

It's 8 AM. Do you know who your gay and lesbian patients are?

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While applying for PA school, I shadowed a PA at a busy pediatric clinic. During a wellness visit, the PA asked a 16-year-old male if he had a girlfriend. The young man shifted his gaze downward and bashfully answered “no.” I winced. The PA had assumed that this patient was heterosexual when to me he appeared to be gay. This assumption, however benign it may seem on the exterior, probably sent a subtle yet powerful message to this young man: It's not okay to be gay; you aren't like the rest of us.

The assumption of a patient's heterosexuality during the health care encounter has the potential not only to leave the gay or lesbian patient feeling invisible but also to leave the PA with an incomplete picture of that patient's physical and mental health. Even the keenest practitioners rob themselves of important clues about a patient's health when they fail to ask about the patient's sexuality. The sexual orientation of a patient may explain the etiology or risk profile for breast cancer, depression, substance abuse, hepatitis, or anal papilloma. By asking about a patient's sexual orientation, the clinician also gains an important inroad to the support system and family structure of the patient. This is critical for gay and lesbian people, who typically have “families of choice” made up of friends who also are gay or gay-friendly.

Making room for gay and lesbian patients in your practice does not require a total rewrite of office policies or sponsoring a float in the gay pride parade. It does, however, require three things: an awareness of the non-heterosexual population and their unique health concerns; conscious, genuine reflection about your internal prejudices and assumptions about gay and lesbian people; and, finally, a commitment to change the way you view and communicate with all of your patients.

Challenging our assumptions

Every gay and lesbian person has a unique and rich coming-out story. Mine is linked to my path to becoming a PA—and to becoming one who is committed to making a

difference in the care of her nonheterosexual patients. Years ago, during my third year of physical therapy school, I came out as a lesbian. Struggling with rejection by my friends and family, I failed a course and had to withdraw from school. I was never readmitted, so my life took a very different path than the one it might have followed. I wish that back then someone at the school had acknowledged my sexuality and the struggles I faced because of it. Sometimes the most important thing a gay or lesbian person needs is validation of the uniqueness of their lives—acknowledgement of the challenge of living in a world that often ignores them, disenfranchises them, or judges them.

In caring for your gay and lesbian patients, the simplest, most powerful action a PA can take is this: Ask. Ask about your patient's sexual orientation. If the patient identifies as gay or lesbian, return this act of vulnerability with messages of reassurance and acceptance. Ask about family: Does the patient have a partner or children? In making these simple inquiries, you begin building what may be the first trusting, open relationship that your gay or lesbian patient has ever had with a health care provider.

Challenging our prejudices

PAs who have not acknowledged their own homophobia and heterosexism will probably at some point provide inferior care to their gay and lesbian patients—or worse yet, inflict direct physical or psychic injury. A provider's discomfort with a gay or lesbian patient has a direct impact on how they communicate (see “How to appraise your comfort level,” page 70). Even the most astute PAs may miss important clues and symptoms because they are preoccupied or uncomfortable with the patient's sexuality. A 1987 study gauged the attitudes of 119 medical students toward four fictitious narratives featuring two male patients, one gay and one heterosexual, one suffering from leukemia and the other from AIDS. Students viewed the gay patients as being more responsible for their illness and suffering less pain than their heterosexual counterparts. The students also characterized the gay patients as less “appropriate,” more “offensive,” less “truthful,” less “likable,” and “inferior” in comparison to

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the heterosexual patients portrayed in the narratives.¹ In another study of 25 lesbians and their health care experiences, 96% of participants thought that disclosure of their sexuality would precipitate poor treatment from their providers. One lesbian participant spoke of her experiences: “Some people have very negative, very violent reactions. I don’t think they can separate from their personal prejudices. It is like putting your life in someone’s hands who really hates you.”²

Communicate and model inclusiveness

In creating a safer and more sensitive environment for gay and lesbian patients, we must make room for non-heterosexual identification at the onset of a patient encounter. Health history forms should include designations for nonheterosexual relationships. Gay patients find no way to describe their relationships in response to a marital status question that offers single, married, or divorced as the only choices. In communicating with our patients, we should use gender-neutral language until they reveal their sexual orientation. Discussions of family should be broad enough to include nontraditional structures such as same-sex parents, adopted children, or children conceived through an anonymous donor.

In addition to broader designations on health questionnaires, we can model inclusiveness to our staff and our heterosexual patients through the use of brochures on gay and lesbian health and posters or artwork that portray nonheterosexual couples and nontraditional families. Displaying decals that communicate “gay and lesbian safe space” sends an important message to both gay and heterosexual patients. Keeping brochures inside the treatment rooms provides gay and lesbian patients, or patients who are questioning their sexuality, a safe and confidential way to access the information. A posting of the clinic’s official policy of nondiscrimination on the basis of sexual orientation also conveys a clear statement of the kind of treatment and respect that gay and lesbian patients can expect to receive.

How to appraise your comfort level

Ask yourself these questions:

- Do I lower my voice or stutter when saying *gay* or *lesbian*?
- Do I create more physical distance in the exam room between my gay and lesbian patients and myself than I do with my heterosexual patients?
- Do I become uncomfortable or change the subject when a patient comes out to me?
- Do I avoid touching gay or lesbian patients?

Source: Eliason MJ. *Who Cares? Institutional Barriers to Health Care for Lesbian, Gay, and Bisexual Persons*. New York, NY: National League for Nursing Press; 1996:234.

A commitment to inclusiveness for nonheterosexual patients begins with the appropriate education of future PAs. Currently, most PA programs lack course content that adequately addresses the gay and lesbian patient population. A survey of training directors in 1988 found that only 2.5 hours of instruction related to gay and lesbian sexuality was provided to medical students during their entire four years of didactic coursework.³

In her book *Sexual Orientation in Child and Adolescent Health Care*, Ellen Perrin carves out five ways in which medical training programs can begin to eliminate heterosexism in their curriculum and training. She suggests an increased level of education regarding gay and lesbian issues, the support of a group or center for nonheterosexual students and faculty members, a concerted effort to increase the visibility of gay and lesbian issues, clinical programs specifically designed for the needs of gay patients and their families, and finally, the development of research aimed at the unique health concerns of nonheterosexual people.⁴ On a grassroots level, PA faculty and administrators can begin to incorporate this “cultural competence” via didactic instruction, role-playing exercises in a clinical lab, and supervised patient encounters during clinical rotations.

Change begins with me

Heterosexual clinicians are not alone in carrying the responsibility for providing safe and compassionate health care for gay and lesbian patients. Nonheterosexual providers must respond to the call by coming out to their patients and staff. This may pose a risk to some providers who fear losing their heterosexual patients. But it may also save the lives of young gay or lesbian patients who find a gay or lesbian PA in whom they can confide.

Often gay and lesbian patients must choose between perpetuating their own invisibility by not coming out to their provider or facing the potential for negative consequences if they do. I believe that gay and lesbian patients owe it to their own health to come out. Nondisclosure perpetuates stigma and feeds into feelings of dishonesty and low self-esteem. In turn, these feelings—or the silence itself—can manifest in symptoms and ensuing illness. When gay or lesbian patients receive substandard care, they must speak out. They must accept nothing short of quality, dignified, and respectful care at each encounter. □

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