Lehmann et al. (1998) also found that 39% of lesbian women surveyed claimed to have had or currently have a drug or alcohol problems. According to the World Health Organization (WHO) (2002), in the United States, smoking kills more than one in five individuals and is the leading preventable cause of disease and premature death. This statistic is especially alarming for lesbian and bisexual women due to the reports of higher rates of smoking and amount of alcohol use and abuse (Valanis et al., 2000).

Bisexual women of all ages were also only about one-third as likely as heterosexual women to be classified as having had adequate cholesterol and mammography screenings (Koh, 2000). Breast health and cholesterol were not the only areas lacking proper
screening. A study by Marrazzo et al. (2001) found that women who have only ever had sex with women were, on average, significantly older at the time of their first PAP tests (22.5 years old) than women who have sex with women and also had a male partner in the past year (17.4 years old). Women who only have had sex with women also had fewer Pap tests on average in the past five years than women who have had a male partner in the past year (2.3 vs. 3.5). A larger lapse of time between their last two Pap tests was also reported (2.2 vs. 1.3 years) (Marrazzo et al.). Current recommendations by the American College of Gynecology (ACOG) suggest that all women regardless of sexual activity begin receiving yearly PAP smears at the age of 21 (American College of Obstetrics and Gynecology, 2010). As the current recommendations for cervical cancer screening become less strict, in time the discrepancies described above may become less of a disparity for lesbian and female bisexuals, but it is important that healthcare providers follow screening techniques that meet the current recommendations for standard of care.

A 2004 study consisting of 1700 men and women patients who were diagnosed with anal cancer from 1986 to 1998 in the Seattle, Washington area found that of the men who were not exclusively sexually active with women, 97.7% of tumors contained DNA of human papillomavirus (HPV) strains (Daling et al.). Anal intraepithelial neoplasia (AIN) among MSM is at a higher rate due to the common practice of anal intercourse, but one study found that only that 14.3% of self-identified gay men questioned had ever received an anal Pap smear, and only 45% surveyed knew about HPV and its associated risks (Pitts, Fox, Willis, & Anderson, 2007). While there are no current recommendations for anal pap smears, there are emerging data that may prove to be beneficial for the detection and early intervention of AIN (Salit et al., 2010). It is important for healthcare providers to remain
current on all standards for screenings of a variety of cancers and diseases and its importance for healthcare providers to recognize those individuals that are at higher risks due to sexual practices.

In a 2003 British study, 86% of the 296 lesbian or bisexual women surveyed who reported having oral sex with women also reported never used barrier devices or dental dams for personal protection (Bailey, Farquhar, Owen, & Whittaker). Although for women who exclusively have sex with women, it is not important to stress the use of contraceptives, it is still important to address the risks of sexually transmitted diseases (STDs) and how to avoid contracting them. In the same British study, 22% of the 127 lesbian or bisexual women who reported sharing sex toys never washed them before sharing; of those individuals, 52% never used condoms when sharing (Bailey et al.). This highlights a possible misconception that women who have sex with women may have regarding perceived risks of the transmission of sexually transmitted diseases and infections, especially the human papillomavirus (HPV).

Drug and alcohol use, depression, STDs, and failure to receive regular health screenings are a few of the topics of concern regarding the health care of LGB individuals. With higher rates of depression and illicit drug use, it is important to screen such patients to prevent the lethal combination of the two. Screening for HPV, other STDs, and cancers will improve the rate of detection of such diseases and improve outcomes due to earlier detection. As healthcare providers become increasingly aware of the special needs of LGB patients, a second hurdle to overcome is communication difficulty between healthcare providers and their LGB patients.
Barriers in Patient-Provider Communication

A covenant of trust between the patient and the provider is the foundation of quality healthcare. The first step toward building a strong rapport with patients is respecting and understanding their values and needs. It takes commitment and personal self-awareness to put aside preconceived notions and focus on the patient as a whole. Without a strong foundation for the patient-provider relationship, patients are less likely to disclose their full histories during the crucial, yet limited time of with the healthcare provider; this can leave the provider with incomplete information, potentially compromising the healthcare of their patients.

Verbal and non-verbal interactions can shift the balance of trust and openness in a conversation between a patient and a provider (Rondahl et al., 2006). Nonverbal communication is a powerful predictor of the strength of connections between individuals, from the distance they are positioned from each other, the exchange of facial expressions, and the information provided in office waiting rooms. One study found that that before a patient saw a clinician, they had already experienced several forms of heteronormativity in waiting rooms, forms, and during the admission and interview processes (Rondahl et al.). A 30-year-old women who was interviewed in the Rondahl et al. study spoke about her interactions with nursing staff, “...if they could leave the possibility that the person in front of them may not be living in a heterosexual life, and if they could ask questions that make me feel comfortable telling them that I'm worried about how I'm going to be treated – if they could ask if I have a partner instead of if I’m married and have children, their questions just assume that you’re heterosexual – then it’s up to me what I tell them” (p. 377).
A small study of 94 LGB individuals in New York City found that 78.9% of males and 54.5% of females shared their sexual practices with their practitioner, but of those individuals, only 50.9% of the males and 25% of the females felt comfortable discussing sexual issues with their provider (Klitzman & Greenberg, 2002). It is understandable how difficult this can be because even heterosexual patients may find it hard to talk about such sensitive topics with their healthcare providers. The reluctance of LGB patients to discuss their sexuality could be attributed to the reported 31-89% of healthcare professionals that were found to have displayed negative reactions to their patients when the patients disclosed their lesbian or gay status (McNair, 2003) or it could also be attributed to a common complaint among LGB patients that there are no built-in opportunity to disclose such personal information (Williams-Barnard et al., 2001).

When healthcare providers were surveyed about the topic of sexuality and whether they discussed it with their patients, consultation time constraints caused several providers to not ask because they felt that it would lead to further discussion that they did not have time to appropriately address (Gott, Galena, Hinchliff, & Elford, 2004). That same study found that a significant number of general practitioners admitted that they were uncomfortable discussing sexual health issues with “non-heterosexual patients”, with some reporting that they felt that they would not be able to put their own feelings about homosexuality aside from their clinical practice (Gott et al.). Other general practitioners felt that information such as sexual practices were “up to the patient to raise the subject” (Westerstahl & Bjorkelund, 2003, p. 207). Another practitioner reported, “There is no reason to tell if there is no problem about it, or it has to be important for the present consultation, even the patient does not have to mention it if she feels safe about it”
Healthcare providers justify not discussing sex with their patients with these reasons. Could the breakdown in communication be due to comfort levels of providers talking about sex or could it be the general deficiency of knowledge and confidence of the providers about LGB health issues and sexual practices?

A study conducted in 2003 of general practitioners regarding heteronormativity discovered a provider that had never encountered a patient known to be a lesbian in his practice. He confessed, “I was shocked, having thought of myself as a tolerant person, and yet ... sending out signals of a different kind.” The same physician later reported that he had interacted with a lesbian patient, but he was “totally at a loss” and did not know what to ask or do (Westerstahl & Bjorkelund, p. 206). This suggests a need for education about the needs of LGB patients to be incorporated in medical and professional healthcare education so that when a patient does feel comfortable enough to disclose sensitive personal information, the provider is comfortable and confident enough to utilize such information properly. Another study looked at the difference of patients being able to choose a LGB doctor versus not and their comfort level of discussing sex. They found that the individuals who could choose a LGB doctor, 54.8% reported being very comfortable discussing sex while only 22.6% (p = 0.009) of individuals with no choice for an LGB provider reported being very comfortable (Klitzman & Greenberg, 2002). This supports the need for current research on the perspective of LGB patients and how non-LGB healthcare providers can meet their needs to allow them to feel comfortable disclosing personal information, such as, sexual orientation and practices. By keeping abreast of current issues and knowing patient populations, healthcare providers can work toward being more well-rounded providers.
If clinicians are deferring the responsibility to the patient to bring up the topic of sexual practices and if patients are reporting no opportunities to disclose sexual practices, it is likely that communication between healthcare providers and LGB individuals will be less than ideal. This further exemplifies the need for research on clinician and LGB patients' relations and how to better improve communication and the care provided, resulting in better health for the LGB population.
Methodology

The population sampled was adult lesbian, gay and bisexual individuals living in the state of Ohio. The research excluded transgender individuals because the health care needs of transgender individuals are different and more complex than those of LGB non-transgender individuals. The researchers wanted to focus on a narrow, more specific population, and this was confirmed by the test pilot discussions. Because the study chose to focus on non-transgender people, however, this does not minimize the need for research on transgender people’s experiences with healthcare providers. It is also important for healthcare providers to learn about the health needs of transgender individuals throughout the transition process.

Sampling was of a convenience/snowball method using Ohio LGBT organizations to distribute invitations to participate in the study. Emails were sent to the head of several Ohio LGBT organizations to request their permission to distribute the invitation to participate in the survey to their membership/mailing lists or other communication avenues. The organizations were asked to post the invitation and link to their members/mailing lists through their newsletters, email, Facebook, etc. At no time did the investigators have access to the contact information of individuals receiving the invitations, maintaining participant anonymity. Upon receipt of an approval email, each organization was supplied with an invitation of participation (Appendix A) with the link to the online questionnaire, as well as instructions for distribution to the organization’s membership/mailing lists and other communication methods. In addition, participants were encouraged to forward the link to other LGBT individuals who might be interested in completing the questionnaire. Participants were asked to fill out the survey only once.
Two organizations accepted the invitation to participate in distribution of the online invitation. As a follow-up, each organization was later asked how the invitation was distributed. One organization reported that the invitation was sent via their monthly e-newsletter to their membership (over 15,000 individuals) and posted on their Facebook page. The other organization did not respond to the request for distribution methods. In addition, the primary investigators also distributed the survey using their Facebook pages for friends and family to participate.

Data was collected through an anonymous online questionnaire using Google Docs (http://docs.google.com). Even though the distribution of the invitation was through LGBT organizations, the sensitive nature of the questions necessitated that the survey be anonymous and each question included an option for respondents to decline to answer. The questionnaire included questions about sexual orientation and the gender of sexual partners (in order to identify people who do not identify as a sexual minority but have sex with people of the same sex). The majority of the questions addressed relationships and communications with healthcare providers. Other issues addressed included problems encountered with their healthcare provider, who should bring up the issue of sexual orientation/behaviors, how should these issues be brought up, and what providers can do to make their practices more LGB-friendly.
Results

A total of 49 individuals completed the online questionnaire; 36 individuals meeting the pre-set criteria of being 18 years and older, bisexual or homosexual, and non-transgender Ohioans (see Figures 1-3). To evaluate the comfort level of the surveyed individuals about their sexuality; they were asked who they were “out to” or to whom they were open about their sexual orientation or behaviors (Figure 4). The options included to friend(s), parent(s), sibling(s), partner, healthcare provider(s), colleague(s)/coworker(s), and everyone. Individuals were able to select more than one option, allowing the sum of all responses to be greater than the 36 individual respondents. The majority, 52.8%, of individuals were out to everyone with a close second of individuals being out to their friends, 47.2%. No participants reported being completely closeted (not open with anyone about their sexual orientation/practices).

To determine if lesbian women, gay men, and bisexuals perceived their healthcare providers to be open and accepting of their sexual orientation, participants were asked to rate their HCP attitude as positive, negative, neutral or unsure (Figure 5); 45% of individuals questioned felt their HCP has a positive attitude about their orientation. No one felt that their HCP was negative, but 22% were unsure how their providers would respond.

There are varied opinions and thoughts as to whose responsibility it is to obtain/disclose sexual practices and/or behaviors (figure 7). Participants were asked to answer whether their healthcare providers asked about their sexual practices or if they (the participants) had to initiate the conversation. Of the participants, 41.7% had healthcare providers that asked them first, and 27.8% of the respondents brought up the topic first (Figure 6).
Qualities that the surveyed LGB individuals look for in a healthcare provider include the clinician displaying traits of openness and honesty. LGB individuals need to be able to trust that the information obtained is only being used to improve their quality of care. Some individuals reported they would be more apt to discussing sexuality with healthcare providers of the same sex. Others felt that asking about sexual orientation/practices should be a part of any general intake/history and part of the individual’s permanent medical record. One individual suggested that the key is “normalcy” when asking questions, meaning that questioning should be done in a manner that would be appropriate to every patient, not making the LGB patient feel singled out. Suggestions as to how to ask about sexual practices included questions being asked in course with other intake information, not making assumptions, and stating the importance of knowing such information.

LGB individuals were also asked to identify qualities they look for in provider offices that suggest the providers are LGB-friendly. Suggestions identified by respondents included displaying ally signs/stickers on main office door, having all-inclusive options on all intake forms, pamphlets of gender/sexuality-specific health issues in the waiting room, and hiring staff members who are LGB-friendly (Figure 9).

When questioned about the impact of healthcare providers knowing their sexual orientation/practices, common concerns included negative interactions with office staff and whether the outcome could have a negative impact on their health care, due to prior upsetting experiences of the participant. Many LGB individuals would seek a HCP that had a good reputation by word-of-mouth for being ‘gay-friendly’. As shown in Figure 10, 47.2% participants rely on referrals and word-of-mouth to find a reliable friendly healthcare provider.
When questioned about situations in which the topic of sexual behaviors should be asked, the a large percentage (28%) of individuals felt that sexual practices and orientation should always be asked and included as basic part of everyone’s healthcare regardless of sexual orientation. One lesbian stated, “proactive communication, rather than reactive, allows the [healthcare] provider to provide proactive-focused information” and healthcare. Some suggest that this knowledge and information can be used when assessing risks associated with STDs, relationship counseling, and women’s and men’s health issues. A majority of individuals questioned (39%) felt that there are situations in which sexual orientation/practices should not be included in the discussion about their health. Situations included being treated for the common cold, treating broken bones, or other non-sexual health topics. A minority (5%) of LGB respondents felt that their sexual orientation should never be questioned by the healthcare provider. A common theme among LGB individuals who report not feeling comfortable disclosing such information had concerns of privacy and sharing of the information with insurance agencies and current or future employers.
Discussion

The current research shows the patient-provider relationship between LGB individuals and healthcare providers, as perceived by LGB respondents. LGB individuals in this study reported more positive patient-provider relationships than in past studies, with the majority of respondents’ healthcare providers’ attitudes perceived as positive. In past literature, McNair et al (2003) reported, 31-89% of healthcare professionals displayed negative attitudes toward LGB patients. Our research found that none of the individuals who responded to the questionnaire perceived their healthcare provider as having negative attitudes, and 22% were not sure how their provider would respond (Figure 5). Even if the 22% of individuals that were ‘unsure’ would have answered as ‘negative’ this new percentage is an improvement from the previous estimates. This may be an actual improvement or self-selection bias (for example, if people with previous negative encounters with healthcare providers chose not to participate).

Although healthcare providers’ attitudes are reported to be mostly positive, less than 50% of respondents reported that the providers asked them about sexual practices and behaviors, with 27.8% of LGB patients (15.3% males and 34.7% females) reporting having to initiate the conversation (Figure 6). These numbers are inconsistent with a small study done in New York (Klitzman & Greenberg, 2002); however, this could be due to the small sample sizes of both the New York study (94 individuals) and our study (36 individuals) as well as differences in geographic area and the time of the research. No conclusions can be definitively drawn, but the small percentage of respondents who were bringing up the topic of sexual practices and orientation without a prompt from HCP
suggest that providers should try to close the gap by asking the other 70% of individuals that did not disclose without prompt.

If practitioners are improve their rates about asking their patients about sexual orientation and practices, it is important that they embody qualities that LGB individuals are looking for in a trustworthy healthcare provider. The surveyed individuals wanted a practitioner that was open and honest and in whom they could trust that disclosure of such information would not affect them negatively in any way. Healthcare providers should explain to each individual why it is important to know such information as sexual practices and how it would complete their medical picture as a standard for all individuals. By completing this picture the practitioner could then provide the individual with quality customized healthcare.

A common way the participant found a medical provider with the qualities they valued in a clinician was by word-of-mouth. Of the surveyed individuals, 47.2% used word-of-mouth as their method of locating a reliable practitioner. Healthcare providers can use this information as insight as how to gain the trust of their LGB patient; it begins with first impressions. By healthcare providers creating a respectable reputation with their current LGB patients they are more apt to receive referrals from other LGB patients. Another way healthcare providers can promote themselves as a LGB friendly provider is to join the Gay & Lesbian Medical Association safe provider list. If an LGB individual is to see a practitioner’s name on the safe provider list, they may be more apt to disclose information about sexual behaviors and orientation.

Many of the surveyed LGB individuals believe that their sexuality should be a topic of discussion with their healthcare providers and part of their permanent medical record.
One respondent felt that it is important for their healthcare provider to not only ask about sexual orientation, but to get to know and feel comfortable talking to their patients’ significant others, “[healthcare] providers should ask if there is a significant other to be contacted just as if a heterosexual couple were in the same situation”. Another individual stated, “Any lifestyle functions that affect health ranging from stress of a loss of a partner to sexual practices. I don’t see a difference in the way homosexuals should be treated than heterosexuals, and this includes having my healthcare provider remember my partner’s name”.

While the minority (5%) of the respondents felt that sexual practices should not be a topic of discussion between the patient and provider, it is important that healthcare providers provide a welcoming clinical environment. One bisexual female felt that if a practitioner is not in a position to be concerned with their overall health or reproductive health there is no need to know about sexuality/practices. This individual stated, “My podiatrist doesn’t know I’m bi because my foot is just a foot.” While this statement may be true in some circumstances, it is also important to note that just because a practitioner is a part of a subspecialty does not mean that they do not look at the body as a whole. Another bisexual female declared, “I am skeptical that sexual orientation would ever be a topic that would be relevant to my health as I am bisexual”. It is important that practitioners educate these individuals about health issues that may be influenced by their sexual orientation/practices. Practitioners are able to offer support and resources to every individual’s unique need if they have the whole representation of the individual.

There were several limitations to the study. One limitation was the sensitive nature of the questionnaire. Because the investigators wanted to uphold the anonymity of the
research, they chose to rely upon the LGBT organizations to distribute the survey. In order for individuals to receive the survey they had to have been on a membership/mailing list of the two participating organizations, or to be in contact with the organization via Facebook or other social media. This did not allow the questionnaire to reach the vital subpopulation of lesbian, gay, and bisexual individuals who were not in contact with a LGB organization.

Another limitation to the research was that some organizations choose not to participate in distribution of the survey because it did not include transgender individuals. The researchers acknowledge and recognize lesbian, gay, bisexual, and transgender individuals have their own individual healthcare needs. By choosing to not include transgender individuals with this research project was in no way aimed to minimize or overlook the needs of transgender individuals. The researchers felt it would be unjust to the transgender community to have their needs consolidated in as the same as lesbians, gays and bisexuals. It is important that additional research be carried out for the transgender community that is more specific and tailored to their distinct requests of their healthcare and providers. Future research in this area should welcome participation by individuals from all groups to increase response rates; as needed, group data can be analyzed separately.

This descriptive research study had a small number of participants. One organization reported to have distributed the invitation to participate in the research to over 15,000 individuals via email and Facebook, but it was unclear exactly how the invitation was distributed. Having the organizations distribute the invitation a second time might have increased the number of participants. Another limitation may have been the short period of time for which the questionnaire was available: only three months due to
the time frame of that the total research project had to be completed. If the questionnaire were open longer, more responses could have been collected. The survey was also limited to respondents living in the state of Ohio. Suggestions for future research include reopening the questionnaire to the entire United States. This would increase population size and increase the number of respondents. Most importantly, responses to open-ended questions on the online questionnaire suggest that additional research using qualitative methodologies such as interviews would provide rich information that may not be adequately captured by open-ended questions.

It is important that barriers and concerns that limit communication between lesbian, gay and bisexual patients and their healthcare providers were identified. If healthcare providers can help individuals feel comfortable enough to share their sexual orientation/behaviors by asking the right questions in the right way, they will then be able to receive more complete care to their patients. While someone’s foot may be just a foot regardless of that person’s sexual orientation or practices, there may be other instances that knowing that information from the start could be beneficial. Previous research has already identified the numerous healthcare disparities of LGBs; it is important that healthcare providers now adapt their current approach to patients to better accommodate people of different backgrounds (Appendix C). Healthcare providers need to recognize that like heterosexual patients, not all lesbian, gay and bisexual individuals respond the same way to questions. By being able to accommodate to every patient’s unique needs, wants and fears, we as healthcare providers will be doing justice to all of our patients and not just the ones that were thought to be “heterosexual until proven otherwise”.
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Figures

**Figure 11. Distribution of gender among age groups.** As shown in the above figure, the majority of the participants were female in gender and between the ages of 26-65. The majority of males to participate were between the ages of 26-45 years old. The least represented age was 65 and older with one respondent and the most represented ages were between 26-45 years old.

**Figure 12. Distribution of race among age groups.** The majority, 33/36 or 91.7%, of respondents provided white/Caucasian as their race; where 3% were multiracial, 3% Hispanic/Latino and 3% black/African American.
Figure 13. Distribution of race among sexuality and gender. Of the bisexual participants 5/5 were female and 4/5 were white/Caucasian with one multiracial individual. Of the homosexual male respondents 13/13 were white/Caucasian and of the homosexual females 15/17 were white/Caucasian.

Figure 14. Level of individuals being “out”. The above figure illustrates the level of surveyed individuals’ openness about their sexual orientation. If the individual selected ‘To everyone’, their other selections were not calculated into the totals. Of the respondents the majority, 19/36 or 52.8%, were open to everyone. No one individual selected that they weren’t “out” to anyone. The second least popular answer was to colleagues/coworkers at 2/36 or 5.6%. 
Figure 15. Lesbian, gay and bisexuals' perceived attitudes of their HCPs about homosexuality and bisexuality. Of the surveyed individuals 16/36 or 44.4% felt that their healthcare provider had a positive attitude about their sexual orientation.

Figure 16. Number of HCPs that are asking their LGB patients about sexual practices. Of the respondents 15/36 responded that their healthcare provider asked them about their sexual practices, 10/36 responded that their HCP has not asked about their practices, and 10/36 told their HCP about their practices before they asked.
**Figure 17.** Perceived responsibility of addressing sexual behavior topics. The majority of individuals feel that it is the responsibility of both the HCP and the LGB patient to address such sensitive material.

**Figure 18.** Comfort level of LGB individuals talking with their healthcare providers. Of the individuals surveyed 23/36 or 63.9% are comfortable discussing sexual behaviors and their sexual orientation with their provider.
Figure 19. Ways that increase the likelihood of an LGB patient disclosing their orientation. Of the surveyed individuals 27/36 individuals felt that if the pre-visit forms included gender neutral terms and all inclusive options they would be more comfortable discussing such sensitive subject matter.

Figure 20. Ways LGB individuals find LGB-friendly healthcare providers. Majority, 17/36 or 47.2%, use the method of referral to find an open-minded healthcare provider.
Appendix A

How is your relationship with your health care provider?

You are invited to participate in a research project to identify barriers that prevent open communication between health care providers and their lesbian, gay and bisexual (LGB) patients. The research will also identify characteristics of medical practices that support positive, open relationships between providers and their LGB patients. The research is being done by Kaitlyn Hogan, a graduate student in Physician Assistant Studies at the University of Toledo. Her goal is to help health care providers make their practices welcoming to LGB patients, and in turn, provide better quality care to those patients.

If you are interested in completing this online survey, follow the link below. It will take about 20-30 minutes to complete. There are no reasonably foreseen risks to participation in this study. The survey is anonymous, which means that no one will know that you completed the survey or what you answered. You don’t have to answer all the questions and can stop answering questions at any time. Feel free to forward this invitation to friends and family who you think might be interested in participating, but each person should only complete the survey once. The survey will be open until May 31st, 2010.

If you have any questions about this research, you may contact Kaitlyn (Questions.LGBTsurvey@gmail.com) or her advisor, Jolene Miller (jolene.miller@utoledo.edu or 419.383.4959). This research has been reviewed by The University of Toledo Social Science, Behavioral and Education Institutional Review Board and designated as exempt research on 18 March 2010 (IRB#106895).

Thanks for considering participating in this important research. Click here to complete the survey:
http://spreadsheets.google.com/viewform?formkey=dEVHUFM0eDZFai1sbTViZU16T19uU3c6MA
Appendix B


Demographics

1. State of primary residence? _____________

2. Age
   a. Under 18
   b. 18-25
   c. 26-45
   d. 46-65
   e. Over 65

3. Race/Ethnicity
   a. American Indian or Alaska Native
   b. Asian
   c. Black/African-American
   d. Hispanic/Latino/Latina
   e. Native Hawaiian or other Pacific Islander
   f. White/Caucasian
   g. Multiracial
   h. Another race ________________

4. Gender?
   a. Female
   b. Female-to-male
   c. Male
   d. Male-to-female
   e. Other ________________

5. How do you define your sexual orientation?
   a. Bisexual
   b. Heterosexual/straight
   c. Homosexual/gay/lesbian
   d. Other ________________

6. Your past and current sexual partner(s) include:
   a. Men only
   b. Men and women
c. Women only

d. No partners

e. Other _______________

Disclosure/Openness

7. How “out” are you? Select all that apply
   a. To friends
   b. To parent(s)
   c. To sibling(s)
   d. To partner
   e. To health care provider
   f. To no one
   g. To everyone
   h. No need; I’m not LGBT
   i. Other _______________

8. Do you believe your care would be/is adversely affected if your healthcare provider knew about your sexual orientation/practices?
   a. Yes
   b. No
   c. I don’t know

9. How and why do you think your care is/would be adversely affected? If you don’t think it would, why not?

LGBT Patients and their Healthcare Providers

10. On average how many times per year do you see your current healthcare provider?
   a. 0
   b. 1-2
   c. 3-4
   d. 5+
   e. Other _______________

11. How long have you been seeing your current healthcare provider?
   a. <1 year
   b. 1-2 years
   c. 3-5 years
   d. 6-8 years
   e. 9+ years
f. Other ________________

12. Do you always see the same healthcare provider during each visit?
   a. Yes
   b. No
   c. I don’t know

13. Did you ever change healthcare providers because of how he or she reacted to information about your sexual orientation/practices?
   a. Yes
   b. No
   c. I don’t know
   d. Other ________________

14. If you’ve tried to find a LGBT-friendly healthcare provider, how did you do that?
   a. Asked other people for recommendations
   b. Searched online/in the phone book
   c. Looked through directories/web site listings of LGBT-friendly providers
   d. Looked through advertisements in LGBT publications/web sites
   e. I’ve never tried to find a LGBT-friendly provider.
   f. Other ________________

15. How would you describe your current healthcare provider’s attitude about LGBT individuals?
   a. Positive
   b. Neutral
   c. Negative
   d. I don’t know
   e. OTHER ________________

16. Does your current healthcare provider remember on subsequent visits your sexual orientation/practices?
   a. Yes
   b. No
   c. I don’t know
   d. Not open with provider
   e. See a different provider at every visit
   f. Other ________________
17. Do you feel comfortable talking about your sexual orientation/practices to your healthcare provider?
   a. Yes
   b. No
   c. Maybe; it would depend on the circumstances
   d. Other ______________

18. Has your current healthcare provider asked about your sexual orientation/practices?
   a. Yes
   b. No
   c. I don’t know

**Patient-Provider Communication**

19. Who do you feel is responsible for bringing up the subject of sexual orientation/practices during a visit with a healthcare provider?
   a. Yourself
   b. Your partner
   c. You and your partner together
   d. Your healthcare provider
   e. Other ______________

20. Who decides if the subject of sexual orientation/practices is important to discuss with a healthcare provider?
   a. Yourself
   b. Your partner
   c. You and your partner together
   d. Your healthcare provider
   e. Other ______________

21. Are there situations in which you feel healthcare providers should ask about sexual orientation/practices?

22. Are there situations that you feel healthcare providers should **NOT** ask about sexual orientation/practices?

23. If you are hesitant to talk about your sexual orientation/practices with your healthcare provider, what are the reasons?
   a. It’s not necessary for my provider to know.
   b. My provider might have a negative reaction.
c. My provider might give me lower quality health care.
d. I'm afraid that others might learn about my sexual orientation/practices.
e. I'm not comfortable talking about my sexuality, even to my health care provider.
f. I don't hesitate to talk about my orientation/practices.
g. Other _______________

**Improving Communication**

24. What some ways that would make you more comfortable to talk to your health care provider about issues dealing with sexual orientation/practices?

25. Which of these would make you more likely to disclose your sexual orientation/practices to your healthcare provider?
   a. Inclusive information on safer sex in the waiting room
   b. Having a LGBT provider
   c. Patient forms with gender-neutral terms and inclusive options
   d. Provider asks about partner in a gender neutral way
   e. Seeing provider on a LGBT-friendly practice list
   f. Other _______________

**Additional Comments**

26. If you want, please use the following space to share a positive or negative healthcare experience.

27. Please use the following space to provide any general additional comments or clarifications.
Good Practices: Below you will find suggestions for healthcare providers on how to communicate with lesbian, gay and bisexual patients. These suggestions were accumulated from a review of the literature and from my current research. It is my hope that this information will be used to provide quality healthcare for every individual regardless of sexual practices and to create an LGB-friendly atmosphere within every practice.

♦ Know your community
  - Learn more about the LGBT community in your area: organizations, events, etc.
  - Learn more about the concerns of LGBT individuals: health, employment, legal protections (or lack thereof), parenting, domestic violence, etc.
  - Learn more about health issues relevant to LGBT individuals and what they might mean for your practice

♦ Become an ally
  - Become aware of your attitudes, preconceptions, and prejudices toward LGBT individuals
  - Provide inclusive options on patient forms
  - Hire a staff that is LGBT-friendly
  - Display an LGBT-friendly sign in office
  - Join the Gay & Lesbian Medical Association provider list
  - Provide safe sex material in waiting room
  - Learn to talk with parents who think their child is or might be gay

♦ Talk to your patient
  - Get to know your patient
  - Become comfortable initiating and having conversations about sexual orientation and practices
  - Ask every patient about sexual practices as part of the standard history
  - Do not make assumptions
  - Be aware of your verbal and nonverbal communication
  - Use gender-neutral terms until you know more about a patient’s sexual orientation
Abstract

OBJECTIVE: To identify barriers and concerns that limit communication between lesbian, gay, and bisexual patients and their healthcare providers as perceived by the LGB community.

METHOD: Population sampled was adult lesbian, gay and bisexuals living in Ohio. Data was collected through an anonymous online questionnaire distributed by participating LGBT organizations.

RESULTS: Results show perceived positive attitudes from HCP about their LGB patients’ lifestyle (45%). More HCP are asking their patients first about sexual behaviors (41.7%). Respondents reported relying on word-of-mouth referrals for a safe provider with qualities such as openness and honesty. Minority of individuals were apprehensive about disclosing sexual orientation with concerns about insurance and employment issues.

CONCLUSION: HCPs’ relationship with their LGB patients may be more positive, but there is room for improvement. It is important practitioners identify qualities within themselves that keep their patients from disclosing complete information and understand every individual has their own unique needs.