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ORIGINAL ARTICLE

Being lesbian – does the doctor need to know?

A qualitative study about the significance of disclosure in general practice

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Abstract

Background. A lesbian woman will have to choose whether to disclose or not in every new encounter, including when consulting her general practitioner (GP). She may fear a negative reaction in the doctor, based on knowledge of marginalization and prejudice of homosexuals throughout history. *Objectives*. To explore patients' experiences concerning disclosure of their lesbian orientation to general practitioners (GPs), focusing on why they find it important, and what GPs can do to promote disclosure. *Methods*. One group interview was conducted, audiotaped, and transcribed verbatim. Qualitative analysis was conducted by systematic text condensation inspired by Giorgi's phenomenological approach. Six women aged 28–59 years, who self-identified as lesbian, were recruited through a web-based, publicly accessible network for research on homosexuality. *Main outcome measures*. Accounts of experiences where the patient thought that information of a lesbian sexual orientation was of importance in the consultation with a GP. *Results*. Disclosure can imply information of medical relevance, explain circumstances, and generate a feeling of being seen as one's true self. The intentional use of common consultation techniques may facilitate disclosure. *Conclusion*. Lesbian patients may want to disclose their sexual orientation to the general practitioner but they experience certain barriers. These can be overcome when the GP provides an open and permissive context. GPs can benefit from knowledge concerning sexual orientation in their work with lesbian patients.

Key Words: *Communication, family practice, female, homosexuality, truth disclosure*

The estimated prevalence of lesbian women varies between 2% and 10% in Western societies [1]. The group called lesbian women is heterogeneous and dynamic, and includes a variety of lifestyles and sexual practices [1–3]. The majority have heterosexual experience [2,4]. Outside this group, there are women who have relations of love and sex with other women but feel they belong to other categories. Changes of orientation and identity may occur within a life span.

It is usually not possible to see from a woman's looks that she is a lesbian. If she wants it to be known, she has to tell. This act of informing people she meets regarding her sexual orientation is called *disclosure*. A lesbian woman will have to choose

Lesbian women think disclosure of sexual orientation to their GP may be important and improve healthcare.

- For lesbian patients, disclosure of their sexual orientation may be considered medically relevant when consulting for depressive disorders and gynaecological conditions, it may be considered crucial to be seen as a whole person, and it may be necessary to explain circumstances and to include a partner.
- The attitudes and consultation techniques of the GP may be decisive for the woman's decision whether to disclose or not.

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whether to disclose or not in every new encounter, including when consulting her general practitioner. The lesbian patient may fear a negative reaction in the doctor, based on knowledge of marginalization and prejudice against homosexuals throughout history, in general and in medicine [5–7].

A number of studies concerning lesbian women's encounters with healthcare professionals have been performed during the last two decades [1,5], of which just a few have been European [8]. As the situation for homosexual people is improving, and varies between cultures, most of the existing research may be only partially relevant for doctors of today in Northern Europe. As GPs, we have experienced uncertainty in how to encourage and respond to a patient's disclosure in the consultation, even though we ourselves have a lesbian orientation. Through discussions with colleagues, who more often than not share this uncertainty, we have become aware of the need for knowledge. We therefore wanted to explore patients' experiences with disclosure of their lesbian orientation to GPs, focusing on when and why they find it important, and what GPs can do to promote disclosure.

Material and methods

A qualitative group interview was chosen to illuminate common experiences in this subgroup, where opinions may be subjected to prejudice in society. Group interviews are considered particularly suitable for the study of people's knowledge, attitudes, and experiences, and to help identify group norms and cultural values [9].

Data were drawn from one group interview lasting 90 minutes. The informants were recruited through a web-based, publicly accessible network for research on homosexuality. The resulting convenience sample consisted of six women aged 28–59 years, average 41, who self-identified as lesbian. All were well educated and had fairly well-paid jobs within management. Three suffered from chronic disease. The informants saw a GP 1–17 times a year, median 3.5. All were of Caucasian ethnicity, and they lived in the capital of Oslo or nearby.

The group interview, inspired by focus-group technique, was opened by the moderator (KM) with a question about when it is important that the GP knows the patient's lesbian orientation, urging for stories to be told. The informants responded by sharing experiences and reflections from consultations with different GPs. Among questions covered were "When and why is it important that the GP knows of your lesbian orientation, and when is it not important at all?"; "Who decides when this subject is important, and who is responsible for bringing it up?"; "Why is disclosure difficult when it is important?"; "Are there situations when the GP should not ask about sexual orientation?". The interview was observed, audiotaped, and transcribed verbatim by the first author (MB). Qualitative data were analysed by both authors in cooperation through systematic text condensation inspired by Giorgi [10] and modified by Malterud [11]. The analysis followed these steps: (i) reading all the material to obtain an overall impression and bracketing previous preconceptions; (ii) identifying units of meaning, representing different aspects of the importance of disclosure experienced by women, and coding for these; (iii) condensing and summarizing the contents of each of the coded groups; and (iv), generalizing descriptions and concepts reflecting when and why disclosure might be important.

Results

According to the participants, disclosure can be medically relevant, it generates a feeling of being seen as a whole person, it simplifies the explanation of circumstances, it facilitates communication concerning practical solutions, and it permits the inclusion of a partner. They emphasized that GPs should bear in mind the possibility of a same-sex orientation, as well as creating an atmosphere where disclosure can be facilitated.

To be seen as one's true self

There was broad agreement among the participants that disclosing the lesbian orientation led to being seen as the person one is, and being able to be oneself in a genuine way. Conversely, when not able to tell, or in the case of the GP not knowing, she would not be seen as her true self, said the women. As a woman in her late twenties summed up:

> *The doctor that I have now, she knows that I am a lesbian, and she remembers. And I am there around once or three times a year. And then I become glad inside, when she speaks of "she" or "do you have the same lover and is she . . ." and so on. I think it is very nice. Not to have to come out, that the doctor remembers me, and how I live and who I am and so on.* (1)

On the other hand, and of equal importance, was that to tell the GP about the lesbian orientation could involve a risk of being seen only as a lesbian in a marred or disproportionate way, depending on the GP's personal view on homosexuality. Therefore, some informants explained, the preceding assessment of the GP's likely attitude to homosexuality

would always be extensive. Included in this assessment was the medical relevance of the information to the problem at hand. The close consideration of when to tell and when not to tell may be the reason why none of the participants in our study had actually experienced a negative response.

Disclosure as circumstantial information

The necessity of disclosure in order to explain the context around medical issues was highlighted in different ways: The patient might see the GP for sick leave or sleeping pills in connection with the breakup with a female partner; she could want her partner to be acknowledged in the case of a serious disease; the GP might need to be aware of the patient's supports or burdens during a disabling illness. A divorced woman living in a rural area illustrates the situation:

> *Yes, life was not so easy because I had left a marriage with children, and then I entered a relationship with a woman, and it was very difficult, I thought a lot about the children, and we lived out in the countryside.... And I went to the doctor and I said: "I have to have something that can help me sleep at night."* (3)

Also in these cases, where the participants considered information on their sexual orientation to be more of an incidental matter, they expressed concern about the reaction of the GP. They might avoid disclosure if they anticipated that the GP would overstate the importance of the lesbian issue, worrying that it could interfere with the GP's attention to the actual problem.

> *Or prejudices or that it will be difficult for the doctor so that I don't get good treatment, because he is so preoccupied with me being a lesbian, and that he then erects a barrier against me or something.* (1)

Disclosure as medical information

The informants illustrated in different ways how they expected the GP to utilize information regarding their lesbian orientation as a tool for achieving correct diagnosis and treatment. The women also mentioned a number of conditions where the question of sexual orientation was considered to be of no significance, such as colds, tendinitis, or fractures. The impact of disclosure on gynaecological and reproductive issues was regarded as evident, for example when diagnosing and treating genital infections. One woman in her fifties shared a typical experience:

> *And then he prescribed an ointment that I could apply, and then he prescribed something else that he said that my partner could apply on his genitals, and then I just had to say that "I am with a woman". Then he laughed and said "oh", and then he gave me two identical prescriptions.* (2)

GPs should have knowledge of the depression that can occur during the process of becoming aware of one's lesbian orientation, often referred to as "the coming out process", said the group. Informants who had experienced the situation thought that their symptoms would have been relieved if the GP had had this differential diagnosis in mind. One participant, who had consulted her GP during an episode of depression, put it like this:

> *... but I thought that maybe my doctor should have known that I was in a coming out process concerning being a lesbian, and that was why I felt that most stuff in my life was pretty heavy for a while.* (1)

Not taking heterosexuality for granted

The experiences of these women illustrated how ordinary consultation techniques may apply to this subgroup of patients. To demonstrate caring, a genuine interest or an unprejudiced mind, and enough time, had enhanced disclosure for these women. The divorced woman had had a positive experience:

> *I said it was a divorce, and she seemed very understanding I think, and kind of leaned forward and, "how has it been and how do you feel", and I gained confidence really quickly then.* (3)

Our informants emphasized especially the importance of the GP not taking a heterosexual orientation for granted, and always bearing in mind that any patient may be of a same-sex orientation.

> *I think that is the doctor's responsibility. Not to think automatically that this is about men.* (5)

Furthermore, they recommended that the GP should remember to use gender-neutral language, so as not to restrain a possible disclosure, and at the same time demonstrate open-mindedness. A sign to watch for would be when the patient consistently avoids the use of a personal pronoun regarding her partner; she may for instance repeatedly say "my partner" instead. If so, the GP may simply ask "is your partner a man or a woman?", the informants thought.

> *I often use expressions like my cohabitant, an impersonal pronoun; they can at least notice that. It is often a sign that it is not a man.* (3)

On the other hand they considered the responsibility for informing the doctor of a same-sex orientation to be mainly the patient's own responsibility.

Discussion

This study addresses the significance of the lesbian issue to the consultation with the GP, from the patients' viewpoint. We gained insight into why disclosure of lesbian orientation is perceived to be important in different clinical settings. The vulnerability of the patient in this situation is illustrated, and we discovered indications of how to facilitate disclosure.

The present study was intended as exploratory, with only one group interview. Nonetheless, we gained valuable information. The group was quite homogeneous concerning education and interest in lesbian-related issues, but had a good range of ages and a common use of primary healthcare services. Our group can be regarded as representatives of a "best case scenario"; if these educated women with safe living conditions and a special awareness around lesbian issues think that disclosure is vulnerable and risky, so would less confident women as well. That the researchers belonged to the same subgroup is believed to have strengthened the group process, making the informants feel more comfortable, not having to explain 'the basics' about lesbian life.

From the existing research, we know that many lesbians think disclosure to healthcare professionals is important [12,13], but the rates of actual disclosure vary widely (18–90%) between studies [4,5,14,15]. The reasons not to disclose include fear of a negative reaction or impaired healthcare, not being given the opportunity, being single, and perceiving it a private or not relevant [16,17]. Signs of the doctor's attitude before disclosure and any reaction afterwards are most often monitored [18]. Delay in seeking healthcare due to fear of negative reactions has been documented [5,19].

As lesbian and gay people may experience prejudice, many live hidden lives and are inaccessible to research. The consequences are of two kinds: first, we do not know the characteristics of the population "lesbian women", and second, recruitment will always result in convenience samples. From this it follows that we cannot make general assumptions about all "lesbian women", and we cannot compare "lesbian women" with "women in general" [1]. Nevertheless, a number of papers do just that [19]. Lesbian health research is dominated by North American studies [8], and a minor part of the research focuses on general practice. We do not know to what extent American findings are applicable to a North European primary care setting, due to both the significant differences in the organization and use of healthcare services, and the position of lesbian women in society.

Our study adds to previous knowledge by revealing the diverse reasons lesbian women might have for disclosure, and how lesbian patients themselves evaluate the importance of informing their GP of their lesbian orientation. We also gained insight into lesbian women's own advice to GPs on how to accommodate disclosure. Findings from previous studies have been elaborated, such as the extensive and ongoing considerations that precede disclosure, and how the assumption of heterosexuality can be difficult to counter during the consultation. Theories of heteronormativity [20] offer an understanding of the pervasive and fundamental nature of the assumption that a heterosexual orientation is taken for granted in most situations. Medical professionals are no exception [21].

This study, although small, gives significant messages to GPs. Our findings demonstrate the importance of cultural sensitivity among our patients, of meeting every new patient with an open and accepting mind, and of being conscious of how language can make a difference.

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