



The same but different: clinician–patient communication with gay and lesbian patients

Kathleen A. Bonvicini^{a,*}, Michael J. Perlin^{b,1}

^aBayer Institute for Health Care Communication, 400 Morgan Lane, West Haven, CT 06516, USA

^bSouthern Connecticut State University, 144 Farnham Avenue, New Haven, CT 06515, USA

Received 7 March 2002; received in revised form 15 August 2002; accepted 22 August 2002

Abstract

Surveys estimate that 3–6% of the patients seen by physicians are gay or lesbian. There are unique health risks of gays and lesbians that are important to the clinician in determining an accurate diagnosis, providing patient education, and arriving at an appropriate treatment plan. One of the most significant medical risks of these populations includes avoidance of routine health care and dissatisfaction with healthcare. Many of these healthcare risks are not addressed because of lack of communication based on a number of common assumptions including the assumption that the patient is heterosexual. This article includes a summary of the medical literature through computerized searches to March 2002 in MEDLINE, PsychInfo, HEALTHSTAR, and bibliographies in articles on health care with gay and lesbian patients. The search strategy included health care of gays and lesbians and clinician–patient communication, partner and family issues. Secondly, it will examine common communication barriers and provide strategies for enhancing communication with patients in a gender-neutral, non-judgmental manner including suggestions for enlisting the inclusion of patients' families.

© 2002 Elsevier Science Ireland Ltd. All rights reserved.

Keywords: Clinician–patient communication; Gay; Lesbian; Healthcare; Family

1. Introduction

Surveys estimate that 3–6% of the patients seen by physicians are gay or lesbian [1]. Despite variability in survey estimates, the fact is that gay and lesbian patients are an integral part of medical practices. Gay and lesbian individuals are represented by all racial, economic, geographic, religious, cultural, and age groups. The diversity within the gay and lesbian populations becomes even more evident with consideration to family and relationship structures.

1.1. What is different?

We know that there are certain health needs of gays and lesbians that are unique and different from those of the heterosexual patient population [2]. One might erroneously attribute these differences only to the impact of sexually transmitted diseases (STDs). However, there are a variety of

distinctive health needs and issues of these populations that are important to the clinician in determining an accurate diagnosis, and appropriate treatment plan.

Harrison and Silenzio [2] reported the most significant medical risk for lesbians and gays is the avoidance of routine health care. Recent studies [3–5] indicate that lesbians continue to have lower rates of preventive care including cancer-screening services such as mammography or Papanicolaou (Pap) tests than do women in the general population. Other studies indicate that gay men are also less likely to seek preventive health care than their heterosexual counterparts [6].

A study by White and Dull [7] revealed that gays and lesbians report dissatisfaction with the health care they do receive. Thus, the overall relationship and dialogue between clinician and gay or lesbian patients is one deserving of close examination.

This article will summarize the medical literature related to health care communication with gay and lesbian patients. The summary will include relevant definitions and an overview of the medical and psychosocial issues of this population. Secondly, it will examine common and widespread communication barriers and provide effective strategies and skills for enhancing communication in a gender-neutral,

* Corresponding author. Fax: +1-203-812-5951.

E-mail addresses: kathleen.bonvicini.b@bayer.com (K.A. Bonvicini), perlin@southernct.edu (M.J. Perlin).

¹ Fax: +1-203-392-6965.

non-judgmental manner. The article will conclude with a discussion of practical implications and recommendations for enhancing clinician–patient communication with gay and lesbian patients as a means of improving health outcomes.

1.2. Definitions

Although the definition and components of sexual orientation vary with some authors [8], this article uses the one suggested by Patterson in her testimony to the Institute of Medicine Committee on Lesbian Health Research Priorities [9]. Thus, in the context of discussion of healthcare needs and dialogue with gays and lesbians, we refer to four relevant terms: sexual orientation, homophobia, heterosexism, and coming-out.

1.2.1. Sexual orientation

Sexual orientation refers to psychosocial and sexual attraction that an individual has towards those of the same sex (gay/lesbian), those of the other sex (heterosexual/straight), or both (bisexual) [9]. According to the Healthy People 2010 Companion Document [10], sexual orientation is a complex construct that is multidimensional, has a great deal of variability, and includes the following dimensions. *Sexual identity*: Sexual identity refers to one's self-definition or identification as a lesbian or as a gay man. *Sexual desire*: Sexual desire is the attraction one feels towards one sex or the other or both regardless of whether the individual acts upon that attraction. Thus, this attraction can be independent of one's behavior. *Sexual behavior*: Sexual behavior is of utmost concern to the clinician in assessing risks and arriving at an accurate differential diagnosis. It refers to the dimension of sexual orientation concerned with specific sexual activities one engages in, or has engaged in, and activities one plans to engage in.

There are at least two facts related to sexual orientation that are crucial to an effective clinician–patient dialogue. First, these three dimensions may not be congruent with one another. For instance, clinicians should know that sexual identity may reveal little about individual sexual behavior. This includes the example of a man who has sexual relations with men but does not self-identify as gay. Another fact is that sexual behaviors often vary over time. An example would be a woman who identifies as lesbian but engages in occasional sex with men.

In the context of assessing biomedical risks, the sexual behavior dimension of sexual orientation is the paramount consideration. However, in one's assessment of patients' bio-psychosocial needs, including lifestyle and support networks, each of the dimensions is critical. For example, Kelly [11] reported that knowing a patient's sexual identity and lifestyle allows the clinician to make clinical decisions from a more substantial base and, if appropriate, to make use of the "significant other" as a source of support for the ailing or recovering patient.

1.2.2. Homophobia

Homophobia describes negative attitudes towards gays and lesbians [12,13]. Overt expression of homophobia can range from the social ostracism a gay teen may feel to hate crimes or violence against gays or lesbians.

1.2.3. Heterosexism

Heterosexism refers to characteristics of an ideological system that purports a heterosexual lifestyle as the normative and more valued lifestyle [14,15].

1.2.4. Coming-out or come out of the closet

This is a phrase used by gays and lesbians to describe the process of disclosing one's sexual identity. Feeling safe in discussing one's sexual identity can allow the gay and lesbian individual to find social support and self-acceptance [15].

2. Medical and psychosocial needs of gay and lesbian patients

Although an exhaustive review of the medical needs of gay and lesbian patients is beyond the scope of this article, a brief overview is presented to provide an adequate foundation for understanding the communication needs in clinical practice with this population. Reviews of epidemiological studies reveal relationships between specific behaviors and diseases. For example, studies [16,17] indicate that there are increased risks of certain medical conditions in gay men that are related to specific behaviors such as receptive anal intercourse and oral–anal sexual contact. These include an increased risk for gastrointestinal infections and sexually transmitted diseases, including HIV and hepatitis B viruses. Analyzing studies on lesbians is more problematic because of methodological problems in identification of this population. Rompalo [16] argued that the medical establishment was forced to re-evaluate gay men's health when AIDS appeared, but lesbians have lacked the same visibility. However, fewer lesbian women become pregnant than their heterosexual counterparts, and epidemiological studies suggest an increased risk of various cancers based on child-bearing status in women [18]. It has also been reported that smoking is more prevalent in lesbians than in straight women [19]. In addition, according to Hall [20], lesbians are more likely to abuse alcohol. As a result of these behaviors, Harrison and Silenzio [2] reported lesbians were predicted to have a higher risk of morbidity and mortality from breast, ovarian, lung, and endometrial cancers than their straight counterparts.

As previously stated, one of the most significant medical risks for gays and lesbians is that they avoid routine health care. Studies have shown that both lesbians and gay men avoid prevention and treatment services more than their straight counterparts [21,22]. Reasons are varied for this delay or avoidance of health care. For instance, Trippet and Bain [23] attributed the delay to fear of the consequences of

disclosing sexual identity because of perceived insensitivity among health care personnel. White and Dull [7] found that difficulty communicating with their primary care provider was associated with delay in seeking health care. Thus, patient dissatisfaction appears to be high among gay and lesbian patients. Schatz and O'Hanlan [24] found that many lesbians and gay men report that their doctors are insensitive to their particular health needs, concluding that the patients do not disclose pertinent information about treatment or prevention.

Harrison and Silenzio [2] reported that due to homophobic society views, many gays and lesbians choose to keep their sexual identity secret. As a result, there may only be a small circle of confidants who are aware of their sexual identity. This is in contrast with the openness of discussing significant relationships that heterosexuals traditionally enjoy with their families, friends, co-workers, or religious community. This lack of social support may cause considerable distress in the lives of gay men and lesbians [2] that could manifest in a number of health-related ways including higher rates of alcoholism and other psychoactive substance abuse [15]. A study [25] of psychiatric risk among individuals with same-sex partners reported a higher risk for anxiety, mood, and suicidal plans than among individuals with partners of the other sex.

The use of alcohol or other drugs may provide a sense of relief from distress as well as foster a sense of self and other's acceptance. In a survey that compared women's use of preventive health measures, lesbians were about twice as likely as their heterosexual counterparts to have used illicit drugs in the past 30 days [26]. Other factors may contribute to the reported increased use of alcohol and other drugs in this population. Historically, many gays and lesbians have sought social contact in bars and clubs, which typically promote alcohol use. In our current society, although social alternatives have increased, these sites still often remain the initial social venue of choice for many gays and lesbians [27].

It has been estimated that 30–40% of gay teens have attempted or seriously considered suicide, a figure six times the national average, according to the Report of the Secretary's Task Force on Youth Suicide [28,29]. Debate about these figures exists, due to difficulty in the accurate identification of sexual identity at this early age. However, the process of sexual identification, often occurring in adolescence, makes the young gay or lesbian vulnerable to a number of health-related problems including depression, substance abuse, homelessness, and other associated risks, particularly if there is a lack support of family or friends. The American Academy of Pediatrics released a statement in 1993 that "pediatricians who care for teenagers need to understand the unique medical and psycho-social issues facing homosexually-oriented youth" [30]. Clinicians should be alert for these potential risks in gay and lesbian adolescents and consider issues related to sexual orientation and/or lack of social support in determining differential diagnoses [18].

As an outcome of homophobic societal attitudes, another reality for gays and lesbians is as targets of hate or bias crimes. A 1999 study for the US Department of Justice [31] reported that lesbians and gay men may be the most victimized groups in the nation. A study, utilizing data from the National Longitudinal Study of Adolescent Health [32], found that youth who report same-sex or both-sex attraction are more likely to experience extreme forms of violence than youth with only other-sex attraction. Also, just as in heterosexual relationships, the experience of battering or partner abuse is a risk within gay and lesbian relationships. In one study [33], more than a third of lesbians 22–52 years old reported partner abuse, with alcohol or other drug use involved in most of the incidents. Further, it has been reported [34] that lesbian victims of partner abuse are even less likely than their straight counterparts to seek help in shelters or from counselors, feeling that they may be stigmatized or treated inadequately.

3. Barriers to effective communication with gay and lesbian patients

3.1. Clinician attitudes

When attitudes of clinicians have been examined, the range of their beliefs about gays and lesbians generally reflect those of the society at large. For instance, Mathews et al. [35] found that 39.4% of physicians surveyed acknowledged that they were sometimes or often uncomfortable providing medical care to patients who were gay. In a later study by Shatz and O'Hanlan [24] where health providers were surveyed, 67% of respondents believed they had seen gay or lesbian patients receiving "substandard" care because of their sexual orientation. Several studies [23,24,36] have addressed patient satisfaction among gay and lesbian patients and found that doctors are often insensitive to health risks and needs of these populations.

3.2. Medical training

In a survey of American medical schools, Wallick et al. [37] reported a total of 3 h and 26 min was the average total amount of time spent on the topic of homosexuality in all 4 years of medical school. The majority of that time was spent in lectures on human sexuality, which the author contends trivializes the topic's importance. In addition, the survey found that medical schools historically have given limited attention to the important area of human sexual health. Wallick et al. concluded that physicians emerge from medical school inadequately trained to counsel patients about a broad range of sexual issues.

Other health providers lack training in care of gay and lesbian patients. For instance, a study among mental health providers [38] reported that a majority of respondents had little or no training of the needs and in communication skills in the care of gay and lesbian individuals.

3.3. Clinician level of skill/confidence

Many clinicians express concern or embarrassment about discussing sexuality with patients. A key barrier may be fear of inadequacy in an area where they feel untrained or uncomfortable. In a study of pediatricians [39], 90% had reservations about approaching the issue of sexual orientation due to lack of skill and knowledge. However, many clinicians express an eagerness to learn more about the needs of gays and lesbians. Of these clinicians, 72% wanted more information related to gay health and 48% requested further training.

3.4. Mistaken clinical assumptions

There are a number of incorrect assumptions about gay and lesbian patients held by clinicians. These assumptions create barriers to effective communication and patient interaction. In the remainder of this article, we discuss five of the most common assumptions presented in two categories: (1) assumptions about the individual gay and lesbian patient; and (2) assumptions about the gay and lesbian family. These assumptions were developed in response to the problems noted in the literature cited by the authors where patients discuss communication difficulties they have encountered. In addition to a focus on the five most common assumptions, strategies for improvement and enhancement in communication with gay and lesbian patients will also be presented.

4. Five common assumptions

4.1. Assumption #1: about the sexual orientation of the patient

A number of studies [7,40,41] concluded that false assumptions about the sexual orientation of the patient can reduce the quality of care. As previously stated, eliciting accurate sexual orientation and relationship status of patients is crucial in the process of arriving at an accurate diagnosis and appropriate treatment recommendations. However, false assumptions about heterosexuality are often made in the medical encounter. For instance, many lesbians report receiving irrelevant health education, lectures regarding birth control, and heterosexual-biased questions [42]. These are common examples that frequently arise from this assumption. As a result, many gays and lesbians report that these experiences make the “coming-out” process even more difficult [23]. Confidence is diminished. Trust is decreased. Adherence is reduced. And, seeking medical care is made less likely, which may lead to an increased risk of illness.

Whether or not an individual decides to disclose his or her sexual identity depends on a number of factors, including the phase of the coming-out process for the individual and level of personal comfort. However, being gay or lesbian doesn't

automatically mean that the patient has difficulty with their sexual identity. Or, for that matter, that they are completely comfortable either. Many patients are unwilling to disclose their sexual orientation for fear of being treated with insensitivity or experiencing retaliation and discrimination for their disclosure [43]. This reluctance may be a function of past negative experiences manifested as anticipatory anxiety.

Geddes [42] reported that 89% of lesbians who had not come out to their physicians stated they would have if given the opportunity although 11% had no wish to disclose. Thus, the atmosphere created by the clinician in the medical interaction is an important factor in facilitating patient comfort and willingness to self-disclose his or her sexual identity. In a study of lesbians [44], respondents rated the communication style of the clinician as the most important characteristic in determining ease of discussion about difficult issues. Those who disclosed their sexual orientation were more likely to seek preventive care, such as a Pap test, and to report increased comfort in their interactions with their clinician. Alternately, those who had identified difficulty in their interactions with clinicians were more likely to delay seeking health care.

In a Canadian study [42], 94% of lesbian patients surveyed believed it is important to them to come out to their doctor. The reasons were as follows: (1) they felt that it would lead to more accurate diagnoses and medical understanding; (2) they had a desire for increased honesty with their physicians and wanted to be fully understood; and (3) they had a desire for inclusion of their partner and to clarify the structure of their family.

4.2. Assumption #2: about gay and lesbian sexual behaviors

As with any population group, not all gay and lesbian patients share the same concerns or the same behaviors. When an individual does identify as gay or lesbian, a frequent and potentially incorrect assumption is made about the sexual behaviors and history of that individual. This could hamper the accuracy of determining risks for particular diseases and for developing appropriate medical recommendations. For instance, Johnson et al. [45] reported that 77% of lesbians had a history of heterosexual intercourse. When obtaining a sexual history, past, present, and planned sexual behaviors are all important determinants of risk. Given the diversity of sexual behaviors existing among individuals who identify as gay or lesbian, assuming behavioral practices based on sexual orientation could be subject to significant error.

4.3. Assumption #3: about messages sent through the medical practice to gay and lesbian patients

Communication messages are sent through a variety of channels. One of the primary steps in creating a safe

environment for patients is to examine the practice environment and the messages sent through verbal and non-verbal behavior and the physical setting. This includes messages sent by professional and support staff, neither of whom are immune from homophobic attitudes. There are many cost-effective ways in which the practice setting can be made more inclusive and gay- and lesbian-friendly without alienating other patients.

4.4. Assumption #4: about the family structure of gay and lesbian patients

A re-examination of how “family” is defined is essential for clinicians in providing effective care to gay and lesbian patients and their families. Stacey [46] reported the difficulty of arriving at a clear definition of a gay and lesbian family since gays and lesbians live in many different kinds of family structures, as evolved over the past 50 years. According to the 2000 US Census Bureau, gay and lesbian families reside in 99.3% of all counties in America [47].

Contrary to public perceptions, it has been reported [48] that the majority of gays and lesbians are in committed, monogamous relationships, not unlike heterosexual relationships. Many gays and lesbians are raising children, others may be living alone, some may be in traditional marriages, some are celibate, and others have a series of sexual encounters. For many lesbian and gay individuals, the primary partner, a network of close friends, or both constitute an alternate traditional family structure [49]. This family structure of close friends can be particularly important for many individuals in the gay community who may have strained relationships with their family of origin, or traditional families where they were reared. Because the family structure of the gay and lesbian patient may not be legally recognized, O’Hanlon et al. [43] argued that partners or “family” members of the gay patient may be restricted from visitation privileges and instead viewed by hospital personnel as “non-relatives”.

Because many patients turn to those close to them for emotional and psychological support during illness, it is crucial for the clinician to recognize and honor the patient’s significant relationship(s). As with heterosexual patients, the importance of acknowledging a patient’s primary source of social support for gays and lesbians has been addressed in the literature. In one study [42], 74% of the lesbian patients had asked their partners to accompany them to the doctor to provide support and comfort, to assist in decision-making, to alleviate fear, and to ensure they would be identified as next-of-kin. Thus, physicians can expect their gay and lesbian patients to attach as much significance to their partners as straight patients do to their marital or long-term partners. According to the AMA’s Council on Scientific Affairs Report [50], physicians should inquire about partner relationships of gay men and lesbians when medical decisions are involved, particularly in the context of life-sustaining treatment.

4.5. Assumption #5: about the role of significant relationships and family in the health care of the gay and lesbian patient

Given societal norms, legal issues related to medical decision-making for gays and lesbians can be complex. For instance, unless a gay or lesbian couple has signed legal papers (i.e. Durable Power of Attorney) authorizing mutual or surrogate medical decision-making, blood relatives can override decisions by the partner of the gay or lesbian patient. Considering that the blood relative may lack intimate knowledge related to the patient’s ethical, medical, or religious preferences, this could be devastating [15]. O’Hanlon et al. [43] reported only a small fraction of gays and lesbians have taken these legal steps to avoid this problem. Whenever possible, the clinician should explore surrogate decision-making preferences of their gay and lesbian patients before the need arises and become educated about relevant state and local laws.

In addition, in the area of medical insurance, coverage is often unaffordable or unavailable to the gay and lesbian patient, compared with heterosexuals. Domestic partnership coverage is still rare, although some progress has been made. For instance, a recent survey [51] found the percentage of large employers, those with 500 or more workers, that offer same-sex domestic-partner coverage rose to 16% in 2001 from only 12% in 2000. The lack of insurance coverage contributes to overall poorer health maintenance behaviors among gays and lesbians [52]. Both gay men and lesbians in committed relationships are at a disadvantage compared to married straight couples because many insurance companies and employers continue to deny spousal benefits to unmarried partners [53,54].

The number of lesbian, gay, and bisexual people having children has increased steadily in the past 20 years. Estimates suggest 3–8 million gay and lesbian parents in the US are raising between 6 and 14 million children [55]. Because of the challenge to traditional social norms, some clinicians may wonder whether being raised by a gay or lesbian parent adversely impacts these children. In studies comparing children raised by gay and lesbian parents with those of heterosexual parents, researchers found no difference in self-concept, locus of control, moral judgment, intelligence, sex-role behavior, peer and adult relationships, or sexual orientation [56–59]. In addition, the belief that gay and lesbian adults are unfit parents has no empirical foundation according to numerous studies [59–62].

Stacey [46] argued that gay and lesbian parents and children do face special risks because of their embattled legal status. Legal concerns for the gay and lesbian parent may be related to divorce and custody issues. In one study [63] of lesbian mothers, concerns included worry about how the child would deal with the absence of a known father, and fear that the child would experience teasing or discrimination while growing up as a consequence of homophobia present in current society. Clinicians should be aware and

sensitive to these and other voiced concerns. It should be acknowledged that research on gay and lesbian parents and their children is still very new and relatively sparse. Less is known about children of gay fathers than lesbian mothers. Longitudinal studies that follow gay and lesbian families over time are needed. However, professional organizations are slowly showing public support for gay and lesbian parents as evidenced in the recent position of the Academy of Pediatrics supporting laws allowing same-sex couples to “co-adopt” children [64].

In the event that a referral for consultation is indicated, having a list and network of resources of colleagues who are gay–lesbian-family sensitive is imperative. Enlisting the assistance of local gay and lesbian health projects may provide a listing of support groups where a sense of community and extended family is actively fostered and psychologists or other helping professionals who are experienced working with gay and lesbian families.

5. Practice implications and recommendations

There are a number of strategies that can be used to provide a message of acceptance and inclusion to gays and lesbians seen in the medical setting. The following suggested strategies may serve useful to communicate more effectively with gay and lesbian patients.

5.1. Strategies for eliciting accurate sexual orientation and relationship status of patients

- Until the sexual orientation of the patient is known, frame questions using gender-neutral and sensitive language allowing patient permission to come out, i.e. “Do you have a partner?” or “Are you currently in a relationship?” versus “Are you married?”
- If inquiring about conception control, ask “Do you have a need to discuss birth control?” rather than “What type of birth control are you using?”
- Let the patient provide information at his or her own pace with encouraging statements: “I’m happy to discuss any concerns you have.”
- Send a normalizing and reassuring message to the patient that discloses that he or she is gay or lesbian. For instance, recommendations [65] include:

“I realize that discussing sexuality can sometimes be difficult. Many people struggle with this issue, whether they are straight, gay, or bisexual. How do you feel about it?” or, “Is there anything about your sexual orientation that you would like to discuss?”

- Explain why such personal details need to be asked or discussed, i.e. “It’s helpful for me to understand each of my patient’s lifestyle and behaviors, so I can make an accurate and thorough assessment of his or her health needs.”

- Consider a more detailed written medical history that covers specific sexual behaviors and provide specific and relevant data when providing education and health counseling.
- Become familiar with some of the common sex practices of gays and lesbians and common terminology. Ask the patient about any aspect of his or her practices or lifestyle that is unfamiliar to you [65].

5.2. Strategies to communicate a safe and welcoming practice environment

- Explain the practice policy on confidentiality including what is recorded in the medical chart (as one should with all patients).
- Consider posting a written policy of practice such as a general statement of principle that explicitly includes a commitment to equal treatment for all regardless of sexual orientation. This can be displayed next to the posted Patient’s Bill of Rights.
- Evaluate what communication messages are sent through the waiting room in the range of educational materials, and include materials on gay and lesbian health.
- Role model sensitivity and inclusiveness to colleagues and staff.
- Circulate important findings related to gay and lesbian health.

5.3. Strategies to communicate consideration of partner and family relationship

- Inquire about significant relationships and patient’s family structure. Examples include “Who are the important people in your life that you count on for support?”
- Present a positive, accepting attitude when aspects of social and family life are revealed.
- Acknowledge and encourage inclusion of partner or significant other in health care.
- Provide message of acceptance when discussing significant relationships including parent–child relationships.
- Encourage gay and lesbian patients to express any parenting concerns.
- Extend the system appropriately, with referral sources that are gay-family sensitive.

The primary goal of raising awareness, providing knowledge, and facilitating communication skills in clinicians is to improve the health care and health outcomes of patients—in this case, gay and lesbian patients. Sensitizing clinicians to the unique health and psychosocial needs of gay and lesbian patients should increase their level of confidence in providing care to these populations. Patients who are satisfied with their healthcare experiences are more likely to participate in routine healthcare and adhere to medical recommendations. Patients who feel understood, respected, and confident in their clinicians’ communication and technical skills, in

partnership with their clinician, comprise a highly effective collaboration likely to produce positive patient health outcomes. The authors encourage further research to elucidate the unique health and psychosocial needs, concerns, and access patterns of this population in order to provide comprehensive medical care. Further, the authors advocate for the provision of training for practicing clinicians on the specific needs of gay and lesbian individuals and on sensitivity issues for enhancing communication in a gender-neutral, non-judgmental manner.

Acknowledgements

This article evolved from a workshop with a similar title that was conducted by the authors at the 2001 Annual Symposium of the Bayer Institute for Health Care Communication. The authors wish to acknowledge and thank colleagues at the Bayer Institute, family members, and friends who have been influential in the fruition of this article.

References

- [1] Laumann EO, Michael RT, Gagnon GH. *Sex in America—definitive survey*. Boston: Little, Brown and Company; 1994.
- [2] Harrison AE, Silenzio VMB. Comprehensive care of lesbian and gay patients and families. *Prim Care* 1996;23:31–47.
- [3] Aaron DJ, Markovic N, Danielson ME, Honnold JA, Jonosky JE, Schmidt NJ. Behavioral risk factors for disease and preventive health practices among lesbians. *Am J Public Health* 2001;91:43–6.
- [4] Cochran SD, Mays VM, Bowen D, Gage S, Bybee D, Roberts SJ, et al. Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women. *Am J Public Health* 2001;91:591–7.
- [5] Rankow E, Tessaro I. Cervical cancer risk and Papanicolaou screening in a sample of lesbian and bisexual women. *J Fam Pract* 1998;47:139–43.
- [6] Wadsworth E, McCann K. Attitudes towards and use of general practitioner services among homosexual men with HIV infection or AIDS. *Br J Gen Pract* 1992;42:107–10.
- [7] White JC, Dull VT. Health risk factors and health seeking behavior in lesbians. *J Womens Health* 1998;6:103–12.
- [8] Shively MG, DeCecco JP. Components of sexual identity. In: Garnets LD, Kimmel DC, editors. *Psychological perspectives on lesbian and gay male experiences*. Chichester (NY): Columbia University Press; 1993. p. 80–8.
- [9] Patterson CJ. Testimony on behalf of American Psychological Association on lesbian health care before Committee on Lesbian Health Research Priorities, Institute of Health, 1997.
- [10] Gay and Lesbian Medical Association and LGBT health experts. *Healthy people 2010 companion document for lesbian, gay, bisexual, and transgender (LGBT) health*. San Francisco (CA): Gay and Lesbian Medical Association; 2001.
- [11] Kelly CE. Bringing homophobia out of the closet: antigay bias within the patient–physician relationship. *Pharos* 1992;2–8.
- [12] Hudson WW, Rickets WA. A strategy for the measurement of homophobia. *J Homosex* 1980;5:357–72.
- [13] Speight KR. What health professionals should know about their gay, lesbian, and bisexual patients. *Med Encounter* 1998;14:7–9.
- [14] Williams KL. Lesbian health care issues. *J Fam Pract* 1995;41:224.
- [15] Dean L, Mayer IH, Robinson K, Sell RL, Sember R, Silenzio VMB, et al. Lesbian, gay, bisexual and transgender health: findings and concerns. *J Gay Lesbian Med Assoc* 2000;4:101–51.
- [16] Rompalo A. Sexually transmitted causes of gastrointestinal symptoms in homosexual men. *Med Clin North Am* 1990;74:1633–46.
- [17] O’Neill J, Shalit P. Health care of the gay male patient. *Prim Care* 1992;19:191–201.
- [18] Davis V, Christilaw JE, Edwards C, Francoeur D, Grant LJ, Parish B, et al. Lesbian health guidelines. *J Soc Obstet Gynaecol Can* 2000;22:202–5.
- [19] Bradford J, Ryan C. *National lesbian health care survey*. Washington (DC): National Gay and Lesbian Health Foundation; 1987.
- [20] Hall JM. Alcoholism in lesbians: developmental, symbolic interactionist, and critical perspectives. *Health Care Women Int* 1990;11:89–107.
- [21] O’Neill J, Shalit P. Health care of the gay male patient. *Prim Care* 1992;19:191–201.
- [22] Stevens P, Hall J. Stigma, health beliefs and experiences with health care in lesbian women. *Image: J Nurs Scholarsh* 1988;20:69–73.
- [23] Trippet SE, Bain J. Reasons American lesbians fail to seek traditional health care. *Health Care Women Int* 1992;13:145–53.
- [24] Schatz B, O’Hanlan KA. *Antigay discrimination in medicine: results of a national survey of lesbian, gay and bisexual physicians*. San Francisco (CA): Gay and Lesbian Medical Association; 1994.
- [25] Gilman SE, Cochran SD, Mays VM, Hughes M, Ostrow D, Kessler RC. Risk of psychiatric disorders among individuals reporting same-sex sexual partners in the national comorbidity survey. *J Am Med Assoc* 2001;91:933–9.
- [26] Koh AS. Use of preventive health behaviors by lesbian, bisexual, and heterosexual women: questionnaire survey. *West J Med* 2000;172:379–84.
- [27] Skinner WF. The prevalence and demographic predictors of illicit and licit drug use among lesbians and gay men. *Am J Public Health* 1994;84:1307–9.
- [28] Ramafedi G, Farro JA, Deiser RW. Risk factors for attempted suicide in gay and bisexual youth. *Pediatrics* 1991;87:869–75.
- [29] Gibson P. Gay male and lesbian youth suicide. Report of the Secretary’s Task Force in Youth Suicide, US Department of Health and Human Services, 1989.
- [30] Committee on Adolescence. *Homosexuality and adolescence*. *Pediatrics* 1993;92:631–3.
- [31] Bureau of Justice Statistics. *Criminal victimization 1999: changes 1998–1999 with trends 1993–1999*. National Crime Victimization Survey. Washington (DC): Bureau of Justice Statistics, US Department of Justice.
- [32] Russell ST, Franz BT, Driscoll AK. Same-sex romantic attraction and experiences of violence in adolescence. *J Am Med Assoc* 2001;91:903–6.
- [33] Moran N. Lesbian health care needs. *Can Fam Physician* 1996;42:879–84.
- [34] Morrow SK, Hawxhurst DM. Lesbian partner abuse: implications for therapists. *J Couns Dev* 1989;68:58–62.
- [35] Mathews WC, Booth MW, Turner JD. Physicians’ attitudes toward homosexuality—survey of a California County Medical Society. *West J Med* 1986;144:106.
- [36] Smith EM, Johnson SR, Guenther SM. Health care attitudes and experiences during gynecologic care among lesbians and bisexuals. *Am J Public Health* 1985;75:1086–7.
- [37] Wallick MM, Cambre KM, Townsend MH. How the topic of homosexuality is taught at US medical schools. *Acad Med* 1992;67:601–3.
- [38] Ryan CC, Bradford JB, Honhold JA. Social workers’ and counselors’ understanding of lesbians. *J Gay Lesbian Social Serv* 1999;9:1–26.
- [39] East JA, Rayess FE. Pediatricians approach to the health care of lesbian. *J Adolesc Health* 1998;23:191–3.
- [40] Siegel K, Krauss B, Karus D. Reporting recent sexual practices: gay men’s disclosure of HIV risk by questionnaire and interview. *Arch Sex Behav* 1994;23:217–30.

- [41] Allen LB, Glicklen AD, Beach RK, Naylor KE. Adolescent health care experience of gay, lesbian, and bisexual young adults. *J Adolesc Health* 1998;23:212–20.
- [42] Geddes VA. Lesbian expectations and experiences with family doctors. *Can Fam Physician* 1994;40:908–20.
- [43] O'Hanlan KA, Cabaj RP, Schatz B, Lock J, Nemrow P. A review of the medical consequences of homophobia with suggestions for resolution. *J Gay Lesbian Med Assoc* 1997;1:25–39.
- [44] White JC, Dull VT. Health risk factors and health seeking behavior in lesbians. *J Womens Health* 1997;6:103–12.
- [45] Johnson SR, Smith EM, Guenther SM. Comparison of gynecologic health care problems between lesbians and bisexual woman. *J Reprod Med* 1987;32:805–11.
- [46] Stacey J. *In the name of the family: rethinking family values in the postmodern age*. Boston: Beacon Press; 1996.
- [47] Smith DM, Gates G. Gay and lesbian families in the US, same sex unmarried partner households: a preliminary analysis of 2000 United States census data. *A Human Rights Campaign Report*, 2001.
- [48] Klinger RL, Cabaj RP. Characteristics of gay and lesbian relationship. In: Oldham JM, Riba MB, Tasman A, editors. *American Psychiatric Press Review of Psychiatry* 1993;12:101–25.
- [49] American Psychological Association Council of Representatives. *Guidelines for psychotherapy with lesbian, gay and bisexual clients*. *Am Psychol* 2000;55:1440–51.
- [50] American Medical Association Council on Scientific Affairs. *Health needs of gay men and lesbians in the United States*. *J Am Med Assoc* 1996;275:1354–9.
- [51] Human Rights Campaign. *Study shows companies provide DP benefits to help recruit and keep employees*. *Work Net: Covering Issues in the Workplace*, 2002.
- [52] Lock J. Strategies for reducing homophobia during medical training. *J Gay Lesbian Med Assoc* 1998;2:167–74.
- [53] Stevens P, Hall J. Stigma, health beliefs and experiences with health care in lesbian women. *Image: J Nurs Scholarsh* 1988;20:69–73.
- [54] Denenberg R. Report on lesbian health. *Womens Health Issues* 1995;5:181–91.
- [55] Martin A. *Lesbian and gay parenting handbook*. New York: Harper Collins; 1993.
- [56] Patterson C. Children of lesbian and gay parents. *Child Dev* 1992;63:1025–42.
- [57] Patterson CJ. Family relationships of lesbians and gay men. *J Marriage Fam* 2000;62:1052–69.
- [58] Stacey J, Biblarz TJ. How does the sexual orientation of parents matter? *Am Sociol Rev* 2001;66:159–83.
- [59] Patterson CJ. *Research summary on lesbian and gay parenting*. American Psychological Association Public Interest Directorate, 1995.
- [60] Turner PH, Scadden L, Harris MB. Parenting in gay and lesbian families. *J Gay Lesbian Psychother* 1990;1:55–66.
- [61] Harris M, Turner P. Gay and lesbian parents. *J Homosex* 1985;12:101–13.
- [62] Flaks DK, Ficher I, Masaterpasqua F, Joseph G. Lesbians choosing motherhood: a comparative study of lesbian and heterosexual parents and their children. *Dev Psychol* 1995;31:105–14.
- [63] Leiblum SR, Palmer MG, Spector IP. Non-traditional mothers: single heterosexual/lesbian women and lesbian couples electing motherhood via donor insemination. *J Psychosom Obstet Gynecol* 1995;16:11–20.
- [64] Perrin EC. Technical report: coparent or second-parent adoption by same-sex parents. *Pediatrics* 2002;109:341–4 [Committee on Psychosocial Aspects of Child and Family Health. American Academy of Pediatrics].
- [65] *Gay and Lesbian Medical Association. Guidelines for sexual history taking*. San Francisco: Gay and Lesbian Medical Association; 2001.