

Lesbian sexuality

Do GPs contribute to lesbian invisibility and ill health?

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During the past 11 years, several consumer surveys have examined lesbians' health needs, starting with Bradford's 1988 survey of 1925 USA lesbians.¹ This was followed by a study of 390 lesbians in 1992.² Further studies in Canada, Australia and New Zealand followed.³⁻⁵ All of these surveys confirm that lesbians have major concerns regarding a lack of awareness, knowledge and sensitivity of health care providers to their needs. These concerns are based on experiences within the health care system ranging from heterosexism (assumption of heterosexuality) to homophobia and discrimination.

Some lesbians fail to seek health care, thus reducing opportunity for health promotion, illness prevention (including screening), early intervention and health education.

For many women who partner women, the actual or perceived risk and associated fear of entering a homophobic and potentially abusive medical system outweighs the perceived risk of illness.⁶

This reduced access is analogous to that seen within other minority groups where a failure to adequately cater to their needs by health care providers forms a significant barrier to accessing services.

A recent Australian national survey of young people attracted to the same sex illustrates this failure to access health care services. The survey included 750 people aged 14-21, 45% of whom were gay or lesbian and 35% bisexual. Only 11% had sought help from doctors for health related problems, although two thirds of these had found this help useful.⁷

Lesbians Need Pap Tests Too
A resource for general practitioners

Why the need for screening?
Lesbians, like all women, are at potential risk of cervical cancer. Important points to keep in mind when discussing screening and sexual health issues with your patients are that:

- Apart from same-sex partners, many lesbians have had past sexual contact with men and some may have ongoing contact.
- Transmission of HPV can occur during female-to-female sexual activity through genital skin contact with genital secretions, or shared sexual aids.
- Smoking is a co-factor in the development of CIN, particularly when HPV is present. There is evidence to suggest lesbians are heavier smokers than heterosexual women.
- The risk of cervical cancer among all women increases with age due to lower levels of screening. Lesbians, it must be remembered, are represented in all age groups.

Barriers to screening
There are several factors that can affect a lesbian's decision to have a Pap test. These include:

- Homophobia**
Some lesbians are uncomfortable, even fearful, of presenting to doctors, particularly around issues of sexual health. Past experiences of prejudice or discrimination because of their sexuality, assumptions of heterosexuality by doctors, or concerns that practitioners may not be experienced in lesbian health care, may all lead to reticence in presenting for a Pap test.
- Confidentiality**
Some lesbians are worried about the confidentiality of medical records. While the doctor taking their history may be non-judgmental and approachable, subsequent doctors may not be. It may be that other clinic staff members have access to medical files or that records may be used by other clinics. For this reason lesbians may request that their sexuality not be recorded on their history.

Answering sexual history questions
For some lesbians, questions like 'Have you had sexual intercourse?' or, 'What form of contraception are you using?' can be difficult or embarrassing to answer. In some situations, women may feel comfortable disclosing they are lesbian, but this is not always the case.

Strategies to overcome barriers to sexual history taking
Sexual history taking is an important component of providing comprehensive health care. It enables both the doctor and patient to assess risk factors for cervical cancer and sexually transmitted diseases (STDs). It also provides an opportunity for education about these issues. Some doctors, however, feel uncomfortable taking a sexual history. Some are concerned that they may appear inquisitive, while others are embarrassed to ask questions about sexual issues or practices they are unfamiliar with. Some may simply feel they have inadequate knowledge to answer specific lesbian health concerns.

Anti-Cancer Council
ParStream Victoria

Are lesbians invisible within medical practice?

Lesbians who do enter the health care system often choose not to disclose their sexual orientation. International studies report that at least 40% of gay men and lesbians conceal their sexual orientation.⁸⁻¹⁰ Research however reveals that 'most lesbians and gays believe their health care would be of higher quality if they could safely disclose their homosexual identities'.¹⁰

Patients choose to remain invisible for many reasons, the most common being a fear of disapproval or discrimination. Discrimination by the medical profession is not just a fear but a reality for some lesbians. In a 1994 study of members of the Gay and Lesbian Medical Association in the USA regard-

ing anti-gay discrimination in medicine, 52% of respondents had observed colleagues discriminating against patients because of their sexual orientation, and 88% reported hearing colleagues make disparaging remarks about lesbian, gay and bisexual patients.¹¹

Consequences of invisibility

Non-disclosure of sexual orientation within the consultation forms a major barrier to the development of an honest and open patient-doctor relationship. It denies GPs the opportunity to demonstrate an accepting and non judgmental attitude. It also creates a sense among practitioners that they are not seeing lesbian patients. Responsibility for lesbian invisibility does not entirely lie with the

consumer's reluctance to disclose, but lies equally with the failure of practitioners to create an environment in which disclosure is safe or indeed beneficial.

Lesbian invisibility also prevents GPs from addressing particular lesbian health needs. A comprehensive review of lesbian specific health issues in Australia has been conducted by the Coalition of Activist Lesbians (COAL).⁴ It covers a wide range of issues including mental health, sexual and reproductive health, special life cycle issues and the effects of homophobia, heterosexism and discrimination on health status. One of the recommendations of this report was a call for funding ...

of health education programs targeting identified lesbian health issues and utilising positive and diverse lesbian images and information. Issues to be targeted should include: equity in health care to ensure non homophobic and non heterosexist delivery, ageing lesbians, lesbians in midlife, lesbians and cervical cancer, breast cancer, safe sex, smoking, drug and alcohol use, coming out, lesbian relationships and the social context of lesbian health.⁴

This report generates a compelling argument that in order for the health needs of lesbians to be met, they must be visible within the health care system. Visibility would in turn provide the imperative for health care practitioners to inform themselves of the key issues affecting the health of their lesbian patients.

Lesbians, pregnancy and parenting

Pregnancy and parenting is one example of a specific issue affecting lesbians for whom GPs could provide significant support, education and medical care. Traditionally lesbians have raised children resulting from previous heterosexual relationships. Increasingly, lesbians are seeking to achieve pregnancy either through self-insemination with a known sperm donor or through anonymous insemination programs. Barbel's survey of young lesbians found that 43% were

considering having children in the future.¹² A 1995 readership survey by a lesbian magazine in Sydney found that 19% of the 732 respondents already had children, and a further 12.4% wanted to become mothers.¹³

In Australia, lesbians are often denied access to insemination services, either by law (such as the prohibitive Infertility Treatment Act in Victoria) or by the exclusion criteria of specific services. As a result, many lesbians are self-inseminating, without adequate information regarding donor screening or their own pre-pregnancy screening, as they don't feel they can access health services, even for advice. General practitioners are in an excellent position to redress this perception. This relies on lesbians first feeling comfortable enough to disclose their sexual orientation, and only then being able to reveal plans for pregnancy and enable pre-pregnancy advice and screening. An affirming attitude will then allow an open doctor-patient relationship to develop that could sustain the pregnancy and subsequent care of the whole family. Attracting and retaining these patients within the medical system provides an excellent opportunity to engage their trust and affirm general practice as an appropriate service for their health care needs.

Lesbian health policy

Horsely and Tremellen argue strongly that lesbian health must be legitimised.¹⁴ They remind us that the first National Women's Health conference in 1985 formally protested the lack of lesbian visibility, yet little has been achieved in the intervening years with regard to health policy or research into lesbian health in Australia. They suggest two strategies to demonstrate the legitimacy of lesbian health: recognition of the specific health needs and recognition of the minority status of lesbians. They also raise the issue of consumer dissatisfaction with health care services, and assert that there is a cultural ignorance among health care providers.

The fact that any woman attending a medical consultation — young or old, of aboriginal or non English speaking or Anglo Saxon background, pregnant or mother or childless — could be a lesbian is invariably ignored by practitioners.

This should challenge us to reassess our underlying assumptions of patients.

Education regarding specific lesbian health issues

There is a deafening silence during undergraduate and postgraduate health and medical education programs about lesbian health issues. The resultant lack of knowledge combined with the reported health issues confronting many lesbian women raises a strong argument for the inclusion of lesbian health as a subject at undergraduate, graduate and continuing medical education levels. By avoiding the inclusion of lesbian health issues, education institutions are contributing to the health problems of lesbians. In a report on the health care needs of gay men and lesbians by the Council of Scientific Affairs, American Medical Association (1996) the negative attitudes of doctors towards gay patients is raised.¹⁵ It states that including gay and lesbian issues in undergraduate and postgraduate medical education will improve confidence and encourage a non-judgmental attitude among doctors. This will, in turn, enhance rapport with their gay and lesbian patients and allow optimal medical care.

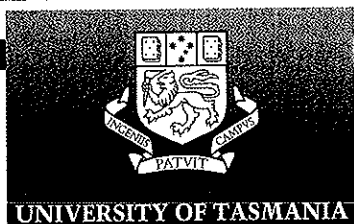
General practitioners work within a psychosocial model of health, acknowledging that health is more than the absence of disease, and that all aspects of life impact on health and wellbeing. Treating patients without a wider knowledge and understanding of their lives ignores these broader determinants of health. For lesbians, invisibility, homophobia, heterosexism and the consequent physical, emotional and mental health issues underlie many of the problems with which they present, and yet without knowledge of these

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■ Lesbian sexuality

issues, practitioners are only treating the symptoms, not the causes of ill health. The first step in understanding our lesbian patients is to facilitate disclosure of their sexual orientation, thus enabling the development of an honest relationship and better health care.

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