

Addressing the Health Needs of Gay and Lesbian Patients

Minority Health Perspective by Matthew Murguia

Closing the Gap, The Problem of Accessing Health Care • August/September 1999

When it comes to gay and lesbian health issues, the first topic that often comes to mind is HIV/AIDS. But as more and more research shows, gay and lesbian health issues include more than AIDS.

While gays and lesbians suffer from the same health issues as other individuals, issues such as substance abuse, mental health, cancer, suicide, and smoking may affect gays and lesbians disproportionately. We don't know for sure because not enough research has been done.

Combine these concerns with health care access issues that racial and ethnic minorities face and the social stigma that still surrounds homosexuality, and you end up with a potent mix of factors that impact the health of gay and lesbian minorities.

Last year, the policy committee of the Gay and Lesbian Medical Association discussed the "Catch 22" that lesbian, gay, bisexual, and transgender patients face. First, in order for their specific health needs to be adequately addressed, gays and lesbians must discuss their sexual orientation with their health care provider. But by doing so they risk facing hostility, denial of care, and substandard care.

Unless a gay or lesbian patient knows that a health provider will treat them with the same respect and dignity that all patients deserve (and the literature suggests that the health field is still not gay "friendly"), many gays and lesbians will continue to conceal their sexual orientation, especially in situations where the patient does not get to choose the doctor.

Other articles in this issue of *Closing the Gap* highlight the challenges of improving access to health care for racial and ethnic minorities. Issues such as insurance coverage, cultural and linguistic competency, institutional policies, and the "isms" are all important. However, rarely is homophobia or training on gay and lesbian issues addressed in medical schools or health care settings.

Not enough data

The lack of training for health professionals may be due in part to a lack of data about specific health care needs of gays and lesbians, and whether being gay or lesbian increases one's risk for certain diseases or health conditions.

A recent report from the Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future*, underscored that while lesbians were not at higher risk for any particular health problems because of their sexual orientation, some risk factors for certain diseases may be more common among lesbians. One key finding of the report was the lack of data on the role that sexual orientation may play in access to health care.



The Gay and Lesbian Medical Association (GLMA) also recently highlighted the need for more research on this issue in its response to the U.S. Department of Health and Human Services' draft *Healthy People 2010* (HP2010) for the nation.

Nearly 400 comments on the need to address gay and lesbian health issues were submitted during the public comment period, many by GLMA and its members. GLMA was especially concerned that gay and lesbian health issues were only addressed in the objectives related to HIV/AIDS.

GLMA recommended that measures dealing with sexuality be incorporated into HP2010 areas such as sexually transmitted diseases, injury/violence prevention,

substance abuse, access to quality health services, health communication, and tobacco use.

Other public comments focused on a report that showed that up to one third of youth who attempt suicide do so because of issues dealing with sexuality, and the need for HP2010 to track this health measure.

Dangerous assumptions

Without data, health care professionals operate in a vacuum that may lead to assumptions about patients and their needs, including assumptions about a person's sexual orientation. This in turn may mean that treatment decisions are based on assumptions and not on fact.

For example, health care professionals may assume that because a person is male and married, he has not engaged in sexual activity with other males. Or, health professionals may assume that because a woman acknowledges she is a lesbian, she has not engaged in sexual activity with men. This may mean that a full sexual history will not be obtained, and risk factors for STDs and other issues may not be identified.

In *Health Care News of Gay Men and Lesbians in the United States* (Report 89 of the Council of Scientific Affairs), the American Medical Association (AMA) committed to taking a leadership role and called for educating physicians on the current state of research in and knowledge of homosexuality, along with the need to record an adequate sexual history.

AMA states that these efforts should start in medical school, but must also be part of the continuing medical education. It also stressed the need to educate physicians about recognizing the physical and psychological needs of gay and lesbian patients. The AMA encouraged physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the needs of this population.



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Steps toward improvement

One area where additional work is needed is in the training of health care professionals on how to interact with gay and lesbian patients in a fair and nonjudgmental way. The issue of cultural competency as it relates to gays and lesbians may be a new concept for many, but it is an important step in ensuring effective provider-patient interaction.

The first step in this process will be for health care providers to learn about the specific health care needs of gays and lesbians, and then to put that training into practice. Training could be offered to current students through the current health professions training programs educational system, and for those who are already involved in health care delivery, offered as CME and CEU credits required as part of ongoing staff training.

Nine ways to improve care for gay and lesbian patients

1. **Make sure all staff**—from the janitor to the doctor—understand that a patient's known or perceived sexual orientation

should not have any effect on how patients are treated or services provided.

2. **Teach health care providers** to ask about sexual history rather than make assumptions about a patient's sexual orientation.

3. **Promote the use** of "gender-neutral" terms between patient/provider to enhance the level of communication.

4. **Make and distribute** gender-neutral brochures and materials so the patient will feel more comfortable and can identify with health messages.

5. **Consider posting a statement** of non-discrimination based on sexual orientation in the patient waiting and exam rooms.

6. **Prior to taking a sexual history**, repeat a pledge of confidentiality.

7. **Participate in training** on gay and lesbian health concerns conducted by local gay and lesbian health organizations.

8. **Make an on-site resource directory** available for use in referrals to other providers in case a patient decides to obtain a specific service elsewhere.

9. **Conduct patient satisfaction surveys** with gays and lesbians who have disclosed their sexual orientation to determine if there are ways to improve health services.

All patients, regardless of sexual orientation, face myriad challenges in navigating the health care system. Regardless of whether a patient has private insurance or receives services through publicly funded sources, each deserves to be treated with dignity and respect. It is in the best interest of both the provider and patient.

Specific action should be taken to ensure that all patients, regardless of sexual orientation, feel free to share risk factors without concern for how a health care provider will react. Research that focuses on health needs of gays and lesbians must be enhanced so that special needs can be identified and addressed. That research must be translated into practice. ❖

New Study on Patient/Physician Relationships

African American patients rated their visits as less participatory than whites in models adjusting for age, gender, education, marital status, health status, and length of the patient-physician relationship, according to a study published in the August 11, 1999 issue of the Journal of the American Medical Association (JAMA).

Researchers also found that patients seeing physicians of their own race rate their physicians' decision making (PDM) styles as more participatory.

Researchers conducted a telephone survey between November 1996 and June 1998 of 1,816 adults aged 18 to 65 years.

This study shows that female physicians had more participatory visits with patients than male physicians. The authors suggest that all patients prefer participatory visits because patient satisfaction was linked to PDM scores for patients across all ethnic groups.

Researchers recommend patient and physician interventions to improve communication in primary settings. This requires interventions that empower minorities to become more involved and active consumers of care, along with increasing the number of minority physicians.

The authors also state that communication training programs for medical students, residents, and practicing physicians emphasize the importance of understanding our increasingly diverse population. ❖

