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Lesbian Health Guidelines

This Policy Statement has been reviewed and approved by the Social and Sexual Issues Committee and was approved by the Council of the SOGC

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Abstract: there has been significant progress in women's health care over the past decade, however, there remains a paucity of literature and research about health and the lesbian woman. Lesbian patients are frequently an invisible subset in a physician's practice. If the sexual practices of an individual are unknown or assumed, medical management may be compromised. The attitudes of physicians affect the care of their patients, especially if they are homophobic or heterosexist. Education on sexuality and sensitivity skills will enable health care providers to obtain bias free histories. For the lesbian patient to receive appropriate care, her sexual orientation and lifestyle must be known and understood by her health care providers. Education is the first step towards improving care for lesbian patients; the final step is the enlightenment of attitudes towards sexuality among health care providers.

PURPOSE OF THE GUIDELINES

The purpose of the guidelines is to address the barriers that lesbian patients face when accessing medical care. Homophobia and heterosexism permeate all levels of society, and the health care system is no exception. The term heterosexism implies a belief that heterosexuality is a healthier lifestyle, superior to homosexuality.[1] This term is preferable to homophobia as this denotes a persistent abnormal fear of or aversion to homosexuality. Lesbian patients tend to avoid routine health care checks. Once they turn to a health care provider they are vulnerable to prejudice. The women must decide whether to "come out" and risk provider hostility, or remain secretive and risk suboptimal treatment due to lack of disclosure. Lesbians may not get the treatment they require because health care providers either assume the patient to be heterosexual or do not incorporate knowledge about lesbian issues into diagnosis and treatment.

Health care providers should be aware of the effects their thinking patterns and biases have on patient care, especially in minority groups. The patient-physician relationship is a critical factor in a patient's well-being. "Health" is a holistic concept that includes physical, mental, emotional and social well-being. It is difficult for a physician to nurture the conditions that improve health if the patient/physician relationship is based on misinformation, assumptions and bias.

UNDERSTANDING LESBIAN CULTURE AND LIFESTYLE

Large gaps exist within the medical community when it comes to understanding gay and lesbian culture and lifestyle. It is estimated that five to ten percent of women are classified as gay, lesbian or homosexual.[2,3] Lesbians are women whose primary

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emotional and sexual relationships are with women. Sampling difficulties lead to an inaccurate portrayal of lesbians, as sexual identity must be separated from sexual behaviour. Lesbians live in all communities and represent a diverse group in race, ethnicity, education, age and sexual practice. They may be celibate or sexually active with men, women or both.[3] This makes lesbians difficult to describe in a collective fashion and leads to invisibility.

With the advent of AIDS, the medical establishment was forced to re-evaluate health care and attitudes for gay men but lesbians had no such marker to increase their visibility. When a woman enters a health care provider's office, unless questioned in a nonjudgemental fashion about sexual orientation, she will be treated as heterosexual. The patient may perpetuate the assumption unless she believes the health care provider will handle the information with respect and confidentiality. The latter is especially true in small communities. Education concerning gay and lesbian patients must begin in medical school with efforts put into continuing medical education events to upgrade the knowledge of other health care providers. Health care providers are often naïve about the influence that heterosexual assumptions can have on the ability to communicate with gay patients.[4] All health care providers need to identify their internal heterosexism and determine their limitations and abilities. If a health care provider is uncomfortable with gay or lesbian patients, a therapeutic bond cannot be established and the patient will not receive optimal health care. Under these circumstances, the patient should be referred to someone who can convey acceptance or a nonjudgemental attitude. Those physicians, especially obstetrician/gynaecologists, who believe they do not see lesbian patients, may not be asking the right questions. Even at five percent, this is not a small minority.

Women worldwide often receive suboptimal health care. Many health care providers do not offer routine or indicated Pap. smears, cervical cultures, pelvic, rectal, breast or abdominal examinations because of difficulties with "intimate examinations" (especially in the opposite sex). This may be exacerbated in those individuals who identify themselves as lesbian due to heterosexism or additional discomfort with an individual of the opposite sex that does not fit the physician's concept of sexual norms.

ROUTINE SCREENING

Canadian lesbians use the health care system with approximately the same frequency as other women, whereas American lesbian women see health care providers less frequently.[5] This may represent the lack of resources in American non-socialized medicine and negative experiences with the health care system. Similar to Americans, Canadian lesbians are less likely to undergo screening tests, specifically Pap. smears, mammograms and breast examinations, even when needed. Approximately 15 percent of lesbians do not go for regular checkups as they believe heterosexism will negatively affect their treatment.[6] Lesbians see physicians for different reasons than women in general; as a result they may not receive advice about screening tests (Pap. smears, mammograms and breast examinations). This advice is often given when providing contraceptive counselling and may be omitted when a woman is known to be lesbian. Lesbian women in North America consume alcohol, smoke and use street drugs more often than women in general, setting them up for related health problems.[5,7]

HISTORY TAKING

Many health care professionals take care of lesbian patients without being aware of their patients' sexual orientation. In a recent survey, 51 percent of lesbian patients did not "come out" to health care providers, even though 91 percent believed it was important that their regular doctor knew of their sexual orientation. Factors that influenced "coming out" to doctors were:

- being asked about sexual orientation;
- an intake form that provided an opportunity to disclose sexual orientation;
- trust that the information will be treated with respect and confidentiality.

In the same survey, only 32 percent of physicians asked their patients about sexual orientation and 13 percent had open intake forms.[6] When an intake form facilitated acknowledgement of sexual orientation, 97 percent of lesbians and gays "came out".[6]

Until the sexual orientation of a patient is known, it is important to use language free of heterosexual assumptions, for example what type of birth control are you using? This assumes the woman is heterosexual, and may create a barrier for a lesbian patient who must decide whether to correct the assumption. There are many ways to determine a patient's sexual orientation in a nonjudgemental fashion by asking:

- Are you in a relationship?
- Are you sexually active?
- Do you have a partner or partners?
- Is your partner a man or a woman?
- Have you been sexually active with a man, woman or both?

Questions should be phrased so the patients will be assured that self-disclosure will not elicit a negative reaction from the health care professional.

When an individual identifies herself as lesbian, the assumption is often made that sexual relations are exclusively with other women. In one study, 77 percent of gay women had heterosexual coitus and in some instances with gay men.[8] The specific sexual practices of a patient determine her risk of particular diseases and are important in developing individual medical recommendations, for example the need for Pap. smears. Complete histories of past and present sexual behaviours will help to determine the risk of human immunodeficiency virus (HIV),

sexually transmitted disease (STD) and human papilloma virus (HPV) infection. It is important to ask about drug abuse, especially intravenous, due to the health problems associated with these lifestyles.

MENTAL HEALTH ISSUES

Mental health problems tend to be more common in lesbians, probably due to a lack of familial and societal support when growing up. A sense of isolation along with a hidden lifestyle contribute to emotional stress that can predispose to substance abuse, depression and suicide.[9] Though only one Canadian survey has been gathered from a major urban centre, large sampling biases may have occurred. Canadian lesbians tend to have less depression than their American counterparts (14 versus 37%).[5,9]

Health care providers should be aware of the mental health issues affecting lesbians, all of which are exacerbated in the adolescent group.

THE ADOLESCENT LESBIAN

Lesbian adolescents are particularly vulnerable to the process of discovering their homosexual identity. This tends to occur at a time when all adolescents are struggling with their identities, and becoming aware of homosexual feelings compounds the turmoil in this phase of life. Without the support of family and friends, emotional problems may develop in the form of low self-esteem, depression, poor school performance and substance abuse. A health care provider should screen for these signs, and consider confusion about sexual orientation in the differential diagnosis. Lesbian youths are two to three times more likely to attempt suicide, and homosexuality may account for up to 30 percent of completed suicides.[10] Young lesbians try to hide their sexual identity by having heterosexual intercourse and even by intentionally becoming pregnant, or alternatively they may be too busy for dates. Lesbian youths are also at risk for homelessness and its associated risks, including a non-supportive home environment.

LESBIAN WOMEN AND PREGNANCY

Fewer lesbian women become pregnant than heterosexual women. This may put those women at risk for cancers (breast, endometrial) that epidemiologic studies suggest are associated with nulliparity, late child bearing and not having breastfed a baby.[11,12] There is evidence that suggests an increased risk of ovarian and endometrial cancer in women who have not used oral contraceptives and in nulliparous women.[13-15] It must be noted that no specific studies associating these cancers and lesbians have been found. The risks are theoretical, based on nulliparity and reduced hormonal contraceptive use. The risk of cervical cancer depends on the frequency of heterosexual contact and other known risk factors. Screening should be performed according to published guidelines. Those women who have solely homosexual contact are at reduced risk for cervical cancer, however, there is an absence of specific data in lesbian patients. A maintenance-screening interval of three years seems reasonable.[16] Under this circumstance, routine testing for STDs is unwarranted.

LESBIAN WOMEN AS PARENTS

Many lesbian families include children from previous heterosexual relationships in one or both partners, through adoption, heterosexual intercourse for the purpose of conception and therapeutic donor insemination. There is extensive research on the effects that gay parenting have on children. In a large literature review, it was found that children of gay or lesbian parents did not differ in psychological health or social relationships from children of heterosexual parents.[17] There were also no differences detected between these groups in the development of gender identification, gender role behaviour or adolescent sexual orientation. Both groups had equivalent rates of psychiatric disturbances and behavioural or emotional problems. Children of gay or lesbian parents are less likely to be victims of parental sexual or physical abuse, and tend to be more tolerant of diversity.

Lesbians are no less likely to desire children than other women, and in one survey up to sixty percent of lesbians considered parenting.[7] However, due to the lack of support from society and the medical community, these women are less likely to attempt to conceive. Adoption and fertility programmes can be difficult for lesbians to negotiate so they may subject themselves to health risks to conceive, for example, intercourse with strangers or insemination with sperm from unscreened donors. No medical service should be restricted to an individual because of sexual orientation (artificial insemination with tested anonymous donor sperm or any other profertility technology).

ASSAULT AND SEXUAL ABUSE

Health care professionals should be alert to the possibility of current or past abuse. Similar to women in the general population, approximately 38 percent of lesbians are survivors of childhood sexual abuse and 40 percent report sexual assault.[9] Lesbians can also be victims of partner abuse. In one Canadian study, the rate of emotional abuse by a partner in a lesbian relationship was reported to be 40 percent, similar to rates found in heterosexual women, however, physical abuse rates were much less in lesbian couples (50 versus 14%).[5] If it is difficult for lesbians to disclose their sexual orientation, then revealing partner abuse must be next to impossible. Lesbians are also targets for anti-gay violence. As many as 92 percent of lesbians report they have been subjected to anti-gay verbal abuse or threats.[18]

SUMMARY

Lesbian health care issues are women's health care issues. Anything that interferes with a patient's ability to get optimal health

care should be identified and heeded so that change can be effected. Health care providers should look at themselves, identify their biases and evaluate their need to adapt. Research consistently demonstrates that disclosure of sexual orientation is important to lesbians, and most believe it facilitates a higher quality of care. Once a patient is identified as lesbian, health risks of heterosexual origin must not be ignored until an in-depth sexual history is taken. Omission of indicated screening tests might also lead to later culpability, whether or not it is intentional.

Adequate training should be provided for health care professionals to enable them to deal appropriately with their responsibilities when providing care for lesbians. Post-secondary educational institutions and professional associations can play an important role in developing the necessary knowledge, expertise and sensitivity. Education programmes on human sexuality should be initiated in medical schools in an attempt to reduce homophobia and heterosexism. These programmes should teach the skill of obtaining histories free from bias towards sexual orientation. Health care providers need to refine their attitude towards sexuality to promote taking in-depth sexual history without becoming awkward or uncomfortable.

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