Assumptions and misconceptions about lesbian, gay, bisexual, transgender and queer patients can lead to a poor quality of care. For example, studies have shown that women who identify as lesbian and bisexual tend to receive fewer Pap tests than heterosexual women, despite their having an equal, if not higher, risk of developing cervical cancer.

While about 2% of the Canadian population identifies as gay, according to a 2008 Statistics Canada survey, it is believed that this number is substantially higher in reality. In fact, data from Alfred Kinsey’s landmark investigations in the 1940s and ’50s put those whose sexual behaviour differs from heterosexual at around 10%. “That’s a large portion of the population for which there’s little to no education for doctors,” says Dr. Trevor Cornell, Vancouver Coastal Health’s medical director for urban primary care and a clinical professor at the University of British Columbia.
According to Dr. Corneil, medical students tend to receive education only about the psychosocial aspects resulting from LGBTQ (lesbian/gay/bisexual/transsexual/queer) people's marginalization in society. The cultural and the biomedical issues relevant to the LGBTQ community are rarely covered in medical education, says Dr. Corneil.

Unsurprisingly, he and Dr. Hershel Kagan, a gay family doctor who specializes in prenatal, pediatric and gay and lesbian health in Ottawa, have both had gay patients complain about homophobia from previous physician encounters. “They felt uncomfortable. They felt that the doctor didn’t take them seriously or wasn’t sensitive to their needs,” says Dr. Kagan.

By educating themselves on LGBTQ health issues, physicians can help these patients feel respected, while ensuring important risk factors aren’t missed. Here are some issues to consider in your practice:

1 Ask about behaviour

Just as physicians indiscriminately ask patients about their number of sexual partners and whether they use protection, so too should they ask whether partners are male or female. Dr. Kagan strongly recommends avoiding labels initially and simply asking about behaviour, with a question such as, “Do you have sex with men or women or both?” Questions such as, “Are you homosexual?” may not only be taken offensively, they can lead to misunderstandings. A male patient might identify as heterosexual but occasionally have sex with men, for example. Similarly, a woman who identifies as a lesbian may in fact have both male and female partners, in which case contraception should be discussed.

Dr. Kagan

To ensure his patients don’t feel singled out, Dr. Kagan often shows patients his computer screen during initial and annual comprehensive consultations. The questions are divided into boxes that include current and past medical history, medications and personal information, the latter of which includes information about diet, alcohol, exercise and sexual behaviour. “When they see the list, they see that everyone gets the same questions,” Dr. Kagan explains.

2 Understand how patients identify

While it’s best to avoid labels until sexual behaviour has been established, it helps to know which labels patients prefer, says Dr. Corneil. Patients will feel more respected and understood if physicians use their own language. For instance, knowing that queer youth have a higher incidence of depression, a physician can then ask a question along the lines of, “You’ve identified as a bisexual man. Are there any issues that cause you stress or affect your mood?”

Once it’s become clear that a patient may not identify as straight, a physician can simply ask, “How do you identify yourself?” Or, if the question isn’t clear to the patient, “Do you identify as gay/queer/lesbian, or is there another term you prefer?” Non-straight people are used to answering questions about their identity, says Dr. Corneil, so physicians need not feel uncomfortable asking.

In very broad terms, gay, transgendered or bisexual individuals younger than 40 prefer to use the word “queer,” while those older than 40 often feel less comfortable with the word, Dr. Corneil explains. Meanwhile, non-straight First Nations patients often refer to themselves as “two-spirited.” Some may prefer to eschew labels altogether. The bottom line: Follow the patient’s lead, and write their identity in their chart, recognizing that how someone identifies may change over time.
3 Discuss the biomedical risks

Here are some key biomedical factors all family doctors should be aware of, according to Dr. Corneil:

- Women who identify as lesbian and bisexual have been shown in various studies to receive fewer Pap tests than heterosexual women, despite their having an equal, if not higher, risk of developing cervical cancer.
- Queer-identifying youth are 1.5 times as likely to suffer depression and almost three times as likely to commit suicide than their straight counterparts.
- In Canada, there are three times the number of HIV-positive men who have sex with men compared with those who have sex with women, according to the Public Health Association of Canada.
- The Canadian Rainbow Health Coalition also notes drug and alcohol abuse also affect the LGBTQ population at much higher rates.

Dr. Corneil recommends broaching subjects such as depression, substance abuse or STIs by noting the population health indicators. A physician can say to the patient, “People within your community in your age group are at a higher risk for X,” before asking the patient whether he or she is concerned about the issue, has been tested, etc.

4 Make a conscious effort to be inclusive

Queer-identifying individuals often “feel a little on edge” when they’re expected to open up to straight people, including physicians, says Dr. Kagan. This isn’t surprising considering the off-handed homophobic comments and direct bullying or discrimination queer people frequently encounter. How can physicians provide a safe and comfortable environment? Start by using gender-neutral language. If a patient says they’re in a relationship, use terms such as “partner” or “spouse” until they specify a gender. Other small efforts such as putting a rainbow sticker somewhere in the office can go a long way to showing LGBTQ patients they’re welcome.

Additionally, physicians should take stock of their waiting room literature. Be sure to have pamphlets on sexual health that cater to queer audiences and tackle some of the physical and psychosocial issues specific to gay and bisexual youth. Dr. Kagan recommends thinking beyond the medical literature, as well. Stock some magazines that aren’t specifically directed toward heterosexual audiences, as most women’s and sports magazines are. Networks including the Pink Triangle Services (www.pinktriangle.org) can also provide literature on LGBTQ organizations in the community.

5 Educate yourself

Dr. Corneil once had a physician say to him, “You’re the first gay patient I’ve had, so let’s work on your health together and you can tell me what issues you’re concerned about.” While Dr. Corneil was initially
impressed with what seemed like a patient-centred response, he later felt stigmatized and poorly cared for. “That physician was asking me to look after my own health,” he explains.

Numerous online resources are available for physicians who feel they lack knowledge of the biomedical risks, cultural aspects and psychosocial needs of the LGBTQ community. To get started, the College of Family Physicians of Canada has compiled LGBTQ health resources here: http://tinyurl.com/6sggewz.

CME courses on LGBTQ health can help physicians communicate in a non-judgmental way with their patients, learn how to tackle depression related to bullying for LGBTQ youth and how to be more supportive of transgendered patients, for example. Rainbow Health Ontario offers four CME courses for physicians: www.rainbowhealthontario.ca/training/RHOTraining/ CME.cfm.

Tags: bisexual, discrimination, education, gay, lesbian, marginalized, queer, transgender