SAME-SEX ATTRACTED WOMEN AND THEIR RELATIONSHIP WITH GPs: IDENTITY, RISK AND DISCLOSURE

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Submitted in total fulfilment of the requirements of the degree of Doctor of Philosophy

October 2009

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Produced on archival quality paper
ABSTRACT

Patient-doctor relationships between same-sex attracted women and general practitioners (GPs) have been presented as problematic in the literature. The problems arise from women’s concerns about the potential for negative attitudes amongst GPs. They also relate to GPs’ concerns about offending patients if they ask about sexual orientation due to the stigmatised nature of minority sexual orientation. As a result, disclosure of sexual orientation can be difficult and the patient-doctor relationship can be compromised. The aim of this study was to explore the nature of patient-doctor relationships in this context and how optimal relationships can be achieved.

Using a critical hermeneutic approach, I conducted in-depth interviews with 33 same-sex attracted women and 28 doctors. This included 24 pairs of people in a current patient-doctor relationship. I found that women commonly experienced silencing of their minority sexual orientation within general practice settings, but that this was occasionally desired and not problematic for some women and most GPs. For other women and for many GPs, the silence resulting from a lack of disclosure was a response to perceived risks to women’s personal identity and GPs’ professional identity. Few GPs asked directly about sexual orientation, placing the burden of responsibility for disclosure on same-sex attracted women. Building reciprocal trust could overcome the perceived risks inherent in revealing minority sexual orientation. I initially defined optimal patient-doctor relationships in terms of existing models of cultural competence and patient-centredness; however I found that such relationships were built on cultural sensitivity rather than cultural competence, and relationship-centredness rather than patient-centredness.

I developed a new model of sexual identity disclosure that demonstrated the key influences on disclosure of sexual orientation to GPs for same-sex attracted women. These influences were women’s sexual identity experience, risk perceptions, and the level of knowing within the patient-doctor relationship. The model depicts women’s range and
fluidity of sexual identity experiences and challenges current assumptions that disclosure is essential for effective health care. The model has transformative potential for general practice education and research. It could assist GPs to understand that not all women desire disclosure, but that the majority of women are happy to disclose if asked. GPs would be encouraged to take note of the socio-political environment in which women live and its influence on women’s fears and actual experiences of discrimination. Finally, understanding the role of trust and reciprocal knowing in mitigating perceived risks would encourage GPs to focus more on relationship building. This could also assist GPs to overcome their own perceptions of risk and encourage them to broach the subject of sexual orientation, ultimately enhancing the patient-doctor relationship.
DECLARATION

This is to certify that

a) the thesis comprises only my original work towards the PhD,
b) due acknowledgement has been made in the text to all other material used, and
c) the thesis is less than 100,000 words in length, exclusive of tables, figures, references and appendices.

Signed:

Ruth Patricia McNair

Date:
ACKNOWLEDGEMENTS

I am indebted to the most important people in my life, namely my partner Rhonda and son Samuel, for enabling my research time, enriching my leisure time and always supporting me. My mother Patricia and step-father Chris Begg have also provided quiet encouragement.

The research could not have been possible without my supervisors, Kelsey Hegarty and Angela Taft, who have been integral at all stages of the process, from submission of my scholarship application to submission of my thesis. We have been on this journey together, and they provided me with exactly the right blend of guidance and trust that shaped my sense of autonomy as a researcher.

The study was brought alive by the 61 participants. They were all willing and open to share sometimes difficult, often moving and always pertinent experiences with me, in a spirit of altruism and hope that the future experiences of same-sex attracted women and their GPs could be enhanced by this research. I will continue to work towards bringing these aspirations to fruition.

I could not have proceeded without the funding support of the NHMRC through a full-time scholarship, and also research grants from the RACGP and the Australian Lesbian Medical Association. I would also like to thank the Diamond research team, in particular Jane Gunn, Gail Gilchrist and Maria Potiriadis for providing me with access to some of the respondents to the initial Diamond survey.

Many other people have helped me in so many ways. The Advisory Group members Amelia Bassett, Meg Gulbin, Patty Robertson, Jo Harrison, Darren Russell and Debra Wilson each responded enthusiastically to my invitation and maintained a keen interest throughout the study, keeping me grounded in reality. The Confirmation and Completion panel members Jane Gunn, Priscilla Pyett, John Furler, Meredith Temple-Smith and Chris
Dowrick provided timely advice. I am grateful for the transcribing expertise of Bonnie Simons, Sue Foley and Sylv Meltzer; the graphic design artistry of Greer Sansom for the design of the study logo and Adrian Saunders for the design of the identity disclosure model diagram; and the fine editing of Fiona Johnston. Finally, becoming part of a community of committed researchers provided me with enormous inspiration and encouragement. This included being part of a growing academic Department of General Practice and its postgraduate student group. In particular, thank you to Jan Cole, Deb Colville, Lyn Clearihan, Sue Dibble, John Furler, Lyn Gillam, Marilyls Guillemin, Tonda Hughes, Anne Kavanagh, Cate Nagle, Rhian Parker, Amaryll Perlesz, Marie Pirotta, Jen Power, Kerry Proctor, Kate, Robins-Browne and Jo Wainer for their generosity in sharing their own work with me and taking an interest in mine.
# GLOSSARY

I have used the following words and terms within the body of the thesis. Some of the definitions relating to sexual orientation are taken from the Victorian Ministerial Advisory Committee on Gay and Lesbian Health Action Plan (Leonard, 2003).

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALSWH</td>
<td>Australian Longitudinal Study of Women’s Health.</td>
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<tr>
<td>Bisexual woman</td>
<td>Sexual identity label increasingly used amongst women with bisexual attractions.</td>
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<tr>
<td>Coming out</td>
<td>A process of personal or public acknowledgement of minority sexual orientation.</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development is the process of gaining and maintaining skills and knowledge following attainment of a specialist medical qualification such as the Fellowship of the RACGP.</td>
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<td>Gay</td>
<td>Sexual identity label used by some same-sex attracted women.</td>
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<td>GP</td>
<td>General practitioner, which is the term used in Australia for medical practitioners who deliver primary medical care.</td>
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<td>GLBT</td>
<td>Acronym for gay, lesbian, bisexual and transgender communities.</td>
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<tr>
<td>Heteronormativity</td>
<td>A culturally embedded and tacit tendency to assume heterosexuality.</td>
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<td>Term</td>
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<tr>
<td>Heterosexism</td>
<td>A belief that heterosexuality is more natural, normal and morally correct than minority sexual orientation.</td>
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<tr>
<td>Homophobia</td>
<td>A fear or hatred of lesbian and gay people.</td>
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<tr>
<td>Lesbian woman</td>
<td>Sexual identity label commonly used amongst same-sex attracted women.</td>
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<tr>
<td>Minority sexual orientation</td>
<td>Sexual orientation other than an exclusively heterosexual orientation.</td>
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<tr>
<td>NHMRC</td>
<td>The National Health and Medical Research Council is Australia's peak body for supporting health and medical research; for developing health advice for the Australian community, health professionals and governments; and for providing advice on ethical behaviour in health care and in the conduct of health and medical research.¹</td>
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<tr>
<td>Queer</td>
<td>A term used by some same-sex attracted people to indicate minority sexual orientation, which began as a postmodern rejection of identity labelling.</td>
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<tr>
<td>RACGP</td>
<td>The Royal Australian College of General Practitioners is the peak body for general practice training and standard setting in Australia.</td>
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<tr>
<td>Same-sex attracted woman</td>
<td>A woman who is sexually attracted to women. This may be an exclusive attraction, or she may also be attracted to men.</td>
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</tbody>
</table>

Sexual identity  A self-defined label indicating the meaning of sexual orientation personally or publicly.

Sexual orientation  A multi-dimensional concept including a person’s sexual attraction, sexual behaviour and sexual identity. These dimensions may not be congruent with each other, and may be fixed or fluid.
GUIDE TO PARTICIPANTS

Table 1 - Participant pseudonyms and woman-GP pairs

<table>
<thead>
<tr>
<th>Patient - doctor pairs</th>
<th>Same-sex attracted women+</th>
<th>Age</th>
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Separate patients & doctors

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+ All names are pseudonyms
* Culturally and linguistically diverse background
^ Doctor who is lesbian or gay
# Doctor had two patients who participated in the study
# TABLE OF CONTENTS

ABSTRACT ............................................................................................................................... III
DECLARATION .......................................................................................................................... V
ACKNOWLEDGEMENTS .......................................................................................................... VI
GLOSSARY ............................................................................................................................... VIII
GUIDE TO PARTICIPANTS ...................................................................................................... XI
TABLE OF CONTENTS ............................................................................................................ XIII
LIST OF TABLES AND FIGURES .......................................................................................... XVI

## CHAPTER 1 - INTRODUCTION

- STUDY AIM .......................................................................................................................... 1
- TERMINOLOGY ..................................................................................................................... 2
- RATIONALE FOR THE STUDY ............................................................................................ 3
- RESEARCH QUESTIONS ....................................................................................................... 9
- THEORETICAL FRAMEWORK AND METHOD .................................................................. 9
- THESIS STRUCTURE ........................................................................................................... 10
- THESIS ARGUMENT .......................................................................................................... 12

## CHAPTER 2 - METHODOLOGY

- THEORETICAL FRAMEWORK ............................................................................................ 14
- THEORY INFORMING THE METHODS .............................................................................. 21
- ETHICAL CONSIDERATIONS .............................................................................................. 24
- DATA SOURCES ................................................................................................................ 41
- DATA GENERATION .......................................................................................................... 51
- DATA ANALYSIS ................................................................................................................ 57
- SUMMARY ........................................................................................................................... 63

## CHAPTER 3 - PREFERENCES AND EXPECTATIONS OF GENERAL PRACTICE CARE

- MODELS OF PATIENT-DOCTOR RELATIONSHIPS ........................................................ 66
- LITERATURE ON SPECIFIC HEALTH CARE NEEDS ....................................................... 69
- OVERVIEW OF WOMEN’S CARE NEEDS ..................................................................... 77
- PREFERRED STYLE OF CARE ............................................................................................ 79
- PREFERRED PROFESSIONAL ATTRIBUTES OF GPs ...................................................... 87
- EXPECTATIONS OF TRUST ............................................................................................... 99
- SUMMARY ........................................................................................................................... 105

## CHAPTER 4 - LIFEWORLDS ABSENT OR PRESENT IN THE PATIENT-DOCTOR RELATIONSHIP

- HABERMAS AND THE LIFEWORLD WITHIN HEALTH CARE .......................................... 109
- FEMINIST ACCOUNTS OF THE LIFEWORLD WITHIN HEALTH CARE ........................... 113
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>CHAPTER 5 - IDENTITY AND DISCLOSURE WITHIN GENERAL PRACTICE</td>
<td>162</td>
</tr>
<tr>
<td></td>
<td>GIDDENS, GOFFMAN AND IDENTITY</td>
<td>163</td>
</tr>
<tr>
<td></td>
<td>FEMINIST PERSPECTIVES OF PERSONAL AND PUBLIC SPACES</td>
<td>166</td>
</tr>
<tr>
<td></td>
<td>LESBIAN AND BISEXUAL IDENTITY FRAMEWORKS</td>
<td>166</td>
</tr>
<tr>
<td></td>
<td>SEXUAL IDENTITY EXPERIENCES – THE PERSONAL NARRATIVE</td>
<td>172</td>
</tr>
<tr>
<td></td>
<td>SEXUAL IDENTITY EXPRESSION – THE PUBLIC PRACTICE</td>
<td>189</td>
</tr>
<tr>
<td></td>
<td>GP UNDERSTANDING OF SEXUAL IDENTITY</td>
<td>203</td>
</tr>
<tr>
<td></td>
<td>SUMMARY</td>
<td>212</td>
</tr>
<tr>
<td>6</td>
<td>CHAPTER 6 - MUTUAL RISK AND RESPONSIBILITY FOR DISCLOSURE</td>
<td>214</td>
</tr>
<tr>
<td></td>
<td>GAPS AND ASSUMPTIONS WITHIN THE DISCLOSURE LITERATURE</td>
<td>215</td>
</tr>
<tr>
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<td>LITERATURE ON PATTERNS OF DISCLOSURE</td>
<td>217</td>
</tr>
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<td>PREFERENCES REGARDING WHO IS RESPONSIBLE FOR DISCLOSURE</td>
<td>218</td>
</tr>
<tr>
<td></td>
<td>EXPERIENCES OF DISCLOSURE</td>
<td>228</td>
</tr>
<tr>
<td></td>
<td>GP REACTIONS TO DISCLOSURE</td>
<td>235</td>
</tr>
<tr>
<td></td>
<td>SUMMARY OF PATTERNS OF DISCLOSURE</td>
<td>243</td>
</tr>
<tr>
<td></td>
<td>GP BARRIERS TO FACILITATING DISCLOSURE</td>
<td>244</td>
</tr>
<tr>
<td></td>
<td>SUMMARY</td>
<td>259</td>
</tr>
<tr>
<td>7</td>
<td>CHAPTER 7 - CAPACITY FOR TRANSFORMATION</td>
<td>261</td>
</tr>
<tr>
<td></td>
<td>SUMMARY OF FINDINGS</td>
<td>262</td>
</tr>
<tr>
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<td>THEORISING SILENCING USING GIDDENS’ LEVELS OF CONSCIOUSNESS</td>
<td>268</td>
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<td></td>
<td>TRANSFORMATIVE MOVES</td>
<td>271</td>
</tr>
<tr>
<td></td>
<td>EDUCATIONAL IMPLICATIONS</td>
<td>291</td>
</tr>
<tr>
<td></td>
<td>PERSONAL REFLECTIONS AND PRAXIS</td>
<td>295</td>
</tr>
<tr>
<td></td>
<td>STRENGTHS AND LIMITATIONS</td>
<td>298</td>
</tr>
<tr>
<td></td>
<td>FURTHER RESEARCH NEEDED</td>
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<td>CONCLUSION</td>
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<td>APPENDIX 1 – PLAIN LANGUAGE STATEMENTS</td>
<td>320</td>
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<tr>
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<td>PLAIN LANGUAGE STATEMENT FOR GPs</td>
<td>324</td>
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<tr>
<td>2</td>
<td>APPENDIX 2 – CONSENT FORM</td>
<td>327</td>
</tr>
<tr>
<td>3</td>
<td>APPENDIX 3 – PRE-INTERVIEW SURVEYS</td>
<td>329</td>
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<tr>
<td></td>
<td>SAME-SEX ATTRACTED WOMEN’S SURVEY</td>
<td>329</td>
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<td>GPs’ SURVEY</td>
<td>335</td>
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</tbody>
</table>
APPENDIX 4 – INTERVIEW SCHEDULES ................................................................. 340
SAME-SEX ATTRACTED WOMEN’S INITIAL INTERVIEW SCHEDULE .................. 340
GPs’ INITIAL INTERVIEW SCHEDULE ................................................................ 344

APPENDIX 5 – CODING FRAMEWORK ............................................................... 348
CODES FOR SAME-SEX ATTRACTED WOMEN .............................................. 348
CODES FOR GPs ......................................................................................... 354

APPENDIX 6 – DISSEMINATION ........................................................................ 359
WEBSITE ........................................................................................................ 359
PROFESSIONAL CONFERENCES ................................................................. 361
COMMUNITY PRESENTATIONS .................................................................... 372
ACADEMIC PUBLICATIONS ........................................................................ 374
GUIDE FOR GLBTI INCLUSIVE PRACTICE .................................................. 375
GP GUIDELINES ON THE SENSITIVE CARE OF LESBIAN AND BISEXUAL WOMEN. 376

APPENDIX 7 – DRAFT GP GUIDELINES ........................................................... 377

APPENDIX 8 – PUBLISHED PEER-REVIEWED PAPERS ................................. 383
LIST OF TABLES AND FIGURES

TABLE 1 - PARTICIPANT PSEUDONYMS AND WOMAN-GP PAIRS ........................................................XI
TABLE 2 - A HIERARCHY OF EVIDENCE AND RIGOUR IN QUALITATIVE RESEARCH ......ERROR!

BOOKMARK NOT DEFINED.
TABLE 3 - THE SEXUAL ORIENTATION OF THE NON-DEPRESSED WOMEN INTERESTED IN
OTHER STUDIES WHO COMPLETED THE DIAMOND SCREENING SURVEY ....................... 47
TABLE 4 - PARTICIPANT DETAILS......................................................................................... 50
TABLE 5 - COMPARING THREE IDENTITY FRAMEWORKS WITH THE STUDY FINDINGS......... 188

FIGURE 1 - CRITICAL HERMENEUTIC CIRCLE FOR THE STUDY.............................................. 22
FIGURE 2 - RECRUITMENT METHODS AND OUTCOMES......................................................... 45
FIGURE 3 - PICTORIAL REPRESENTATION OF FOUR TYPES OF IDENTITY EXPERIENCE ...... 174
FIGURE 4 - IDENTITY DISCLOSURE MODEL ILLUSTRATING THE THREE INFLUENCES ON
WOMEN’S SEXUAL IDENTITY EXPRESSION TO GPs .......................................................... 197
FIGURE 5 - SEVEN WOMAN-GP PAIRS ILLUSTRATING THE IDENTITY DISCLOSURE MODEL 283
FIGURE 6 - HOME PAGE FOR THE STUDY WEBSITE............................................................ 360
CHAPTER 1 - INTRODUCTION

In this chapter, I summarise the central issues that I sought to address and my motivations for conducting the study. I then describe the structure and argument of the thesis.

**Study Aim**

The aim of my study was to understand what constitutes an optimal patient-doctor relationship between same-sex attracted women and their usual general practitioner (GP) and how this can be achieved. I define an optimal patient-doctor relationship as one that fulfils the expectations of women and their GP with regard to the inclusion or otherwise of minority sexual orientation. My motivation for conducting the study was to explore the problems that are identified in the literature from the perspective of same-sex attracted women and GPs, and to discover solutions that are being, and could be, used in the Australian general practice setting. The problem repeatedly raised in the literature is that same-sex attracted women find it difficult to introduce their sexual orientation into general practice consultations, despite their desire to do so, partly because doctors rarely ask about sexual orientation (Boehmer & Case, 2004; Steele, Tinmouth, & Lu, 2006; Stein & Bonuck, 2001). Some GPs are said to be homophobic and many consistently make heterosexual assumptions (Hunt & Fish, 2008), creating perceptions for women that disclosure is a risk-taking activity (Hitchcock & Wilson, 1992). This leads to reduced satisfaction and reduced continuity of primary care amongst lesbian and bisexual women (Tjepkema, 2008). The problem from the GP perspective is that GPs have had little formal education and minimal experience of seeing this patient group, and do not perceive the clinical relevance of minority sexual orientation (Hinchliff, Gott, & Galena, 2005; Westerstahl, Segesten, & Bjorkelund, 2002). Yet, same-sex attracted women have significant health disparities that need to be addressed within general practice (Hunt & Fish, 2008; Tjepkema, 2008).
Terminology

There are a number of terms that can be used for women who are not exclusively heterosexual. Many women do not label themselves as lesbian or bisexual, yet have same-sex partners or same-sex attractions (Smith, Rissel, Richters, Grulich, & de Visser, 2003), and all of these women were eligible for my study. I initially used the term ‘non-heterosexual’, however this describes a group of people by an attribute they do not possess, so I rejected it as disrespectful. Instead, I chose to use the term ‘same-sex attracted’ (SSA) as this is the most inclusive term in that it applies to all of the women in my study. When referring to the group as a whole I chose to use the term minority sexual orientation, which represents the marginalised status of these women. I do use identity labels of lesbian, gay and bisexual when women used these themselves, or when referring to the literature that predominantly uses these terms. I have deliberately used the word lesbian as an adjective not a noun, just as bisexual or gay is usually used, to indicate that it is a part of the woman’s identity, without necessarily signifying her whole being.

Similarly, there are several terms for a medical primary care provider including doctor, primary care physician, clinician, health care provider and GP. GP is the preferred term in the Australian health system, so I have used it in the thesis. I will also refer to the relationship between same-sex attracted women and their GP as the patient-doctor relationship because the defining identities of the two people in the context of that relationship are as patient and doctor. I have chosen to use the word experience to explore the patient-doctor relationship (Barry, 2002) rather than to focus on the many possible components of the experience that might indicate quality or effectiveness, such as satisfaction, quality, care, trust, comfort, empowerment, control or enablement. Concepts such as satisfaction and quality are complex and not necessarily indicative of the positive or negative nature of the experience for patient or doctor (Winefield, Murrell, Clifford, & Farmer, 1995). Therefore, as Williams (Williams, 1994) recommends, research should explore the terms that patients (and I would add doctors) use to evaluate their experience, rather than apply pre-conceived notions of quality.
Rationale for the Study

I was motivated to conduct the study by three influences. First, the same-sex attracted women that I have contact with in my work as a GP and activist have provided me with a clear understanding of their needs and preferences for sensitive primary medical care. Second, my own personal perspective as a lesbian woman and GP has enhanced this interest, and particularly my roles as patient, doctor, and policy advocate. Third, the literature on the primary health care needs of lesbian and bisexual women, and the patient-doctor relationship motivates further research in this area to fill gaps including understanding how and why disclosure occurs. My own previous research has also formed a background to the current study. I will now describe each of these influences.

Same-sex Attracted Women’s Perspective

Finding a sensitive GP and developing an ongoing relationship is a pressing need for many Australian same-sex attracted women. Since a web-based clearinghouse was established by the peak body Gay and Lesbian Health Victoria (GLHV) in 2004, the most common inquiry amongst thousands received every week has been how to find a lesbian or gay sensitive GP. Similarly, I established a lesbian and bisexual women’s health website as part of the study project in 2005 and have received many emails requesting this information. I received one typical email via my study website in June 2008 from a lesbian woman who had recently moved from Sydney to Melbourne. She was searching for a new GP. She outlined the issues as she saw them and the potential for general practice to provide solutions, and gave me permission to include her email here:

I have personally experienced situations pertinent to your study... I actually find what you are doing extremely interesting, relevant and important. When I came out to my GP [in Sydney] I wasn't sure of his views, whether it was relevant and important for him to know. I'm pretty open about my sexuality to my friends and family, but telling a service professional, who I had only been seeing for about three months before I came out, was daunting. However, I would imagine that as
with genetic/family history or previous medical issues, the GP treating you would benefit from knowing your sexual orientation and would see it as an integral part of the patient profile.

You have the chance to quite be open and vulnerable with a GP, and the opportunity to discuss issues openly in a setting of strict confidence could be of great benefit. I believe that GPs could potentially be (and absolutely should be) a very important touchstone for adolescents or people of any age contemplating their sexuality or experiencing physical/emotional issues stemming from it. How many young gay/lesbian lives could be saved/bettered if invited to discuss gay/lesbian issues without fear of judgement?

I would really like to find a GP who is comfortable discussing lesbian issues and whom I feel comfortable discussing them with. Then there’s the question of a male or female GP… I’d lean towards female for obvious reasons however, my last GP [in Sydney] was male and he was simply outstanding. I wish I could still see him.

This insightful woman raised a number of personal issues that I will cover in my thesis; including the difficulty of knowing whether a GP is sensitive, and the need for reciprocity so that both the woman and her GP feel comfortable. She also assumed that GPs have an important role in sexual identity support, which is backed up by my study findings.

Finally, she challenged the myth that female GPs would be preferable by revealing her experience of seeing an ‘outstanding’ male GP. Her brief request echoes the process of my study, from searching for an optimal GP relationship, to finding it, and then searching again as her situation changed. Equally, the study that I present in this thesis is an iterative and ongoing process, which I hope will do justice to the persistence and reflexivity that many same-sex attracted women display in achieving optimal relationships with their GP.

**Personal Perspective**

I am personally engaged in this study at a number of levels. First, I am a lesbian woman with a female life partner and am very involved in the social aspects of the lesbian community. I ‘came out’ as lesbian during the mid 1990s, and prior to that I identified as
heterosexual. Second, I am a GP and currently work in an inner urban practice that specialises in lesbian and gay health care. This work launched my interest in the health needs of same-sex attracted women, and I have become involved in lesbian community and medical education and research in the areas of health care, conception and parenting. Third, I am an activist for lesbian and bisexual women’s health and legal rights. I was co-founder of the Australian Lesbian Medical Association, and was on the Advisory Committee to the Victorian Law Reform Commission inquiry into access to reproductive technologies and adoption. I currently sit on the Victorian Ministerial Advisory Committee on Gay and Lesbian Health and have done since its inception in 2000.

As a result of these various positions, I commenced the study with a number of preconceptions, which I constantly reassessed during the interview process and analysis. Throughout I have attempted to remain open to hearing unexpected perspectives and to challenge my own position. The preconceptions that I began with were related to:

1. My belief system as a GP.
I use a patient-centred approach in my work which includes valuing and incorporating the context of my patients’ lives. Part of this philosophy led me to believe that the patient-doctor relationship would be more useful if same-sex attracted women could discuss their sexual orientation openly with their GPs. The literature regarding disclosure of lesbian sexual orientation to GPs also makes this assumption.

2. My professional experiences as a GP.
I have seen a large number of same-sex attracted women in my practice who have told me about negative experiences they have had with other GPs. I realise that I am more likely to hear negative than positive stories, as those women with positive experiences are unlikely to need to consult with me. Also, I am involved in GP training on lesbian health, and have been consistently faced with GPs who, despite their willingness, have little knowledge or awareness of same-sex attracted patients. These negative stories were disturbing and motivated me to conduct this study to understand the broader range of women’s and GPs’ experiences that I hoped would exist.

3. My political experiences as an activist.
I have advocated for, and witnessed, change within the political system for a number of years, and firmly believe in the capacity for change at this level. Likewise, I started the study with a belief that the general practice system and GPs themselves could change to improve the health care experience for same-sex attracted women.

Throughout the thesis I show that my preconceptions have been challenged in some areas, particularly regarding the universal need for disclosure; and have been upheld in others, most notably the capacity for change in general practice.

**Research Perspective**

The literature provides evidence that same-sex attracted women can have distinct health care needs. These needs can arise from the socio-political context, involving experiences of discrimination that create health inequalities, further generating specific mental health, emotional and physical health needs (Mayer et al., 2008). The needs can also be purely situational due to women’s sexual orientation, such as conception advice for same-sex partners (Ross, Steele, & Epstein, 2006) or sexual health management (McNair, 2005). In addition, there is evidence that health care usage and satisfaction is lower for same-sex attracted women than heterosexual women (Heck, Sell, & Gorin, 2006), because women have more unmet health care needs (Tjepkema, 2008), and that disclosure of sexual orientation can improve continuity and satisfaction (Bergeron & Senn, 2003). I contend that this literature provides a compelling case that the minority sexual orientation of their patients is relevant to GPs. I outline this literature where relevant in each of the chapters that follow.

I have been involved in two research projects which contributed further background understanding for my current study. The first was a qualitative study exploring the interface between the public and private worlds of lesbian parents, in which I analysed in-depth interview transcripts regarding participants’ health care experiences. The second was an analysis of two surveys in the Australian Longitudinal Study of Women’s Health
(ALSWH) comparing the health care experiences of young non-heterosexual and heterosexual women. We used the term ‘non-heterosexual’ in our publications from this study (Hillier, de Visser, Kavanagh, & McNair, 2004; McNair, Kavanagh, Agius, & Tong, 2005).

**Health Care Experiences of Lesbian Parents**

This study involved in-depth interviews with 20 lesbian parented families accessed using convenience sampling. I have had a paper published from this study on the health care experiences, which I have included in Appendix 9 (McNair, Brown et al., 2008). In summary, many women described positive experiences with individual health care providers, although there were also frequent experiences of providers assuming heterosexuality. Central themes were concerns about safety versus vulnerability, and the level of control women had within their health care experience. Three disclosure strategies were present amongst these parents, which we labelled private, passive and proud. Women with a private strategy chose not to disclose and had the most positive health care experiences when their chosen silence was achieved. Women with a passive approach relied on being asked before they would tell. Those using a ‘proud’ strategy chose to disclose wherever possible and were satisfied when their disclosure was met with a positive response. Disclosure itself was not necessarily the determining factor in health care satisfaction, but rather the level of control that lesbian parents had over disclosure, which improved their perceived safety. We recommended that further research was needed to understand the health care provider perspective, and also the underlying motivations for women’s disclosure approach. I have included both of these additional areas of research in my current study.

**Australian Longitudinal Study of Women’s Health (ALSWH)**

I have worked with two research teams to analyse two surveys (2000 and 2003) completed by the young cohort of the ALSWH. So far, the first team has published results from the
2000 survey regarding mental health (McNair et al., 2005) and drug use (Hillier et al., 2004; Hillier, De Visser, Kavanagh, & McNair, 2003), but not yet regarding health service use and satisfaction. In both surveys we found that the physical and mental health status of the non-heterosexual women was worse than their heterosexual peers and that they attended general practice more frequently. However, the non-heterosexual women (particularly the bisexual women) were less likely to have a regular GP and were less satisfied with their GP experience including the personal manner of the doctor. These differences were similar in both surveys. This study provides the first Australian population-based data comparing health care experiences according to sexual orientation. However, the study cannot explain why women were more dissatisfied and had less continuity of care. This encouraged me to undertake a qualitative study to understand women’s perspectives and answer this question.

**Summary of Issues Relevant to General Practitioners**

I have little doubt that all GPs see same-sex attracted women as patients. These women represent a wide variety of people such as the adolescent woman struggling with her sexual identity, the woman of any age in a same-sex relationship, the middle-aged woman who is coming out after being married, and the older woman who has lost her female life partner. Increasingly rigorous research over recent years shows that lesbian and bisexual women are more likely than heterosexual women to suffer a range of health inequalities related to marginalisation including mental health issues, drug and alcohol abuse, and increased health risk factors. In Australia, they are more likely to attend general practice more frequently but with less continuity, which is related to lower levels of satisfaction. This has an impact on the extent to which they can build trust in order to disclose. There is emerging evidence that bisexual women are even more disadvantaged than lesbian women in all of these areas, although the reasons for this are not clear. In addition minority sexual orientation is relevant as an important demographic fact in health care. These issues, coupled with evidence that disclosure can improve the patient-doctor relationship and health care, make a strong case for GPs to take note of the sexual orientation of their
patients. However, as I will describe in Chapter 4, GPs have had little education in this area and are largely unaware of the pertinent issues of lesbian and bisexual women’s health that they could address in their practices.

**Research Questions**

I developed three research questions for the study, based on my reading of the literature, consultation with the study Advisory Group, as well as the personal experiences I have previously outlined.

1. How do same-sex attracted women and their usual GP experience their clinical relationship?
2. How is disclosure of minority sexual orientation negotiated between same-sex attracted women and their GP?
3. What could be changed within general practice settings to improve the health care experience of same-sex attracted women?

**Theoretical Framework and Method**

I chose a pluralistic approach incorporating three research paradigms: a) hermeneutic phenomenology, which provided a focus on the lived experience of the participants as well as being grounded in existing theory and practical knowledge (Patton, 2002); b) critical theory to explore experiences of social injustice, marginalisation and the emancipatory potential of the study findings (Lincoln & Guba, 2003); and c) liberal feminism to incorporate concepts of power within relationships. I have also applied the feminist principles of reflexivity to understand my own pre-conceptions and role in the research process (Alvesson & Sköldberg, 2000; Lather, 1986). I used in-depth interviewing to understand the experiences of both same-sex attracted women and GPs.
Thesis Structure

This introduction (Chapter 1) is followed by a chapter on methodology, four findings chapters and a discussion chapter including the thesis conclusion. I critique relevant literature within each chapter rather than presenting a separate literature chapter. The first research question is answered within Chapters 3 and 4, the second question within Chapters 5 and 6, and the final question in Chapter 7. I will refer to each chapter using the chapter number.

Chapter 2 - Methodology chapter
This chapter includes sections explaining the theoretical framework, outlining ethical considerations (including the implications of my being an insider researcher) and my responses to them, describing my data sources, data generation and data analysis.

Chapter 3 - Preferences and expectations of general practice care
I start by outlining the theories of cultural competence (American Institutes for Research, 2002) and patient-centredness (Stewart, 1995), which I use to define the optimal patient-doctor relationship. I critically evaluate the literature on lesbian and bisexual women’s expectations of medical care and their specific health needs. I then present findings that answer the questions for the chapter: a) what influence does the sexual orientation of same-sex attracted women have on their preferences and expectations for general practice care?; and b) can cultural competence and patient-centredness accommodate the preferences of same-sex attracted women?

Chapter 4 - Lifeworlds absent or present in the patient-doctor relationship
I introduce my choice to use Habermas’s Theory of Communicative Action (Habermas, 1984) because it applies well to the general practice setting and helps to explain why certain patient needs can be unmet (Barry, Bradley, Britten, Stevenson, & Barber, 2000; Barry, Stevenson, Britten, Barber, & Bradley, 2001). I outline the current evidence for differences in health care usage and satisfaction amongst same-sex attracted women compared with heterosexual women, and critique the literature on deficiencies of medicine
in accommodating the lifeworlds of same-sex attracted women. I then answer three questions for the chapter: a) what are the deficiencies in accommodating the expectations of same-sex attracted women, in particular their expectations of cultural, empathic and humane knowing?; b) what are the influences on whether GPs can accommodate the lifeworld of same-sex attracted women?; and c) what are the elements of the patient-doctor relationship that enable knowing, and specifically accommodation of the lesbian and bisexual lifeworld?

Chapter 5 - Identity and disclosure within general practice
I use Giddens’ (1991) theory on identity and modernity because his concept that identity is self-created and both a public and private phenomenon applies well to sexual identity as women described it in the study. I add liberal feminist perspectives on the private and public aspects of our being so as to relate specifically to women’s identities (Arneil, 1999), and add Goffman’s (1971) work on the presentation of self because it brings an understanding of how stigma influences women’s disclosure to GPs. Next, I summarise three diverse lesbian and bisexual identity frameworks (Cass, 1979; Fingerhut, Peplau, & Ghavami, 2005; Kitzinger, 1987), each of which provide useful perspectives that correlate with some of the women’s experiences in the study. I then answer two questions: a) how does sexual identity influence women’s preference for inclusion of their sexual orientation in the consultation?; and b) how well do GPs understand sexual identity?

Chapter 6 - Mutual risk and responsibility for disclosure
I critique the gaps and assumptions within the disclosure literature, then return to the application of Habermas’s (1984) and Giddens’ (1991) theories to disclosure in this context, in particular the themes of risk, control and responsibility. I answer the questions: a) how is disclosure negotiated between same-sex attracted women and their GP?; b) who has control over disclosure?; and c) who expects to take responsibility for disclosure?

Chapter 7 - Capacity for transformation
I summarise the key findings of the study including reframing the problems presented by women and GPs, and presenting some of the methods they were using to create optimal
patient-doctor relationships. I then answer the final question of the thesis that addresses what could be changed to transform the general practice experience. I close with personal reflections, limitations and strengths of the research, further research needed, and finally summarise the key findings and implications of the study.

**Thesis Argument**

My starting point was that same-sex attracted women have specific health issues and concerns, which make minority sexual orientation relevant for GPs. I found that cultural competence and patient-centredness were relevant methods to enhance the patient-doctor relationship for same-sex attracted women seeing GPs and to enable inclusion of minority sexual orientation. However, there was not a universal preference by women to disclose their sexual orientation to GPs. Also, women and GPs each experienced barriers to disclosure, which led to the silencing of minority sexual orientation within some patient-doctor relationships. I theorised women’s experiences of silencing using Habermas (Habermas, 1984) to suggest that this part of the lifeworld was silenced due to ‘colonisation’ or dominance by the medical system world and a motivation to achieve control by doctors and sometimes women. This was largely due to heteronormative approaches by GPs, which were influenced by very limited exposure to minority sexual orientation in medical education, and limited professional and personal experiences with same-sex attracted women. Many of the women and GPs had overcome this silencing through developing relational knowing, which involved reciprocity within the patient-doctor relationship and even professional friendship. These methods revealed the motivation to improve mutual understanding through the consensus that Habermas predicts.

Relational knowing did not always lead to disclosure, and I developed a new ‘identity disclosure’ model, which explained the three main influences on women’s disclosure to GPs. The first influence was women’s sexual identity experience, which had a strong influence on women’s need to disclose their identity to GPs. This confirmed Giddens’
(1991) concept that personal identity is inter-connected with public identity. A woman who placed little importance on her minority sexual identity was likely to believe that this identity was not relevant to her GP, while a woman who strongly identified as lesbian or bisexual was likely to want to disclose. The second influence was the risk of negative responses from GPs that could compromise the patient-doctor relationship, which reduced the likelihood of disclosure. The third influence was an optimal patient-doctor relationship, which could mitigate this risk.

Most GPs had little understanding of the range of minority sexual identity amongst women, or of its relevance in the consultation; and I argued for the need for GPs to understand issues of diversity and relevance from women’s perspectives. I addressed the question of why GPs found it so difficult to accommodate minority sexual identity despite their patient-centred approach, and found that perceptions of risk formed a significant barrier to GPs facilitating disclosure, just as they did for women. It followed that GPs generally did not take responsibility for disclosure. These risks were partly overcome for some GPs through reciprocal knowing and trust of the patient, again replicating women’s experience. Using Giddens’ theory linking risk and control (Kaspersen, 2000), I argued for the need for control by both women and GPs, and a return to the patient-centred concept of shared responsibility as a way forward.

Finally, I reassessed the theories of patient-centredness and cultural competence in the light of the need for GPs to understand the diversity of sexual orientation amongst same-sex attracted women, and the centrality of the patient-doctor relationship in overcoming risk for women and GPs. I contended that in this context, cultural sensitivity and relationship-centredness are more useful frameworks, as they encourage a focus on diversity and reciprocity respectively. I argued that the identity disclosure model could assist GPs to become more sensitive to the needs of same-sex attracted women and to overcome some of their own barriers in this area. I also present the potential for the model to be applied to other minority identity groups.
CHAPTER 2 - METHODOLOGY

In this chapter, I will demonstrate how the pluralistic theoretical framework I have used has informed my research methods and research process throughout. I have chosen to use qualitative methodology, which Trish Greenhalgh and Rod Taylor (Greenhalgh & Taylor, 1997) suggest can provide a depth of understanding by making sense of the meanings people bring to the health care environment, which is one of my interests in this study. My central motivation has been to understand and improve the health care experience for same-sex attracted women and for GPs. This motive has been integral to my conceptualisation of the study questions, the epistemological approach, the choice of sampling frame and data gathering methods, the analysis, and ultimately the findings on which I have chosen to focus.

I contend that my role as a primary health care clinician provides certain benefits to the study, which have also been highlighted by other GP researchers (Britten, Jones, Murphy, & Stacy, 1995; Malterud, 2001a). These benefits exist at all stages of the research process including the ability to select research questions that are clinically relevant, the choice of practical research settings and access to the clinical field, the addition of tacit clinical knowledge to the analysis, the will to report study findings in a clinically applicable way, and an ongoing commitment to the researched population (Reed & Procter, 1995). Similarly, my personal position as a lesbian woman has conveyed advantages. However, I am also aware that there are some pitfalls pertaining to being an insider researcher and I address these in the ethical considerations section of this chapter. Finally, I consider the topic of this study to be relatively sensitive for all participants and have discussed the ethical issues and challenges in this light.

Theoretical Framework

The epistemological positions I have chosen are interpretive (hermeneutic phenomenology), emancipatory (critical theory) and feminist. Hermeneutic
phenomenology lends itself to the study of communication and to interpretation of various meanings within the patient-doctor relationship. Critical theory is important when attempting to encourage social change as a study outcome. Feminism encourages reflexivity, which has allowed a rigorous understanding of my personal impact on the research process and outcomes. My choice to use both an interpretive and emancipatory approach has been a pragmatic decision based on my personal and political interests that I have outlined. I have also been deliberately pluralistic to enable flexibility and the achievement of my diverse aims for the study. Yvonna Lincoln and Egon Guba (2003) note that pluralistic approaches have been increasingly popular since the mid 1990s and that it is possible to blend elements of one paradigm with another where the paradigms share values and are ‘commensurable’. In addition, pluralism can be seen as a creative approach that enables matching of research questions and methods (Whittemore, Chase, & Mandle, 2001).

Further, qualitative social scientist Mats Alvesson (2002) advocates the use of reflexive pragmatism and calls for “epistemological awareness rather than philosophical rigour” (p.172). He suggests that the use of different paradigms enables “meta-theoretical understanding”, which enhances the research (Alvesson, 2002, p.172). Alvesson and Skoldberg’s (2000) text on reflexive methodology describes reflexive hermeneutics and reflexive critical theory and I have chosen this as my central guide when integrating the theories.

I will now discuss each of these theories in more depth and then demonstrate how the three theories are commensurable within the context of my study.

**Hermeneutic Phenomenology**

Hermeneutic phenomenology enables interpretation of the structure of communication while also interpreting the context of the conversation (Patton, 2002). This has suited my study very well. Phenomenology enabled interpretation of the individual experiences of
the same-sex attracted women and GPs, with an understanding of how they construct their experience of the patient-doctor relationship. Using this approach, I centred the interviews on exploring participants’ experiences within the general practice consultation setting and included people from both groups to ensure that I could understand both perspectives. In the analysis of interviews I searched for commonality within and between the groups, and any essence of a shared experience. However, one of the principles of pure phenomenological analysis is that the researcher brackets the individual experiences, removing any reference to pre-existing knowledge or theories. Bracketing was not appropriate for my study, as I needed to both reflect on my own pre-existing knowledge and incorporate the socio-political context of each participant.

Hermeneutics encourages a contextual interpretation, therefore incorporating pre-existing knowledge from history and culture, and “considers the political and socially constructed nature of findings” (Rice & Ezzy, 1999, p.34). The hermeneutic circle starts with theory and pre-existing interpretations, which shape the life experiences of participants and the way the data are interpreted, which in turn inform the re-development of theory. I have created my own hermeneutic circle for this study, which I present in Figure 1 (p.22).

A central thesis of hermeneutics, which appeals to my nature as a health care practitioner, is that the interpretation of meaning is assisted by the researcher’s empathy for the situation and feelings of the researched (Alvesson & Sköldberg, 2000). It seems to me that there are similarities between the way in which the researcher uses hermeneutics to understand the researched, and the way in which the clinician uses the patient-centred clinical method to understand the patient. Both focus on the need to understand and empathise with the ‘other’s’ context, both find new meanings through everyday life, and both must communicate these meanings back to the other and assist in redeveloping the original understandings. Both also emphasise the importance of language and communication in this process. So, I felt it was appropriate to use a hermeneutic approach.
Critical Theory

Critical theory seeks to move past a purely interpretive research outcome to bring about change through generating critical debate and focusing on social justice (Crossley, 2005). Same-sex attracted women are a marginalised group within society who often experience discrimination. Critical theory is important for my study as it focuses on “how injustice and subjugation shape people’s experiences and understandings of the world… it seeks not just to study and understand society but to critique and change society” (Patton, 2002, p.130). So, while hermeneutic phenomenology has provided me with a framework for understanding the participants’ experiences within a cultural and historical perspective, critical theory enabled me to engage in the societal power asymmetries that can affect the individual. Critical theory necessitates engagement of research participants in the study in order to involve them in the process of change. Such engagement has been shown to encourage lesbian women to participate in research, particularly if they have control over the outcomes (Bradford, White, Honnold, Ryan, & Rothblum, 2001). I will describe my methods for engagement in the consumer involvement section of the chapter.

Critical hermeneutics is an interpretative form of critical theory, which has become increasingly important during the 1990s (Kincheloe & McLaren, 2003). “In the critical theory context, the purpose of hermeneutical analysis is to develop a form of cultural criticism revealing power dynamics within social and cultural texts” (Kincheloe & McLaren, 2003, p.445). Adding critical theory to the hermeneutic circle helps to understand hidden or tacit cultural dynamics. This has been described as triple hermeneutics (Alvesson & Sköldberg, 2000, p.144):

1. Simple hermeneutics: the individual’s interpretation of their own meanings and reality.
2. Double hermeneutics: the researcher interprets the individual’s experience.
3. Triple hermeneutics: the researcher adds a critical interpretation of the unconscious processes and socio-cultural dynamics.
I have applied triple hermeneutics by focusing on a change agenda throughout. In the initial and particularly the follow-up interviews I asked participants to consider their own capacity to change within the general practice system. Finally, an ultimate outcome was to produce guidelines for GPs and guidance for same-sex attracted women in order to make the study findings accessible and useful for the broader communities. I have drafted the GP guidelines, included in Appendix 7.

**Feminism**

My feminist stance includes elements of liberal feminism, which argues for the importance of the autonomy of the person; and post-modern feminism, which recognises multiple social constructions of women who are marginalised. These are two of the seven types of feminism that Rosemarie Tong has outlined (Crotty, 1998). Feminism is said to enhance qualitative research in three ways: a) through advocating to incorporate the participants into the research process, b) through politicising the research, and c) through acknowledging that the researcher is reflexively embedded in the research process (Rice & Ezzy, 1999). I have used these feminist research principles throughout the study because they enhance my desired focus on praxis.

First, I have made efforts to involve participants in the study design, generation of findings and dissemination of findings. This included engaging a consumer advisory group with whom I met periodically throughout the study. I describe the group in detail in the ethics section of this chapter. I have committed to involving the participants in the development of outcomes including guidelines for same-sex attracted women and GP interactions by conducting follow-up interviews. I describe these methods further in the ethical considerations and data generation sections of this chapter.

Second, my study has been political in that I have challenged the role of the medical system and particularly the power of the doctor to determine the content of the consultation. Feminism has provided me with a helpful framework to conduct an analysis
of the dynamics of power within the patient-doctor relationship. Here I particularly referred to the work of Lucy Candib (1995), who reframed family medicine from a feminist perspective, including concepts of empathy and reciprocity. In addition, I believe that my findings will be useful to encourage systemic and political change, which is an important focus of feminist research (Reinharz & Davidman, 1992). Shulamit Reinharz and Lynn Davidman (1992) suggest that ever since the first wave feminist movement in the 1870s “feminist researchers used interviews for social reform purposes” (p.21). Patti Lather (1986) also argues for a ‘praxis-orientated paradigm’ to create a more just society. “For researchers with emancipatory aspirations, doing empirical research offers the powerful opportunity for praxis to the extent that the research process enables people to change by encouraging self-reflection and a deeper understanding of their particular situations” (Lather, 1986, p.263).

Third, I have reflexively examined my role in the research process, which I have detailed in the ethics section of this chapter. Patti Lather (1986) suggests that a feminist approach to reflexivity is to make the researcher’s influence on the research at all levels clear throughout the research process and subsequent report. This includes the influence on the selection of the paradigm, generation of questions, data collection methods, sampling, analysis and interpretation (Lather, 1986). One definition of reflexivity is that it is “an effort to reflect on how the researcher is located in a particular social, political, cultural and linguistic context” (Alvesson, 2002, p.179). However, this definition ignores the researcher’s individual attributes. I openly acknowledge that my gender and sexual orientation contributed to motivating my interest in the study. In being reflexive, I have taken heed of the warning to strike the right balance when inserting oneself into the text. Having too little detail could simply create an air of authority, whereas having too many personal “ruminations” could overwhelm the participants’ voices (Fine, Weis, Weseen, & Wong, 2003, p.170).

Part of the process of reflexivity is to start by identifying the researcher’s own preconceptions, which feminist GP researcher Kirsti Malterud (Malterud, 2001b) argues are only biases if the researcher fails to acknowledge them. She cautions against confusing
intuitive knowledge present before the research began with knowledge that is emerging from the inquiry. I identified my preconceptions early in the research process and outlined them in the introductory chapter. I have continued to reflect on them throughout the research process.

**Commensurability of the Research Paradigms**

Phenomenology and hermeneutics are grounded in the interpretive tradition, and critical theory is grounded in the emancipatory tradition, yet these paradigms are compatible. Matts Alvesson and Kaj Skoldberg state that “critical theory is characterised by an interpretive approach combined with a pronounced interest in critically disputing actual social realities” to such an extent that critical theory has been “referred to as critical hermeneutics” (Alvesson & Sköldberg, 2000, p.110). I have used a critical hermeneutics approach in my study. For example, Jurgen Habermas utilised the phenomenological concept of the lifeworld to explain the cultural meanings that individuals use to interpret their environment, while also acknowledging that system meanings can co-exist (Habermas, 1984). So, critical theory can be used to apply an interpretive perspective to cultural and socio-political environments. In other words, the intention of hermeneutics to understand human experience according to historical perspectives is made more relevant by adding a critical understanding of current and future perspectives.

Feminism has been described as a theory that can overlay all other theoretical paradigms, in that it demands the particular lens of gender in any setting and challenges certain assumptions in any paradigm (Lather, 1988). It is therefore pluralistic and can critique and yet value elements of any paradigm (Reinharz & Davidman, 1992). Feminist theory deliberately blends a focus on the individual’s experience with a need to understand the impact of socio-political forces on that experience, and that praxis orientation necessitates an emancipatory agenda for research. It also challenges the phenomenological assumption that our understandings are fully rational and suggests that false consciousness can be present if the influence of the political system is not fully understood (Lather, 1986).
While feminism focuses on the need to emancipate women, third wave feminist theory acknowledges the similar needs of other marginalised groups (Olesen, 2003), making it compatible with the broad focus of critical theory. Habermas developed a theory of contemporary social movements (including feminism) in which he argued that they would assist in the decolonisation of the lifeworld by demanding a focus on self-identity (Ray, 1993). This is an example of a space in which critical theory and feminism are commensurable.

The three theories are compatible particularly in the setting of my study, which is in the understanding of human interaction within the structured system of medicine. The interest here is on the dialectic between the scientific interest of medicine and the human interest of the people involved in the patient-doctor relationship, and whether potential conflicts can be overcome through consensus. All three paradigms bring perspectives on this dialectic which inform and complement each other. Hermeneutic phenomenology enables focus and respect for the individual experience, critical theory requires reflection on the political influences and possibility for change, and feminism draws the personal and political together and considers the influences of gender and power. The theories are also appropriate to my chosen method of in-depth interviews as each seeks a focus on the individual experience. While critical theory would also seek to observe the patient-doctor interaction from an independent perspective, the addition of this method was not feasible within the scope of a PhD study. Comparison of the women’s and GPs’ perspectives during analysis partly enabled this perspective.

I will consider the commensurability of the three theories in terms of validity at the end of this chapter.

**Theory Informing the Methods**

I developed a critical hermeneutic circle for my study, which explains the link between my chosen theories and methods (Figure 1). In brief, my main method of data gathering was a
single in-depth interview with same-sex attracted women and with GPs. Prior to the interview I asked participants to complete a brief written survey, which included questions on demographics and sexual orientation. I also conducted a brief follow-up interview with some participants to discuss emerging findings and obtain feedback from them about key study findings. I will now discuss my interviewing methods in more detail.

**Figure 1 - Critical hermeneutic circle for the study**

<table>
<thead>
<tr>
<th>Pre-existing theories</th>
<th>Shape the methods chosen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hermeneutic phenomenology: Lived experience of GP care</td>
<td></td>
</tr>
<tr>
<td>Critical theory</td>
<td></td>
</tr>
<tr>
<td>Feminism: gender and power, praxis, reflexivity</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Modify/redevelop theories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generate critical debate</td>
</tr>
<tr>
<td>Analysis of data and interpretation</td>
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</tbody>
</table>

**In-depth Interviews**

I chose to use in-depth interviews in order to understand the meaning that participants brought to their experiences, consistent with hermeneutic phenomenology. Purely phenomenological interviewing requires an unstructured approach with virtually no prepared questions, whereas I needed to hermeneutically introduce pre-existing concepts and knowledge. So, I used semi-structured interview schedules, while maintaining
flexibility within the interview for participants to become tangential and introduce their own ideas. I have included the interview schedules for the women and the GPs in Appendix 4.

Victor Minichiello and colleagues define in-depth interviewing as “a conversation between researcher and informant focusing on the informant’s perception of self, life and experience, expressed in his or her own words” (Minichiello, Aroni, Timewell, & Alexander, 1995, p.61). I based my interviewing style on this definition, as well as on feminist principles in an attempt to minimise the power imbalance that invariably exists between interviewer and interviewee and to encourage participants to feel that they had some control over the process. Shulamit Reinhartz and Lynn Davidman described the semi-structured interview, where the “researcher plans to ask questions about a given topic but allows the data-gathering conversation itself to determine how the information is obtained” (Reinhartz & Davidman, 1992, p.281). They outlined the following four principles for conducting research interviews that I adopted:

1. **Rapport and trust building.**

To encourage rapport, I defined myself as a listener and learner rather than the traditional objective stranger. Some feminist researchers advocate the development of a friend relationship with participants (Oakley, 1993). This assumes multiple contacts with each participant, whereas my method used one predominant interview, and then a follow-up interview several months later, which was not amenable to this approach. I tried to present myself more as a friendly stranger, which I believe was sufficient to establish good rapport.

2. **Respect.**

The interviewer should start the interview believing the participant, and clarify contradictions if they arise. I also strove to demonstrate respect by valuing participants’ stories, providing appropriate empathy and listening carefully.

3. **Reciprocity and self-disclosure.**
The interview was a two-way process or conversation, as Minichiello and colleagues (1995) suggest. This style allowed me to interact, to answer participants’ questions, to express my own feelings where appropriate and to allow digression. Ann Oakley claims “there is no intimacy without reciprocity” (Oakley, 1993, p.83) and I found that when I shared a similar experience with participants this improved rapport and the depth of the discussion. I elected to disclose my lesbian identity and GP identity to most participants either during recruitment or early in the interview process to facilitate this mutual knowledge. I will discuss the ethical implications and limitations of this approach below.

4. Reflexivity.
I engaged in a reflexive approach throughout, writing memos on the process of the interview as I transcribed, thinking about my role and influence on the interview. I also included a question at the end of each interview asking participants how they felt having talked about the issues. This question encouraged participants to reflect on the impact of the interview and some of them talked of its transformative power. I have used these reflections within my analysis of the praxis of the research.

Reinharz and Davidman (1992) and Patti Lather (1986) have encouraged the addition of follow-up interviews with participants, which have the purpose of checking the findings. In my study, these interviews enabled presentation of my analysis and emerging conclusions, and then negotiation of the meanings with participants in a collaborative way. In my experience, this created room for discussion about possible contradictions and misinterpretations, as well as an opportunity for participants to change their self-understandings in the light of the findings.

Ethical Considerations

The University of Melbourne Human Research Ethics Committee approved the study.
Ethical Framework

The framework I have used is that of social ethics, which moves beyond the usual utilitarian approach that focuses on the autonomous individual, to recognise the power of social institutions particularly over marginalised groups (Christians, 2003). I have chosen this approach because my study is potentially sensitive for the participants. It is sensitive for same-sex attracted women, who exist within a marginalised and often vulnerable community. It is also sensitive for GPs because their work with same-sex attracted women has been heavily criticised. I will first outline my reasons for suggesting that this is sensitive research, and then describe social ethics in more detail.

Sensitive Research

Raymond Lee and Claire Renzetti (1993) have been influential in defining sensitive research and outlining the ethical, political and legal problems that can arise in this context. They define a sensitive research topic as “one that potentially poses for those involved a substantial threat, the emergence of which renders problematic for the research and or the researched the collection, holding and or dissemination of research data” (Lee & Renzetti, 1993, p.5). They give examples of four social contexts for research that can lead to heightened sensitivity:

1. Research on “deeply personal experience” such as sexual or financial issues.
2. Research involving the social control of “deviance”, where there is a fear of discovery and subsequent stigmatisation.
3. Research that challenges people in power, where findings might be misused or misappropriated for political reasons.
4. Research on sacred issues.

The context of sexual orientation and its place within the general practice consultation can fit into at least the first three of these examples. Considering the ethical implications of sensitive research, Joan Sieber suggests that the risks and benefits are the same as in other
research but of “greater magnitude”, and advocates the use of cultural sensitivity and rapport building to overcome the risks (Sieber, 1993, p.14). In her critique, she assumes that the researcher is an outsider to the issues, which is not entirely the case for me. Recommendations have been developed regarding how to be culturally sensitive in research involving members of stigmatised minority groups such as lesbian and bisexual women. Researchers have been urged to take special care to ensure that the research process respects participants’ rights to anonymity and confidentiality; is transparent and does not exploit participants; and has relevance for same-sex attracted women’s lives, with study outcomes that provide some benefit (Martin & Knox, 2000). I will discuss below the methods that I used to fulfil these responsibilities.

The third example given by Lee and Renzetti (1993) that research can challenge those in power could apply to my study and therefore threaten the integrity of the study itself. This is because the findings could be regarded as controversial or radical by the powerful systems with which I need to engage to create change including general practice (to influence education), journal editors (to obtain publications) and government (to alter policy). For example, publication of lesbian health research can be difficult if editors do not believe that it has currency with readers. A review of all Medline listed publications over the past 20 years found that only 0.1% included lesbian, gay, bisexual and transgender populations (Boehmer, 2002), whereas prevalence of these sexual orientations in Western populations is at least 3% (Sell, Wells, & Wypij, 1995). Research findings may be overlooked even if they are published and disseminated widely. Ann Oakley (Oakley, 2000) highlights that research producing unexpected or politically difficult findings can be ignored by policy makers, even when they have commissioned the research.

Social Ethics

Considering the sensitivity of the study, and the feminist and emancipatory principles that I have adopted, I consider that my ethical framework must incorporate more than just a utilitarian protection of the individual participant. Social ethics provides a broader
perspective, which is based on relationship building using a collaborative approach. It has been developed since the 1980s by feminist researchers such as Carol Gilligan (Gilligan, 1982). Clifford Christians (2003) suggests that social ethics incorporates three ethical principles: a) the representation of multiple voices, b) the enhancement of moral discernment (rather than being morally neutral), and c) the promotion of social transformation (Christians, 2003, p.227). Therefore, this ethical framework complements the theoretical frameworks of feminism and critical theory. To put these principles into action, I chose to actively collaborate with consumers throughout the research process. I was also transparent during interviews with participants regarding my social justice and change agenda rather than presenting a neutral moral stance.

I will now discuss the ways that I upheld the ethical principles of collaborating with consumers, preventing harm, achieving informed consent and maintaining confidentiality, and overcoming the challenges of being an insider researcher.

**Consumer Involvement and Collaboration**

I have followed Christians’ (2003) advice that “participants should have a say, in what to study, what methods, whether the findings are valid or acceptable, how the findings should be used or implemented” (Christians, 2003, p.227). The NHMRC statement on consumer and community participation in health and medical research similarly recommends that health care consumers should be involved as equal partners (NHMRC, 2002). For example, consultation with gay and lesbian community agencies during the design phase is advised by the NHMRC (NHMRC, 2001). They recommend consumer involvement in the following areas:

1. Deciding what to research – development of research goals, development of research questions, the use of research literature that describes people’s experiences.
2. Deciding how to research – development of methodologies.
3. Carrying out the research.
4. Disseminating results.
5. Deciding what to research next.

To achieve this level of consumer involvement in my study, I used several methods of engagement including the formation of the Advisory Group, involving participants in a follow-up interview about emerging findings, and disseminating findings widely to the involved communities.

**Participant Gift**

Payment to research participants has come under scrutiny as to whether it is ethical or necessary (Fry et al., 2005). Ethical concerns include whether payment is a form of coercion, which would compromise the voluntary nature of the involvement, and whether sampling would be skewed to involve participants of lower economic status. Conversely, the NHMRC recommend payment of consumers who are involved in an advisory capacity (NHMRC, 2002). I sent each interview participant a $50 gift voucher with my letter of thanks after the initial interview. These payments were made possible by a Family Medicine Research Grant that I received from the Royal Australian College of General Practitioners. I regarded this payment as a gift in appreciation of participants’ involvement, rather than an incentive payment, so I did not let participants know that they would receive it during the recruitment period. This avoided the possible ethical problem of offering a payment as coercion to be involved. It also avoided the potential criticism from GPs that $50 was an insufficient reimbursement for their time. A few people expressed their surprise and gratitude to me following receipt of the voucher and one of the pilot participants preferred not to accept the voucher. Unfortunately, I did not have enough money to pay the members of the Advisory Group.

**Advisory Group**

I convened an Advisory Group in May 2005 just after my PhD confirmation. This included two lay lesbian consumers, one of whom had also been involved in lesbian health
promotion; a lesbian woman who had conducted qualitative research in a lesbian health field; a lesbian woman who worked as a clinician and lesbian health researcher; a female GP and a male GP. My two supervisors were also involved.

The terms of reference for the group, which we collaboratively developed, were to provide advice to myself and my supervisors on:

1. The salience of the research questions.
2. The appropriateness of the methods.
3. The content of the plain language statements and interview schedules before and after pilot interviews, particularly for the sensitivity of trigger questions and adequacy of pre-existing thematic inclusion.
4. The validity of emerging themes and conclusions.
5. The dissemination of findings – where and how.

The Advisory Group met approximately twice a year throughout the study. I sent a study update by email between meetings on average three times per year and invited comments and questions each time. The majority of the group members responded with comments which were useful and appropriate. These included suggestions for recruitment strategies, wording for the pre-interview surveys, recommended papers or authors to read, comments on emerging findings, and ideas for community conferences at which to present the findings. An early example of a significant contribution was the decision about the most appropriate terminology and inclusion criteria to use for same-sex attracted women. Another example was that the lesbian women on the Advisory Group highlighted the importance of whether young lesbian women discuss coming out issues with their GP, particularly in rural areas where confidentiality is more crucial. This prompted me to recruit more younger and rural women into the study. The GP members also provided perspectives on the application of the findings to practice. I consider that their input significantly enhanced the study by making it relevant and grounded in current consumer needs. I also obtained feedback on the study findings from the group at our final meeting held soon after the Completion Seminar. This was a valuable collaborative process and led to important changes with regard to improving the Identity Disclosure Model diagram.
Dissemination of Findings to Consumers

I discussed draft findings with participants during follow-up interviews. I will be sending final findings in the form of a brief report to all study participants and adding it to the study website. I have also written community articles and presented at community events and conferences. I have summarised these dissemination activities in Appendix 6.

I developed a study website during the recruitment phase and updated it throughout the study. This contains two sections, one that is designed to inform consumers and health providers of health issues for same-sex attracted women and includes lists of resources and local agencies. The second section is devoted to the study and includes information about the research team and Advisory Group, research method, links to my published papers and to other relevant research. I have also added conference abstracts and key study findings, and there is a facility for feedback to my email address.

There have been several outcomes from the website. Feedback from some study participants has indicated that they considered the website a useful source of information about the study and health issues. I regularly receive emails via the site from lesbian and bisexual community members asking for information, or to find a local lesbian-sensitive GP. For example, one email was from a father whose daughter had just told him she was lesbian. He wanted to know whether there were any nearby resources and support groups to assist their family, which I was able to supply. In addition, a lesbian psychiatrist emailed me after reading about the study on the website and offered her support. She agreed to participate in an interview, which provided a valuable new perspective on the same-sex attracted woman-GP relationship from her professional and personal experience.
Preventing Harm

One of the major ethical challenges of the study, given its sensitive nature, was to prevent harm to participants, to myself as the researcher, and to the wider lesbian/bisexual and GP communities.

Preventing Harm to Participants

I anticipated that the participants might fear, or might actually experience, harm related to inadvertent breaches of confidentiality, or to becoming distressed during interviews. I was careful to reassure participants that their identity and sexual orientation would remain confidential. This was very important to some same-sex attracted women participants. For example, one woman worked as a health care provider in a rural area and asked for reassurance from me at different stages of the interview, which I gave, that her identity would not be revealed in any reported findings. Another woman, who lived with her parents, did not give me her real name and asked for all correspondence to be by email, as she wanted to prevent her parents discovering her sexual orientation. The study method involved seeking permission from women for me to approach their GP for an interview. Some women had not disclosed their sexual orientation to their doctor, and yet agreed for me to interview him or her. I was careful to reassure them that I would not reveal their identity to the doctor. I also did not inform women whether their GP had agreed to be involved. I will discuss my processes for ensuring confidentiality below.

There was the potential for embarrassment during interviews. For example, some GPs came to realise that their routine questioning style made assumptions of heterosexuality and that this may negatively affect some patients. Others were concerned about their lack of specific knowledge or skills in the area of lesbian health. To minimise participant embarrassment, I attempted to react in a non-judgemental manner. Some women became distressed during interviews while conveying negative experiences, especially if they had not discussed them before. For example, a few women related difficult experiences with
GPs including sexual boundary violations, and homophobic or judgemental reactions. I attempted to create space during these interviews for women to discuss their feelings, and also ensured that interviews ended on a positive note. I gave all participants a pamphlet at the end of the interview that contained a list of lesbian/bisexual support groups and counselling services in Victoria as well as internet based resources, which were also available on the study website. I also provided my contact details for further support, however no-one contacted me for that purpose.

**Preventing Personal Harm**

During the study, threats arose for me as the researcher. One threat was the potential for negative consequences due to revealing my own sexual orientation to participants, or having this disclosed by participants to others outside of my control. I had planned to reveal my lesbian and GP identities to all participants. This presented no personal problems for me with the same-sex attracted women participants; however I sensed problems with some GPs who presented negative attitudes quite early in our interview. Therefore, in reality I chose to reveal my lesbian identity to GPs only during the course of the interview if it appeared safe for me to do so. I chose selective disclosure for two reasons. The first was to protect myself from personal vilification, which occurred with one GP (Dr Normal) simply because I was researching this group of women. The second reason was to avoid the risk that if the GP knew I was lesbian they might be more circumspect in revealing their own negative attitudes.

Another problem for me was hearing about participants’ negative experiences, which was quite distressing at times. Other researchers have highlighted the lack of formal processes for researcher debriefing inherent in the research community (Dickson-Swift, James, Kippen, & Liampittong, 2006; James & Platzer, 1999). I was particularly affected after the interview with Dr Normal and I sought personal support after this event.
Researching lesbian health can lead to marginalisation of the researcher and reduce the chance of career progression or receiving future funding (Kitzinger, 1987; McNair, Gleitzman, & Hillier, 2006). For example, in the politically conservative era of the George W. Bush Administration in the USA, researchers working in lesbian and gay health were placed on a blacklist to receive no further funding, and projects underway had their funding removed. As a researcher who has overtly revealed my systems change agenda for the study, I am also at risk of being criticised by other academics who “presume if one is interested in, engaged by, or drawn to policy, one’s scholarship is less trustworthy, tainted by advocacy, commitment, passion or responsibilities” (Fine et al., 2003, p.197). While I have chosen to take these risks, I will discuss how I have dealt with this when discussing my role as an insider researcher.

**Managing Community Repercussions**

Michelle Fine and colleagues (1993) raise the issue of how to report ‘bad stories’ from research, for example stories that may reflect badly on the community to which participants belong. They suggest this is particularly important for already stigmatised groups as there is a risk that in seeking to highlight the outcomes of injustice, such reporting might perpetuate negative social attitudes. I experienced such negative lesbian community responses when I reported findings from the Australian Longitudinal Study of Women’s Health showing higher levels of depression and suicidality amongst lesbian and bisexual women compared to heterosexual women. Some community members suggested that these findings should remain private as they could pathologise lesbian women further. Fine et al. (2003) recommend continuing to report most of the difficult findings, while publishing cautions as to the way these might be misinterpreted. In this study, the harm in this regard is potentially to the reputation of Australian general practice. I am concerned that reporting negative behaviours described by a few GPs may worsen the pre-existing apprehension that some lesbian women have about seeing GPs. I hope by also presenting the many positive experiences that women have had with their GP this may alleviate this risk to some extent.
**Consent**

I provided written information about the study in a plain language statement to all participants before the initial interview (see Appendix 1). This stated that they could withdraw their consent to be involved at any time. I included information about the choice to be involved in a follow-up interview, and a statement for the women that I would seek their permission to approach their usual GP for an interview. Having read the plain language statement, some participants asked questions, for example to clarify the de-identification process. All participants signed a consent form (see Appendix 2). At the end of the initial interview, I asked women with a usual GP whether they were happy for me to approach their GP to be involved. All but two women agreed. I then collected the GP’s name and practice details. I reassured women that their own involvement in the study was not reliant on their GP’s involvement. The majority of participants also agreed to be involved in a follow-up interview.

**Confidentiality**

Ensuring confidentiality was important for all participants. I recruited participants in three ways: a) through another general practice based research study, b) via snowballing from other participants, and c) via known contacts in the lesbian or GP community. I discuss these recruitment methods below. I did not know the names of the potential same-sex attracted women from the other study until they had agreed to be contacted by me. They were offered two options of method of contact for my study, either for their name to be passed to me to phone them, or to complete an expression of interest form and return it to me. During recruitment of GPs known to the same-sex attracted women participants, I was also careful to ensure that I did not reveal the identity of their patient to them. Similarly, during snowball recruitment via participants, I asked participants to pass on my name and contact details to the person they thought might like to be involved, rather than taking the
person’s name directly. Finally, I assured all participants via the plain language statement that the transcript of their interview would be de-identified.

There are two major limitations relating to the public presentation of my study findings that may have compromised my attempts to ensure confidentiality. First, I was unable to completely de-identify interview transcripts in that I did not remove demographic features such as age, sexual orientation, approximate location, or gender of the GP. I considered that these features were important for my analysis of factors that influence the patient-doctor relationship and the health care experience, however in combination may be identifying. Second, due to the small size of the communities to which participants belonged, they were more likely to know each other and perhaps to be able to identify an individual participant through a quotation that I used publicly (Woodman, Tully, & Barranti, 1995). I attempted to overcome this by sending the de-identified interview transcript to each participant to provide an opportunity to remove potentially identifying information. Just one participant, the lesbian psychiatrist, requested that a few potentially identifying comments be removed.

**Ethical Implications Regarding the Insider Researcher**

I have at least two identities in common with the participants in my study as I described in Chapter 1, being a lesbian woman and a GP. Feminist researchers have emphasised that identity is complex and relative: “‘Outsiderness’ and ‘insiderness’ are not fixed or static positions, rather they are ever-shifting and permeable social locations that are differentially experienced and expressed by community members” (Naples, 1997, p.71). With this in mind, I regard myself as a partial insider in relation to the participants in my study because I only share certain aspects of each of these identities with them. Indeed, many of the participants may have considered me to be an outsider because my particular experience as a lesbian woman or GP differed significantly from theirs. Conversely, I would appear to be an insider from the point of view of an observer of the study who is neither a GP nor same-sex attracted and who does not consider the diversity within each
identity. The relevance of whether I am regarded as an insider or an outsider relates to perceptions of bias and privilege versus trustworthiness.

Victor Minichiello and colleagues (1995) highlight that an “insider-outsider controversy” has existed in terms of research involving specific ethnic groups since the 1970s (Minichiello et al., 1995, p.182). The controversy pertains to whether an insider or an outsider is the most appropriate person to research minority communities that have specific cultural beliefs and behaviours, including ethnic or sexual minorities. Arguments against insider researchers have related to the potential for bias in the interpretation of findings if the subjectivity of the researcher interferes with their ability to fully probe for divergence from their own position (Minichiello et al., 1995). Conversely, one of the central arguments for the involvement of insider researchers is that they would, at least to some extent, understand the cultural beliefs and health inequalities of the researched group (McEvoy, 2001).

In recognising the insider debate, I have considered the negative and positive ethical implications of being a partial insider researcher. In Australia, there is little guidance for the insider researcher from an ethical perspective, a gap that was acknowledged within the National Health and Medical Research Council information paper on ethical aspects of qualitative research (NHMRC, 1995). I will now discuss my approach to the potential ethical problems, as well as ethical advantages that I have perceived in being a partial insider. Overall, I believe that I overcame the challenges of being an insider and upheld the ethical principles of respect, beneficence and confidentiality by using praxis, including reflexivity and reciprocity throughout the research process. My supervisors and I have had a paper published, which argued for such a reflexive approach to overcome challenges for the novice clinician researcher (McNair, Taft, & Hegarty, 2008). This is included in Appendix 8.
Potential Ethical Problems on Being an Insider Researcher

I identified three potential problems that may have arisen as a result of my partial insider position: inadvertent coercion of participants to be involved, boundary violations, and compromise to the trustworthiness of the findings.

I used two methods to avoid possible coercion to participate. First, during recruitment I took care to avoid making the initial approach to potential same-sex attracted participants myself. This avoided the possibility that someone may have felt obliged to participate from a sense of wanting to help me personally. However, I did directly approach the potential GP participants myself, initially through a letter of introduction and then a phone call, explaining that I had interviewed one of their patients and was contacting them with the patient’s permission. I believe that GPs would feel at an equal level of power to me as a GP colleague and therefore they would have had full control over their decision to participate.

Second, to avoid coercion, I did not disclose my lesbian health policy and advocacy roles to potential participants. I feel that such disclosure may have created an obligation for some same-sex attracted women, and perhaps GPs, to participate if they also had a social justice sensibility. I believe that only four women participants and three GP participants were aware of my other roles. Two of the women and two GPs were personally known to me and had agreed to participate in the pilot interviews. The other two women knew me through my work in the lesbian community, and I think this did sway their decision to participate. The third GP was a lesbian woman and had heard of my work with the Australian Lesbian Medical Association (ALMA), although she had not been involved in ALMA at all and we had not previously met.

Virginia Dickson-Swift and colleagues (Dickson-Swift et al., 2006) have suggested that there are particular challenges related to boundary issues for qualitative researchers researching sensitive topics. They interviewed 30 Australian public health researchers who had researched sensitive topics including sexual behaviour. Their participants identified
three boundary issues that had created some difficulties, all of which I managed to avoid. The first was emotional involvement with participants, which I prevented due to my friendly stranger approach. The second was crossing the friendship-research boundary, which especially applied to researchers who had repeated contact with participants. This was not a problem for me as I had so few contacts with each participant. The third was crossing the research-counselling boundary, which particularly occurred for clinician-researchers. In my case, just a few same-sex attracted women participants asked me health-related questions during our interviews, because they knew I was a GP. I either answered immediately, or deferred until the end of the interview if I felt my response could alter the course of the interview.

A potential boundary issue that I could have faced was interviewing known GP colleagues or same-sex attracted women from my own practice or private life. I elected not to interview any participant who had seen me as a patient, was a close colleague or was a personal friend. I had previously known all four of the people involved in the pilot interviews, however none fell into my exclusion categories. I had not met any of the other same-sex attracted women who expressed interest in being involved and I was subsequently able to recruit all of those women. Unfortunately, two of the women participants each elected my personal GP as the GP for me to interview. I spent some time deciding whether to approach her for an interview, or whether one of my supervisors could interview her. I finally decided not to invite her to participate, as regardless of who conducted the interview, I would read and analyse the transcript, and although unlikely, may have found that some of her responses might have compromised my opinion of her as my own GP.

Finally, insider researchers can be regarded as less trustworthy in their analysis and reporting due to bias. Victor Minichiello and colleagues suggest that “the methodological issue inherent in the insider-outsider controversy focuses on who can provide more satisfying or better sociological knowledge” (Minichiello et al., 1995, p.183). The main problems that arose in my interviews as an insider were that at times I made assumptions of shared values or knowledge and did not probe or clarify what participants actually
meant. Fortunately, these issues were detected by my supervisors when we reviewed the pilot interview transcripts and I was able to take more care in later interviews. Conversely, some participants revealed attitudes and values that differed from my own experience. In these cases, I was careful during data analysis and reporting not to filter out ideas or concepts that did not fit my preconceptions. My supervisors also assisted by cross-coding interview transcripts and identifying examples where I might have filtered or misinterpreted data.

_Ethical Advantages of Being an Insider Researcher_

I contend that being a partial insider researcher has resulted in a number of advantages for my study. I agree with Ann Oakley’s (1993) position that personal involvement in the research is more than a ‘dangerous bias’, “it is a condition under which people come to know each other and to admit others into their lives” (Oakley, 1993, p. 242). A precedent for insider researcher involvement has been set within indigenous research in Australia, which has embraced the inclusion of indigenous researchers to overcome community mistrust (Anderson, 1996). Similar mistrust of researchers has been reported within the lesbian community, related to uncertainty of researchers’ motives, and how the findings would be used (Martin & Knox, 2000). Three reasons for the success of indigenous researcher involvement in indigenous research are cultural safety, accountability and ownership (Pyett & VicHealth Koori Health Research and Development Unit, 2002). I believe that these also apply to research involving same-sex attracted women and GPs.

Cultural safety is the most salient issue ethically, that is to ensure that the research is appropriate to the culture and sensitive to the individual needs and understandings of participants, thereby minimising potential harms. Also, clinician researchers may be placed in a greater position of trust by consumer and clinician participants by virtue of their status and experience in the field, therefore encouraging research participation and the exploration of sensitive issues (Richards & Emslie, 2000). Same-sex attracted women may be more willing to participate in research when researchers are part of their
community, due to a belief that the research has been developed in such a way that respects their lives and gives them a voice (Bradford, Ryan, Honnold, & Rothblum, 2001). Engendering cultural safety and trust can improve the relevance of the research, and increase the likelihood of disclosure of sensitive issues. It can also improve the quality of informed consent because the insider researcher is conversant with specific cultural issues influencing the potential benefits and harms of the research (Pyett & VicHealth Koori Health Research and Development Unit, 2002).

In terms of recruitment, I do not know whether my lesbian identity assisted in encouraging women to participate in the first place. However, in disclosing my lesbian identity to same-sex attracted women participants, I believe that this did engender a sense of shared cultural understanding. During our interviews, several women freely discussed culturally sensitive issues that a heterosexual researcher may not have fully understood, for example the common tensions between lesbian and bisexually-identified women around issues of dress code, assumptions, behaviour and identity. Similarly, GPs freely discussed their perceptions of tensions within the GP system.

Accountability to participants is important, as one of the criticisms of research in the lesbian community has been that the community does not see tangible outcomes or benefits of the research (McNair, Anderson, & Mitchell, 2001; Plumb, 2001). As an insider researcher, I have made a commitment to retain a connection with the researched community following the conclusion of the study as I have both a personal and professional sense of obligation and accountability to the participants. Through the study website and planned community talks and articles, I intend to continue the discussion regarding how to best use the findings to improve the health care access and experience for Victorian same-sex attracted women and their GPs.

My collaborative approach with the study participants, the Advisory Group and my wider community contacts may have partially removed the power imbalance that often exists between researcher and researched (NHMRC, 1995). One simple method to equalise power was to ask participants to elect where the interview took place. The majority of
same-sex attracted women chose their own home and most of the GPs elected their clinic and usually their consulting room. One of the motivations for same-sex attracted women to enter research is to create positive change for their community (Plumb, 2001), and this was also the case for some of the participants in this study. Through a sense of shared ownership, I feel that I have been able to develop recommendations for GPs and same-sex attracted women that are meaningful and will truly benefit the social change agenda of the study (Saulnier & Wheeler, 2000).

### Data Sources

Selecting appropriate sources of research data is important to ensure rigour. I have used a hierarchy for assessing the rigour of qualitative research for my study that was developed by Jeanne Daly and colleagues (Daly et al., 2007), and I present this hierarchy in Table 2 (p.43). They have designed this model to assist in the inclusion of qualitative research in systematic reviews, and to guide junior researchers’ understanding of the quality of qualitative studies.

### Sampling Frame

Sampling is one of the four criteria of rigour used by Jeanne Daly et al (2007), and I have elected to use the most rigorous level of sampling in their hierarchy, namely to develop a sampling frame that is guided by theoretical concepts and the literature, reviewed during recruitment and analysis, and extended to improve the diversity obtained. In this way, I aimed to generate a sample that was as demographically diverse as possible and that encompassed people with a broad range of life experiences and attitudes. Using the theoretical framework of fluidity of sexual orientation, I developed a sampling frame that contained my desired range of same-sex attracted women and GPs. I reviewed and modified the sampling frame about half way through recruitment and again near the end, and extended my search for specific participant characteristics, for example young
women, bisexual women, and GPs with rural experience. The sampling framework applied largely to the women participants rather than to GPs. While I purposively sampled just a few GPs for demographic diversity, I could not use a theoretical sampling strategy for this group as I sampled the GPs predominantly via the women.

Finding a diverse range of same-sex attracted women is challenging. Sexual orientation is complex and engenders multiple and often shifting identities (Gamson, 2003). Some of the many dimensions of sexual orientation include sexual identity (a self-defined label), sexual behaviour, sexual attraction, emotional attraction, social connection with other lesbian/bisexual women/communities, degree of disclosure of sexual orientation to others, time since self-identity as lesbian/bisexual, and degree of fluidity of sexual orientation (Laumann, Gagnon, Michael, & Michaels, 1994). Michelle Fine and colleagues (Fine et al., 2003) emphasised in their work on race that the frame of the work must be clearly defined in recognition of the complexity of the multiple identities that people hold, and this holds true for the women in my study.

My minimum criterion for inclusion of women of minority sexual orientation was that they had had a significant experience of same-sex attraction, as this was as inclusive as possible. My minimum criterion for GP inclusion was that they had been practising as a GP for at least two years. Beyond these criteria, I sought demographic diversity amongst both groups in location of residence or clinic and in ethnicity. Regarding sexual orientation, I hoped to include women who currently identified as lesbian, as bisexual, and as having no sexual identity; and who were currently in same-sex, opposite sex, and no relationship. I also hoped to include at least one lesbian or gay GP. I sought diverse experiences of GP care from positive to negative, and women who did and did not have a regular GP. Similarly, I sought GPs with a variety of attitudes towards minority sexual orientation and diverse personal and professional experiences with this group. Finally, regarding disclosure, I hoped to include women who desired and women who did not desire disclosure, and at least a few GPs with no known lesbian or bisexual patients.
Table 2 - A hierarchy of evidence and rigour in qualitative research

<table>
<thead>
<tr>
<th>Level*</th>
<th>Framework</th>
<th>Sampling</th>
<th>Analysis</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>I  ‘Generalisable’</td>
<td>Literature review and a theoretical review are used.</td>
<td>Sampling frame is determined by both theory and the literature, and is extended for diversity during the study.</td>
<td>Procedures are comprehensive and clear. Categories are saturated. Full range of views analysed.</td>
<td>Relevance to other settings is assessed by comparing with the literature. (Full reporting limited by word length of papers).</td>
</tr>
<tr>
<td>II  ‘Conceptual’</td>
<td>Literature review and a theoretical review are used.</td>
<td>Sampling frame is determined as in level I but limited to a number of subgroups. Not extended for diversity.</td>
<td>Conceptual analysis recognises diversity of views. Categories may not be saturated.</td>
<td>Links well with theoretical concepts. Identifies need for further research in other subgroups.</td>
</tr>
<tr>
<td>III  ‘Descriptive’</td>
<td>Practical literature is used but not theoretical issues.</td>
<td>Sample of a specific group based on practical issues, not diversified.</td>
<td>Full range of responses is not reported. Use of illustrative quotes of many or some but not all participants.</td>
<td>Describes the existence of phenomena in a defined group, but not why or how there are differences.</td>
</tr>
<tr>
<td>IV  ‘Single case study’</td>
<td>Practical literature is used.</td>
<td>Sample of one case or a small group. Provides rich data.</td>
<td>Can provide insights in unexplored contexts.</td>
<td>Does alert practitioners to a phenomenon. Not applicable to other contexts.</td>
</tr>
</tbody>
</table>

* The authors indicate that the labels for each level are “tentative” and subject to further development (Daly et al., 2007, p.46)

**Sampling Challenges and Achieving Diversity**

Many of the existing studies of lesbian and bisexual women’s health have relied on convenience sampling through community groups and events. This tends to generate a homogenous sample of women comprising predominantly white, well-educated, middle-
class, urban, lesbian women (Boehmer, 2002; Sell & Petrulio, 1996). Sampling of specific groups appears in levels III and IV (the least rigorous) of Daly’s hierarchy (Daly et al., 2007)(see Table 2). Patton (2002) argues that convenience sampling is “the most common and least desirable” due to the resultant lack of diversity (Patton, 2002, p.180). I have used recruitment methods that have avoided this limitation.

Sampling for a broad range of GPs can be equally problematic for different reasons. GPs can be reluctant to participate in research due to a lack of perceived benefits to themselves or their own patients, or lack of time in an increasingly pressured clinical work environment. Research also suffers from a lack of credibility amongst some GPs and a lack of ownership can also prevent involvement (Howie, 1996). Therefore, it is likely that those GPs who agree to participate in research projects do not reflect the broad range of GPs. GPs with an interest in research may also have an interest in medical education, and perhaps be more highly aware of the theoretical basis of their work, and more reflexive within their own practice (Gunn, McCallum, & Sanci, 2008). The recruitment methods of GPs for my study did not overcome these limitations in accessing a broad range of GPs.

**Recruitment Methods**

I used multiple recruitment methods for same-sex attracted women and GPs in an attempt to overcome some of the sampling challenges and locate a diverse sample. I also needed to include several woman-GP pairs. I used three recruitment methods for women and GPs. The first was through a general practice based screening survey of patients, which was part of the first phase of the Diamond study that I will describe below (Gunn, Gilchrist et al., 2008).

The second was snowball sampling from existing study participants. The third was convenience sampling through the lesbian/bisexual and GP communities. I present the outcomes of each recruitment method in Figure 2 (p.45). I started recruitment of women in January 2005 and finished in June 2006. I recruited the first GP in May 2005 following the first woman’s interview, and the last in September 2006. The entire period of
recruitment of women and GPs was therefore 21 months. In addition, a lesbian psychiatrist approached me to be involved and participated in an interview in March 2007.

**Figure 2 - Recruitment methods and outcomes**

<table>
<thead>
<tr>
<th>Same-sex attracted women: Total of 33</th>
<th>Doctors: Total of 28</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Diamond screening survey sampling</strong></td>
<td></td>
</tr>
<tr>
<td>Random list of 30 Victorian general practices</td>
<td></td>
</tr>
<tr>
<td>Patient surveys sent to 10,792 women (17,780 total) (~600 per practice) by Diamond team</td>
<td></td>
</tr>
<tr>
<td>5,081 women respondents (7,667 total) (Women’s response rate 47%) of which 207 women (4.1%) were not exclusively heterosexual</td>
<td></td>
</tr>
<tr>
<td>Depressed (CES-D &gt;= 16) 1,252 women (1,793 total)</td>
<td>Not-depressed (CES-D &lt;16) 1,531 women, of which 48 (3.1%) were not exclusively heterosexual</td>
</tr>
<tr>
<td>Recruited for Diamond study 563 women (791 total)</td>
<td>48 non heterosexual women phoned by the Diamond team and asked about participation in my study</td>
</tr>
<tr>
<td>Interested = 29 Not = 14 Un-contactable = 5</td>
<td></td>
</tr>
<tr>
<td>Agreed to participate = 18 (one removed after interview)</td>
<td></td>
</tr>
<tr>
<td>17 from 14 Diamond practices</td>
<td>13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Snowball sampling</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.a) from participant women</td>
</tr>
<tr>
<td>2.b) from participant GPs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Convenience sampling</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.a) from lesbian/bi community</td>
</tr>
<tr>
<td>3.b) from medical community</td>
</tr>
</tbody>
</table>

* 2 GPs and 1 psychiatrist
Diamond Study Screening Survey

The Diamond study (Diamond) is a longitudinal study of experiences of depression care in general practice being conducted at the Department of General Practice at which I am based. Thirty general practices were recruited to be involved in Diamond from a random list of Victorian general practices. The first phase of Diamond involved sending a screening survey on emotional wellbeing to random lists of patients of each practice. Surveys were sent to 17,780 people aged 18-75, 60.7% of whom were women, and 7,667 were completed (overall response rate 43.1%) (Potiriadis et al., 2008). This survey included the CES-D scale, which screens for depression (possibly depressed if the score is at least 16). Only those respondents who scored as possibly depressed were invited to participate in the Diamond study, and only those who were not depressed were eligible to participate in other studies such as mine. The survey contained a single sexual orientation question, which is commonly used in population-based studies including the Australian Longitudinal Study of Women’s Health (McNair et al., 2005):

Which of these most closely describes your sexual orientation?

a) I am exclusively heterosexual,
b) I am mainly heterosexual,
c) I am bisexual,
d) I am mainly lesbian/gay,
e) I am exclusively lesbian/gay, or
f) I don’t know.

Screening survey respondents were invited to indicate whether they were interested to be involved in other studies and if so provided their first name and contact details. I made an agreement with the Diamond study team that I could recruit from a particular group of survey respondents. These were women who selected any response other than exclusively heterosexual and scored in the non-depressed range and provided their name for follow-up.
This method provided me with a general practice sample of women with a diverse range of sexual orientation. The screening survey was completed by 5,081 women. Of these, 207 (4.1%) were not exclusively heterosexual, which included 84 (1.7%) lesbian and bisexual women and 123 (2.4%) who selected ‘mainly heterosexual’, which tends to be same-sex attracted women (Thompson & Morgan, 2008). A further 71 women (1.4%) selected ‘I don’t know’ and 185 (3.6%) did not answer the question. While there are no officially gathered statistics on the actual number of same-sex attracted women attending general practice in Australia, these proportions are similar to those found in the population based samples. International population-based studies indicate a prevalence of lesbian and bisexual identity of around 1.5%, with up to 8% of women reporting same-sex desire or behaviour (Gruskin, Hart, Gordon, & Ackerson, 2001; Sell et al., 1995; Smith et al., 2003). Of the screening survey sample, 1,531 women were not depressed and were interested in follow-up, and 48 (3.1%) of these were also eligible for my study (see Table 3). So, while 4.1% of the total sample of women was not exclusively heterosexual, 3.1% of the non-depressed sample was non-heterosexual. This indicates that a greater proportion of the same-sex attracted women scored in the depressed CES-D range.

<table>
<thead>
<tr>
<th>Sexual orientation</th>
<th>Number</th>
<th>%</th>
<th>% of the 48 same-sex attracted women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusively heterosexual</td>
<td>1,471</td>
<td>96.08</td>
<td>-</td>
</tr>
<tr>
<td>Mainly heterosexual</td>
<td>27</td>
<td>1.76</td>
<td>56.2%</td>
</tr>
<tr>
<td>Bisexual</td>
<td>4</td>
<td>0.26</td>
<td>8.3%</td>
</tr>
<tr>
<td>Mainly lesbian</td>
<td>3</td>
<td>0.20</td>
<td>6.3%</td>
</tr>
<tr>
<td>Exclusively lesbian</td>
<td>14</td>
<td>0.91</td>
<td>29.2%</td>
</tr>
<tr>
<td>I don’t know</td>
<td>12</td>
<td>0.78</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,531</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Five of the 48 women who were eligible for my study were un-contactable by the Diamond team: two had a disconnected phone number and three could not be contacted after at least six attempts. Twenty-nine of the 43 contactable eligible women were interested in my study, 18 were sent letters and 11 elected that I could phone them. Eighteen of these 29 agreed to participate in my study and they were from 14 Diamond general practices. I interviewed one of the 18 women early in the study who had indicated on the survey that she was ‘mainly heterosexual’. It transpired that she was just inquisitive about same-sex attraction, but had not had any significant same-sex attraction herself. Following discussion with the Advisory Group, I decided to exclude her from the study.

Purposive Snowball Sampling

I asked all interviewed women who had a usual GP whether they would consent for me to interview their GP. Twenty-five of the 33 women had a usual GP and all but two agreed for me to interview that GP. All but two of these GPs agreed to participate, resulting in 24 woman-GP pairs involving 22 GPs. I also used snowball sampling to recruit more women, asking selected participants whether they knew of anyone who might participate, and recruited five women in this way. I selected the participants who were more likely to have contact with women of non-English speaking background or rural origin, as I needed more women from these groups. I used the same method with participant GPs when I was looking for younger GPs and those with rural experience, and I recruited three GPs in this way.

Purposive Convenience Sampling

I used purposive convenience sampling through the lesbian/bisexual and GP communities to fill further gaps in the sampling frame including cultural diversity and more young and bisexual women. For example, I invited two different women who had contacted me on other matters as part of my role in lesbian community leadership, who both agreed to participate. I approached one of the culturally-specific support groups in Victoria, and
three women in this group volunteered, two of whom I recruited, one being bisexual and the other lesbian. I also needed more young rural women, so I approached two rural same-sex attracted youth groups and one invited me to attend a meeting. I recruited three young women from this group. So, I recruited 11 women using convenience sampling. I invited two GPs from the GP community, one a GP registrar and the other a retired doctor who had approached me about another matter related to lesbian health. I largely satisfied my sampling aims using these methods, to the extent that I did not need to fall back on general advertising within either community. However, I did not achieve a broad range of bisexual women, or women who did not identify as lesbian or bisexual, which I discuss within the limitations section in Chapter 7.

**Sample**

My initial target number of participants was 20-30 same-sex attracted women and 20-30 GPs. This was based on the number of people I thought I needed to cover the sampling frame without excessive duplication. The final sample contained 61 participants, 33 women and 27 GPs, including 24 woman-GP pairs, and one psychiatrist. I believe that I satisfied my final sampling frame for women and GPs. I present the summary of participant details in Table 4.
Table 4 - Participant details

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Women - 33</th>
<th>Doctors – 28 (27 GPs and 1 psychiatrist)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>mean 41.6 years, range 21 to 72</td>
<td>mean 50.8 years, range 30 to 85</td>
</tr>
<tr>
<td>Gender</td>
<td>all female (no transgender)</td>
<td>female 16 (57%), male 12 (43%)</td>
</tr>
<tr>
<td>Location a)</td>
<td>inner urban 16, outer urban 8, regional 4, rural 5</td>
<td>inner urban 10, outer urban 12, regional 5, rural 1 (+ 3 ex rural)</td>
</tr>
<tr>
<td>Ethnicity b)</td>
<td>ethnic minority 7 (21%)</td>
<td>ethnic minority 5 (19%)</td>
</tr>
<tr>
<td>Income c)</td>
<td>low/none 13, middle 13, high 7</td>
<td>NA</td>
</tr>
<tr>
<td>Relationship</td>
<td>female 20, male 3, no partner 10</td>
<td>NA</td>
</tr>
<tr>
<td>GP years practising</td>
<td>NA</td>
<td>mean 20.2 years, range 2 to 50 years</td>
</tr>
<tr>
<td>GP sessions per week d)</td>
<td>NA</td>
<td>mean 7.5 sessions, range 0 (1 retired) to 11</td>
</tr>
<tr>
<td>GP training</td>
<td>NA</td>
<td>2 trained overseas</td>
</tr>
<tr>
<td>Sexual identity</td>
<td>lesbian/gay 25 (76%), bisexual 6 (18%), no identity 2 (6%)</td>
<td>heterosexual 25, lesbian, gay male 1</td>
</tr>
<tr>
<td>Sexual attraction</td>
<td>exclusively to women 24, mostly to women 3, equal to women and men 3, mostly to men 3</td>
<td>exclusively to opposite sex 20, mostly opposite sex 3, mostly to same-sex 1, to same-sex 2, not answered 2</td>
</tr>
<tr>
<td>Socio-political involvement</td>
<td>range of importance of sexual identity from none to defining, socio-political involvement- from none to extensive.</td>
<td>GPs who advocate as part of their GP role 12</td>
</tr>
<tr>
<td>Gender of usual GP</td>
<td>female 17 (52%), male 8 (24%), no usual GP 8 (24%)</td>
<td>NA</td>
</tr>
<tr>
<td>GP awareness of sexual orientation</td>
<td>current GP aware: yes 21 (64%), no 12 (36%)</td>
<td>recall seeing same-sex attracted women as patients: yes 26 (93%), no 2 (7%)</td>
</tr>
<tr>
<td>GP knowledge of SSA women’s health</td>
<td>NA</td>
<td>very 2 (7%), moderate 7 (25%), some 12 (43%), not very 7 (25%), none 0</td>
</tr>
</tbody>
</table>

a) Location: inner urban = within 5 km of the city centre, regional = population of 50,000 or more, rural = population less than 50,000
b) Ethnic minority = English not the first language for the person or at least one of their parents (Australian Bureau of Statistics)
c) Income: low = up to $26,000 per year, middle = $26,000 to $78,000, high = more than $78,000
d) GP session: a session is approximately 3 to 4 hours, generally 2 sessions per day
Data Generation

I will use the word ‘generation’ rather than ‘collection’ of data because this recognises the role of the researcher in influencing and constructing the data obtained (Mason, 1996). This is central to the epistemological position of interpretive and critical paradigms that emphasise the subjectivity of the research process and the involvement of the researcher. I used three data generation methods, which were participant completion of a brief survey prior to the first interview, in-depth interviews with all individual participants, and follow-up interviews with selected participants. Initial interviews with same-sex attracted women commenced in May 2005 and the GP final interview occurred in October 2006, a period of 17 months.

Participant Surveys

All participants completed a brief survey, which included demographic details including their age, sexual identity, attraction, behaviour and relationship status (see Appendix 3). For women, the survey also contained questions on their health status and estimates of how many GPs they had seen. For GPs, I added details about their medical training and current practice setting. I posted the survey to each participant prior to the first interview and the majority had completed it and gave it to me before we started the interview. Some participants posted or faxed the survey to me soon after the interview and a handful of people needed multiple reminders and additional copies sent before they returned them. Generating demographic information in this way rather than via the interview saved time during the interview and avoided establishing a question/answer pattern. It also ensured that I had access to a standardised set of attributes for each person, which assisted with later analysis. The interview process was easier if I had a chance to read the survey responses briefly before the interview started, as I could see relevant information at a glance, such as sexual identity or length of time in practice. Some participants were also able to clarify or explain their answers with me during the interview. This was especially
helpful for the sexual identity questions and highlighted the limitation of requiring people to select specific identity categories, when in fact they may not use any of the labels given, or may be quite fluid in their identity experience.

**Initial Interviews**

I conducted in-depth, semi-structured interviews with each of the 61 participants. I chose to do all of the interviews myself to ensure a consistent approach.

**Interview Schedule Development**

I developed a draft schedule for same-sex attracted women and another for GPs before the first interviews, which was based on themes from the literature and my own pre-existing knowledge, and guided by my theoretical frameworks. I structured the draft schedules to have a logical flow, moving from a general question to a personal or specific example. For example, I asked women about their experiences of seeing GPs overall, then asked about their current GP. It was important that the women’s and GPs’ schedules followed similar themes in order that I could later compare and contrast within woman-GP pairs and also between the two overall groups. So, in development of the schedules I created common themes for both, which were:

1. **Introduction** – to the study, desired outcomes, time for the interview, questions, clarifications from the participant survey.
2. **Experiences and expectations** – for women of health care in general, of seeing GPs overall and their current GP; for GPs of their practice style, how patients might perceive them.
3. **Practice environment** – description, level of comfort, perceived attitudes of all staff.
4. **Disclosure of sexual orientation** – importance for women and for GPs from each perspective; why, when, how, who.
5. **Social environment** – awareness of social attitudes, experiences of discrimination, does being same-sex attracted affect health.
6. Change – for women, their wish list of the best GP they could imagine; for both, anything they might change in their interactions with GPs/same-sex attracted women.
7. Close – anything they would like to add, reflections on why they participated and how they felt at the end of the interview.

I piloted the interview schedules with two same-sex attracted women and two GPs and asked them to provide me with feedback regarding the flow of the interview and style of questions. These participants felt comfortable with the interview style and content. One particularly helpful suggestion was to ask participants to prepare for the interview by recalling specific experiences of seeing GPs (or for GPs of seeing same-sex attracted women). I added this suggestion to the letter I sent with the participant survey, and had several comments that this helped preparation. Following the pilot interviews, I made minor changes to the women’s schedule, mostly related to the order of questions; and more extensive changes to the GP schedule. This reflects the fact that I was much more familiar with the issues that might be pertinent for women, both because I had heard many stories from a personal and professional perspective, and also because the literature from the women’s perspective is fairly detailed. By contrast, the perspectives of GPs are minimally outlined in the literature and I had only discussed the issues with a small circle of GP friends.

After the first five or six interviews with each group I revisited the comparison between the interview schedules and made further minor changes to ensure a better match. For example, in the sections on disclosure of sexual orientation, I added a question for women on whether they thought it was relevant for the GP to know, and for GPs on why women might want them to know as distinct from whether they themselves feel it is relevant. I did not change the schedules after this, however my interview style became more flexible, so that I became better at following the participants’ lead and coming back to earlier parts of the schedule later where possible. I also realised that I did not need to cover every aspect with every participant. The final version of each interview schedule is in Appendix 4.
Interview Process

I asked participants to select their preferred place and time for the interview. The majority of women (18) elected to do the interview at their home; four at their workplace; four at the university; three at a youth health centre, of which two of these were finished by phone as they were both rural; another two by phone as they lived interstate; one in a hotel foyer where she was staying; and one at a regional Division of General Practice. Most of the women electing the university or another neutral place were concerned about privacy and confidentiality. Sixteen GPs and the psychiatrist elected their clinic as the interview setting, either during their lunch break or late afternoon; eight GPs elected to do the interview by phone; and three GPs chose to be interviewed at their home.

The setting of the interview did not appear to affect its content, or the degree to which rapport was established. In particular, the phone interviews did not present a barrier, with rapport developing quickly and participants seeming to be relaxed and open. The main barrier using the phone was the lack of visual and non-verbal cues that I often used during face-to-face interviews. This included the appearance and manner of the same-sex attracted women, and so I asked both phone-interview women something about their appearance. This clearly also mattered to one of these women as she asked me how old I was. Given that I interviewed more GPs by phone, I found this was a barrier to the interview mostly if they had not returned their survey to me before the interview. I then had to ask them a few demographic questions at the beginning, such as how long they had been practising.

I anticipated that interviews would last about one hour and I included this estimate in the recruitment letters and phone calls. The actual mean time for women’s interviews was 80 minutes, ranging from 50 minutes to 1 hour and 50 minutes. Women’s interviews tended to be shorter if they had not disclosed their sexual orientation to any GP, and/or if they did not feel their orientation was at all relevant to their GP care, as there was less to explore. The length of the interview was often a point of negotiation during GP recruitment as many GPs felt pressured for time. In fact, most of these GPs allowed the interview to
proceed for longer than we had negotiated, indicating their interest and engagement with the topic, which perhaps they hadn’t expected. The mean time for GP interviews was 63 minutes, with a range from 30 minutes to two hours.

Follow-up Interviews

The purpose of the follow-up interviews was to discuss emerging study findings and seek feedback from participants. Critical theory, feminism and social ethics necessitate involvement of research participants in the research outcomes in order to engage them in the process of change. At the end of the initial interviews I asked all participants whether they were interested to receive information about emerging findings, and whether they would like to do a short interview to discuss the findings. All participants were interested in receiving findings, and 22 (of 33) women and 16 (of 27) GPs and the psychiatrist were happy to do a second interview. I sent interested GPs a letter including draft GP guidelines and followed this up with a phone call to arrange the interview time. So far, I have conducted follow-up interviews with 11 GPs and the psychiatrist. All but one of these was by phone, and lasted an average time of 28 minutes, with a range of 10 to 50 minutes. The content of the interview was predominantly about the content and format of the draft GP guidelines. I also asked whether they had noticed any differences in their practice when seeing same-sex attracted women since our first interview.

The follow-up interviews will continue over the next few months with the remaining GPs and the women who expressed interest. I am in the process of developing the next draft of the GP guidelines in response to feedback to date, which I will send to the remaining GPs before the follow-up interview. I will also be developing a consumers’ guide to seeing GPs, which I will send to the same-sex attracted women participants prior to our interview.
Data Preparation and Handling

I audio-taped all interviews with participant consent. I wrote field notes immediately after each initial interview, describing the interview setting and participant. I transcribed about half of the initial interviews myself (16 of the 33 women’s and 14 of the 27 GPs’ interviews) and the remaining initial interviews were transcribed by other people. I edited all transcripts by listening to the audio-tape and correcting any errors. I added text in square brackets [ ] that indicated pauses or longer silences and non-verbal utterances such as laughing, crying or sighing. I felt that these added meaning to the transcripts at times. I did not transcribe the follow-up interviews, but rather took notes from the audio-tapes on the key points of the feedback.

Regarding confidentiality issues, I de-identified all transcripts. I asked each participant to choose their own pseudonym and ensured that there were no duplicated names. One woman chose a male name (George), which had been used as a family nickname. A whole analysis could be done on the choice of pseudonym in itself, as some names reflected the participant’s sense of humour (one GP decided on Normal), or their alter ego (celebrities were represented such as Jamie-Lee Curtis and Angelina Jolie). A few GPs chose their internet user name. I removed any names of people and places of residence, work or study from the transcripts and replaced them with a description, for example a town’s name became [rural town in NW Victoria], and a child’s name became [son].

I included a step for participants to check their interview transcript. I asked all participants at the end of the initial interview whether they would like me to send them a copy of the interview transcript. I explained that there were two purposes for this, the first to check its accuracy, and the second for them to let me know if there were sections of the interview that they would prefer I removed or altered to better reflect their experience or to ensure confidentiality. Twenty-seven of the 33 women, 12 of the 27 GPs, and the psychiatrist agreed to receive the transcript, which I sent within two months of the interview. I sent the de-identified and edited transcript with all memos removed. Only the psychiatrist requested changes to her transcript, mostly to further de-identify it. Just a few contacted
me by email or letter to thank me for the accompanying gift voucher and to make brief comments about the transcript or the impact of the interview.

I maintained a database that contained identifying information of participants and their pseudonyms. This was not accessible to my supervisors or the Advisory Group. I stored hard copies of de-identified interview transcripts in a locked filing cabinet. I will keep the hard copies for five years from the date of publication of the thesis, then destroy them by shredding. I will retain electronic files. I entered all edited transcripts into N-Vivo version 7 computer software (QSR International, 2006).

When presenting a quotation in the text of the thesis, I have used the following convention of participant identification and abbreviation:
1. I use participant pseudonyms to identify them. I add Dr to the pseudonym of the GP to distinguish them from the women participants who had a patient role in the study.
2. To provide context for each participant, after the pseudonym I note their age, location, and sexual identity where they were same-sex attracted. For example: Betty (41, lesbian, inner urban) or Dr Holly (39, lesbian, inner urban).
3. I refer to myself as ‘Interviewer’.
4. All quotations are indented in the text.
5. If I omitted materials from the quotations within a sentence I add (…), and between at least two sentences I add (…) in its place.
6. Words in [ ] were my explanatory material added during transcribing and editing.
7. I use italics to indicate emphasis.

Data Analysis

I used a systematic method of data analysis with a view to confirming existing (a priori) themes, finding new themes and building theory (Miles & Huberman, 1994; Ryan & Bernard, 2003). My units of analysis were the initial interview transcripts, as well as field notes, memos and notes from the follow-up interviews. I will describe in detail the
processes I used for memo writing, coding and theory building, and finally will comment on rigour.

**Memo Writing**

I used memos particularly to encourage early analysis. I wrote them while I was transcribing and editing interviews in order to document my ideas, changes to codes, possible themes, and divergent experiences. I also wrote memos about the interview process, especially for early interviews, which was part of my reflexive approach to improving the rigour of the data generation. One of the purposes of my analysis was to compare and contrast the experiences of same-sex attracted women and their own GPs, which I did for each of the 24 woman-GP pairs. To assist with comparison, before editing the interviews of GPs with linked women, I wrote a summary of what the woman had said about that GP and added it to the GP transcript. I could then easily compare issues women had raised about their GP with the GP’s perspective, which I noted in memos written in the GP transcript.

As suggested by Minichiello and colleagues (Minichiello et al., 1995), I also kept a diary or 'personal file' throughout to describe emerging codes and ideas and link them with the literature. This included a contemporaneous record of socio-political events related to the lesbian and bisexual communities, such as the Federal Government overturning the ACT Civil Partnerships legislation for same-sex couples, and discussions that we were having in the Ministerial Advisory Group on Gay and Lesbian Health about gaps and opportunities for research in Victoria. This diary has become a useful record of when and why new themes emerged.
**Coding Process**

I started with an initial list of *a priori* codes from my pre-existing knowledge and the literature. I then created additional codes inductively from the data. Creating the list of codes continued throughout the transcribing, editing and reading of all interviews. Even during the last interviews I occasionally found a new code. Initial codes were descriptive, and later codes were interpretive. The final list of codes included headings of seven overall themes for each of the two groups of participants, with a hierarchy of codes beneath each in a coding tree structure (see Appendix 5). For each interview transcript, I allocated text to the codes, finding convergence, or recurring categories and also divergence, or deviant cases (Patton, 2002). If there was a ‘deviant’ example I decided whether that required a new code, modification of the definition of an existing code, or simply annotation as an outlier.

My two supervisors and I undertook cross-coding so that we could all reach agreement on the code list and definitions as recommended by Miles and Huberman (1994). My supervisors checked that my coding was consistent and the codes were comprehensive. In my analysis I used an interpretive framework, which led to coding the meanings of people’s experiences (phenomenology), their own interpretations of those meanings in relation to pre-existing theories (hermeneutics), honouring the participants’ perspective (feminism) and looking for change and socio-political impact and awareness (critical theory). All of these coding perspectives required that the interpretations that I applied to the data in the codes were meaningful to different researchers and not just to me as a lesbian GP.

Our cross-coding method was that each of my two supervisors independently reviewed my early coding list and suggested adding codes that were missing based on their pre-existing knowledge. We all then coded the same randomly selected woman’s transcript, and we reviewed the code list together. We clarified the meanings of various codes and added a few. One of the main areas of uncertainty was in relation to sexual identity. It was clear that we had different ideas and interpretations, which required further literature review and
clarification. This process assisted me to develop my new model of sexual identity. My supervisors also suggested improvements in the hierarchy of some codes. I did a quantitative analysis of the level of agreement between the allocation of codes to the same transcript between myself and each supervisor. I found 92% of the allocations were the same with my social scientist supervisor and 82% the same with my GP supervisor. We felt that this was an adequate level of agreement. Subsequently, my supervisors coded another and different interview each and compared codes with me, which were both very similar.

**Building Theory - Matrices and Models**

While allocating the text to codes, I used reasoning that was inductive (purely from the data) and also abductive. Abduction is deriving hypotheses from the data or “working from the consequence back to the cause” (Patton, 2002, p.476), much like detective work in solving a crime. I started building theory during this process. For example, in explaining the influences on disclosure patterns, the meaning of sexual identity for women and GPs became an important factor. I used a mixture of matrices and models to display the theories that I was developing (Miles & Huberman, 1994).

**Rigour**

Yvonna Lincoln and Egon Guba laid the ground-work for determining appropriate criteria for rigour in qualitative research (Lincoln & Guba, 2003), which are still regarded as the gold standard criteria by many, despite the ongoing debates (Whittemore et al., 2001). These criteria are credibility and authenticity (equivalent to internal validity in quantitative research), transferability (external validity), dependability (reliability) and confirmability (objectivity). They relate to the degree of trustworthiness of the research process and its outcomes. Since then, multiple researchers have criticised and re-worked these criteria. I have used criteria for rigour recommended by Kirsti Malterud (2001), Patti Lather (1986)
and Jeanne Daly (2007) because they add a feminist perspective, as well as the ‘emerging confluences’ described by Lincoln and Guba (2003). Malterud suggests that there are three essential standards for qualitative research, which are relevance, validity and reflexivity (Malterud, 2001b). I consider that relevance is equivalent to Lincoln and Guba’s criterion of transferability, validity covers their internal validity criteria, while reflexivity is a particularly feminist addition. I have already demonstrated the relevance of my work in the introductory chapter and my reflexive approach throughout. Here, I will specifically discuss how I have addressed rigour in relation to validity, using the term validity to indicate credibility, authenticity and transferability. I also address rigour in relation to analysis and reporting, which is part of Daly et al.’s hierarchy of quality (Daly et al., 2007).

**Validity**

Validity as it applies to hermeneutic phenomenology relates first to whether the lived experiences represented in the analysis are authentic representations of the participants’ story. To ascertain this level of validity, I initially sent transcripts to all participants to ensure that they had the opportunity to remove or alter their own words to better reflect their experience. Triangulation is a further method to clarify the meanings by representing different perspectives on the same experience and to demonstrate their credibility. I endeavoured to triangulate by interviewing women and their GP, and then comparing and contrasting their experiences of the patient-doctor relationship throughout my analysis.

Patti Lather has described three types of validity as it applies to critical theory, which are construct, face and catalytic validity, which I have used (Lather, 1986). Construct validity is demonstrated when showing that pre-existing theories and knowledge have been altered by the data. I used a hermeneutic process to constantly reflect on this during the data analysis. Face validity is how the data are perceived by the participants, which is the same concept as the authenticity and credibility required within phenomenology. I addressed this by presenting my findings to participants and the Advisory Group and seeking their
feedback. As a result of their perspectives on the findings, I refined the study conclusions and the application of the findings. Catalytic validity is the degree to which involvement in the research process creates a new consciousness amongst participants of their own reality, which then encourages them to transform it. This is a concept that is the least compatible with pure phenomenology, which assumes that individuals are able to fully explain their own experiences, whereas critical theory speaks to the presence of false consciousness where individuals can be unaware of their own oppression. I dealt with this tension by accepting that participants may take either position. I asked participants during the follow-up interviews whether they considered there was anything that required change within their own experience or same-sex attracted women in general. I have detailed this in Chapter 7.

I have demonstrated complementary perspectives of validity from hermeneutic phenomenology and critical theory paradigms, and I consider that feminist notions of validity further draw these perspectives together. First, the need to represent the range of voices rather than the dominant voice is critical, and feminist researchers seek to give space to all perspectives in their version of authenticity (Reinharz & Davidman, 1992). Trustworthiness and social responsibility are central considerations of validity that drive feminist researchers (Fine et al., 2003). I have sought to ensure these standards of validity by including all participants in some way within the analysis and presentation of findings, and by taking my findings back to participants and the wider communities represented for discussion and critique. Validity also applies to motivations for transferability, where, for example, researchers may deliberately seek to address whether transformative research findings that relate to women may apply to other oppressed groups. I have included a brief discussion of transferability of my findings in Chapter 7.

**Rigour in Analysis and Reporting**

Jeanne Daly and colleagues (Daly et al., 2007) have developed a hierarchy of evidence for assessing qualitative health research. Previously, I discussed the hierarchy in relation to
defining the research framework and sampling, and presented the full hierarchy in Table 2. Analysis and reporting are also included in their model. Level I (best quality or ‘generalisable’ studies) must show that categories of analysis have been saturated, that is that no new material was emerging from the final data generated. There also must be a thorough analysis of all views and experiences presented. Reporting should include an assessment of the relevance of findings to other settings. I consider that my study has approached level I on these criteria. Saturation has not occurred, and indeed in critical hermeneutics this is not usually the aim, unlike grounded theory. Critical hermeneutics places a stronger emphasis on satisfying a thorough theoretical sampling frame to ensure a range of views are included, which I have done. In Chapter 7, I do claim that some of the findings may have specific relevance to other health care settings and other marginalised population groups, while highlighting that such a study really cannot be generalised and any possible relevance requires testing in the new setting.

I have chosen to present some of my findings numerically in order to display that I have analysed and represented all of the participants’ experiences. For example, when discussing the range of findings on a particular issue, I have described how many participants of the whole group fell into different categories, as well as providing their names. I did this in order to present all views, rather than to suggest any hierarchy of importance or meaning related to the number of people with specific views.

Summary

My pluralistic methodological approach has been enabling of both an intimate focus on the experiences and meanings of the patient-doctor relationship, and a contextual focus on the various socio-cultural influences on that relationship. It encouraged my commitment to consumer involvement in the study and assisted in ensuring that the research methods and process were appropriate to the sensitive nature of the subject. I have endeavoured to overcome the potential difficulties associated with being a partial insider to the study by understanding what these challenges might be and addressing methods to prevent them
throughout. On balance, I consider that my position as an insider has been reassuring to the participants and beneficial to the study. Sampling for a diverse group of participants is one of the challenges when studying minority sexual orientation. I have shown that I achieved a diverse sample by recruiting participants through a large general practice based survey, and then purposively recruiting using snowballing and convenience sampling. In Chapter 5, I will reveal the benefits of this diverse sample in allowing me to develop my Identity Disclosure Model. Finally, reflexivity and a commitment to praxis has informed my own journey through the study, which I will describe in Chapter 7.
CHAPTER 3 - PREFERENCES AND EXPECTATIONS OF GENERAL PRACTICE CARE

This chapter focuses on the same-sex attracted women participants of the study and their preferences and expectations of general practice care and the patient-doctor relationship. I have chosen two related clinical methods as a framework for the analysis of preferences for care, which are cultural competence and patient-centredness. Cultural competence places each patient’s culture at the centre of the clinical encounter. I consider minority sexual orientation to be a form of culture in that it imbues a set of values and beliefs, social behaviours and connections. I use a broad definition of culture, which is “the customary beliefs, social forms, and material traits of a racial, religious, or social group” [http://www.merriam-webster.com/dictionary]. I have chosen patient-centredness because it arose within general practice, and is the basis of Australian pre-vocational and vocational medical education, so would be familiar to most GPs in my study. I also use this model in my day-to-day clinical practice and in medical student education.

I will address two questions in this chapter, which are sub-questions of the first thesis question on the experience of the patient-doctor relationship:

1. What influence does the sexual orientation of same-sex attracted women have on their preferences and expectations for general practice care?
2. Can cultural competence and patient-centredness accommodate the preferences of same-sex attracted women?

I will start the chapter with a brief literature review of cultural competence and patient-centredness, as well as current definitions of lesbian and bisexual sensitive care. Having described the framework for the chapter, I will briefly critique the relevant literature before presenting the findings. I have divided the findings into three areas: a) the preferred style of care, b) preferred GP attributes, and c) expected outcomes relating to the patient-doctor relationship. I close with reference to relational knowing, which emerged as an over-riding preference amongst many women.
Models of Patient-Doctor Relationships

The models of cultural competence and patient-centredness share a number of important features. They have similar aims to broaden the biomedical approach to incorporate the social and psychological aspects of patient care. They are both concerned to address patient agendas and expectations for care (Epstein et al., 2005), and both call for reflexive practice. Cayla Teal and Richard Street (Teal & Street, 2009) have reviewed these models and suggest that the key difference between them is that patient-centredness focuses on the quality of individual care, whereas cultural competence expands this to improve the quality of care for disadvantaged groups at a population level. I will describe the application of these two models to the care of same-sex attracted women in general practice, keeping these similarities and distinctions in mind.

Cultural Competence

Culturally competent care has been defined in the following way:

Culturally appropriate refers to an unbiased attitude and an organisational policy that values cultural diversity in the population served. Cultural competence reflects an understanding of diverse attitudes, beliefs, practices, and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age, gender, sexual orientation, or generational and acculturation status. It includes awareness that cultural differences may affect health and the effectiveness of health care delivery. (Hunter & Baer, 2007, p.659)

This definition appeared in the context of a chapter on HIV prevention and care. It demonstrates the current endpoint in a relatively short development period originating in the cross-cultural work of medical anthropologists such as Arthur Kleinman during the
1970s (Kleinman, 1980). This work highlighted the influence of ethnicity on health beliefs, health seeking behaviour and health status, and suggested that when health care providers understand this influence they can provide more tailored and appropriate care. This approach was soon expanded to include other forms of culture, and during the last decade has incorporated sexual orientation in a wide range of fields including nursing (Dootson, 2000), social work (Charnley & Langley, 2007; Van den Bergh & Crisp, 2004), clinical psychology (Yali & Revenson, 2004) and HIV medicine (Schilder et al., 2001).

This inclusive definition of culture has also begun to appear in the field of family (general) practice in the United States, and to a more limited extent in Australia. The USA Office of Minority Health released an environmental scan which was designed to assist in the development of cultural competence curriculum for family physicians (American Institutes for Research, 2002). The authors specifically include sexual orientation in the range of social groups requiring cultural competence. They suggest that three areas of health research provide a rationale for including culturally competent care as an integral part of professional competency. These are health disparities faced by cultural minorities, difficulties in health care access, and patient-centredness that requires patient preferences and beliefs to be taken into account. All three areas apply to minority sexual orientation. The central elements of culturally competent care according to this scan are a patient-centred focus, effective doctor-patient communication, balancing factual and attitudinal competence, and understanding the influence of culture on health. This report also places emphasis on ‘cultural humility’, which is training to reduce power imbalances between doctors and patients. Another element of cultural competence that is frequently addressed in the literature is the need for self reflection by health care providers, which again stems from Kleinman’s early cross-cultural work (Kleinman, 1980). This includes awareness of our attitudes towards lesbian and gay patients (Van den Bergh & Crisp, 2004; Yali & Revenson, 2004) and also awareness of our own stereotypes and biases (Dootson, 2000).

Australian and New Zealand general practice policy recognises cultural competence as important. The RACGP Standards for General Practices, which form the basis of the practice accreditation system (Royal Australian College of General Practitioners
(RACGP), 2007) include Standard 2.1.1 on “respectful and culturally appropriate care” (p.43). One of the indicators for this standard is ensuring that practices do not discriminate against patients according to their cultural attributes and these are listed as “gender, race, disability, Aboriginality, age, sexual preference, beliefs or medical condition” (p.44). Similarly, the Royal New Zealand College of General Practice (RNZCGP) released Cultural Competence Guidelines in 2007 (Royal New Zealand College of General Practitioners, 2007). In these, culture is defined broadly with “gay/homosexual and transgender” people being included as “commonly recognised cultures in New Zealand” (p.4).

**Patient-centredness**

I will focus on a particularly influential model of patient-centredness called the Patient-centred Clinical Method, which was developed by Moira Stewart (Stewart, 1995) and colleagues for doctors to use in their clinical work, in medical education and in medical research. The model arose in response to patient calls for greater autonomy in medical care and a more egalitarian relationship with doctors. It incorporates six inter-related components of the patient-doctor interaction, which include two that are relevant to my study: understanding the whole person and enhancing the patient-doctor relationship. With regard to whole person care, the model calls for integration of the three components of bio-psycho-social care rather than viewing them as separate. The social component incorporates concepts of patient culture, and the model calls for doctors to take responsibility for understanding any cultural differences, including sexual orientation. “Cultural differences not only are based on ethnicity, but also include sub-cultural groups defined by age, social class, gender, sexual preference, education, occupation and religion” (Stewart, 1995, p.51).

Regarding the patient-doctor relationship, the model requires doctors to consciously enhance the relationship through personal self-awareness, unconditional positive regard, empathy, genuineness, sharing power and caring (Stewart, 1995). Nicola Mead and Peter
Bower (Mead & Bower, 2000) conducted a comprehensive literature review on the health outcomes of patient-centredness. They identified five common dimensions of patient-centredness within the patient-doctor relationship: a) a biopsychosocial perspective, b) patient-as-person, c) sharing power and responsibility, d) therapeutic alliance, and e) doctor-as-person. I will reflect on these dimensions as I present the analysis of the general practice care preferences of same-sex attracted women.

There are limitations of the Patient-centred Clinical Method in relation to same-sex attracted women as patients. The method is based in a psychological framework, and so while recognising the importance of individual culture, as Teal and Street (2009) point out, patient-centredness does not acknowledge the influence of social norms and stereotypes on the health care experience. Also, while suggesting that doctors should share power with patients, Stewart (1995) and colleagues do not fully recognise the difficulty for socially marginalised patients to achieve such autonomy. So, I consider that including patient-centredness in my framework enables a detailed analysis of the patient-doctor relationship, and including cultural competence provides a broader understanding of how the whole system of general practice and social systems more widely impact on same-sex attracted women’s experience of the patient-doctor relationship.

**Literature on Specific Health Care Needs**

I will start by briefly summarising the literature on the expectations by any patient of general practice care. I will then demonstrate that the literature provides a good case that same-sex attracted women have specific health issues that GPs should be prepared for, and they also have specific expectations relating to their minority sexual orientation.
General Expectations of General Practice Care

Patient expectations of their GP have been well documented. For example, Angela Coulter cites a review of 19 studies of patient priorities for GP care, with the highest priority being humanness 86%, then competence 64%, involvement in decisions 63%, and time for care 60% (Coulter, 2005). The qualities of interactions with the doctor were more highly regarded than the structure of service. Dana Safran and colleagues (Safran et al., 1998) designed and validated a Primary Care Assessment Survey, which was a patient-completed questionnaire designed to understand patient priorities for care. The survey contains seven domains of primary care, which demonstrate the following patient expectations:

1. Comprehensiveness - competence for biological, social and psychological issues.
2. Clinical interaction – excellent clinician-patient communication and thoroughness of physical examinations.
3. Interpersonal treatment – positive values including humanness.
4. Trust - a multi-dimensional domain requiring the fulfilment of all of the other domains.
5. Continuity.
6. Integration with other services - a realistic use of resources including team work with other health care providers.
7. Accessibility - organisational and financial.

Both the priorities and the domains show that patients expect both clinical competence and optimal patient-doctor relationships. These expectations incorporate the dimensions of patient-centredness, in particular the biopsychosocial perspective and patient-as-person. The therapeutic alliance dimension is also achieved through continuity. Continuity with the same practice and same doctor where possible is a particular aim for general practice care by the RACGP, because it forms the basis of the therapeutic relationship:

Relational continuity is a sustained relationship between a single practitioner and a patient (or sometimes more than one practitioner and a patient) that extends beyond individual consultations or episodes of illness. This can be described as a
sense of affiliation between a patient and their doctor (‘my doctor’ or ‘my patient’). It is often viewed as the basis for continuity of care. (Royal Australian College of General Practitioners (RACGP), 2007, p.29)

Specific Health Issues of Same-sex Attracted Women

There is an increasing evidence base that same-sex attracted women experience significant health inequalities compared to heterosexual women (Mayer et al., 2008). This is predominantly related to the socio-political climate of ongoing homophobia creating discrimination and social exclusion, which can result in increased levels of mental health problems, experiences of abuse, drug use and other risk taking behaviours. There is convincing evidence from several international population-based studies that lesbian and bisexual women have higher rates of depression, anxiety and suicidal ideation than heterosexual women. These studies are from the USA (Gilman et al., 2001), the Netherlands (Sandfort, de Graaf, Bijl, & Schnabel, 2001), New Zealand (Fergusson, Horwood, & Beautrais, 1999) and Australia (McNair et al., 2005). The ALSWH also reveals that lesbian and bisexual women have twice the likelihood of experiencing all forms of abuse over their lifetime compared with heterosexual women (McNair et al., 2005). Drug and alcohol use is reported to be higher amongst lesbian and particularly bisexual women in several large studies in the UK (Mercer et al., 2007), the Netherlands (Sandfort, Bakker, Schellevis, & Vanwesenbeeck, 2006), the USA (Koh, Gomez, Shade, & Rowley, 2005) and Australia (Hillier et al., 2003), and is thought to occur at least partly as a coping mechanism against discrimination. Substance abuse in turn increases the risk of sexual and other risk taking activities (Koh et al., 2005; Mercer et al., 2007). A recent systematic review on mental health and substance use has reiterated these findings (King et al., 2008).

Lesbian and bisexual women are also less likely to access preventative screening. Reduced cervical, breast and cardiovascular screening rates have been found in several population-based USA studies (Cochran et al., 2001; Diamant, Schuster, & Lever, 2000; Valanis et
al., 2000). One comparative study of 1,284 women attending USA primary care services showed that bisexual women were less likely than heterosexual or lesbian women to have lipid or mammogram screening (Koh, 2000). Screening rates have not been reliably compared in the UK and Australia, although they are also lower in Canada (Tjepkema, 2008). There is concern that lower screening rates coupled with higher risk factors will, for example, increase certain cancers and cardiovascular disease amongst same-sex attracted women (Cochran et al., 2001; Dibble, Roberts, & Nussey, 2004).

Apart from socio-political differences, some same-sex attracted women have specific health needs related to their sexual orientation *per se*. These include specific sexual health needs regarding sexually transmissible infections (STIs) (McNair, 2005) and conception and parenting issues (Ross et al., 2006).

*Expectations of Lesbian and Bisexual Women Sensitive Care*

There are many studies that address lesbian women’s actual experiences of care, and I will discuss these in Chapter 4. There has been less exploration in the literature of lesbian and bisexual women’s preferences and expectations for care. Christine Saulnier (Saulnier, 2002) made this observation and also found from her review of the literature that differences between lesbian and bisexual women’s preferences were yet to be described. Overall, satisfaction is higher if expectations of cultural competency are fulfilled by doctors (Hutchinson, Thompson, & Cederbaum, 2006; Polek, Hardie, & Crowley, 2008). Some women expect whole person care that incorporates GP knowledge of their sexual orientation as a demographic fact (Mathieson, Bailey, & Gurevich, 2002), and lesbian women actively seek out doctors with lesbian-specific competency (Barbara, Quandt, & Anderson, 2001; Klitzman & Greenberg, 2002; Stein & Bonuck, 2001). Several studies have described lesbian women’s preference for holistic care but none have highlighted the potential for diverse preferences. Patricia Stevens’ (Stevens, 1994a) study detailed women’s specific expectations of a holistic approach, which were an appropriate power...
balance, emotional respect, to be valued as a person, recognition of demographic diversity by providers, and to have a voice within the consultation.

The literature contains various terms regarding accommodation of lesbian women’s preferences including lesbian awareness, lesbian friendliness and lesbian sensitivity. I will use this last term, and will include bisexual women, in order to signify that there may be specific bisexual issues to address.

**Defining Lesbian Sensitive Care**

A comprehensive definition of lesbian sensitive care was derived from an action research study by Christine Saulnier and Elizabeth Wheeler conducted in New York (Saulnier, 2002; Saulnier & Wheeler, 2000). This included a community survey of lesbians (n=106), five focus groups (n=33 lesbians), and a survey of health care providers (n=47). The lesbian participants defined lesbian sensitive providers as being comfortable with treating lesbians, receptive, and inclusive of women’s partners. They were knowledgeable of common concerns held by lesbians such as ageism, sexuality and reproduction; and were aware that these concerns could differ from those of heterosexual women, particularly relating to socio-political issues. In addition, lesbian sensitive providers would understand the significance of documenting sexual orientation in their notes and would obtain permission from their lesbian patients to do so. Some women not only wanted providers to acknowledge their minority sexual orientation, but preferred providers to overtly affirm it (Saulnier, 2002). The authors noted that expectations of sensitive health care tended to be low amongst the lesbian participants and that “most wanted only to be treated with the same dignity accorded more socially accepted care recipients” (Saulnier, 2002, p.361). The generally low expectations meant that at the least women expected tolerance of their sexual orientation, however at best hoped for sensitivity and even affirmation.

Involvement and support of the female partners of lesbian patients is another specific cultural aspect of health to which providers need to be sensitive (Rondahl, Innala, &
Carlsson, 2006). Active involvement of the partner becomes even more relevant as women age due to increased care needs at home or in aged care facilities (J. Harrison, 2005). Conversely, not all lesbian women want their partner involved in medical decision making, but this requires further research regarding women’s preferences (Lees, Shelton, & Groff, 2001). A further form of sensitivity is to understand the impact of minority sexual orientation on health. A qualitative study of HIV positive men in Vancouver showed that most of the gay and some of the bisexual men sought out primary care doctors who understood their social context and identities (Schilder et al., 2001). They wanted their identity, beliefs and values affirmed and acknowledged by their doctor, and wanted to be dealt with as a whole person, not as a risk factor. They also wanted doctors to acknowledge the stress of being marginalised, and to know about sexual identity variations.

**Disclosure of Sexual Orientation**

There is evidence that perceived provider sensitivity increases the likelihood of disclosure of sexual orientation, and that this in turn can result in better health care for lesbian and bisexual women and an improved patient-doctor relationship. Disclosure of sexual orientation is found to improve health care at a number of levels. First, it may improve utilisation of health care through better continuity. A community survey of 489 Canadian lesbian women who saw a GP at least once per year revealed that disclosure strongly influenced continuity with the same GP (Steele et al., 2006). Disclosure was more likely if the GP was felt to be ‘gay-positive’, however this term was not defined in the paper. Second, disclosure has been found to improve the quality of preventive care through increasing comfort levels with the health care provider (Bergeron & Senn, 2003). For example, a survey of 6,935 lesbian women from all USA states found that disclosure was significantly associated with having Pap smears (Diamant et al., 2000). Third, disclosure enables involvement of the female partner as a decision maker and recognised support person (Boehmer & Case, 2004; van Dam, Koh, & Dibble, 2001). Finally, when health care providers know about minority sexual orientation they can theoretically provide more
targeted care for issues such as STIs (Cochran & Mays, 1988; Klitzman & Greenberg, 2002), parenting and coming out support (van Dam et al., 2001).

Several studies have shown an association between disclosure and a better patient-doctor relationship via improved satisfaction (Barbara et al., 2001; Bergeron & Senn, 2003; Cochran & Mays, 1988; Dardick & Grady, 1980; Fitzpatrick et al., 1994; Klitzman & Greenberg, 2002). This satisfaction has been attributed to more culturally sensitive communication (Stein & Bonuck, 2001; White & Dull, 1998), and is associated with increased disclosure of other sensitive issues including STI risks and substance abuse (Klitzman & Greenberg, 2002). However, it is important to consider the direction of this apparent effect on the patient-doctor relationship, as disclosure to GPs may indicate an already trusting relationship as well as enhancing that trust. For example, a study describing disclosure patterns to all important members in the social network of 89 gay men and 55 lesbian women found that the relationship quality was better with people who knew about their sexual orientation (Beals & Peplau, 2006). This was both because participants selected those they already respected to disclose to, and disclosure subsequently further enhanced the relationship.

**Health Care Provider Knowledge**

Lesbian and bisexual women want providers who are knowledgeable about lesbian health, and they report educating their regular providers in this area (Mulligan & Heath, 2007). The literature on lesbian-specific cultural competence refers to the requirement for specific knowledge in understanding terminology, the health impact of discrimination, specific community resources, as well as diversity amongst the population (Van den Bergh & Crisp, 2004). Family physicians have specifically been called to understand these specific health care needs (A. E. Harrison, 1996; Moran, 1996). Health care providers are also required to have awareness of their own attitudes and interpersonal skills in order to display lesbian cultural competence (Hutchinson et al., 2006), which is also part of patient-centredness.
Avoiding Assumptions of Heterosexuality

Many studies call for providers not to automatically assume heterosexuality. Assumption of heterosexuality by health care providers is the most commonly cited example of a lack of specific competence in the literature (Platzer & James, 2000; Stevens, 1992; Wilton, 2000). An influential narrative study on the health care experiences of 45 lesbians in San Francisco, USA was conducted by Patricia Stevens (1992). One of Stevens’ central arguments is that the assumption of heterosexuality by doctors is a major barrier to effective health care for lesbian women (Stevens, 1992). The health care needs amongst her sample were “to be known, seen, heard, believed and valued (...) and not accused, censured, devalued, silenced or subordinated” (Stevens, 1994a, p.655). I interpret Stevens’ findings as the desire for patient-centredness from a feminist perspective. Her lens is the power dynamic within the health care experience and she describes participants’ stories as either displaying doctors acting in solidarity with patients (which I would describe as patient-centred) or dominating their patients (doctor-centred) (Stevens, 1996). Stevens’ markers of solidarity included doctors providing ”compassionate competence”, ”empowering information exchange” and ”negotiated action” (p.29).

Summary of Lesbian Sensitive Care

Lesbian sensitive care shares many elements with patient-centredness including sharing power, patient-as-person and biopsychosocial care. It is also culturally competent by acknowledging the health effects of marginalisation and avoiding heterosexual assumptions. One of the gaps in this literature is any sense of the diversity of needs amongst same-sex attracted women, which may reflect the use of convenience sampling as I described in Chapter 2, and also a failure to specifically analyse for difference. Few papers have addressed variations in women’s preferences for GP knowledge or practice environment. So in summary, the literature suggests that lesbian and bisexual women sensitive care, as a form of cultural competence, should involve an inclusive practice
environment, specific knowledge, and sensitive attitudes of providers. Women want providers to avoid assumptions of heterosexuality so that their minority sexual orientation and same-sex partners can be included in their health care.

**Overview of Women’s Care Needs**

The findings that I will present in this chapter provide a detailed understanding of same-sex attracted women’s preferences and expectations for general practice care. I will refer to expectations as needs that are grounded in women’s experiences, and preferences as needs that are more aspirational. I will focus on women’s needs regarding the patient-doctor relationship using cultural competence and patient-centredness as the general frames of analysis and comparison, and lesbian/bisexual sensitivity as the specific frame.

I analysed women’s general practice care preferences by first examining their responses to my question at the end of each interview asking for their wish list of qualities of the best GP they could imagine for themselves. In my view, this question gave women the chance to summarise their priorities for care in relation to preferred GP characteristics. The preferences largely related to three attributes: interpersonal treatment, communication and competence; which correspond with three of the seven domains of primary care described by Safran et al. (Safran et al., 1998). The next phase of the analysis was to examine each of the codes for GP attributes and also to look at other preferences including style of care. Finally, I analysed the expected outcomes of care, which were trust and continuity.

**Experience Determining Expectations**

The expectations of women in the study were most influenced by positive experiences they had had with GPs. Sixteen of the women stated that the best GP they could imagine was their current GP. This was the majority of the 25 women who had a usual GP, indicating a high level of satisfaction. Twelve of these women had a female GP and the
other four had a male GP. The 16 women spanned the age spectrum of participants and
had been with their current GP for anywhere from a few months to 25 years. For example,
I interviewed same-sex partners Susan and Betty who saw the same GP. Susan had been
seeing her for 18 years, and Betty started seeing her when she met Susan nine years
before. Both felt their GP satisfied their needs completely:

   Interviewer: Thinking back to GPs generally, if you had a wish list of the most
   perfect GP you could imagine, what would that person be like?
   Betty (41, lesbian, inner urban): I would say [Current GP female] (laughing). I
   think [Current GP female] to me is just the bees knees, and Susan will probably
   agree. She’s just adorable.

And Susan’s response to the same question in her interview indicated the reliance that she
felt on her GP:

   Susan (43, gay, inner urban): I think [Current female GP]’s pretty much the
   jackpot for what suits me. I couldn’t get better, and when [Betty] told me she was
   going on maternity leave in September, I said, but what are we going to do? I just
   felt like my life was going to have to start all over again, finding someone.

Women who did not think their current GP fulfilled all of their expectations tended to
provide a list based on their experiences with several GPs. Jenny (72), who was the oldest
participant in the study, stated “the ideal GP would be a collection of the ideals that I’ve…
of what I’ve found best in all the GPs that I’ve been to.” She felt that one GP in particular
had created very high expectations for her: “I had a woman doctor who was extraordinary
and that spoiled me. She was like a godmother to the whole family”. Similarly, Indigo (30,
bisexual, rural) described one particular male GP she had seen in the past as “one of the
most caring and genuine people that I’ve ever met”. She went on to say “I suppose I’ve
used him as a yardstick for other GPs and compared other GPs against him”.

Negative experiences also influenced women’s expectations by clarifying the GP
attributes that they did not want. I will describe women’s negative GP experiences in the
next chapter.
Preferred Style of Care

The preferred style of care relates to two issues: a) the range of care offered, and b) who provides that care. Women had a preference for either focused or holistic care, and for the convenience of seeing any GP or continuity with one GP. Holism and continuity versus focused care correspond with two distinct philosophical positions that GPs may also hold, either a commitment to understanding the whole person (Howie, Heaney, & Maxwell, 2004), or a biomedical standpoint in which patients are de-contextualised from their psychological, social or spiritual dimensions (Borges & Waitzkin, 1995). The lesbian health literature on expectations that I described above tends to assume that lesbian women prefer continuity and holistic care, and authors do not explore alternative preferences. It also focuses on lesbian sensitivity as the main requirement for such continuity without recognising that some women may prefer holism and continuity that does not include knowledge of their sexual orientation. I have found very little literature about lesbian and bisexual women’s preferences for continuity of care.

Amongst the 33 same-sex attracted women in my study, 18 preferred focused care and 15 preferred holistic care; and six women preferred care of convenience, while 27 preferred continuity. I will now describe each of these preferences and their relationship to women’s sexual orientation.

Focused Care

Eighteen women did not expect holistic GP care. They preferred care that was focused either purely on physical issues (Jamie-Lee, Mae, Gabrielle, Eileen, Angelina, Sally, Robyn, Kiama, Flo, Sharon and Madison) or on physical and emotional care for specific episodes in their lives (Esther, Jenny, Betty, Jill, Kirsti, George and Mina). These women did not need the GP to have comprehensive knowledge of their lives and context. It might
be expected that women who did not desire holistic care also would not desire or have a usual GP, however this was not the case. All of the women wanting episodic physical and emotional care, and all but four of those wanting just physical care (Robyn, Flo, Sharon and Madison) had a usual GP, with equal numbers of male and female GPs.

Some women stated that they did not feel it was the GP’s role to deal with the whole person or with emotional issues. Others lacked awareness of the ability or willingness of GPs including their own to provide holistic care, despite the fact that some of these GPs were interested in emotional or holistic care. This applied to Jamie-Lee and Dr Joseph, Lucy and Dr Imogen, Jill and Dr Cahill, Jenny and Dr Soula, Eileen and Dr Tyl. Many of these women had required professional emotional care and had sought and found it outside of general practice. For example, Dr Tyl (61, regional) felt that her patients often used her as a ‘sounding board’ for their emotional problems, yet when I asked her patient Eileen (45, lesbian, rural) whether she would have considered seeing her GP for the grief counselling she had found elsewhere she said “No, no. No I wouldn’t have. It would never have actually occurred to me.” Madison’s preference for purely physical care from the GP was based on her experience of brief GP consultations and her low expectation of GP skills in psychological care:

Madison (24, lesbian, outer urban): I would not go to a GP for mental health issues. I have other resources.(….)

Interviewer: Is there a reason you wouldn’t see a GP?

Madison: Um….given current experiences with GPs of feeling rushed and not being able to ask any questions, that would be the main factor I’d say. I don’t know how much training GPs are given on counselling either.

A preference for focused care did not always prevent a need to disclose sexual orientation. For example, Kiama (23, bisexual, inner urban) had told her GP about being lesbian, but only desired physical care. Conversely, Madison preferred not to discuss her sexual orientation with the GP. Some of the women who preferred focused care may have told their GP about their sexual orientation if they had believed the GP had an interest. Jamie-Lee (47, gay, inner urban) had not told Dr Joseph about being lesbian, and when she
needed support in relation to her sexual orientation she deliberately sought out a counsellor. Towards the end of the interview with me, she said she wished she could tell him. Her misunderstanding of the care he offered contributed to her reticence. She said she wanted him to “show an interest in me and what other things are happening in my life”. By contrast, Dr Joseph believed that he offered this level of interest to his patients:

Dr Joseph (57, outer urban): I certainly think they feel free to come to me with psychological and mental health issues. I have fairly broad experience in those areas as well and have been involved in a number of [research] projects. (...) So I think I’m open to people’s problems and worries.

Therefore, a focused care preference was generally unrelated to women’s need or otherwise to include her sexual orientation in the consultation, and more related to lack of expectation regarding GPs’ holistic role.

**Holistic Care**

Fifteen women preferred whole person care (Alice, Anne, Bear, Dora, Helen, Indigo, Jane, Kate, Lesley, Lucy, Mina, Miranda, Mitzy, Nede and Susan). This was a diverse group of women whose age, work background and economic status ranged across the full spectrum in the study. Most were over 30, but Jane, Mina, Flo and Bee were in their early to mid 20s. Five women were bisexual and 10 were lesbian/gay. Two of the women (Indigo and Nede) did not have a usual GP at the time of the interview.

Women defined holistic care in different ways. Most felt holistic care meant that GPs had a broad interest in their whole life, potentially including their sexual orientation. This fulfils the patient-centred expectation of patient-as-person. For example, Mina (23, bisexual, inner urban) appreciated “a willingness to hear the whole story”, Jane (21, lesbian, regional) felt her GP displayed an interest in her “general life”, and Bear (25, lesbian, inner urban) believed her GP treated her “as a human being”. Four women (Dora, Mina, Miranda, Mitzy) described the importance to them of GPs making the connection
between various parts of their life and their health. Indigo also preferred this sense of holistic care, referring to a biopsychosocial approach as it is framed in the patient-centred clinical method (Stewart, 1995):

Indigo (30, bisexual, rural): [I prefer a GP who] knows how to express a broader sense of caring or interest in the person’s well-being other than just the particular physical ailment. It’s more of a whole…I suppose a holistic approach, that deals with psychological, emotional as well as the physical side of it.

In addition, Bee (bisexual) and Flo (same-sex attracted) had never experienced seeing a doctor who took an interest in their social context, however our interview had revealed the possibility that GPs could provide such holistic care. These two women were in their mid twenties and reveal a group with limited experience but broad aspirations for GP care:

Interviewer: Would you want GPs to take an interest in your social life or context?
Bee (25, bisexual, inner urban): Maybe that would be nice. [Laugh] I’ve never experienced any of them doing that but no. I just realised now I think I would prefer it because I just… it probably has a lot of effect on your physical well being (…), so I guess what you do with your life is quite important to your health.

The preference for the style of care had changed over time for some women, with the typical pattern being a shift from preferring care for purely physical issues as young adults to holistic care later.

Thirteen of the 15 women wanting holistic care felt their sexual orientation was relevant to the consultation, however two (Indigo and Lesley) did not. Bee and Flo also felt it was irrelevant to their GP. So, just as a preference for focused care did not necessarily preclude a need to disclose sexual orientation, a preference for holistic care did not automatically include revealing their sexual orientation. For example, Lucy believed her sexual orientation should be part of this holistic approach:

Lucy (45, bisexual, outer urban): I think it would be nice to know that they had the complete sheet on you. To do the, I’m going to find out everything I can about you
and work from a solid base, instead of working from a medical base which really just encompasses the last three visits. (…).

Interviewer: And would the big picture be about your sexuality as well?
Lucy: Yes. Absolutely. I’d like to feel that she did know me wholly and she had an understanding of those added pressures that are there in life that could blow into an incident. I’d hate to be dealing with an incident or a trauma in my head that had to do with my sexuality, and I had to come out and explain it all to her there and then. Like she was trying to diagnose and help me from a base of “I’ve known about this for five minutes”.

By contrast, Indigo preferred holistic knowing by her GP on all levels apart from her bisexuality. She felt that “it’s no-one’s business but my own” and said “if I went and saw a GP I’d like to think…well what would be important for me would be that they would see me as a professional (….) I wouldn’t say anything [about sexual orientation] unless I had to”. So, Lucy’s position matches the lesbian sensitive care approach suggested in the literature, for example that GPs should understand the ‘added pressures’ of dealing with discrimination. However, the four women who did not feel their sexual orientation should be part of the consultation despite preferring holistic care did not need lesbian sensitive holistic care.

**Care of Convenience**

Six women preferred to see a range of doctors or not to see GPs at all unless absolutely necessary. None of these women apart from Sally had a usual GP at the time of the interview. Sally attended her usual GP (Dr Normal in the study) infrequently for follow up of a chronic medical condition but preferred to see alternative health care providers because they “take more care”. Four preferred focused physical care from GPs, while Indigo and Bee preferred holistic care; and Flo, Madison, Indigo and Sally had attended other health care providers for mental health issues. Apart from Sally, these women were healthy with no perceived need for regular health care, and were all thirty or under,
indicating that this preference was predominantly related to life-stage. Ten other women in the study (George, Helen, Miranda, Dora, Eileen, Lucy, Mae, Mitzy, Nede and Susan) retrospectively recalled the same pattern in their younger adult life. All of these ten women were over 40 when interviewed and now preferred continuity because health concerns or life circumstances encouraged them to attend more regularly and to see the same GP.

Some of the women who currently or previously had preferred care of convenience were motivated not by lack of need but by reticence to attend GPs. For example, Nede (55, lesbian) had recurrent pelvic pain as a young woman but did not seek medical help as she did not trust GPs and feared homophobic responses. She said “I think back about it now, I should have really investigated it’. While a lack of continuity in early adult life is a common issue regardless of sexual orientation, as I reported earlier the literature suggests that lesbian women have added reasons including low satisfaction, fears of negative attitudes, and repeated assumptions of heterosexuality. Similar to Nede, Dora had avoided GP care despite having a significant medical problem and she related this avoidance specifically to her sexual orientation:

Dora (41, gay, inner urban): It [being lesbian] probably stopped me from going to a GP for a very long time. (…)
Interviewer: What stopped you?
Dora: I don’t know maybe I feel they’re going to judge me or something.
[a little later]
Dora: Some of the doctors were a bit like “oh you’ll be wanting to start a family”, ‘cos as I say, I used to suffer really bad period pain. (…) And then I never went back ever again because I thought I’m never going to have children and I don’t really want to talk about it. So I never went back, never had it investigated and never have had.

For other women the lack of need for continuity of care was more practical yet related to their sexual orientation in that most did not require reproductive or contraceptive care. Just one of the six women currently preferring convenience (Indigo) had had a child and just
two (Flo and Indigo) were sexually active with men. Likewise, of the ten women preferring convenience when younger, only two (Helen and Lucy) had had children, although six had needed contraception.

Therefore, while some of the women preferring care of convenience did not need regular care, others avoided regular GP contact to avoid heterosexist assumptions or negative GP attitudes. For some women, such as Nede and Dora, this was potentially detrimental as their health needs were not met; while for others this merely suited their lifestyle and lack of practical need for GP care.

**Continuity**

The majority (27) of the 33 women in the study preferred continuity of GP care. This is not surprising as they were recruited largely through a general practice study, and recruitment also alerted them to my interest in interviewing their usual GP if they had one. All but three of the 27 women preferring continuity (Kate, Nede and Sharon) had a usual GP. Regarding life-stage, while most of these women were over 30, young women were represented in this group. Kate, Jane, Kiama, Mina and Bear were all in their early to mid 20s. Mina and Bear wanted continuity as a result of their educated awareness that this would provide them with better health care. Kate and Jane both had chronic health conditions, which encouraged continuity. Kiama (23, bisexual, inner urban), unusually, had maintained contact with her childhood GP. Her GP had deliberately created the opportunity for Kiama to start seeing her alone at around 15 years of age, and this had built trust and an independent relationship, which she wanted to maintain.

Most of these women preferred continuity because they valued the GP knowing them well. For some, this knowing was not necessarily connected to their sexual orientation. Jane (21, lesbian, regional), amongst others, felt that a usual GP would know her medical history, which would enable a better quality of care. This reflected her need to build a therapeutic alliance, which is one of the reasons for continuity stated by the RACGP
(Royal Australian College of General Practitioners (RACGP), 2007). Kiama said she needed her GP to know her personal beliefs about health care, such as avoiding antibiotics. Lucy and Dora, who had avoided GPs in their past, both found the familiarity and predictability of having a usual GP comforting and easy. As Lucy (45, bisexual, outer urban) said “the whole comfort zone, [Current GP]’s there and I know her, and I know pretty much what’s going to happen every visit. There’s not going to be any scary stuff.”

Continuity for some women related to the GP knowing their sexual orientation. Nine women had specifically sought out a lesbian sensitive GP with whom to build such a relationship. One (Nede) deliberately attended a lesbian and gay focused clinic to be sure of sensitivity, four (Esther, Mitzy, Miranda and Sharon) had relied on recommendations by lesbian friends, and four (Betty, Dora, Esther, Helen) a referral by their female partner. A personal recommendation from a lesbian friend was a reliable method of curtailing the often slow process of determining a GP’s attitudes towards minority sexual orientation. Betty described seeing her current GP, Dr Olive (43, inner urban), because her partner Susan saw her. While Susan had found Olive by chance, she had since recommended many lesbian friends to see her: “I’ve sent so many friends to her and they’ve all been extremely happy, her rapport’s fantastic, outstanding.” Betty reiterated this in her interview: “I know Susan’s referred a lot of people to [Dr Olive] and they all love her to death.” Similarly, a lesbian referral had allowed Sharon to feel comfortable at the clinic as a whole:

Sharon (40, lesbian, inner urban): I remember when I started going to see her [GP] that a lesbian friend of mine had been seeing this doctor for a long time and really had highly recommended her, so I guess I had that bit of knowledge that she was okay about it. (....) I knew of two or three other lesbians that had been seeing her for quite some time, so I think there was a bit of a word of mouth thing around about her.
Summary of Preferred Care Styles

Women had a range of care preferences from purely physical to holistic care, and from care of convenience to continuity. In answer to the first question of the chapter, sexual orientation rarely played a part in influencing these preferences. Rather, preferences for the source of care were strongly related to life-stage and generally shifted to a need for continuity as women moved into their thirties or forties when health issues became more pressing. Minority sexual orientation did prevent or delay attaining continuity of care for some women who feared judgement, or due to practical issues such as a lack of need for reproductive or contraceptive care, and therefore a reduced need to attend GPs. Just a few women actively sought lesbian sensitive GPs through recommendations of lesbian friends or partners. This broadens the impression gained from the literature that lesbian women are unanimous in their preference for holistic, lesbian-sensitive care. Also, while holistic patient-centred dimensions of biopsychosocial, therapeutic alliance and patient-as-person care were expected by some women, this was certainly not a universal need.

I will present a more complete analysis of the influences on women’s preferences for GPs knowing about their sexual orientation in Chapter 5.

Preferred Professional Attributes of GPs

Women described many generic preferences that did not specifically relate to their sexual orientation. For example, many women wanted GPs to be up-to-date in their medical knowledge, thorough, to provide adequate time and give information clearly. In this section, I will describe three preferred attributes that specifically related to women’s sexual orientation. These were humane values, caring communication and lesbian-specific competence. These match three of Safran et al.’s (1998) domains of primary care, namely interpersonal treatment, clinical interaction and comprehensiveness respectively.
**Humane Interpersonal Values**

Cultural competency includes an expectation that clinicians are respectful of diverse cultures and have some cultural humility in recognising that their own culture and that of the patient should not compete in value. In addition as I outlined earlier, lesbian sensitivity requires GPs to have overtly accepting attitudes towards diverse sexual orientations including engagement with a same-sex partner.

In my study, the majority of women expected their GP to be humane. This is not surprising as humaneness was the most commonly desired GP quality in the review of literature on patient preferences I cited earlier (Coulter, 2005). Humaneness is an expression of compassion, but is also defined as demonstrating liberal values in respecting the views of others (Encarta dictionary). This applies well to a GP who displays cultural competence towards a diverse range of people. Women expected various levels of humaneness with regard to their sexual orientation. At the least they expected non-judgementalism as the minimum attitudinal requirement that demonstrated respect of diversity. Other women expected acceptance of their minority sexual orientation; and one described advocacy, although most did not expect GPs to go this far. I will now describe each of these three levels of humaneness.

**Non-judgementalism**

Thirteen women (Bear, Mina, Kiama, Bee, Jamie-Lee, Sharon, Dora, Jill, Miranda, Flo, George, Susan and Madison) expected their GPs to be non-judgemental. These women represented a wide range of demographic characteristics of age, location and ethnicity. Miranda described why the non-judgemental approach of her usual GP (Dr Jackie) was so important to her:

Miranda (61, lesbian, rural): I feel comfortable with her and I wouldn’t feel that she was judging me in any way. Well I think that’s important in whoever you deal with. (….) I want to have that, where they know my story, my life story and
physical problems and emotional problems and I can be open with them. The whole point is to be open with people and for people not to be judgemental or homophobic. It’s a battle.

Miranda preferred holistic care and continuity with one GP. Her statement clarifies that holism for her included revealing her lesbian orientation, but that this was only possible with a non-judgemental GP. Other women also felt that a non-judgemental approach enabled continuity with the same GP because it formed the starting point to maintaining the relationship, whether they revealed their sexual orientation or not.

Women ascertained that GPs were non-judgmental either indirectly or directly. Some assumed that a GP was non-judgemental regarding sexual orientation by observing their openness to other minority groups or issues such as refugee patients or alternative therapies. The more direct method to determine their attitude was to take note of the GP’s reaction to disclosure of sexual orientation, for example Bear commented that her GP “didn’t bat an eyelid”. Bear expected her GP to react ‘professionally’ to disclosure, believing that medical training or simply being ‘professional’ involved not judging patients, although she felt that this may not necessarily reflect her GP’s underlying personal attitude:

Interviewer: Do you remember whether you expected any particular reaction from [Current female GP] about coming out?

Bear (25, lesbian, inner urban): Um… I expected that she wouldn’t really have one simply because I was thinking she’s a GP, she’s… you see everything as a GP, so I just remember thinking she’ll probably be pretty cool about it, whether she likes it or not or thinks it’s bad or not as a person, won’t have any effect on how she deals with it professionally.

Twenty of the GPs in the study had a deliberately non-judgemental approach towards the diversity of patients they saw, mirroring the breadth of openness that women expected. Drs Fred, Leon, Lith, Tyl and Soula all believed that being non-judgemental would help patients to feel more comfortable in the consultation. Dr Soula was particularly pleased
that her patients perceived this of her, which in fact was the case for Jenny and Dora, who I had interviewed:

Soula (62, outer urban): I hope they will be comfortable to talk to me about anything. (...) I accept what they say and then just go on from there. (...) And I would hope that they sense that from me so that if they need to talk to me about their sexual preference issues then we will, but if they don’t then we talk about other topics. (...) You’re not here to judge, you’re here to help them get through life in the best way they can.

Soula represented most of the 20 GPs who relied on patients to perceive their non-judgemental approach towards minority sexual orientation indirectly through their general openness. Unlike Bear’s understanding that some GPs might project a professional non-judgementalism while harbouring different personal attitudes, almost all of these GPs were genuinely non-judgemental. Being genuine within the patient-doctor relationship is one of the requirements of the patient-centred clinical method (Stewart, 1995).

Acceptance

While non-judgemental attitudes can be demonstrated to patients in an indirect fashion, acceptance of minority sexual orientation requires a much more direct approach. In Saulnier’s study (Saulnier, 2002) many lesbian women hoped for ‘sensitivity’, which meant feeling that providers regarded being lesbian as normal, and demonstrated comfort and receptiveness. This level of sensitivity demonstrates acceptance.

Jill, Alice, Mitzy and Dora hoped for “acceptance” of their sexual orientation by their GP. Dora had explained during the interview that she was especially sensitive to being judged including by GPs. This had prevented her from attending GPs for a long period of her early adult life and related to multiple issues about herself including her weight, mental health and sexual orientation, and she had found acceptance in her GP, Dr Soula, who did know that Dora had a female partner:
Dora (41, gay, inner urban): What I want is somebody who will accept me, not just from the gay point, because they don’t even need to know that, but for me as I am, the weight… the fact that I do get these depression bouts from time to time. The whole thing, just accept me as I am…and don’t judge me.

Acknowledgment that a same-sex partner may be an important part of a woman’s life is one way that GPs can display acceptance of sexual orientation. Ten women (Angelina, Alice, Dora, Betty, Mitzy, Miranda, Susan, Sharon, Helen and Lesley) expected such acknowledgement; seven had a current female partner, one had a male partner (Alice) and two had no partner (Mitzy and Helen). Women needed such acknowledgement so that the GP could involve their partner (or future partner) in their health care and decision making, and acknowledge the partner as their support person. Alice (43, bisexual, rural) said of her previous same-sex partner: “it was a significant part of my life, and with regard to my concept of a family, that was my family”. So her relationship was important in the context of her primary care, which Alice firmly believed should be holistic and inclusive of her whole family. Miranda (61, lesbian, rural) described her decision-making regarding a possible mastectomy for breast cancer and her need for the GP to understand that her female partner had a special sympathy for this issue. Angelina, Dora, Sharon, Susan and Lesley also expected their GP to have a role in supporting them through relationship problems or at least to understand their partner as a source of stress.

For many women it was important not only that the GP acknowledged their partner as important in their health care but also accepted their same-sex relationship. Some had experienced a lack of acceptance in this regard. For example, Dora (41) had experienced an episode of anaphylaxis and her partner had initially been excluded from the emergency room and had to argue for right of entry. Subsequently, Dora insisted on her partner being listed as next of kin with Dr Soula. Serious illness had also triggered this need for Mitzy, who had initially disclosed her female partner to a GP when she was diagnosed with breast cancer. She was single at the time of our interview but still wanted to be sure that her GP would accept her support system and the importance of women in her life:

Interviewer: Why do you need GPs to know [about your sexual orientation]?
Mitzy (61, lesbian, outer urban): Well firstly [so] they know that I’m not relating to a man. That’s important. (…) It’s probably pretty simplistic but I know that my woman doctor knows so that if I get seriously ill or something like that, if I become terminal and I want my friends to come and see me and be with me, or a relationship at the time, then that inclusion is so important.

Similarly, the lesbian psychiatrist Dr Debra experienced attending her GP with her female partner when she had suddenly coughed up blood. In this situation she was relieved that she had previously disclosed her same-sex relationship and knew that the GP’s attitude was accepting:

Dr Debra (56, inner urban): I rang up [female partner] and we went over and saw [male GP]. I don’t usually take my girl-friend to the doctor, but I was worried. It turned out to be nothing, but I wanted to know that I could go with her (…) and that it wouldn’t be an issue. It was so much better than if I was in that sort of crisis [without her], I was very anxious. Now [the GP] was sensitive and made space for me to talk about how I was feeling and [female partner] was there. I can’t imagine a lot of situations where if I’d suddenly sprung a female partner on a GP (…) I would have had to be vigilant about it, and I didn’t, so of course that’s best.

Advocacy

Affirmation was the most highly valued, albeit least common, provider attitude in Saulnier’s study (Saulnier, 2002). This is the ultimate expression of humaneness where a GP supports, protects or advocates for a woman as lesbian or bisexual. In my experience, this can take the form of being sure to refer to a lesbian-sensitive specialist where possible, supporting women through anti-discrimination proceedings, or advocating for legislative change where current laws prevent access to health services. This is part of cultural competency that looks to resolving issues for the disadvantaged group.
None of the women I interviewed actually expected such affirmation from their GP. Only one woman gave an example of experiencing advocacy from her GP, which she very much appreciated:

Esther (36, lesbian, outer urban): At one point I was going to see a [male] GP in the practice and she [Dr Elisabeth- her usual GP] suggested that I don’t go to that GP around particular health issues [relating to becoming pregnant] because she thought his reaction might be more negative. And I thought that that was very open and challenging for her to say that but protective (…) and validating in saying ‘you don’t need to be hurt in having that experience’. [and a little later] I don’t talk to that GP about IVF and [being in a] lesbian family [because of his] religious beliefs.

While women did not expect advocacy, 12 GPs believed they had a role in advocacy for their marginalised or disempowered patients. Their level of commitment to this area of work varied from contemplating it occasionally to strongly believing in the role. For example, Dr Audrey (30, outer urban) said she would be “fairly happy to advocate for people” as long as they were willing to advocate for themselves. Dr Holly (39, inner urban) raised the distinction between advocacy that was patient-initiated (“passive”) or doctor-initiated (“active”), and preferred to be involved only in passive advocacy. She suggested this would be in the form of “making a clear offer of support”. Conversely, advocacy to Dr April (38, inner urban) was “without a doubt a major role”, although Dr April and others did remark that skills in this area were learned through experience rather than in formal education. Dr Margaret was also highly committed to a more active advocacy role, which she related to her commitment to equality:

Dr Margaret (51, inner urban): Everyone should be treated fairly and I will go out to bat for people and I will advocate for people as I do quite often, some patients who aren’t strong enough to advocate for themselves.

GPs gave several examples of methods of advocacy including writing letters of support, or phoning agencies or referral points, which were often about “negotiating the patient through the health system” as Drs April, Margaret and Jackie said. However, just three
GPs gave examples that specifically related to sexual orientation. These were dealing with school counsellors for a same-sex attracted young person, writing a letter of support to be used in a legal case for a gay man who had been discriminated against at work, and advocating for a gay male patient by helping his parents and grandparent come to terms with his sexual orientation. So advocacy regarding sexual orientation was rarely experienced by either women or GPs in this study and not expected by women, although several GPs expressed willingness and capacity to advocate for their same-sex attracted women patients.

**Communication Demonstrating Caring Empathy**

A common expectation relating to communication was what I have called caring empathy. Twenty-four women expected caring empathy from their GP, and many had experienced this. This expectation involved the need for GPs to be openly caring, particularly through active listening and overt interest, and to be genuinely humane. That is, women hoped that GPs would not only appear to be empathic, but would actually care about them as people. Alice, Dora, Betty and Mina all felt that this was an innate quality of particular GPs:

Betty (41, lesbian, inner urban): I think she just genuinely cares. Yeah

Interviewer: How do you know that, what does she do or say?

Betty: Just the way she comes across, her whole persona (…) because she doesn’t rush you when you’re in there. (…) I think she is just a warm, caring, compassionate, genuine person. And you either are or you’re not.

Dr Lith was very aware of the perceptiveness of his patients in appreciating genuine interest:

Dr Lith (44, inner urban): I suppose the manner you talk to them, I think they can tell. You can’t fool everybody all the time. If you are not genuine, the patient will soon find out. Sometimes it’s a bit hard to pinpoint a particular thing, I think if you are with a patient they will know. But you just have to make it clear to them that you are there to help them.
The end result of caring empathy was to feel that the GP really understood them. A few women discussed this understanding in relation to their sexual orientation. Three women (Eileen, Kate and Sharon) criticised their GP for not really understanding this part of their life and wondered whether a lesbian GP might be better able to do so. However, Bear (25, lesbian, inner urban) felt her heterosexual GP (Dr Margaret) did understand when she had told her about negative social reactions to her same-sex relationship and how ‘upset’ this had made her feel. Dr Imogen also discussed empathy towards the impact of discrimination and showed she was able to provide it as a heterosexual person:

Dr Imogen (46, outer urban): … as a doctor you're trying to be empathic and understand people’s life experiences and health experiences. I think being born heterosexual’s definitely the easier option in this society, and if I've got a gay patient I’m always mindful that life might have been a bit tougher for them, lots more issues that they’ve had to contend with that I haven’t had to contend with. And just trying to be sensitive to that when you are treating them as a doctor.

**Lesbian Specific Competence**

As I described within the opening section on lesbian sensitive care, lesbian specific competence addressed in the literature can range from avoiding assumptions of heterosexuality to having specific knowledge about lesbian women’s health issues. While many women in my study expected avoidance of assumptions, specific lesbian knowledge was not a common expectation. Twenty-three of the 33 women interviewed did not expect their GP to have specific knowledge. For example, Alice, a bisexual woman now living with a male partner, felt that her GP did not need specific knowledge. She realised that this was important for other women, although felt GPs with such knowledge could be found in a specialised clinic if needed. This lack of expectation reflects the relatively low expectations reported in Saulnier’s study (Saulnier, 2002). Also, most of these 23 women did not believe they had any specific issues that were different to heterosexual women, or that GPs needed to incorporate sexual orientation into the consultation.
Nine women (Bear, Eileen, Angelina, Esther, Mina, Lucy, Madison, Mitzy and Sharon) wanted their GP to have lesbian specific competence, and to know their “place in the world” as Sharon said. These women represented all ages in the study from 23 to 61, two were rural, all but one had a usual GP and seven had disclosed to their GP. They reflected the literature in that they either expected GPs to avoid assumptions of heterosexuality or expected specific knowledge. For example, Mina wanted GPs to avoid assumptions of heterosexuality:

Mina (23, bisexual, inner urban): Someone who tries to make it clear that they’re open to things sort of outside the sort of normal I suppose. Even questions like you know “how do you identify your sexuality?”, rather than saying “so you’re a heterosexual”, like not making assumptions I suppose.

Esther also had this expectation but equally, she could understand why GPs made heterosexual assumptions:

Esther (36, lesbian, outer urban): It’s just about their capacity… like probably if they frame things that they didn’t assume heterosexuality, but I don’t think that that’s realistic or that (it) would be commonplace for a very long time. And part of it is why would you be bothered if you might only see one lesbian a year, like you’re not going to ask everyone “what’s your partner’s name?”.

Mitzy, Lucy, Madison, Sharon and Mina expected GPs to have lesbian-specific knowledge about particular health issues, sensitive referral options or local support groups. Mitzy (61, lesbian, outer urban) said “I expect that GPs now should be well educated and as part of being a GP I would assume that sexuality comes into it.” Lucy and Madison believed that the GP should be the expert rather than the patient:

Madison (24, lesbian, outer urban): Um…assuming lesbians may have different health needs to heterosexual women for example. And I’m sort of hoping that my GP would be able to identify those and let me know about it, if I were to not be so up to date with my own health.
Madison specifically hoped that a GP might be able to understand the interplay between her Asian and lesbian identities and the “risks” that this might pose to her health. She felt that a GP should have “concern and respect that the Asian community might not be open to my sexuality… and support for that, as in emotional support…would be the main thing”. Mina also had a specific need for GP knowledge, which was not satisfied. She had asked a GP about how she might prevent sexual transmission of herpes from her female partner to herself. That GP could not answer her question:

Mina (23, bisexual): She [her previous GP] had a lot more information about heterosexual sex and the risks that were involved there rather than lesbian sex… it sort of made me reluctant to talk more about any problems I might be having with my sex life that were medical.

[A little later in the interview]:
But it made me feel like a minority and also one that wasn’t worth bothering with in a way. I thought well possibly 10% of the people that you see or whatever the statistic is meant to be are gay… really you should have some information about it. I think if I had said, “Oh my boyfriend has herpes” she would have had heaps of information to give me.

Sharon, Bear, Angelina and Esther were aware that GPs often did not know much but each expected them to find information to meet lesbian patients’ specific needs. Esther was the only woman to specifically mention educating her GP about lesbian health herself:

Esther (36, lesbian, outer urban): I remember when we started with artificial insemination and then later IVF and we needed to get referrals to specialists etc, we would have to go in and say, “we need a referral to a specialist, and this is the person, and can you write this in the letter” and I think some doctors might be affronted by that, or I’m sure most are probably comfortable and it makes the job a bit easier, but also… to ask questions, and say “where do women go?” or “I’ve heard about this, but is that the case?”, so not sort of gossiping or rumour mongering but learning from the patient too.

Interviewer: And how does that feel if a doctor asks you questions?
Esther: I find that validating.
Esther’s GP, Dr Elisabeth, matched Esther’s comments about being happy to be educated by her lesbian patients, specifically referring to patient requests for referral to conception services:

Elisabeth (39, outer urban): I don’t remember ever being terribly thrown by it. Um….and the women are all quite proactive so they would have educated me. I guess I would have let them know pretty early on that I was perfectly happy with that situation and if they wanted to tell me where the services are and what they had to do, then I was perfectly happy to be involved in the referral process.

**Summary of Preferred GP Attributes**

While minority sexual orientation had little influence on preferred style of GP care, it had more influence on the preferred GP attributes. The priorities for these attributes replicated those found in the general literature, which were expectations of humaneness, caring empathy and competence. Specific to sexual orientation, a priority for most women in the study was for GPs to be at least non-judgemental, and preferably accepting. Some women ascertained these values indirectly and others preferred that GPs directly demonstrated acceptance in order to feel comfortable and engage their partner or future partner in their care. These GP values assisted women to feel comfortable enough to be open with their GP about their sexual orientation, and in turn to continue to see the same GP.

Another priority was for GPs to demonstrate caring empathy, and for some women this included a genuine interest and an understanding of their ‘whole story’ including sexual orientation. While some women believed that heterosexual GPs had a limited capacity in this regard, some GPs demonstrated this level of empathy. Just a few women expected GPs to be knowledgeable about specific lesbian health issues, although some hoped that GPs would seek out information if needed. No woman had an expectation that GPs would have specifically bisexual competence. I will discuss GPs’ actual knowledge and attitudes to lesbian and bisexual women’s health in the next chapter (4).
Overall, I did not find differences in the expectations of lesbian and bisexual women. Also, GP gender was not a significant preference in that the values, communication and knowledge of GPs were important regardless of GP gender. My findings were very similar to the literature in terms of expected GP attitudes and communication, but differed in the low level of expectation for specific GP knowledge.

**Expectations of Trust**

I will now focus briefly on trust, which is one of the seven domains of primary care (Safran et al., 1998). Lack of trust in health care providers has been presented in the literature as one of the major barriers to lesbian women attending for routine health care, largely because of repeated experiences of heterosexism and homophobia (Bakker, Sandfort, Vanwesenbeeck, Van Lindert, & Westert, 2006; Peel, 2002; Stevens, 1998). Conversely, the first national lesbian health study in the UK found that positive experiences of care increased trust and health care attendance, leading the authors to argue that training in culturally competent care should include a lesbian focus (Fish & Anthony, 2005). So, by implication the lesbian sensitive GP would engender trust.

Trust is a multi-dimensional concept encompassing a range of pre-conditions (Lynn-McHale & Deatrick, 2000). A systematic review of interventions to improve trust resulted in a list of the dimensions perceived by patients and doctors that lead to trust (McKinstry, Ashcroft, Car, Freeman, & Sheikh, 2006). For doctors, these dimensions are competence, taking responsibility, effective communication, privacy including confidentiality, moral integrity including honesty, and putting the patients’ interests first. Patients’ definitions of trust centre on interpersonal competence including doctors being thorough, understanding the patient’s individual experience, compassion, empathy, advocacy, reliability, building a partnership, being honest and respectful (Berry et al., 2008; McKinstry et al., 2006). Many of these features are part of the patient-centred approach and this approach has been associated with greater trust (Fiscella et al., 2004). Trust and continuity are inter-
connected, in that trust increases commitment to one provider, and continuity leads to improved trust (Berry et al., 2008; Thom, Ribisl, Stewart, & Luke, 1999).

Therefore, in applying this trust literature, the three attributes expected by the same-sex attracted women in the study, of humane interpersonal values, caring empathic communication, and lesbian-specific competence would be pre-conditions for building trust amongst lesbian and bisexual women. My findings show that while trust was expected by a majority of women, it was more dependent on whether general GP attributes were being met than on satisfying lesbian-specific preferences.

**Pre-conditions of Trust**

Trust in the GP was expected by 21 women in the study. Most women discussed the conditions that would lead to trust, and most commonly this was competence. For example, Jamie-Lee (47, gay, inner urban) trusted her usual GP’s judgement because he was “obviously well versed in his field and knows his stuff, I think that goes without saying”. Jane also trusted her GP because he cared and was empathic. Her response here was about competence but also the clinical interaction and interpersonal care:

Jane (21, lesbian, regional): He [her usual GP] recommends stuff to me and like he’ll explain it all to me, and because I have that friendship basis and I pretty much trust him on his decisions, and I feel comfortable with him I pretty much go, I just leave it up to him. Like what he thinks would be in my best interests to do.

Five women raised a more novel pre-condition to building trust, which was for the GP to reveal some personal information:

Jamie-Lee (47, gay, inner urban): A good listener, but also someone who was willing to share a bit about themselves with me, so that I get to know them a bit as well, so it’s not just this is the person (…) and you’re not giving me anything back. I think something that’s really important for me is knowing that you’re an individual and a person and that you’re human and all the rest of it. That there’s
something behind the desk. Um… I think I like someone who I have trust and confidence in.

I will expand on women’s desire for this reciprocal knowledge in Chapter 4.

Just a few women specifically stated that trust arose from the preferred attributes of humaneness or knowledge related to their sexual orientation, or was damaged by their absence. Bear (25) trusted her GP due to her non-judgemental attitude. Bee’s (25, bisexual, inner urban) GP had inquired about the gender of her partner therefore she trusted her to make the correct diagnosis in a situation of a sexually transmitted infection. Eileen, Angelina, Bear, Bee and Mina felt that if they were to perceive a negative reaction to their sexual orientation this would prevent trust. Confidentiality was another precondition of trust for some women. Alice, Dora and Susan all trusted their GPs as they did not tell private information to others including their partner, friends who see the same GP, or their employer. Confidentiality regarding sexual orientation is commonly mentioned as an important aspect of cultural sensitivity in the literature (Hunt & Fish, 2008; Meckler, Elliott, Kanouse, Beals, & Schuster, 2006).

**Outcomes of Trust – Openness and Continuity**

There were two outcomes of trust mentioned by women in this study, which were openness (women felt they could tell their GP “everything”) and continuity with the same GP. These outcomes were also discussed in relation to seeing GPs who were humane and non-judgemental. A lack of trust would also prevent openness and continuity:

Bee (25, bisexual, inner urban): I’ve been in Australia for seven years and I’ve never seen the same GP more than once.

Interviewer: Why is that?

Bee: Um…because I don’t particularly trust one enough to say I will go back to this one. I don’t mind trying someone else who may be better.
Esther (36, lesbian, outer urban) talked of feeling able to be more vulnerable with her GP once she trusted her, which allowed her to talk about her mental health issues. I will discuss women’s risk taking in the context of disclosure of sexual orientation in Chapter 5. Suffice to say that willingness to display vulnerability is mentioned in the literature as an outcome of trust (Thom et al., 1999). Two women specifically described their willingness to be open about their sexual orientation because they trusted their GP. Jill (50, lesbian, outer urban) felt it was about needing to provide the “whole story” so that the GP could make the correct diagnosis, and for Mina it was about holistic care:

Mina (23, bisexual, inner urban): I think it would be great if the trust was so much that you could feel like you could come in with a medical complaint, but at the same time say, “Well I have just broken up with my partner” or something and feel like they were both relevant and possibly connected.

**GP Perspectives on Generating Trust**

I asked GPs how they built trust for their patients. Several said this was through caring and showing a genuine interest in their patients.

Dr Leon (34, regional): I guess you just try and if you can get the patient to relax and encourage them to just say whatever they’ve got to say. Try to you know, never sort of express surprise with whatever they tell you, so they feel, hopefully they can tell you whatever. Yeah, any just, just try and be genuine and try and let them know you’re listening and pay attention to them.

Dr Leon effectively summarised the methods used by most of the doctors. He also reflected women’s preference for non-judgementalism, genuineness and caring. Six doctors said being interested in the patient assisted in trust building. Dr Fred (65, regional) said he generated trust by being “as honest as possible”, and Dr Joseph (57, outer urban) felt it was about being compassionate. Only two mentioned competence and one discussed ensuring confidentiality in this context. So, GPs gave a much more limited range of pre-conditions for trust than those described by women.
GPs did hope that trust would lead to patients being able to tell them “really personal things” as Dr Audrey (30, outer urban) said. Dr April (38, inner urban) listed a range of “difficult issues” that she hoped her patients could reveal to her including sexuality, alcohol, drugs, and mental health issues. Three other GPs felt trust would be required to disclose sexual orientation. Dr Joseph in particular was touched by one example of trust displayed by an older gay male patient, who was able to tell him about the difficulties he had faced as a gay man during his life:

Dr Joseph (57, outer urban): I think he trusted me and he wanted to pour out his life to me. Well, he trusted me all the way along but I think at the end he wanted to pour out his life, while he’d never felt the need to do that before, he did this more or less on his death bed really. And I suppose in a way, while it was very sad, I think it was good that we were able to talk about it, or he was able to talk about it to me. Now I hope that I fulfilled what he needed out of that. I think I did but you know…

In summary, trust was an important component of the patient-doctor relationship for a majority of women in the study. However, the pre-conditions for trust were not necessarily related to their sexual orientation, for example several women expected competence but none suggested that lesbian-specific competence was a pre-condition of trust for them. Confidentiality was another general pre-condition of trust, but most of the examples given by women did not relate to their sexual orientation. Conversely, non-judgementalism was important for trust building, and particularly a positive response to disclosure of sexual orientation, something that some GPs also recognised. Trust, in turn, was a pre-condition for openness about their sexual orientation for a few women, and more generally for maintaining continuity with the same GP.
Relational Knowing

In analysing and comparing the women’s preferences and expectations, I have found that one theme unifies them all, which is relational knowing. I define relational knowing as a reciprocal process where women expected their usual GP to know them as a person, and that they were prepared to reveal more about themselves if they knew enough about their GP. In terms of GPs knowing about their sexual orientation, relational knowing created the pre-conditions for trust and continuity that enabled this knowing where desired. There were three GP attributes that women used to ascertain whether the GP could sensitively incorporate knowledge of their minority sexual orientation if needed: a) a non-judgemental or accepting approach that could result in humane knowing, b) caring empathic communication resulting in empathic knowing, which could enable a deeper understanding of what it meant to be in a sexual minority in our society and c) competence regarding specific lesbian or bisexual issues leading to cultural knowing. Relational knowing was both a means and an end, both part of the process of relationship and trust building and an outcome of an optimal patient-doctor relationship. This was a reciprocal process, in that both women and GPs were building awareness of each other in developing that relationship. I will expand on experiences of reciprocity from women’s and GPs’ perspectives in Chapter 4 and it will become clear that this was an important element within some of the more optimal patient-doctor relationships.

John Scott and colleagues (Scott et al., 2008) explored the basis of healing relationships in primary care and identified “being known” as an important outcome for patients arising from the development of a healing patient-doctor relationship. The authors had identified few studies that described healing relationships within medicine, although there had been many such studies in other disciplines including anthropology, psychotherapy and nursing. They interviewed five ‘exemplar’ family physicians in USA and 23 of their patients, selected because they had a healing relationship with their doctor. There were several similarities with my findings. Patients and doctors described three common precursors to a healing relationship: a non-judgemental bond, a commitment to caring (by the doctor), and
managing power. The relational outcomes were hope, trust and a sense by the patient of being known.

Knowing is not only important to patients, but has also been found to be ‘crucial’ to GPs (Fairhurst & May, 2001). Karen Fairhurst and Carl May (2001) interviewed 15 GPs about their satisfaction with particular consultations and found that GPs particularly valued knowing the patient as a person, rather than just knowing about the patient, which included being able to understand the context of the patient’s life and therefore tailor their advice to the individual. These doctors felt this level of knowing assisted continuity of the relationship. I also found that the GPs in my study had similar expectations to those of the women in terms of valuing their own capacity to be humane, empathic and understanding.

**Summary**

The first question of the chapter related to what influence sexual orientation had on women’s preferences and expectations for general practice care. The most specific expectation relating to sexual orientation was for GPs to have humane interpersonal values expressed by a non-judgemental or even accepting approach. Caring and empathic communication was a general expectation, and as part of this some women hoped that GPs would also understand the sexual minority context of their lives. While the cultural competence literature presents an assumption that people need and want their culture to be ‘acknowledged and affirmed’ by GPs, only some women preferred their sexual orientation to be included within the context of care. For these women the expectations of sexual orientation competence ranged from, at the least, expecting GPs not to assume heterosexuality to, at best, GPs having knowledge of specific lesbian issues, although there was a generally low expectation of such knowledge. Women had a range of preferences for focused or holistic care, which were generally not influenced by their sexual orientation. Continuity preferences were occasionally related to minority sexual orientation due to reducing the practical need to see a GP, or through a fear of being judged.
The second question was whether the two models of cultural competence and patient-centredness can accommodate the preferences of same-sex attracted women. The five dimensions of patient-centredness described by Mead and Bower (2000) were not all represented in women’s expectations relating to their sexual orientation. In particular, women did not directly discuss sharing responsibility and power. However, the dimensions of a biopsychosocial perspective and patient-as-person were frequently associated with women’s preferences for holistic care, continuity, caring empathy and lesbian-specific competence. So, these aspects of patient-centredness are very relevant to the women in my study, in that a GP using patient-centredness would create the environment for trust, continuity and openness that women expect. Cultural competence requires GPs to understand the influence of culture on health and so should assist in fulfilling women’s expectations of cultural, empathic and humane knowing in relation to their sexual orientation.

The main point of departure from the two models was the need to accommodate the range of preferences demonstrated in my study. For example, while patient-centredness assumes patients will want holistic care, this was not the case for all women in my study. Also cultural competence assumes that the GP is fully aware of a person’s culture, however GP awareness about their sexual orientation was not universally desired. Cayla Teal and Richard Street’s (2009) model of patient-doctor communication integrates cultural competency and patient-centredness, and a central focus is to respect diversity within patients’ cultures. For example, they suggest that doctors should “personalise their communication according to the patient’s individual manifestation of cultural identity” (p.534). This modification of the two models brings them much closer to being able to accommodate the diverse preferences of women in my study.

A question arising here is what influences women to want their sexual orientation included or not within the consultation? My analysis did not reveal any significant pattern relating to women’s age, work background, ethnicity or whether they identified as lesbian or bisexual. In Chapters 4 and 5, I will present the two issues that did influence women’s
preferences for inclusion of sexual orientation. The first was whether the patient-doctor relationship was accommodating and the second was the importance of their sexual identity in their lives. In the next chapter I will describe the patient-doctor relationship and how well or otherwise it can accommodate women’s sexual orientation, comparing GPs’ and women’s perspectives. Then in Chapter 5, I will describe the wide range of women’s experiences of their sexual identity, which had a significant influence on their disclosure preferences to GPs.
CHAPTER 4 - LIFEWORLDS ABSENT OR PRESENT IN THE PATIENT-DOCTOR RELATIONSHIP

In the previous chapter, I identified relational knowing as an important element of optimal patient-doctor relationships. Apart from women who preferred purely focused care, women’s expectation was for their usual GPs to know, or have the capacity to know, them as a person, potentially but not necessarily including their sexual orientation. This could then lead to trust and greater openness. These expectations largely arose from women’s positive experiences with GPs. In this chapter, I explore women’s negative GP experiences, which all but three women described, to uncover the breadth of problems that they faced in achieving their expectations. Many of these experiences mirrored those that I had heard repeatedly from women in my own general practice. In addition, I focus on GPs’ perspectives of their capacity and willingness to include minority sexual orientation in the consultation. I finish with describing four woman-GP pairs that exemplified different methods of achieving women’s expectations through relational knowing. I expand on the concept of reciprocal knowing and the extent to which GPs reveal personal information to their patients.

I will answer three questions within the chapter:

1. What are the problems in accommodating the expectations of same-sex attracted women, in particular their expectations of cultural, empathic and humane knowing?
   This completes the over-riding first question of the thesis regarding how same-sex attracted women and their GP experience their clinical relationship.

2. What influences GPs’ ability to accommodate the lifeworld of same-sex attracted women?

3. What are the elements of the patient-doctor relationship that enable knowing and accommodation of the lesbian and bisexual lifeworld?

I have chosen the Theory of Communicative Action of Jurgen Habermas (1984) as the analytical framework for the chapter. It is a critical hermeneutic theory that explains why
we communicate in the way we do, particularly within the context of professional-lay communication and levels of knowledge that can be achieved. Habermas distinguished the system and the lifeworld as two levels of social interaction (Habermas, 2003 (1972)). These concepts have been applied to the patient-GP relationship by Christine Barry and colleagues (Barry et al., 2001) to understand the degree to which the patient’s lifeworld is voiced in the consultation and the tensions between the lifeworld and the medical system. I have used their study as a model for my research into whether minority sexual orientation is included in consultations between same-sex attracted women and their GPs. I have also used liberal feminism in analysing power within the consultation. I have chosen two female medical authors, Kirsti Malterud (1993) and Lucy Candib (1995), and their feminist reworking of the patient-doctor relationship in order to apply a gendered lens to my findings.

Habermas and the Lifeworld within Health Care

Jurgen Habermas is a critical theorist whose theories about human knowledge and communication propose that the art of understanding and being understood is universal and occurs in everyday conversation (Crossley, 2005). Habermas claims that there are three fundamental areas of human interest that lead to knowledge, which are control, understanding and emancipation. We all seek to control our environment and make it predictable, to understand our social context and that of other humans, and to emancipate ourselves from dominant groups to achieve freedom and power. Habermas’s concept of emancipation relates to the Marxist concept of liberation from oppression and he applies that to autonomy in our use of language within communication (Outhwaite, 2009). I contend that these three areas of human interest can be readily applied to the general practice context in that both patients and doctors expect some predictability in the environment of general practice, seek understanding of each other in the patient-doctor relationship, and both aim for some autonomy in the process of care. In this chapter, I will focus on the level of control and understanding that is achieved, and will address emancipation in Chapter 7.
In his Theory of Communicative Action, Habermas (2003 (1972)) describes two levels of social interaction, the ‘system’ and the ‘lifeworld’. The lifeworld is based on intuitive knowledge, assumptions and cultural practices, whereas the system involves technical knowledge (Cooke, 1994). A further aspect of the Theory of Communicative Action is that there are two forms of action utilised in linguistic communication, communicative action that aims at consensus or understanding and strategic action that aims at influence or control. Communicative action assumes that the people communicating are mutually obliged to understand each other’s perspective and accept their position, unless rationally persuaded not to. This agreement then reinforces the social values and individual identity of each person. Conversely, strategic action presupposes there is just one objective perspective or truth, and one or both people in the conversation may use this to achieve an ulterior motive such as power over the other (Cooke, 1994). Habermas claims that the ideal communication is where there is a genuine and cooperative consensus (Outhwaite, 2009).

Elliott Mishler was the first researcher to apply Habermas’s theory to patient-doctor communication, and he defines the system and lifeworld in this context:

The voice of the lifeworld refers to the patient’s contextually-grounded experiences of events and problems in her life. These reports and descriptions of the world of everyday life are expressed from the perspective of a ‘natural attitude’….In contrast, the voice of medicine reflects the technical interest and expresses a ‘scientific attitude’. (Mishler, 1984, p.104)

The lifeworld is shared through mutual understanding between women and GPs. In the context of my study, the lifeworld to be shared is that of identifying as lesbian or bisexual or being same-sex attracted, and to some extent that of being a humane, caring and knowledgeable GP. The system interaction requires technical knowledge to achieve rational action, which in this context is knowledge of medical systems. Habermas describes the common struggle between the ‘system’ in which technical language is used, which can distort communication; and the ‘lifeworld’ in which human or practical language is used, which can balance communication. This is colonisation of the lifeworld
by the system, where the system functions predominate and lifeworld knowledge such as norms, values and cultural beliefs are suppressed. Alternatively, the power of communication and language can resolve differences and overcome the colonisation through communicative action and eventually lead to mutual understanding and agreement. Habermas’s ideal for genuine consensus is also at the philosophical centre of patient-centredness with its emphasis on connecting the biopsychosocial aspects of the patient and reaching a shared understanding (Stewart, 1995).

I contend that Habermas’s theory applies well to communication between same-sex attracted women and their GPs and can help to explain common experiences of miscommunication. The sexual minority lifeworld incorporates the social aspects of being lesbian or bisexual, which can include experiences of marginalisation and discrimination that impact on health. It also engages with specific cultural knowledge, language, beliefs and values. In theory, the patient-centred clinical method would encourage doctors to incorporate this part of the lifeworld by taking an interest in the social context of the patient. Doctors also have a lifeworld which includes their professional identity as well as knowledge, values and beliefs brought from their own personal life. While Christine Barry and colleagues (2001) refer to the lifeworld only in terms of the patient, I have also included the doctor’s lifeworld in my analysis because it was raised as important by some of the women participants in my study. Misunderstandings can arise if either the woman or doctor or both do not fully understand the other’s lifeworld.

The system represents the technical or biological aspects of medicine and can also create misunderstanding between women and GPs. The system tends to focus on disease and pathology rather than on health or patient perspectives of illness, which is a form of colonisation of the lifeworld (Scambler, 2002). This system is traditionally very patriarchal, and tends to maintain power over patients through upholding the technical knowledge (Malterud, 1993). Mishler (1984) shows that where the consultation is conducted in the voice of medicine, the lifeworld of the patient is suppressed and this serves to maintain medical control and a power imbalance. Similarly, I will show in my findings that some GPs can be adept at excluding the minority sexual orientation aspects
of women within medical consultations through focusing on the biomedical. However Habermas’s theory would overcome some of these misunderstandings, as he believed that in human communication there is mutual motivation for understanding the lifeworld. While this has been problematised as idealistic and ungrounded in reality (Crotty, 1998), Barry et al.’s (2001) study does confirm that this is possible between patients and GPs.

Christine Barry and colleagues (Barry et al., 2001) applied Habermas’s theory in their qualitative study of patient-doctor interactions involving 20 UK GPs and 62 of their patients. They found that the voice of the lifeworld was often absent from the medical consultation and in particular the social context of patients was one of the most commonly unvoiced agendas (Barry et al., 2000). Most of the consultations analysed contained significant misunderstandings based on assumptions and guesses by the doctor or patient, which resulted from patients not voicing their expectations and preferences (Britten, Stevenson, Barry, Barber, & Bradley, 2000). So, doctors were not entirely responsible for silencing aspects of the lifeworld, because through not voicing their agendas some patients maintained the dialogue in the voice of medicine. The authors acknowledge that power imbalances may prevent patients from including their social issues and conclude that the “onus would seem to be on doctors to elicit patients’ ideas and expectations thereby showing that this information is a valuable and necessary contribution to the consultation” (Britten et al 2000, p.488).

Barry and colleagues describe four patterns of communication, which they label ‘strictly medicine’, ‘lifeworld blocked’, ‘lifeworld ignored’ and ‘mutual lifeworld’ (Barry et al., 2001). In the first three patterns the patients’ lifeworld was not included in the consultation with GPs. In the first, doctors and patients focussed exclusively on the presenting medical issue and this was often satisfactory for both; in the second two patterns, patients introduced their lifeworld but it was either suppressed or ignored by doctors. The authors suggest that the patients’ identity was threatened when their lifeworld was ignored because they felt dehumanised, disempowered and devalued. In the fourth type of consultation, the lifeworld was openly discussed by both doctor and patient. These consultations were more like natural conversations, with doctors using active listening,
humour, and empathic statements, and allowing and validating emotions. The authors suggest that the lack of a learned format for these consultations assisted in their success: “Not having a pre-set medical formula by which to work, the doctor is now required to fall back on his or her natural communication and life skills” (Barry et al., 2001, p.501). When the voice of the lifeworld was present, patient satisfaction and self-reported adherence improved (Barry, 2002).

That study does not adequately explain why GPs ignore or suppress particularly the social aspects of the lifeworld. However, other medical researchers have started to address this question. John Furler and colleagues studied the incorporation of patients’ socioeconomic status (SES) into GP consultations (Furler, Stewart, Sims, & Naccarella, 2005). They found that GPs were reluctant to ask patients directly about their SES because they were regarded as sensitive aspects of social life. This reluctance resulted from fears of being judgemental, needing SES to be of direct clinical relevance, and preferring to deal with individuals rather than stereotypes. Instead GPs used indirect methods to assess SES including patients’ clothing and behaviour. Carl May and colleagues also have found that GPs are “deeply concerned and frequently troubled” (May et al., 2004), p.151) by patients’ subjectivity, particularly the fact that their social issues and overall values and beliefs are difficult to accommodate in general practice. This is especially troubling to GPs as they become increasingly aware that social issues frequently impact on ill-health and therefore should be addressed.

**Feminist Accounts of the Lifeworld within Health Care**

A liberal feminist approach can explain the power differentials that form a barrier to incorporating the lifeworld. I suggest that the subtext of the work on communication I have cited by Habermas and Barry’s team relates to power imbalances in that doctors are invariably more powerful than patients and can thus direct the content of the consultation away from areas with which they are not so familiar or comfortable. Feminist medical researchers have provided especially pertinent insights in this area. Kirsti Malterud
(Malterud, 1993) studied her own interactions as a GP with her female patients. She suggests that power is related to knowledge and that doctors wield power using both their expert knowledge and their gender. Even female doctors use power in a masculine way due to being medically socialised into ignoring women’s voices. She claims that medicalisation and ignoring are two ‘symptoms’ of medical oppression of women patients, which arise due to inadequate medical knowledge of common health problems of women. Malterud’s (1993) conclusion is that doctors must redefine their knowledge to incorporate women’s health and she describes a method of communication that embraces the patient’s self-concepts and knowledge. Lucy Candib (1995) suggests the patient-centred clinical method does not go far enough in emphasising the need to incorporate women’s perspectives: “understanding the social context includes a commitment to learning about all kinds of factors outside the patient’s medical and even psychological reality” (Candib, 1995, p.233). So, both of these researchers advocate that doctors should develop more knowledge of patients’ social needs in order to actively include their patients’ lifeworld.

**Literature on the Problems in Accommodating the Lifeworld of Same-sex Attracted Women**

There is increasing evidence that same-sex attracted women have lower levels of satisfaction with their health care than heterosexual women, and that this relates to a perceived lack of cultural sensitivity. I will now summarise this evidence from women’s and doctors’ perspectives.

**Health Care Usage and Satisfaction**

The lesbian health literature has repeatedly reported that lesbian women access health care services less frequently than heterosexual women, and that this relates to mistrust, fear of homophobic reactions or previous negative experiences (Banks & Gartrell, 1996; Clark,
Landers, & Sperber, 2001; Mravcak, 2006). A national USA probability study of 93,418 people (614 or 0.65% in same-sex relationships) showed that women in same-sex relationships were less likely than heterosexual women to have seen a doctor in the previous 12 months or to have a regular source of care (Heck et al., 2006). Another USA study indicated that bisexual women had even lower health care access than lesbian women (Rogers, Emanuel, & Bradford, 2003). By contrast, a large Dutch survey study within 104 general practices completed by 9,684 patients, 1.5% of whom were lesbian and 1.2% bisexual women, showed that the ‘homosexuals’ had a higher usage of physical and mental health care services, which was partly explained by lower health status (Bakker et al., 2006). This is similar to our finding in the Australian Longitudinal Study of Women’s Health (ALSWH) that lesbian and bisexual women attended services more frequently, however we found continuity with the same GP to be lower amongst Australian lesbian and bisexual women than heterosexual women (McNair, unpublished).

Satisfaction with health care services is consistently found to be lower for lesbian and bisexual women than heterosexual women (Diamant et al., 2000; Tjepkema, 2008). Dissatisfaction with health services is at least partly due to inadequate cultural sensitivity regarding minority sexual orientation, such as poor communication around a range of misassumptions by providers including heterosexual assumptions (Bonvicini & Perlin, 2003). Similarly, satisfaction with health care is found to be higher when providers and services are more culturally competent (Hutchinson et al., 2006; Mayer et al., 2008; Polek et al., 2008). Low satisfaction with the provider has been linked with reduced likelihood of disclosure of sexual orientation (Meckler et al., 2006).

**Barriers to Cultural Sensitivity**

The literature that explores the experiences of lesbian and bisexual women in health care consistently shows that doctors fail to sensitively accommodate their sexual orientation within consultations. Many studies also focus on evidence that doctors display
homophobic attitudes, although these tend to be earlier studies. There is a limited amount of literature on the doctors’ perspective.

**Women’s Negative Experiences**

One of the expectations of women in my study that I described in Chapter 3 was that GPs should avoid making heterosexual assumptions. However, the literature shows that these assumptions are very commonly experienced, including lack of acknowledgement of women’s female partners by health care providers (Bonvicini & Perlin, 2003; Lehmann, Lehmann, & Kelly, 1998; S. J. Roberts & Sorensen, 1995; Stevens, 1995). For example, large studies of lesbian and bisexual women from New Zealand and UK showed that the majority of health care providers always or usually assumed the women were heterosexual (Hunt & Fish, 2008; Neville & Henrickson). Unfortunately, none of these reports differentiate between the experiences of lesbian and bisexual women, and more generally, the perspectives of bisexual women are rarely reported.

The impact of these assumptions within health care is to marginalise patients who are not heterosexual, to prevent the inclusion of that part of their lives within the consultation and therefore make them feel they are not fully accepted as a person. For example, in the UK study 10% of women had come out to a provider who had subsequently not acknowledged their disclosure by continuing to assume they were heterosexual, and only 10% had felt their partner was welcome during a consultation (Hunt & Fish, 2008). Similarly, a Swedish interview study of experiences of lesbian women and gay men of nursing care in hospitals as both patients and partners showed that participants felt more excluded by heterosexism in their role as partners than their partners did as patients (Rondahl et al., 2006).

Earlier lesbian health literature focused on lesbian women’s experiences of homophobic and discriminatory attitudes amongst doctors (Bradford, Ryan, & Rothblum, 1994; Moran, 1996; White & Dull, 1997). A review of these reports describes a range of negative reactions including embarrassment, inappropriate responses, rejection of patients,
hostility, excessive curiosity, pity or condescension (A. E. Harrison, 1996). A more recent Australian study of a convenience sample of 116 middle-aged lesbian women also shows that 52.6% of women surveyed had experienced homophobia within the health care system (Kelly, 2005). By contrast, most of the recent literature indicates that negative provider attitudes may not be as prevalent as feared, and this finding is likely to be more representative as the new studies are drawing on more diverse samples of women. The NZ and UK studies already cited report that only around 5% of participants had experienced homophobic responses (Hunt & Fish, 2008; Neville & Henrickson, 2006). Nonetheless, as I reported in Chapter 3, fears of negative responses are thought to reduce health-seeking behaviour.

**Health Care Provider Perspectives and Heteronormativity**

There is very little literature on health care provider perspectives on seeing lesbian and bisexual women. The few existing studies reveal a complex set of barriers to the development of lesbian cultural competence, which are based on heteronormativity. Heteronormativity, which is a tendency to assume heterosexuality, is more pervasive than homophobia (Wilton, 2000). It tends to be largely unconscious for the majority of providers (Tolley & Ranzijn, 2006), and results in the sexual orientation of many lesbian and bisexual women being unrecognised in the consultation. I have elected to use this term rather than the more commonly used term of heterosexism as heterosexism implies a more conscious or deliberate motivation. Tamsin Wilton defines heterosexism as “to regard heterosexuality as being better, more normal, more natural or more morally right than homosexuality” (Wilton, 2000, p.7). This formulation of heterosexuality as the privileged or superior orientation is similar to the privileging of men over women by sexism, whereas heteronormativity suggests a culturally embedded and largely tacit set of behaviours.

The studies on health care professionals’ perspectives confirm that they have little knowledge or awareness of the specific health issues of lesbian or bisexual women.
Amongst 76 Swedish GPs (response rate of 52%) only 11% knew of any health issues specific to lesbian women (Westerstahl et al., 2002). Follow up focus groups with 10 of these GPs showed that most assumed families were heterosexual and nuclear, and did not consider the possibility of women having a same-sex partner (Westerstahl & Bjorkelund, 2003). A study of 112 paediatricians in Canada showed that 78% wanted more knowledge about lesbian, gay and bisexual adolescents as they felt unprepared (Lena, Wiebe, Ingram, & Jabbour, 2002). Similarly, 22 interviewed UK GPs felt they did not understand gay and lesbian lifestyles or terminology enough to discuss sexual health with these patients (Hinchliff et al., 2005). These are generally heteronormative approaches rather than homophobic or heterosexist attitudes.

A particular form of heteronormativity is to treat all patients as equal or the same, and to justify ignoring lesbian and bisexual women’s orientation by saying it is irrelevant within health care settings. This attitude was reported by a group of 15 gay and lesbian people who trained a range of health care providers in lesbian and gay awareness (Peel, 2002). They described providers’ motivation to treat everyone the same regardless of sexual orientation, which had the effect of ignoring important differences and silencing lesbian and gay patients. These trainers rarely identified explicit homophobia, although did note frequent stereotypical viewpoints amongst health care providers.

In summary, the literature reveals that levels of satisfaction of same-sex attracted women with their health care are uniformly lower than heterosexual women, and this negatively effects health care access and continuity. The experiences of bisexual women are rarely specifically reported, although satisfaction and access may be even lower than that of lesbian women. Dissatisfaction relates in part to a lack of sensitivity of providers including assumptions of heterosexuality and occasionally overt homophobia. A limited range of studies show that doctors are generally heteronormative, although some acknowledge they have minimal specific knowledge in the area of lesbian and bisexual women’s health. Homophobia is important and still exists, but the heteronormative approach to patients, and doctors’ inadequate knowledge contributes most to overlooking the lifeworlds of lesbian and bisexual women within consultations. These findings are
similar to Kirsti Malterud’s (1993) findings that doctors either ignore or medicalise all women’s issues. The existing literature fails to provide explanations as to why the lifeworld is so comprehensively silenced by doctors.

**Silencing of the Lifeworld**

I will now present my findings of women’s and GPs’ perspectives of problems in accommodating the lifeworld and demonstrate that these largely replicate the literature, with a predominance of heteronormative rather than homophobic responses. I will then extend the literature by considering why the lifeworld is silenced.

**Heteronormative Approaches**

Just as the literature depicts, many women in my study described experiences of feeling silenced about the sexual orientation aspects of their lifeworld within general practice. The silencing was largely initiated by GPs, either as an unintended consequence of assumptions of heterosexuality, or as a deliberate act because they did not believe sexual orientation was relevant to the consultation. Limited knowledge about specific lesbian and bisexual women’s health issues also created silencing.

**Heterosexual Assumptions Leading to Unintentional Silencing**

Unintended silencing occurred through GPs assuming that their same-sex attracted women patients were heterosexual. As anticipated from the literature, this was a common experience amongst women and GPs in my sample. Thirteen women had experienced assumptions of heterosexuality by GPs and 15 GPs told me that they regularly or always made heterosexual assumptions. The other GPs also may have made these assumptions but we did not discuss this during our interviews. Many GPs described their questioning style or the language they used, which indicated that these assumptions were inherent in
their day to day practice. For example, Dr Judy (48, outer urban) felt “a bit guilty because I actually say are you married”. Dr Elisabeth (39, outer urban) said of her male colleague that “his standard opening remark [to women] in a sexual history is ‘so do you have a boyfriend?’ [laughing] I was forever trying to say to him ‘look you can’t say that’”. Dr Katie (47, regional) said “I assume everyone’s heterosexual unless they tell me” and stated that she then feels “terrible guilty” if she “makes a gaff”.

A common example of a heterosexual assumption in my study was to assume the need for contraception. While in theory this may provide an opportunity for women to disclose their sexual orientation or female partner, in fact many did not do so. Sharon (40, lesbian, inner urban) remembered a GP telling her to take the contraceptive pill and she felt “really pissed off that she’d just assume that I needed contraception” but added that she was “too young and naïve to know how to handle it better”. Esther often preferred not to disclose if she was attending a casual GP for a ‘quick’ problem, and so would remain silent when faced by these assumptions:

   Esther (36, lesbian, outer urban): There [are] probably heaps of experiences where I’d go to the GP and they would make some reference to me as though I was a heterosexual woman (…). I might go in with some abdominal pain or some menstrual difficulties and they will always kind of ask questions about pregnancy and I’m absolutely clear that I’m not pregnant, and you know I can’t be pregnant.

Four GPs mentioned “falling into the contraception trap” as Dr Olive said, although they were more aware of the negative impact on women than most GPs in the study. This had even occasionally happened to Dr Holly (39, lesbian, inner urban), who confessed that she “gets slack” and asks “what do you do for contraception?” rather than “do you have a need for contraception?” Dr Holly was very aware of the subtle but powerful impact of the heterosexual assumption underlying the first but not the second question. Dr Phoenix was also aware of the silencing impact of various other closed questions that he regularly asked:

   Dr Phoenix (57, outer urban): In terms of understanding where people come from it’s too easy for me to say “have you got any kids? No. Have you had any
problems or gynae surgery? No. Ever had pap smears? Yes or No” and you might miss the bleeding obvious which is a key part of their life, which is “that I have a stormy relationship with my same-sex partner”, or “I have a good relationship with my same-sex partner”.

The 13 women had a range of reactions to heterosexual assumptions. Gabrielle, Lesley, Bear and Madison (who all identified as lesbian) preferred this assumption and either deliberately presented as ‘straight-acting’ or did not correct the assumption. Jamie-Lee, Kate, Mitzy and Miranda (also all lesbian) expected that GPs should realise they were not heterosexual due to their less feminine appearance, although did not report any adverse consequences and in general did not correct their GPs assumptions. Miranda (61, rural) said “my sexuality has never been questioned. There’s been an assumption made that I’m heterosexual. I have this constant battle (…) and you just let it go on I suppose”. Finally, Esther, Nede, Sharon (all lesbian), Mina and Bee (both bisexual) were upset by heterosexual assumptions and felt their medical care or patient-doctor relationship had been compromised as a result. It is important to note that the two bisexual women in this last group were just as offended by heterosexual assumptions as the lesbian women. Nede (55, lesbian, inner urban) was very open about being lesbian in her life, however these experiences with GPs made her feel that she was “in the closet”, which she “didn’t like at all”. Nede was annoyed at the lack of perceptiveness of many GPs: “I would really like it if somebody [a GP] assumed that my partner’s a woman. What have I got to do, have lesbian tattooed on my forehead?”

The women who preferred assumptions of heterosexuality gave their implicit consent to the silencing of their minority sexual orientation. These women were cooperating with the GPs’ assumptions that they were heterosexual, just as some of the patients in Christine Barry’s (2001) study mutually ignored the social lifeworld with their GP. Some of the women in my study relied on their ambiguous or feminine appearance to reinforce heterosexual assumptions. For example, Gabrielle had seen her current GP (Dr Fred) during the years that she was married, and had recently returned to him and had not told him about her female partner. I asked her what she thought Dr Fred knew about her sexual
orientation and she believed he thought she was with another male partner because she did not “look like a dyke”.

A feminine appearance did play into GPs’ assumptions of heterosexuality as Dr Olive described:

Dr Olive (43, inner urban): There was nothing about her that made me think “you might be gay, I’m not sure”. She was the most…and again there’s no reason why gay women can’t be extremely feminine, but she would dress in a really feminine fashion with very lacy clothes and skirts and the hair was wavy and long, and incredible amounts of make-up, and she tottered about on her high heels [laugh]. I was actually quite flabbergasted to discover that she had a female partner.

Conversely, Dr Imogen was cautious not to simply assume a lesbian orientation without clarification:

Dr Imogen (46, outer urban): There would probably have been times where there will have been something about either the way they present themselves, the way, I mean there’s all sorts of little cues, such as mode of dressing, mode of speaking, even body language I suppose and sometimes I would be right and sometimes wrong. But I would hope that it’s never been an assumption but it might have been a cue that would lead me to ask a question to try and clarify their sexual orientation.

Dr Imogen’s sensitivity to and probing of subtle cues was quite unusual in my sample. So, assumptions of heterosexuality perceived by so many of the women in my study were a common feature in the day-to-day practices of many of the GPs. The silencing of the lifeworld in this way was generated by GPs who did not consider the possibility that their patients were anything other than heterosexual. I will address some of the reasons for this blindness to a minority group when discussing the influences on GPs later in the chapter. Habermas’s Theory of Communicative Action provides an insight into the motivation for this form of heteronormative silencing. Some of these women were consciously using strategic action by influencing GPs to assume they are heterosexual, which is a form of
“concealed strategic action” (Scambler, 2002, p.122). In response, many of the GPs were unconsciously being influenced by the women’s strategic action due to their failure to consider alternatives to heterosexuality, although Imogen provides an exception in at least questioning the validity of the presentation. So, while strategic action has been represented within patient-doctor encounters as being a tool used predominantly by doctors, this suggests that patients can also be strategic.

**Irrelevance Leading to Intentional Silencing**

A second form of silencing occurred when GPs were aware of women’s minority sexual orientation but deliberately avoided any discussion or acknowledgement of it. I will demonstrate that this was a more deliberate or intentional silencing than assuming heterosexuality. Some women had experienced this form of silencing, which created the impression that the GP was disinterested or lacked compassion. This replicated Christine Barry’s (2001) ‘lifeworld ignored’ pattern of communication, which had similarly negative effects on patients. Jenny experienced this form of silencing when she raised sexuality with her GP, leaving her unable to talk about her bisexual attractions and her inadequate sexual life with her husband:

Jenny (72, same-sex attracted, outer urban): I did try to work with him [her previous GP], and I think he tried too, I think he tried to understand where I stood. I mean I don’t ever feel that it was … that I’ve been discriminated ...or I’ve been treated badly because of my sexual preference, but simply because… some people don’t believe that sexuality is very important … and it is for me. (...) [It is] one of the factors that has been ignored.

For other women, this form of silencing resulted in serious consequences for their health. For example, Angelina (37, lesbian, inner urban) had been met with total silence when she simultaneously disclosed her male partner’s abuse and her lesbian orientation to her previous female GP, the impact being that she did not discuss either issue again with a GP for many years. Bee had attempted to disclose, however the GP had disregarded this:
Bee (25, bisexual, inner urban): I saw a GP (...) and she asked me if I had a steady boyfriend. (...) Usually when people ask me about a boyfriend, I refer to my girlfriend as my boyfriend. So then I say yes, right? But because I know when it’s a GP there’s a difference, because male and female biology and all that stuff, so I didn’t know how to answer. And then I said, “well, not like my friends, because they are straight. Guy and girl”. And she goes, “okay well I’ll put you down as single”.

As a result of this silencing, Bee did not reveal that she had been having bleeding after sex with her female partner, a significant and potentially serious medical problem. This is an example of deliberate silencing that seriously compromised the work of the medical system by altering the diagnostic possibilities or silencing pertinent biomedical issues that are connected to women’s minority sexual orientation. Applying Habermas here, the GPs were using strategic action by appreciating just one objective reality, that is their own understanding that a woman’s minority sexual orientation was irrelevant to the consultation. They failed to take into account the validity of the women’s perspective of relevance and made no attempt to use communicative action to reach a consensus in this regard. In doing so, they created a communication “pathology” (Scambler, 2002), literally speaking in some cases.

Twelve GPs concurred with women’s perceptions that they deliberately ignored minority sexual orientation. They justified this stance by minimising any differences, believing that they did not need to differentiate these women from other women. This was either because they valued equality and treating everyone the same, or because they believed that sexual orientation was irrelevant to the consultation. Drs Alan, Joseph, Margaret, Katie and Cam believed in equality and treating everyone as ‘people’, and Drs April, Fred, Judy, Perry, Phoenix, Katie, Olive and Pachy believed that lesbian women’s health issues were entirely or predominantly women’s health issues.

The five GPs with an equality approach said they applied this to all of their patients. This approach worked well for some patients and not so well for others in my study. Dr Katie
(47, regional) said “I think you just see people as people” and her patient Mae was very satisfied with this, also believing she should be treated the same as anyone else. Dr Margaret (51, inner urban) was particularly insistent that she felt it was wrong to single out a particular group of patients for ‘special treatment’. She was really objecting to the possibility of labelling or stereotyping a person, or focusing completely on a particular attribute. “A person is not just their sexuality; a person is everything that they are.” Dr Margaret’s patient Bear (25, lesbian), who had been seeing her for two years, felt that she came across as being very non-judgemental: “she is very professional and nothing bats an eyelid. I mean I could tell her everything and anything”. However, Bear also felt that Dr Margaret could know more about lesbian health, indicating that Margaret’s equality approach did not satisfy some of Bear’s specific health needs.

Dr Joseph was also motivated in terms of equality:

Dr Joseph (57, outer urban): My personal viewpoint is that everybody who comes in here is respected (…) I welcome everybody equally. (…) I know there are patients of mine who are… not heterosexual, both male and female, and that has never made any difference to my practice or the way I treat people. Nor does race, or religion or anything else….. That is a very strong personal feeling of mine, so I hope it’s apparent in the way I practice.

In contrast to Mae and Bear, Dr Joseph’s patient Jamie-Lee felt his lack of direct inquiry indicated that he was disinterested in her personal life, and therefore she had not told him about her sexual orientation. Indeed, some of the GPs with the ‘sameness’ position stated that women’s minority sexual orientation was none of their business. Drs Joseph, Westy and Leon chose to remain silent and not pursue patient cues that they were same-sex attracted, to avoid stereotyping.

On the surface, GP values of equality would encourage a non-judgemental approach and this was effective for some women such as Mae who had a similar value system and did not require more specific focus on her sexual orientation. However, it was limiting and silencing for other women such as Jamie-Lee, Jenny, Angelina and Bee. It also suggests
that these doctors were aligning their personal lifeworld values with their professional values, which in this context means that they ignored the health impacts of discrimination and marginalisation associated with minority sexual orientation. Within both the human rights and cultural competence literature, this ‘sameness’ approach has been criticised for failing to protect the interests of various minority groups and ignoring the enforced differences that this minority status can bring (Miller, 2001; Peel, 2002). For example, when considering cultural competence regarding ethnic minorities, Aziz Sheikh and colleagues say that treating people the same as anyone else is a form of “institutional discrimination” and they claim that this results in “the collective failure to provide an appropriate and professional service” (Sheikh, Gatrad, & Dhami, 2008, p.52). The institutional contribution to this position in medicine is the failure to challenge doctors’ perception of sameness by educating them about the health impacts of discrimination and marginalisation.

*Lack of Specific Knowledge*

Lack of knowledge was an underlying contributor to both assumptions of heterosexuality and lack of belief in the relevance of minority sexual orientation. The majority of GPs in the study lacked knowledge of the biopsychosocial aspects of same-sex attracted women’s health that are relevant within general practice that I outlined in Chapter 3.

For example, Dr Perry (55, outer urban) and Dr Fred (65, regional) both said that they never recorded sexual orientation in the patient file. As Dr Perry explained: “because I think, is that really relevant to the basic demographics of the patient, and is it any of my business to know my patients’ sexuality if it doesn’t impact on their health?” Dr Pachy had a similar perspective:

Dr Pachy (48, outer urban): I couldn’t really think of any situation that it was really essential that I knew that a woman was lesbian. I thought, does this mean I’m incredibly ignorant of health risks associated only with lesbian women, but I
just thought there didn’t appear to be any reason why it was really important in the context of general health.

Drs Pachy, Fred and Perry were all highlighting a common limitation that the medical system generates for GPs when it creates boundaries around knowledge that is ‘relevant’ for the consultation. The assumption is that information about patients is relevant only when it relates to disease or ‘health risks’, which in effect medicalises minority sexual orientation. This is an example of the (medical) system colonising the lifeworld by ignoring it. It disregards the fact that an individual lesbian woman may have no health problem related to her sexual orientation but may still believe it is relevant for the GP to know. Dr Pachy also raises another possibility, which she quickly discounts, that she may be ‘ignorant’ of the actual health risks. Some women were aware of this limited knowledge as Bear had suggested regarding Dr Margaret. Angelina also believed that her current GP, Dr April, may not have known much about lesbian health and hoped that I “might educate her a bit” during my interview with Dr April. Dr April confirmed this perception, saying that lesbian health was no different from women’s health, and during our interview said “I can’t think of any [specific issues]. If you could tell me some that’d be fine”.

Most GPs in my study had very little detailed knowledge of specific lesbian health issues. Eight GPs (Drs April, Fred, Judy, Perry, Phoenix, Katie, Olive and Pachy) believed that lesbian women had no specific health issues. Almost all of the other GPs had a very limited range of knowledge, being able to list only one or two specific issues that they felt were relevant within the consultation. The most common issues raised were related to sexual health or the psychological impact of dealing with negative social attitudes. Only four GPs (Drs Rose, Leon, Audrey and Holly) realised that lifestyle or purely social aspects of sexual orientation could be pertinent to the GP consultation, for example Dr Rose (46, inner urban) mentioned needing to understand “lesbian hangouts”. Dr Tyl (61, regional) suggested that she needed more lesbian health knowledge but that it wasn’t accessible in textbooks, nor could she easily refer women to lesbian specialist services in her rural location. She expressed willingness to show patients that she would find the
information, just as some of the women expected. I will return to the issue of gaps in medical education later in the chapter.

Some GPs were more deliberate in blocking the lifeworld to conceal their lack of knowledge from women. Dr Tyl made a comment that pointed to some discomfort in her lack of knowledge, saying “I do find that hard too because it’s hard to admit you don’t have [knowledge], and in that area which is particularly sensitive (…) You don’t want to shelve them off and you don’t want them to have to go to someone else”. Dr Tyl was uncomfortable in revealing a deficiency, and also in the potential for not being able to satisfy all of her patients’ needs. This speaks to the omnipotence that is one of the values of traditional medicine that many doctors have been acculturated to maintain. Losing face by displaying a gap in knowledge is to be avoided. I will discuss this in more detail when exposing risk as a central barrier to disclosure for GPs in Chapter 6.

By contrast, Dr Holly was unique in being able to list a wide range of psychosocial issues that she considered to be important to the consultation:

Dr Holly (39, lesbian, inner urban): And working out how comfortable they are with their sexuality, are there other things such as substance abuse and depression and unhappiness, is there a background of sexual abuse in there as well. So are we talking about a content, happy lesbian or a deeply conflicted, unhappy lesbian. Also that question about social supports and social networks and relationships with families and expectations about what their future’s going to be, and how’s their sexuality affecting education, work and all the rest of it.

Dr Holly’s point about distinguishing between the “happy lesbian” and the “deeply conflicted unhappy lesbian” is very important. She was flagging the need to recognise the diversity of experience and impact of negative attitudes on lesbian women. Dr Imogen (46, outer urban) also believed that knowing about minority sexual orientation was relevant but felt “it’s a challenge for us about any piece of information we know about our patients’ lives and health is how to see that in context with everything else. And not to give it an unnecessary weighting or pay attention to it where it’s not warranted”. Breaking
the silence can lead to this legitimate concern regarding the need to strike the right balance between paying attention to minority sexual orientation and being overly attentive. This is highly achievable, as Dr Holly suggests, by deliberately getting to know each individual same-sex attracted patient and understanding her particular lifeworld.

**Summary of Heteronormative Approaches**

GPs’ assumption of heterosexuality was a common experience amongst women in my sample, and many of the GPs also acknowledged that they inadvertently made these assumptions. Stephen Buetow (Buetow, 2009) has reframed this form of silencing using the visual arts term of ‘negative space’, which is the space around subjects that we tend to ignore. He suggests that doctors often do not notice what is absent, for example in the “negative communicative space” (p.80) of the consultation, and that this can confirm pre-conceptions. The negative space is created when both doctors and patients exclude certain topics, his examples being illicit drug use, sexuality and family violence. This holds true in the context of my study, in that doctors made heterosexual assumptions and therefore did not perceive the unrevealed minority sexual orientation, and some patients were complicit in creating this silence through encouraging heterosexual assumptions. Buetow (2009) challenges doctors to take note of these negative conversational spaces and therefore avoid pre-conceptions, and he suggests it is the doctor who should take responsibility for this.

The claim by some GPs that minority sexual orientation was irrelevant was a more deliberate heteronormative approach and was equally problematic for women. By seeking to minimise differences between same-sex attracted women and heterosexual women, GPs displayed their inadequate knowledge about the specific health issues and broader cultural issues of sexual minority women. This resulted in treating all women as the same, which effectively meant treating all women as heterosexual. A few GPs believed that minority sexual orientation was only relevant to the consultation if there were associated problems to deal with. In taking such a medical approach to relevance they displayed the dominance
of the biomedical system over a biopsychosocial approach when knowledge is so limited. So, while heterosexual assumptions came from a position of ignoring unspoken agendas, claims of irrelevance arose within an overemphasis of biomedicine and a lack of knowledge.

Habermas (1984) critiqued the traditional philosophies regarding knowledge that focused too heavily on scientific knowledge at the expense of other ‘human interests’. Medicine has come from this more traditional approach and still tends to prioritise the scientific biomedical approach over an understanding of social contexts. Habermas suggested that one of our human interests is to control our environment to make it predictable and therefore more comfortable, which is often the role of science to categorise and simplify the human condition. Traditionally, this resulted in the open use of strategic action in a ‘doctor knows best’ approach such as using medical jargon to control the consultation (Scambler, 2002), or as in my study, in a more concealed strategic action to ignore the lifeworld. To achieve a more communicative action, these GPs would have had to be motivated to understand the minority sexual orientation lifeworld of which most GPs in my study had little experience or education. They did not know much at all about the language, culture and even health issues of this group. So, despite their generally holistic approach and appreciation of the relevance of social issues, to be more in control of their consultation they reverted to the predictable and safe ground of biomedicine, which then silenced the lifeworld.

Whether intended or unintended, these approaches are forms of heteronormative practice in that heterosexuality is assumed, or homosexuality is deemed irrelevant, or sufficiently unimportant or rare to seek information. The resulting silencing had various impacts on women ranging from suiting their preference for silence to creating serious breaches in medical or psychosocial care. Women whose preference for cultural, empathic and humane knowing specifically related to their sexual orientation were particularly disadvantaged by the silencing. However, for all women, not only was their lifeworld silenced, but at times the biomedical work of the consultation was compromised because they could not reveal health information that related directly to their sexual orientation.
Pathologising Approaches

While heteronormative approaches were most commonly reported by women and GPs in my study, women did have experiences of negative attitudes. These were usually subtle but occasionally blatant expressions of homophobia. A few women described sensing negative GP attitudes but not being sure whether this was related to their sexual orientation. This was disconcerting and unsettling particularly as their concern was the possibility of receiving substandard care as a result. This has been a common reason for women to attend my practice and Dr Debra also referred to the commonness of this experience of the lesbian patients in her practice:

Dr Debra (56, psychiatrist, inner urban): I think the sense is that the treatment might be a bit cursory or inattentive and that that might be a homophobic response. It is subtle but obviously this happens (…) They will try to find a GP who doesn’t objectify them. Partly because it makes the consultation more pleasant but also partly because they then trust the medical treatment more.

As the literature suggests, some women in my study expected negative reactions. Dora (41, gay, inner urban) said “I believe that there would probably be GPs out there that would totally freak out, even today”. Bee (25, bisexual, inner urban) also believed that doctors are generally conservative and opinionated and would “justify [homophobic attitudes] with all their medical knowledge”. Only three women in my study, Bear, Angelina and Eileen, had experienced GPs openly displaying negative attitudes towards them. Bear saw a casual GP with her partner when they were both unwell and disclosed because they were seeing him together. He had said to her “pretty girls don’t come along who are gay”, which she found sexualising:

Bear (25, lesbian, inner urban): I just felt uncomfortable because… doctors don’t necessarily comment on that sort of stuff, it’s like you’re there to see a person for their health not comment about what they look like or what they are meant to look like. I think it was also just because he was male, so I mean generally I don’t care
but coming from him it seemed a bit more… like he’d been watching too many porn movies compared to if a female had said it.

Angelina and Eileen had both been sent to GPs during their adolescence by their parents in search of a cure for their homosexuality. For Angelina at 15 years of age, this experience had very negative consequences, making her doubt her lesbian identity and encouraging her to live a heterosexual lifestyle for almost 20 years.

Angelina (37, lesbian, inner urban): He [the GP] said it’s just something that you're going through at the moment, you can’t go this way anyway, it’s wrong.

Interviewer: And how did you feel when you were seeing him?

Angelina: Like he was, you know, he was God and he knew what he was talking about, I started to really doubt myself. Kind of intimidating as well. Bit of a bully.

Interviewer: And do you remember how you felt before that, before your parents found out, were you feeling positive or negative?

Angelina: I was feeling really positive, I hadn’t ever even been with a boy before, so it was just…it was fine with me but the struggle was the family. (...) And that's when I kind of started going a bit downhill and getting out of control. And when I say that, you know, like having big benders and stuff like that. And mum and dad just kept pressuring, pressuring, pressuring. Get married, get married, get married and I did.

At that age, Angelina had what I regard as a traditional understanding of the GP as ‘God’, all powerful and all knowing, which neither she nor any other women in my study retained into adulthood. This displays the patriarchal potential of medicine to dominate and suppress ways of being that are outside of the mainstream experience (K. Davis, 1988). This was not only ‘intimidating’ but also altered her own sense of wellbeing. Eileen (45, lesbian, rural) had a similar experience at 17, saying that the doctor “freaked out” when she told him that she was lesbian. He seemed very uncomfortable and “wasn’t prepared to listen”. She had a similar destabilising outcome saying “I’d never actually felt uncomfortable about my sexuality, but he made me feel that I was unwell or something. And at that stage I didn’t really need that”. In Chapter 5, I will discuss the potentially
helpful role of GPs in the coming out process. However these stories demonstrate the impact of seeing the ‘wrong’ GP at this crucial life stage.

Just two of the GPs that I interviewed expressed negative attitudes towards homosexuality, Dr Normal (Sally’s GP) and Dr Michael (Madison’s GP). Dr Normal (70+, inner urban) stated repeatedly “I mean it’s obviously not the norm. We are not meant to be like that biologically.” Dr Michael said that he thought “homosexuals” have an “inferiority complex” because “they feel like it’s a disease”, and later revealed that he thought they were “psychologically disturbed”. These attitudes reflected the value systems that each GP brought from their personal lifeworld, Dr Michael came from a Muslim and Dr Normal from a Christian perspective. As Dr Normal stated “this [being heterosexual] is how God made people”. Both of these GPs stated that they would not reveal their attitudes to gay or lesbian patients:

  Interviewer: What is your position on homosexuality?
  Dr Michael (55, outer urban): Oh right. My views about it, actually I’m against it as a person but that doesn’t mean that it will influence my practice towards a person…I just treat them like a normal person, treating them physically. That’s his own beliefs, own moral issues, I don’t have to deal with that.

Sally and Madison had both sensed the negative attitudes of their GPs. Sally (42, lesbian, inner urban) said “I don’t think he [Dr Normal] would be accepting (…). I think because of his profession he has to seem like he does.” As a result of her awareness, Madison had not disclosed being lesbian to Dr Michael, saying that she did not want to be judged by him. Madison was also considering seeing a different GP for women’s health issues.

Experiences of negative GP reactions to disclosure or perceived negative attitudes were not only silencing but commonly led women to terminate the patient-doctor relationship. Angelina, Eileen, Mina and Nede had all decided never to return to particular GPs for this reason. Thirteen other women were quite certain that they would not return to a GP if they were ever faced with negative reactions. George had disclosed to Dr Harry fearing that he would reject her, however stated that she would have taken the control first had he reacted
negatively: “I would have been devastated, and would not have gone back”. Lesley (52, lesbian) predicted that she would respond similarly, and that this was only possible because she had developed a positive self esteem as an older woman, saying “I’m me and I’m important too”.

In summary, pathologising attitudes were experienced by few women in the study and present in a minority of the GPs interviewed. Women were adept at picking up cues that indicated negative attitudes or a lack of genuineness, as I described in Chapter 3, even when these were subtle or deliberately concealed by GPs. These experiences had significant effects on women’s readiness to disclose sexual orientation, which I will examine in more detail in Chapter 5. They also affected their self esteem at a vulnerable life-stage. The majority of women had not experienced negative GP attitudes, however were clear that if faced by such attitudes they would take control and terminate the patient-doctor relationship.

Summary of Issues Relating to Silencing

The first question of the chapter exploring the problems in accommodating the expectations of same-sex attracted women is answered by adapting Kirsti Malterud’s (1993) finding that GPs either ignore or medicalise women patients. I have reconceptualised ignoring as heteronormative silencing for these sexual minority women because of the effect it tended to have on women’s willingness to reveal their sexual orientation. I have also reframed medicalising as pathologising because of the very negative impact that this could have on women. Pathologising in this context was about believing that lesbian or bisexual orientations are pathological and require treatment. A minority of GPs in this study adopted a pathologising approach, however some women were concerned enough that this would occur to conceal their sexual orientation from some or all GPs. Both approaches were counter to the expressed preference of some women for GPs to be culturally competent and patient-centred through real or potential
cultural, empathic and humane knowing. The negative experiences of lesbian women compared with bisexual women in the study were no different.

**Influences on GP Attitudes and Knowledge**

The second question of the chapter explores the influences on GPs’ ability to accommodate the lifeworld of same-sex attracted women. I will briefly summarise the literature in the area and then describe my findings related to GP perspectives on what has influenced their attitudes and knowledge. I found that there were three areas of influence: medical education; experiential learning from lesbian patients, personal friends or family; and personal beliefs and values. The fragmented and inconsistent nature of these experiences helped to explain why heteronormative approaches were so common.

**Literature on GP Influences**

The acquisition of medical knowledge and formation of attitudes is a lifelong process, influenced by formal curricula and experiential learning (Greenhalgh, 2007). A review of 51 studies that assessed health care provider attitudes to lesbian women and gay men confirmed these two levels of influence, showing that lack of knowledge and negative attitudes could be modified by formally receiving information and by interactions with lesbian and gay patients (Schwanberg, 1996).

Most doctors state that they have not received adequate formal education about lesbian health (A. E. Harrison, 1996; King, 1994; McNair, 2003). Difficulty accessing information about lesbian and bisexual women’s health begins in medical school and continues throughout their career. To date, there has been no national audit of lesbian health teaching in Australia, however national reviews of gay and lesbian undergraduate course content have been conducted in the USA (Tesar & Rovi, 1998; Wallick, Cambre, & Townsend, 1992), Britain (Bewley & Bolton, 1999), and Canada (Robb, 1996). All
reveal limited time allocation and poorly integrated teaching regarding lesbian and gay health issues, with a tendency to teach about sexual orientation within an illness framework. The British survey of medical and dental schools showed that only 40% of schools included anything relating to gay and lesbian issues (Bewley & Bolton, 1999). None of the curricula surveyed addressed lesbian health specifically. All authors conclude that the topic is marginalised and that teaching and learning about homosexuality should be integrated throughout medical curricula.

Lesbian and bisexual women’s health has also been absent in Australian general practice training. The first time these issues were formally included in the RACGP curriculum was in 2007. General practice texts have traditionally not included specific information, for example, the recommended text in Australia first included information on lesbian health in its fourth edition in 2007 (Murtagh & Health Communications Network, 2007). This information is contained within just two pages, is combined with gay men’s health, and bisexuality is not specifically discussed. Australia’s most recent text on women’s health in general practice has only two references to lesbian health, one regarding lesbian women’s need for pap smears and the other on the sexual transmission of bacterial vaginosis between women (Mazza, 2004). The evidence-base on lesbian and bisexual women’s health is difficult to access as it rarely appears in medical journals. A review of all Medline listed publications over the past 20 years found only 0.1% included lesbian, gay, bisexual and transgender (LGBT) populations (Boehmer, 2002). Only 28% of the articles featured lesbian women and 9% included bisexual women, and over half of these focused on sexual health.

Given the very limited availability of formal training in lesbian and bisexual women’s health, there is some evidence that GPs learn about these issues from patients themselves. For example, GPs in the Swedish questionnaire study (n=76) who were aware of lesbian patients in their practices were more knowledgeable, and indicated that they had learned more through personal than professional avenues (Westerstahl et al., 2002).
**Medical Education Experiences**

The GPs in my study had received very little education in lesbian and bisexual women’s health, replicating the findings in the literature. There are four levels of formal medical education at which GPs could potentially have learned about lesbian and bisexual women’s health. These are medical school, pre-vocational training (the first two or three years as a qualified doctor working predominantly in hospitals), vocational training to become a GP, and finally continuing professional development (CPD). On the pre-interview survey, I asked participants to estimate how many hours of lesbian or bisexual women’s health training they recalled at each of these levels. Sixteen of the 27 GPs and Dr Debra (the psychiatrist) could not recall any specific education. Of the 11 GPs who could recall something, six recalled a single undergraduate lecture. Dr Alan (85, inner urban) was unique in having attended a visiting European lecturer speaking on intersex conditions in 1949. Three attended a psychiatry lecture on homosexuality, Dr Fred in 1965, Dr Soula in 1968 and Dr Perry in 1974; and Dr Joseph recalled something on sexuality during the 1970s. Dr Leon, one of the most recent graduates, had a lecture on sexual orientation during his community medicine training in 1993, as did Dr April; however Dr April thought this had just been about gay men. No GPs had any pre-vocational training in this area. Three GPs, Drs Holly, Leon and Lith, recalled a two hour session on sexual orientation during their GP training, all three having obtained their medical degree since 1993. Dr Audrey, the only other recent graduate (in 1998) did not recall anything. Finally, eight GPs recalled attending between one and four hours of CPD on lesbian or bisexual women’s health.

The content of the training was not universally positive, which reflects that homosexuality was listed as a disease in the Diagnostic Statistics Manual (DSM) until 1973, and in the World Health Organisation’s International Classification of Diseases (ICD) until the tenth edition in 1992 (Kirby, 2000). Drs Fred, Soula and Perry all commented that their undergraduate psychiatry lecture had presented homosexuality as an illness, and all said they had felt uncomfortable about this at the time:
Dr Perry (55, outer urban): When I was in medical school in Melbourne in 1974, a psychiatrist got up and he said homosexuality was a disease. In 1974, I mean people in the lecture theatre nearly exploded, and other people actually couldn’t have given a hoot. And I thought, how can you have that sort of attitude?

Conversely, Dr Alan credits the intersex lecture he attended as an undergraduate student with having a very profound and positive influence on his understanding. The lecture encouraged him to consider homosexuality as a biological reality rather than a psychiatric illness:

Dr Alan (85, inner urban): I think part of it is ignorance [doctors’ discomfort with homosexuality], that they haven’t…I just had that one little break [referring to the lecture he attended]. (…) And that was where I was very grateful to [the lecturer] because he just gave me that understanding that allowed me to be aware. (…) I was very fortunate in just having a seed sown that allowed me to be comfortable for the rest of my life, which so many people don’t have.

The session on sexual orientation that Drs Holly, Leon and Lith recalled had been introduced during the late 1990s. Dr Leon, who represents a new generation being exposed to lesbian health issues during their GP training, felt that this training and his undergraduate lecture had helped his understanding:

Interviewer: How much influence if any did your medical education have?
Dr Leon (34, regional): Obviously a fair bit as well. Like those lectures we had…I guess that taught you a fair bit, even if it is on a theoretical level, at least you sort of realise some of the other issues. So yeah, that probably did have a reasonable impact.

The CPD that eight GPs recalled was largely about sexual health and sexual history taking including the need to clarify the gender of the sexual partner. This reflects the sexual health focus found in textbooks and published papers to which I previously referred. Five of the GPs who recalled relevant CPD (Drs Fred, Joseph, Perry, Katie and Olive) still had the belief that lesbian women’s health issues were the same as any women’s, indicating
the lack of impact of this training. Drs Jackie, Rose and Holly realised there were
differences, although believed that most of this knowledge had come from patients. Topics
beyond sexual health that would be useful to include in CPD reflect the specific health
care needs of lesbian and bisexual women such as mental health, substance use, health
care access, and reproductive health.

**Professional Clinical Experiences**

GPs have a lack of professional experience seeing openly lesbian and bisexual women. As
I detailed in Chapter 1, up to 2% of women in the population identify as lesbian or
bisexual and at least another 2% are same-sex attracted (Smith et al., 2003). Given that
approximately half of these women do not disclose to their GP (Hunt & Fish, 2008),
logically GPs should be aware that at least 2% of their female patients are same-sex
attracted. I have found that most GPs in my study could recall seeing far less than this
proportion, although even this very limited experience had led to valuable experiential
learning.

**GP Perceptions of Prevalence**

I asked GPs on their pre-interview questionnaire to estimate the proportion of their adult
female patients who were same-sex attracted. Six GPs (Drs Michael, Normal, Phoenix,
Leon, Pachy and Perry) could not estimate. Nine GPs thought SSA women made up less
than 1% of their adult female patients; seven estimated 2 to 5%; Drs Cahill, Holly, Rose
and Tyl estimated 10%. Dr Debra had calculated 28% and Dr Lith estimated 50%, which
reflected the specific lesbian focus of their respective practices. Many GPs based their
estimate on what they thought was the population statistic or on the fact that they did not
recall seeing many such women. Drs Rose, Cahill, Holly, Elisabeth, Imogen and Perry all
said they had guessed and subsequently asked me what the actual proportions were. For
example, Dr Rose had believed 10% over-represented the actual number of women she
could recall.
One of the striking similarities across most of the doctors interviewed was that they could actually recall seeing just a handful of openly lesbian women as patients, and only two GPs (Drs April and Rose) recalled seeing bisexual women. The two pathologising GPs, Drs Michael and Normal, could not recall seeing any lesbian women. Drs Judy, Katie, Joseph and Fred recalled two or three; and Drs Margaret, Olive, Perry (in his current urban practice), Cahill, Jackie, Rose and Cam recalled four to six. Nine GPs (Drs Leon, Audrey, Pachy, Elisabeth, Tyl, Soula, Harry, Imogen and Westy) couldn’t provide a number but used phrases such as ‘a few’, ‘not many’, ‘some’ and ‘occasional’.

Just five doctors recalled seeing a larger number of lesbian women. They each had specific practices or styles that were likely to have both increased their awareness and attracted more lesbian women. Dr Alan had directly asked most of his patients about sexual orientation. Dr April worked in a suburb in Melbourne in which a high proportion of lesbian women live. Drs Lith and Debra both specifically targeted lesbian patients and are openly gay and lesbian, as is Dr Holly, who estimated seeing “truck loads, more than 40” lesbian women. Finally, Dr Perry estimated seeing 20 or 30 lesbian women in his previous rural practice, which was because he had a large number of gay and lesbian friends who had referred friends to see him.

**Experiential Learning from Lesbian Patients**

I have understood the importance of learning from patients, especially as I relied on this repeatedly during the early years at my gay and lesbian practice. Also, many patients have told me they had tried to educate GPs. For example, I saw a lesbian couple in my practice that had deliberately seen their local female GP for conception advice and referral because they wanted to educate her. They had given her pamphlets, but ultimately her referral to a fertility specialist had not worked for them, and they came to me for more specific advice. They said they were disappointed as they really liked her and had hoped they would not
need to see me. In Chapter 3, I noted that some of the women I interviewed had educated their GP in a similar way, including Esther who was quite empowered by this.

Eight GPs felt they had learned about lesbian health issues by seeing lesbian patients. Dr Alan (85) stated that “I learnt mostly from my [lesbian women] patients. They were my greatest teachers”. Examples of issues learned were skills to facilitate disclosure, mental health issues related to coming out, and lesbian conception methods. However, Dr Leon (34) recognised that this was insufficient, saying “I’m probably still fairly ignorant on the area [of lesbian health], so I probably need to know more about it. You tend to learn things as you go as a GP in a lot of ways, don’t you”. There are disadvantages of relying on experiential learning. The first is that some patients resent the need to educate their GP or are not empowered or aware of the need to do so (Wilton, 2000). Although none of the women in my study expressed resentment, not all women understood that their GPs had limited knowledge. Also it is doubtful that many women would feel capable of educating their GP, given the power imbalances that continue to be present between doctors and patients. The second disadvantage is that GPs would need to see a wide range of lesbian and bisexual women to gain a broad understanding of the diversity of their cultural issues, health experiences and needs. So, the gaps in medical education were not entirely overcome through experiential learning.

**Personal Experiences**

I have identified various personal influences on GPs’ professional approach to minority sexual orientation women. A personal association with lesbian and gay people influenced some GPs, as did their personal value system. Also, some GPs had experienced discrimination personally which had an effect on their approach to patients who can be discriminated against, including lesbian women. So, while I demonstrated previously that GPs’ homophobic values within their personal lifeworld could negatively influence their interactions with same-sex attracted women, a range of other personal values positively influenced GPs’ professional interactions.
GPs with personal experience of associating with lesbian or gay people were more likely to have more knowledge regarding the specific health needs of lesbian women. Three of the doctors were gay or lesbian, Drs Lith, Holly and Debra, and this influenced their knowledge and attitudes. For example, Dr Lith (44, inner urban) was “angry” about doctors who “discriminate against gay people” saying that being gay made him more aware of this. Four GPs (Drs Alan, Cahill, Harry and Joseph) had a gay or lesbian sibling or cousin. All of these men were aware of the mental health impact of social stigma, for example Dr Cahill used words such as “difficulty”, “struggle” and needing “courage” when referring to lesbian women coming out. Sixteen GPs had friends who were lesbian or gay. These GPs displayed a range of attitudes and knowledge indicating that their personal associations did not guarantee being well informed, although the people they knew did influence their understanding in particular ways. For example, Dr Harry (53, regional) believed his gay friends improved his “tolerance” and understanding. Dr Olive (43, inner urban) had a close male friend at medical school that she supported while he was coming out. She felt this “had a bit of an influence on me…it gave me an idea of the difficulties he went through and that it’s not easy”. Apart from understanding this however, she felt that lesbian women had no specific health issues. So, limited experience with family or friends had some influence in enlightening GPs but left them with inconsistent levels of knowledge and awareness.

GPs’ personal value systems were influential in various ways. Dr Alan (85, inner urban) felt that many doctors were influenced by their own moral values. He said “I know how difficult it is for so many doctors to become totally objective. There is so much subjectivity in doctors: [their] mores, morals, religion”. So, he was suggesting that doctors should be more objective, and should disconnect their ‘subjectivity’ or the values in their own lifeworld from their practice of medicine. In taking this view, he is reflecting the traditional medical model that doctors should be objective at all times. This would be beneficial for sexual minority women when doctors have a negative moral stance, which was the case for Drs Normal and Michael. When I asked Dr Normal whether he had
known any gay or lesbian people personally he said “Not really, no. Maybe because I’ve laughed at people who have talked about it”.

Conversely, many GPs described their own “tolerant” or accepting values, which had a positive influence on their interactions with sexual minority women. Ten of these GPs believed they acquired values such as broad-mindedness and tolerance from their parents (Drs Audrey, Elisabeth, Harry, Jackie, Perry, Soula, Westy, April, Leon and Judy). Several other GPs believed in social justice and for Drs Debra, Rose and Imogen this came from their feminist values. Dr Imogen (46, outer urban) felt that “being a good feminist” gave her a “sense of each human being having to be valued and not be judged”. Despite his protests that doctors should be objective, Dr Alan also brought a social justice framework to his medical work, which arose from his own progressive Christianity. For example, he had advocated for abortion reform during the 1960s, and he described similar advocacy in his approach to lesbian and gay patients.

Several GPs had had personal experiences of discrimination or feeling they were an outsider in some way, which they regarded as being influential on their understanding of lesbian women. Drs Joseph, Margaret, Phoenix and April had experienced disadvantaged family backgrounds, which Dr Joseph (57, outer urban) felt “coloured my politics and my social awareness and my feelings about all sorts of things including new arrivals to this country and refugees and a whole lot of things”. Dr Phoenix (57) believed that this led him “not to make value judgments readily… and to allow people to be themselves”:

Dr Phoenix (57, outer urban): I think it’s just the sense of injustice that is very strong in me and both my parents that adopted me were disabled and there was a high sense of injustice in the way people with disabilities were treated fifty years ago. I grew up with that so I always had a great suspicion of injustice and fairness.

Dr Judy (48, outer urban) was similarly affected through observing reactions to her parents’ migrant status, saying “I think that made me …make sure I see behind it…yeah get to know the person”. Dr Perry’s (55, outer urban) experience of being bullied at school had been “a strong motivator” not to make assumptions about people or to discriminate.
He maintained his sense as an outsider during medical school and described this as being associated with his values of respect and social justice. Drs Judy, Katie and Tyl had also been subjected to gender-based discrimination within medicine. Finally, Dr Holly (39, lesbian, inner urban) had experienced discrimination during her first graduate year by a consultant who treated her “appallingly” due to her lesbian orientation, which had provided her with insight into the personal impact of discrimination that she could apply to her patients.

**Summary of Influences**

In summary, to answer the second question of the chapter, the positive influences on GP attitudes and knowledge predominantly came from their personal experiences, either via values instilled by their own families, or through lesbian and gay friends or family. Personal experiences of discrimination also created some sympathy with lesbian women. Professional experience had some influence, however the very limited number and range of same-sex attracted women that GPs were aware of seeing led to very fragmented levels of knowledge. Formal medical education was the least overtly influential, although recent improvements enabled younger graduates to gain more knowledge. However, medical education was a powerful covert influence because the silence regarding minority sexual orientation signified to GPs that it was irrelevant to their medical work. It also failed to equip GPs with adequate knowledge and skills. Consequently, the medical system ignored the lesbian lifeworld and contributed to assumptions of heterosexuality, lack of perceived relevance and lack of specific knowledge amongst GPs, which created an environment of habitual silencing.

Therefore, while the medical system was a dominating influence in creating the habitual silence, there was evidence that GPs’ own lifeworld had either a negative or positive influence on their understanding of lesbian and bisexual women. In rare instances this led to pathologising of homosexuality through conservative values. However, more often, personal experiences of discrimination and values of social justice encouraged GPs to
move past an objective and silencing medical approach to empathise with the minority status and “see the person” as Dr Judy said. I will now discuss how women and GPs managed to overcome the silencing to include women’s lifeworld.

**Overcoming Silence to Include the Lifeworld**

Given the significant obstacles to GPs’ engagement with the lifeworld of their same-sex attracted women patients, it seems surprising that so many of the women interviewed had achieved an optimal relationship with their usual GP. I define an optimal patient-doctor relationship as one that can fulfil the expectations of women and their GP, and in part, can facilitate overcoming the habitual silence regarding minority sexual orientation if that is desired by individual women. I will now answer the third question of the chapter in describing the elements of the patient-doctor relationship that enabled knowing, and specifically accommodation of the lifeworld of minority sexual orientation. I will demonstrate that a relationship-centred approach can allow the achievement of the Habermasian aim of consensus through communication in which both patient and doctor can feel comfortable enough to disclose.

Two related themes permeated many of the optimal patient-doctor relationships: reciprocal knowing, and the development of a ‘professional friendship’. These themes relate very closely to Lucy Candib’s (1995) claim that medicine can be transformed by feminism, shifting the basis of the patient-doctor relationship from a negotiated contract to a trusting relationship. Here she is challenging the traditionally objective approach of medicine by encouraging doctors to use their subjectivity, just as some of the doctors in my study had done by falling back on their personal values in the absence of medical knowledge. Candib (1995) redefines the patient-doctor relationship as a human relationship in which connectedness is highly valued. This is connection on a number of levels: ‘connected knowing’ both by doctors of the patients’ context and by doctors disclosing about themselves, ‘connected caring’ and ‘connected empathy’. She describes
these various forms of reciprocity as relational caring, which particularly occurs when the patient-doctor relationship is long term.

A decade after Lucy Candib’s (1995) book was published, a medical research group called the Relationship-Centered Care Research Network published a paper on relationship-centred care (Beach & Inui, 2006), which echoed Candib’s thesis. This network has reframed patient-centered care, suggesting that relationship-centred care recognises the quality of provider-patient relationships as central, rather than purely the patient as central. The four principles on which this is based are: recognising the ‘personhood’ of all people in the relationship, including the need for authentic responses; recognising the importance of emotions and challenging traditional calls for medical detachment; understanding that all health care relationships have reciprocal influence and can be friendship based; and that there is moral value in having “genuine relationships” (Beach & Inui, 2006, p.53). The authors suggest there are several outcomes of relationship-centred care including patients feeling respected, being satisfied with and trusting their provider, and adhering to treatment.

The concept of reciprocity is central to the relationship-centred care model and appears in other medical literature, especially in relation to trust building. For example, UK GP David Loxterkamp writes about the value of “a deep and reciprocal dimension to the doctor-patient relationship” (Loxterkamp, 2008, p.30). Knowing the doctor as a person enables patients to identify some of the personal beliefs and values of their doctor. Concordance of patient and doctor beliefs and values is found to increase trust (Krupat, Bell, Kravitz, Thom, & Azari, 2001), as well as satisfaction and adherence with proposed management (Street, O'Malley, Cooper, & Haidet, 2008). The RACGP standards for general practice extend the concept of reciprocity to include reciprocal responsibility: “the ideal GP-patient relationship is a collaboration based on mutual respect and mutual responsibility for the health of the patient” (Royal Australian College of General Practitioners (RACGP), 2007, p.43). Stephen Buetow goes even further in redefining primary care as ‘coprovision’, which he claims is “the only type of clinician-patient interaction that can help to define authentic family medicine in the 21st century” (Buetow,
He defines coprovision as being a commitment to reciprocal caring and mutual responsibility where both patients and doctors benefit.

Many of the successful relationships in my study, which I will now present, concur with Lucy Candib’s (1995) model of relational caring and with the relationship-centred care approach.

**Relational Knowing and Reciprocity Within the Patient-Doctor Relationship**

Several women in the study said that a positive outcome of disclosure for them was that when their GP was aware of their sexual orientation they could present themselves more authentically. This reflected their preference for holism and relational knowing and affirms the relationship-centred emphasis on genuineness. For example, Dora (41, gay) felt her disclosure led to Dr Soula having “a more holistic picture” of her. George (56, lesbian) believed it was “a blessing” to have told Dr Harry because “I didn’t have to live a lie” and that as a result, he “looks at all aspects of my life”. Jamie-Lee (47, gay) felt that if she could tell Dr Joseph, he would “know me more as a person” and Miranda (61, lesbian) realised that not telling GPs in her past had meant that she hadn’t “expressed my entire persona”. Kiama suggested that the fact that her GP knew about her sexual orientation meant she could be more open about other aspects of herself:

Kiama (23, lesbian, inner urban): I think it’s a nice thing to see a GP over time and develop a relationship where you can be quite open about different parts and also feeling like you can throw anything into there that they may not have known about before and that they felt would be accepted as being part of you and not just a new bit of information that is there to shock.

Nine GPs (Drs Jackie, Audrey, Holly, Leon, Olive, Soula, Alan, Cam and Imogen) perceived the benefit for women of being able to present their authentic self in the consultation. As Dr Holly said, “understanding the broader sense of what their life is
about” is important for GPs and women. Dr Imogen reflected Kiama’s point about having the freedom to raise any issues:

Dr Imogen (46, outer urban): [Asking about same-sex partners] is just part of what I consider a useful thing for whole patient care. And so I think by doing it that way it’s really showing to them that it’s no big deal for me whether you’re straight, gay, whatever you are, and hopefully in the end that’s going to mean they’ll have good confidence that they can bring up any sort of issues.

In Chapter 3, I mentioned the preference of some women for reciprocal knowing. Many women and GPs in my study described various levels of reciprocity within the more optimal relationships, which helped to develop trust and overcome barriers to disclosure, such as past negative experiences or GPs’ inadequate knowledge. Conversely, there were women who preferred not to know personal information about the doctor and GPs who preferred not to disclose. For Bear this was about the doctor needing privacy, for Lucy and Kiama about feeling that the consultation should be purely about them. Three of the older doctors, Drs Alan, Normal and Cahill, believed that they should just present as the ‘doctor’ rather than as a person, which highlights a more traditional objective approach to medicine.

Reciprocity took several forms including mutual caring, shared levels of comfort, mutual respect and mutual trust. Women felt that when their doctors disclosed personal information this helped to enhance the patient-doctor relationship. This reveals the ‘doctor as person’ dimension of patient-centredness described by Mead and Bower (Mead & Bower, 2000) and is an expression of reciprocal trust by the doctor of the patient (Lynn-McHale & Deatrick, 2000). Fourteen women (Alice, Angelina, Susan, Betty, Dora, George, Helen, Jamie-Lee, Jane, Jill, Lesley, Mae, Esther and Flo) spoke of appreciating being able to know something personal about their GP. Lesley said of her GP “I think she was prepared to talk a little about her life. It made her a real person, not just the doctor at the surgery”. Flo projected to a time when she might be seeing a regular GP:

Flo (24, same-sex attracted, regional): I think that would come with years of knowing them as well, like I don’t think at the start I would expect to know
anything about them. But maybe as you might have been talking to them about something, they might let you in on a little bit of their life. (...) So it was not just one sided, me talking at you all the time and saying my problems, maybe there’s a bit of like “oh yeah that was sort of like something that happened to me”.

Most women did not expect to know a great deal of detail about their GP’s personal life, but rather “everyday stuff” (Jane, 21, lesbian, regional). The personal information shared by GPs was not always trivial, for example, George (56, lesbian, rural) described her GP Dr Harry telling her about a difficult life situation regarding his mother-in-law developing dementia. Reciprocal knowing resulted in increasing trust. Dr Katie (47, regional) had discussed finding common interests with patients just enough to make them feel comfortable, and her patient Mae (53, lesbian, regional) said that as a result, “you can relate to her [Dr Katie], she’s very friendly and [I] feel comfortable with her.” Esther also felt it helped equalise the power balance with her GP:

Esther (36, lesbian, outer urban): In a way mutual sharing or...a kind of cooperative feel, it just creates a bit more of an equal exchange or platform between us.

Eighteen GPs (Drs Elisabeth, Fred, Harry, Jackie, Leon, Lith, Holly, Margaret, Olive, Perry, Soula, Katie, Cam, April, Imogen, Judy, Rose and Tyl) said they felt comfortable to share personal information with some patients. Again this was largely a limited range of information, “nothing ultrapersonal” (Dr Judy) or “intimate” (Dr Katie). Drs Cam, Elisabeth, Fred and Leon all said they had increasingly shared information as they progressed in their profession and became more confident and comfortable in the role. Given that revealing personal information with patients can be regarded as boundary crossing and frowned upon in medical education circles (Wilson, 2000), I was interested to determine whether it was patient or doctor initiated. Amongst this group it was much more likely to be patient initiated with 15 GPs saying that patients had asked them (some of whom were not prepared to disclose), however eight GPs said they spontaneously made personal disclosures to patients at times. For Dr Perry (55, outer urban) that was often
with new patients to whom he says “look you’ve told me a bit about yourself, I’ll tell you a bit about myself”.

**The Relationship as a Professional Friendship**

There is very little in the literature about friendship within the patient-doctor relationship. This could be partly explained by the enduring legacy of the “myth of objectivity” that Hamish Wilson (Wilson, 2000) describes, and the traditional affective disengagement that the relationship-centred care model opposes (Beach & Inui, 2006). Wilson (2000) suggests that since the teachings of Canadian physician William Osler, the doctor has been conceived of as the detached observer, and has been urged to remain distant from the patient, which results in the myth that the doctor-patient interaction has no influence on outcomes. Lucy Candib (1995) describes the benefits of reciprocity and self disclosure by doctors as part of relational caring, and says this is like a family relationship in its intimacy, although she does not go as far as to suggest this is friendship. Celia Roberts (C. Roberts, 2004) does mention friendship as being an element of relationship-based primary care that GPs need to develop, as well as trust and commitment, while David Loxterkamp (2008) believes that friendship is an important element of the relationship with certain patients. The relational knowing and its reciprocal component that many women in my study preferred had a great deal in common with friendship.

In my study, seven women believed that ideally their GP would be ‘like a friend’. This was not a friendship in the day-to-day sense, but a relationship that contained many elements of friendship. The elements that women felt were friendship-based were a sense of rapport (Dora), trust (Jane), compassion (Betty), caring (Betty, Angelina), warmth (Esther) and comfort (Mae). This form of friendship could result from experiencing a GP who trusted women enough to share personal details and present their human qualities. GPs also defined friendship in the consultation in similar ways, such as caring about patients (Drs Cam, Leon, Imogen), patients caring about them (Dr Olive), reciprocal
affection and respect (Dr Joseph), comfort and ease of communication (Dr Alan), and wanting to be there for patients as a friend (Dr Margaret). All of these descriptions applied to a selected group of longer-term relationships indicating that this developed over time.

Several women made the distinction between receiving a ‘service’ and having a ‘relationship’ with a GP, which again refers to women’s preference for doctors to move away from the objective towards a subjective approach with patients, particularly after disclosure. Alice felt that female GPs were “more relationship based than men” who offered more of a service, although several of the other women had found this level of relationship with male GPs too. Several of the male GPs I interviewed were committed to the relationship, for example Dr Westy (49, inner urban) said “I tend to believe strongly in building relationships with patients, again to enable them to be more open in what they want to discuss”.

For some women (Betty, Esther, Helen, Dora, George and Lesley) the friendship elements within the patient-doctor relationship developed after a successful disclosure of their sexual orientation. Dora (41, gay, inner urban) said of the relationship with Dr Soula after her disclosure that “she immediately knew my situation, so because of that I feel much more comfortable with her. She’s like a real friend, like if I really have a problem I go and talk to her”. Helen (49, lesbian) said that talking about her sexual orientation to her GP was “like being emotionally naked in front of her”, and at that point the relationship moved from being “business-like” to being “stronger and more comfortable”. George described a similar significant shift in her relationship with Dr Harry after disclosure:

George (56, lesbian, rural): Until that time I had a good relationship with him but I don’t think it was quite as open. And he now as I said looks at all aspects of my life. (…) I was very much a patient that went in and saw my GP, went out, paid the money and left. Now I go in, I sit down, we have a couple of laughs and a couple of jokes. I just feel very happy about going to the practice. I don’t think I’m quite as anxious as I used to be.
George, Dora, Alice and Helen’s experience indicates that through the GP knowing them more holistically, the patient-doctor relationship moved from a business-like exchange based in the system world of medicine to a friend-like interaction utilising knowledge of the lifeworld of the woman. The woman’s role shifted from ‘patient’ to ‘person’, and seemingly the doctor’s role also moved from doctor to person, someone, for example, with whom George could share her sense of humour and relax.

The friendship within these optimal patient-doctor relationships differed in important ways from other friendships. Angelina (37, lesbian) and Betty (41, lesbian) both used the phrase ‘professional friendship’, which I will use to signify these differences. In particular, this difference pertained to the boundaries that women and GPs put in place to protect each other and maintain the relationship at a professional level. One of the implicit boundary ‘rules’ was that the relationship remained within the consulting room. Alice (43, bisexual, rural) had a history of becoming “enmeshed” with a previous female doctor, which she partly blamed on her own propensity to create insufficient boundaries. She described needing a “professional distance” with her current GP, Dr Judy. Dr Judy (48, outer urban) also preferred to maintain fairly tight boundaries and used the phrase “professional distance” and said “I think you can be friendly without revealing everything about your life”. Dr Judy’s boundaries regarding self disclosure were similar to several other GPs including Drs Cahill, Debra, Soula, Cam, Elisabeth, Perry and Tyl who only revealed personal information to patients they knew well.

By contrast, some women and GPs rejected the concept of professional friendship, preferring the concept of professional relationship. For example, Helen (49, lesbian) believed that the relationship is “manufactured” and that although there is “a degree of intimacy” with her GP, it is an “instant” and “false” intimacy that would take years to develop with a true friend. Dr Imogen also preferred not to call this intimacy a friendship due to the boundaries that were required:

Dr Imogen (46, outer urban): …you do feel very close to a lot of your patients. Particularly if you have an ongoing relationship with patients (…) particularly if they’ve shared with you a lot of personal information. It does feel like a friendship,
but it isn’t a friendship. So there’s a big difference. I think you can have a really
good doctor-patient relationship that in every other way can feel like a friendship,
but it only ever happens within the context of being here [in the consulting room]...
there are very different boundaries around it to those in a friendship.

In summary, professional friendship was a concept that many of the women and GPs in
my study advocated as being present in their ongoing patient-doctor relationships. For
some women, it had developed as a result of their disclosure, and for others it resulted
from the limited self disclosure of their GP. Others preferred not to use the term
friendship, although still described elements of reciprocal knowing, intimacy and trust,
and had a common concern to preserve strict boundaries.

I will now describe four woman-GP pairs to demonstrate a range of perspectives of
professional friendship and the influence this had on the inclusion of women’s (and GPs’)
lifeworld in the consultation. The women in these pairs all valued empathic, humane and
reciprocal knowing, but had different preferences in terms of holistic or physical care, and
disclosure. These examples display relationship-centred care in action. They also reveal
the way that professional friendship may, or may not, enable improved knowing of the
lifeworld of sexual minority women despite GPs’ limited experience and knowledge.

Susan, Betty and Dr Olive

Partners Susan (43, gay, inner urban) and Betty (41, lesbian, inner urban), and their usual
GP Dr Olive (43, inner urban) had developed a close form of professional friendship.
Susan had been seeing Dr Olive for 18 years, and Betty for nine years. Overall, the three
had corresponding values in that Dr Olive practised in a holistic way, which was preferred
by Susan and Betty. Dr Olive believed that generally lesbian women had the same health
issues as other women, as did Betty and Susan. Dr Olive felt that mostly it was irrelevant
to know about sexual orientation apart from same-sex relationships, and both Susan and
Betty had disclosed in the context of their relationship. These matching values and beliefs,
as well as potentially their matching gender and age, made some contribution to the
development of the professional friendship, which for Susan in particular, had helped her
to overcome feelings of mistrust of GPs.

Susan spoke of the “fine line of doctor-friend” that she had negotiated. She felt that she
and Betty had “gone that little bit further”, moving from feeling comfortable to developing
a mutual trust and having “a certain familiarity” but not disrespecting or “taking
advantage” of Dr Olive. Betty described the relationship similarly:

Betty: I suppose with time, like any relationship, you tend to get closer. I mean I
consider her [Dr Olive] a friend, not that we see her outside of the surgery, but
every time I go to see her it’s like seeing a friend.

Interviewer: And what makes it a friendship do you think?

Betty: It’s the compassion and the caring. Like, I went to see her a few weeks ago,
and of course she’s obviously pregnant now, and the time before that I said “you
bugger, you didn’t tell us that you were pregnant”, she goes “no, I was keeping it a
secret”. So then I gave her a cuddle and “Oh congratulations, that’s great”. I sort of
rubbed her belly, because she just looks beautiful, she’s just glowing. (…) Yeah,
so it’s more of a friendship I think, but a professional friendship.

Dr Olive knew that I had interviewed Susan and Betty, and described them to me as
“almost like very good friends”. She was clear that she was “quite discerning as to what I
share and when and it seems to have been beneficial [to patients]”. She had only recently
realised the extent of their mutual caring.

Dr Olive: Often they inquire about my life, and I don’t have a problem with
sharing aspects of my life I suppose if it’s relevant. For example I’ve just had a
baby so a lot of long-standing patients were very excited about that, surprisingly
so. One woman left the room and she said “I’ve never been so happy about
someone having a baby”.

Interviewer: And what surprised you about that reaction?

Dr Olive: It surprised me that they obviously care about me to a very significant
extent [pause] and want me to be happy too.
So, for these three people, the component of the lesbian lifeworld that they all concurred was relevant for the consultation was the same-sex relationship. The authenticity with which Susan and Betty could present as a lesbian couple assisted in the development of this professional friendship. It had developed over several years, although it had been more overt to Susan and Betty than it had to Dr Olive. Dr Olive had only recently realised the depth of mutual caring, which became obvious to her because part of her own lifeworld, her pregnancy, had become evident to patients.

**Jamie-Lee and Dr Joseph**

Jamie-Lee (47, gay, inner urban) and Dr Joseph (57, outer urban) had known each other professionally for 24 years and had developed a similarly close professional friendship to Susan, Betty and Dr Olive. This demonstrates that having similar age and gender are not necessarily prerequisites. An important difference for this pair from the previous pair was that Jamie-Lee had not disclosed being gay to Dr Joseph. She knew him well on some levels but was not aware of his attitudes about sexual orientation, which prevented her from telling him. In fact, Dr Joseph had a very non-judgemental approach to lesbian women as he displayed when discussing his relationship with a lesbian couple he had seen as patients for 25 years. He told me they were “good friends, wonderful friends”.

Interviewer: What elements were there of friendship?

Dr Joseph: I visited them at their home over the years, many times...we had some interests in common which we used to discuss. I used to always admire their garden when I was there and they were keen gardeners and so am I. So, just personal things like that ...it got to the point where... I considered them friends and I know they considered me a friend.

[Later he describes the mutuality of the professional friendship in general]

It is apparent that it’s not just a clinical thing, there’s a degree of respect and appreciation and affection between patient and doctor. And that’s very important.
Jamie-Lee appreciated Dr Joseph’s willingness to reveal personal information:

Interviewer: How well do you think you know him [Dr Joseph]?
Jamie-Lee: As a person I think I know him reasonably well. I know he’s married, I don’t know whether he’s got children, but I know he’s married and he enjoys gardening and things like that. I do know some personal things about him and some of his interests.

Interviewer: And how do you know that?
Jamie-Lee: Just from going to him for so long. (...) I like to know a little bit about the person that I’m dealing with and their interests as well. And it is more about the person rather than… I mean he’s a very good doctor, but if he wasn’t a nice person I wouldn’t be there.

So, Jamie-Lee valued the reciprocity of knowing Dr Joseph both as a doctor and a person. Again this reflects Lucy Candib’s (1995) concept of connected knowing, of the shift from contract to relationship. Given the level of friendship, it may appear surprising that Jamie-Lee had not told Dr Joseph about her sexual orientation. The barriers here were three-fold: a) Jamie-Lee did not know his attitude and as I mentioned previously, his lack of inquiry made her feel that he was not interested in her sexual orientation; b) they had a shared belief that lesbian women had no specific health issues, so that it wasn’t relevant in the consultation; and c) Jamie-Lee had been seeing him when she was married, creating an assumption that she was still heterosexual. Therefore, this example shows that having a professional friendship does not guarantee openness about sexual orientation when other barriers to disclosure exist, nor does it always overcome the heterosexual assumptions that were so prevalent amongst GPs.

Sharon and Dr Holly

Sharon (40, lesbian, inner urban) and Dr Holly (39, lesbian, inner urban) displayed a professional friendship on another level, with more strict boundaries than the previously described pairs. This meant there was much less reciprocal knowing but still a
connectedness through caring and empathy. For example, Sharon had disclosed being lesbian to Dr Holly, however she was not aware that Dr Holly was lesbian. Sharon explained how well Dr Holly’s approach suited her:

Interviewer: How well did you feel you knew her [Dr Holly] as a person?
Sharon: Well….not very. I didn’t know anything about her private life. (…) I have no idea if she lived with anyone or if she did, what gender they were or if she had kids or whatever. It sounds contradictory, she had a very open manner but I guess it wasn’t relevant for her to be talking about herself. And I don’t think I would have felt comfortable if she had been really.

Interviewer: Why would you not feel comfortable if she talked about herself?
Sharon: I just don’t think it’s appropriate for that relationship. I liked her and if I’d met her in…down the pub or something I’d have thought, she’s nice, I’d like to be friends with her. But she was there as my doctor so I don’t want to be friends with her and I don’t want her trying to be friends with me. So I suppose just having some boundaries there (…) makes me feel more comfortable that it’s just strictly a professional relationship. I wouldn’t really feel comfortable if she’s going to give me a Pap smear or check my breasts or something, I don’t want to know about her personal life. I’d rather she just be there in the doctor role. The fact that she was very caring and kind and concerned and warm and all the rest of it made her a really good doctor. But it always needed to have this…I would always want it to have the professional context or overlay.

Later in the interview Sharon said she thought Dr Holly might be lesbian because of her level of comfort in discussing Sharon’s same-sex relationship break up. However she preferred not to know to avoid any possibility of “bonding” at that level. Dr Holly was also cautious about disclosing too much personal information as she felt “a close relationship with the GP tends to derail or sabotage any therapeutic process”.

Dr Holly: I have to say I never volunteer [about being lesbian]. Um…if they ask me directly, unless there’s an alarm bell or good sense of the inappropriateness of either the time or the patient in general, then in general I’d let them know I’ve got a female partner.
[a little later]
I think it probably comes down to patient by patient. I think there are some patients that to engage them they almost have to know every detail about your life but I guess my sense is that with most patients, you should be able to engage them short of that level of revelation and then you bypass any of those funny territory boundaries.

So, Dr Holly’s approach to telling about her minority sexual orientation in limited circumstances if patients asked her personal information worked well for Sharon who had similar misgivings about the professional relationship becoming too personal. Sharon did not want to enter into Dr Holly’s lifeworld, particularly as she suspected that it may be similar to her own, which Sharon felt could cross sexual boundaries, particularly during intimate examinations. Regardless of the lack of reciprocal knowing, Sharon felt comfortable to be open with Dr Holly due to her caring approach. This was also partly about having similar understandings that lesbian women have different health issues to other women, a context in which Sharon’s disclosure was highly relevant for each of them.

In summary, the three pairs displayed very different ways of experiencing the professional friendship. The professional friendship with Dr Olive at least partly facilitated disclosure of sexual orientation, whereas various barriers prevented this despite a professional friendship with Dr Joseph. Finally, not having a level of reciprocal knowledge was not a barrier to disclosure for Sharon due to Dr Holly’s caring and holistic approach. Indeed, it is important to emphasise that there should be no expectation of this level of relationship within all patient-doctor relationships. Carolyn Chew-Graham and colleagues (Chew-Graham, May, & Roland, 2004) make this point when they suggest that GPs can be demoralised if they focus on the doctor-patient relationship with all patients, even those with whom they feel they have nothing at all to offer. However, I chose these pairs to help answer the final question of the chapter, and found that the elements enabling knowing within the patient-doctor relationship were reciprocal and relational. The elements of friendship including mutual trust and the sharing of personal information may have
existed for some woman-GP pairs, and may have facilitated disclosure of sexual orientation for some but not all women.

**Summary**

I have described a habitual silence amongst many GPs in my study regarding minority sexual orientation, which arose due to heteronormative and occasionally pathologising approaches. Pathologising of minority sexual orientation was uncommon and women generally took control over this by terminating their involvement with these GPs. Heteronormativity leading to silencing arose within a medical system that ignored lesbian and bisexual women’s needs at all education levels, and failed to challenge negative attitudes and value systems that some doctors brought from their own lifeworld. As a result the medical system dominated or colonised the lifeworld by failing to recognise the relevance of sexual orientation within the medical consultation. Therefore, GPs had to rely on their own lifeworld experiences to fill this silence. The strongest positive influences on overcoming the silence were personal experiences of knowing lesbian and gay friends or relatives, or being lesbian or gay themselves. An important outcome of the silencing was to create an environment of uncertainty and mistrust amongst women, which restricted their willingness to disclose. Flowing from this, GPs acquired little or no knowledge through experiential learning because they saw very few women whom they knew to be lesbian patients. The resulting lack of awareness did little to encourage GPs to seek further knowledge through professional development or informal discussion with colleagues, hence revealing a cycle of silencing. Bisexuality was even more hidden despite the likelihood, according to population statistics, that GPs would see at least as many bisexual as lesbian women.

Communication about sexual orientation was not distorted by the medical system as much as disregarded. This was because when doctors had little knowledge in this area they tended to revert to biomedical knowledge that was familiar and safe. Habermas theorises that systematically distorted communication can blind us to gaps in knowledge, which he
termed “pseudo communication”, where participants can’t recognise their misunderstandings, and can generate false consensus (Habermas, 2003 (1972)). The false consensus held by some women and doctors in this study was that minority sexual orientation is irrelevant within the general practice setting. Rather than being a belief that was formed through communicative action for mutual gain, it was a strategic action used by some doctors through their heteronormative approach, and also by some women who deliberately encouraged heterosexual assumptions to avoid disclosure. The purpose of the strategic action here was to gain control through silencing the same-sex attracted lifeworld.

Despite the neglect within the medical system, the majority of the GP participants in my study had a genuine aspiration to understand same-sex attracted women better and to satisfy their needs including a desire to reach a real consensus through communicative action as Habermas suggests. Therefore, the assertion of Carl May (2004), and Christine Barry and colleagues (2001), that GPs are interested to understand the social world of their patients also applies to sexual orientation, assuming GPs become aware that some of their patients want and need this understanding. The habitual silence was overcome within some patient-doctor relationships through the development of professional friendships, or at least through relational knowing. This confirms Habermas’s theory that communication can bring shared understanding by engaging the lifeworld, in this case both the women’s and, to a limited extent, the GPs’ lifeworlds. The relationship-centred approach, including reciprocal knowing that Lucy Candib (1995) describes, created a connectedness that opened the possibility of introducing sexual orientation, and enabling a more authentic presentation of women’s selves.

The medical system and the lifeworld can be presented as a dichotomy. Medicine has been conceptualised as objective, scientific and rational; prone to avoiding the emotional world of patients because it is less predictable and certainly less controllable (Kleinman, 1980). The lifeworld of minority sexual orientation has been presented as subjective, private and irrelevant to medicine (Westerstahl et al., 2002). The forms of professional friendship developed by some of the people in my study indicate that this dichotomy can be
overcome. The business of medicine can become personal and relational, with the patient and doctor becoming humanised; and the issues of sexual orientation can become socially and at times biomedically relevant.

Questions that now remain are how to overcome the habitual silence, not only through relational knowing, but more broadly through education. The issue of who is responsible to broach the subject and reveal the lifeworld is also pressing. I will answer these questions within the following chapters. In the next chapter, I will explore the lifeworld from a broader perspective by explaining the various levels of sexual identity that women described and their influence on the need for women to remain silent or break the silence with their GP. I will introduce the socio-political context in relation to women’s sexual identity expression, in their life generally and within the patient-doctor relationship.
CHAPTER 5 - IDENTITY AND DISCLOSURE WITHIN GENERAL PRACTICE

This chapter addresses personal experiences and public expression of lesbian and bisexual identities and their place in the general practice consultation. On the personal level, I will describe women’s lived experiences of their sexual identities and categorise them into specific groups according to the level of importance of sexual identity to each woman. On the public level, I will present the approaches that different women used regarding disclosure of their sexual identity to their GP. One of the central and ongoing debates amongst feminist theorists relates to the personal/public divide and whether it is a legitimate distinction in modern society or whether the personal domain is indistinguishable from the public (Arneil, 1999). I will explain the close interactions between personal and public sexual identity and demonstrate that they are by no means opposing forces or dualistic poles. Nor are they without boundaries. They are distinct yet inter-related.

The second question of primary focus in this thesis addresses how disclosure of non-heterosexuality is negotiated between same-sex attracted women and their GP. In the previous chapters I demonstrated that women’s preferences and expectations for care, and that their experiences of care only partially influenced disclosure. I will show that there are four ways that women experience and describe their sexual identity and that these have a strong influence on women’s desire to disclose to GPs. In this chapter, I will introduce the socio-political context in relation to women’s sexual identity and demonstrate the manner in which this influences disclosure through perceptions of risk. I address two questions in this chapter:

1. How does sexual identity influence women’s preference for inclusion of their sexual orientation in the consultation?

2. How well do GPs understand sexual identity?
I will first outline the major theories that have helped to guide my analysis of sexual identity. I have drawn upon Anthony Giddens’ (Giddens, 1991) work on self identity and modernity to frame concepts of identity. Irving Goffman’s (Goffman, 1971) work on the ways in which people manage stigma provides some understanding of the impact of negative socio-political attitudes on sexual identity expression. Lesbian and bisexual identity has been theorised since the 1970s. I have developed my own model for sexual identity disclosure to GPs, which expands on an integrated model of identity developed by Adam Fingerhut and colleagues (Fingerhut et al., 2005). It also evokes an essentialist identity formation theory described by Vivienne Cass (Cass, 1979) and a social constructionist theory developed by Celia Kitzinger (Kitzinger, 1987). My model depicts the three central influences on same-sex attracted women’s sexual identity expression to GPs that emerged from my analysis: the identity experience; risk management; and the degree of knowing within the patient-doctor relationship.

Giddens, Goffman and Identity

Anthony Giddens (1991) describes features of modernity that impact on our self and identity development. Previously, tradition provided groups of people with an identity and provided social systems with a fixed set of beliefs that people trusted. Modernity tends to reject tradition, meaning that the individual must determine their self identity, and modern institutions move away from the traditional values. According to Giddens, we continually produce and reproduce our self identity through choices and we then communicate this identity to other people (Kaspersen, 2000). So self identity is a personal and a public entity, and can be fluid. We have a ‘narrative’ of our personal identity and publicly we choose a lifestyle that reflects that identity. Giddens defines lifestyle as:

a more or less integrated set of practices which an individual embraces, not only because they fulfil utilitarian needs but because they give material form to a particular narrative of self-identity…. Lifestyles are routinised practices, the routines are incorporated into habits of dress, eating, modes of acting, and favoured milieux for encountering others; but the routines followed are reflexively
open to change in light of the mobile nature of self-identity. (Kaspersen, 2000, p.105)

Giddens’ self identity description does apply to many lesbian and bisexual women, who have a personal identity and a public lifestyle that may reflect that identity. Equally, the public expression may not reflect the personal identity largely due to concerns regarding the risk of discrimination. Giddens suggests that there is a balance between trust and risk in that “we constantly assess the extent to which our actions entail elements of risk and evaluate the probability of our actions obtaining the expected outcome” (Kaspersen, 2000, p.100). This certainly applies to lesbian and bisexual women in many social settings that may be homophobic. Lesbian poet and activist Adrienne Rich highlighted the common practice of concealing lesbian identity to avoid social stigma and coined the phrase ‘compulsory heterosexuality’, which she claimed was imposed on women by powerful and predominant social attitudes (Rich, 1986 (1979)). Risk can also be perceived in professional settings and Giddens (1991) identifies that the modern individual can recognise the limitations of expert systems rather than just accepting the expertise.

In applying Giddens’ identity and modernity theory to general practice care, it can be argued that traditionally patients automatically trusted doctors, however the modern patient expects to build that trust over time (Berry et al., 2008). In terms of bringing minority sexual identity into the public space of the general practice consultation, same-sex attracted women recognise there is a risk, and part of relationship building and trust is to understand whether negative social attitudes are adopted or rejected by particular GPs. Giddens claims that security engendered by trust is central to our identity development, particularly trust within personal relationships. He described “pure relationships” with a sexual partner or a friend as those that are built on intimacy, trust and reciprocal caring, and that they are constantly negotiated (Kaspersen, 2000, p.153). In my analysis of trust within the patient-doctor relationship, I explore this connection between trust and identity from both the woman’s and the GP’s perspective, and the potential for them to become ‘pure relationships’.
Irving Goffman’s (1963) work on the ways that we deal with stigma is very helpful in understanding how the risk of being stigmatised can modify public expression of sexual identity. Goffman defined stigmatisation as “the condition of being denied full social acceptance” (Goffman, 1963) p.2). Liz Sayce (Sayce, 1998) argues that the term discrimination is preferable to stigma, as stigma can suggest that the victim is to blame, whereas discrimination suggests a social cause. Sayce (1998) defines discrimination as deliberate social exclusion, rejection and subsequent isolation. I will refer to discrimination rather than stigma, while using Goffman’s (1963) work in this area, which remains relevant today. Discrimination moves the focus requiring change from the victim of negative social attitudes to the perpetrator.

Goffman (1971) describes how we structure our social encounters. He suggests that we all seek information or ‘impressions’ about a person we are interacting with so that we know how to act in their presence. We look for evidence of socio-economic status, their concept of self, their competence and trustworthiness. In return, the observed is aware of these observations and gives information or ‘expressions’ about themselves, some expressions being intentional and some unintentional, some verbal and others behavioural. The observed person attempts to control the impression gained by the observer, which Goffman calls impression management. This can involve intentionally providing misleading information. Goffman describes “a kind of information game…a potentially infinite cycle of concealment, discovery, false revelation and rediscovery” (Goffman, 1971) p.20), with which I believe many GPs and patients would be familiar. He does recognise that concealing a stigmatised status can be viewed with sympathy by the observer. The examples Goffman provides (ex-convicts, the ‘deflowered’, epileptics and racially impure) reflect the era in which he was writing, however this could equally apply to people with minority sexual orientations.
Feminist Perspectives of Personal and Public Spaces

Feminists have objected to the dichotomy of personal and public as relegating women to the ‘second sex’ (Beauvoir, 1953). This confined women to the private, nurturing and intimate space of the home; while men occupied the public and rational space of leadership in broader society. As women gradually entered the public realm during the late 19th and 20th centuries, new personal/public divisions and hierarchies of acceptability became evident including those relating to sexual orientation (Arneil, 1999). Similarly, from the first description of homosexuality in the late 19th century until the liberationist movements of the 1970s, homosexuality was regarded as having a lower social status than heterosexuality and was accepted only while it remained concealed (Altman, 1971 (1993)). Barbara Arneil (1999) discusses the way in which postmodern feminism has attempted to overcome the public/personal dualism and enable the personal and public to co-exist and each to have legitimacy and value. This can equally apply to the place of homosexuality. The issue of choice is central to the feminist reworking of personal and public. Both are legitimate spaces for women, both are spaces of choice (Snaith, 2000; Woolf, 1981). Identity has been conceptualised as an “internal-external dialectic” in that “identification is the process whereby all identities are constituted” (Jenkins, 2004, p.18). In sympathy with feminist ideals, this suggests that the internal or personal self identity is influenced by the external definitions of self as seen by those around us. I will use these definitions of identity in my analysis of women’s sexual identity and explore the dialectic between personal and public.

Lesbian and Bisexual Identity Frameworks

There are three overriding frameworks that have evolved since the 1970s to explain sexual identity. The first were staged identity development models that were largely essentialist in that they explained homosexual identity as an innate quality (Cass, 1979). These stage theories have been used in gay affirmative psychology since the 1970s to assist homosexual clients to attain full integration of their sexual identity into their everyday life.
The second framework, which developed through the 1980s, used social constructionist theory, suggesting that homosexual identity is not innate but socially constructed (Kitzinger, 1987). The third and most recent framework has arisen out of queer theory and suggests that we have multiple identities which are at once fluid, innate and social (Fingerhut et al., 2005).

**Staged Identity Formation Models**

Vivienne Cass’s (1979) model of staged identity has been one of the most influential of several developed during the same period, and has recently been revised (Cass, 2005). Cass developed her model of identity stages through observation of lesbian women and gay men in her Australian psychology practice. She distinguishes between personal and public (social) aspects of identity and says that these aspects develop separately but are inter-related. She describes six stages of homosexual identity development, of which the final and, in her view, optimal stage is full integration of the public and personal aspects (Cass, 1979):

1. ‘Identity confusion’ – the person feels same-sex attraction, however it is incongruent with their presupposed heterosexual identity.
2. ‘Identity comparison’ – the person accepts the possibility that they may be homosexual, feels alienated from others and feels they are ‘the only one like this’, continues to pass as heterosexual.
3. ‘Identity tolerance’ – the person does not yet fully accept their homosexual identity but starts making contact with other homosexuals.
4. ‘Identity acceptance’ – the person increases contact with homosexuals, continues to pass as heterosexual sometimes, but selectively discloses homosexual identity and will affiliate with heterosexual and homosexual social groups.
5. ‘Identity pride’ – the person develops a strong commitment to the homosexual group, generates a group identity to which he or she belongs. Anger and pride generates activism and the person now prefers disclosure.
6. ‘Identity synthesis’ – the person tries to attain maximal congruence of personal and public identity while re-integrating with the heterosexual world.

Paula Rust (Rust, 1993) has criticised the staged identity models for being too linear and ignoring the possibility of fluidity between stages. She asserts that they assume that the ultimate goal is to achieve identity synthesis or integration, which may not be the preferred endpoint for some women. Paula Rust (1993) also suggests that the staged models privilege homosexual identity and do not acknowledge that bisexuality or no identity may be equally valid. I consider that some of these limitations arise due to the clinical sample of the men and women from whom Vivienne Cass (1979) derived her theory. They were seeking psychological help in relation to their identity. Cass has recently revised her original model and addresses some of these criticisms in arguing for a more multi-factorial understanding of sexual identity formation, moving away from a purely psychological approach to suggest that the person and their environment reciprocally influence each other (Cass, 2006). While I agree the original model has limitations, I found that it did apply to some of the women I interviewed.

**Social Constructionist Models**

Social constructionists believe that sexual identity formation is not about discovering the essence of an existing identity, but creating identity through social interaction (Dolan, 2005; Rust, 1993). Celia Kitzinger (1987), who used a social constructionist framework, was influential in publishing one of the first studies to focus specifically on lesbian identity. She interviewed a community-based convenience sample of 120 lesbian women in the UK for her PhD. She distinguished between lesbian identity and gay male identity, in that lesbian identity is based on choice and is a social construction, whereas gay male identity is innate. Some theorists now regard this as a significant gender-based difference in expression of non-heterosexuality, and say that it must be acknowledged in research and clinical practice (Martin & Knox, 2000). Others suggest that either a constructed or innate basis can apply to either gender, but that women tend to display more fluidity and
less congruence between attraction, behaviour and identity than men (Dempsey, Hillier, & Harrison, 2001). This incongruence was found amongst more women (8.2%) than men (4.2%) in a large Australian telephone interview study involving 9,134 women and 10,173 men (Smith et al., 2003). Amongst the women in that study, 0.8% identified as lesbian, 1.4% as bisexual, and 15.1% reported same-sex attraction or experience; whereas amongst the men, 1.6% identified as gay, 0.9% as bisexual, and 8.6% reported same-sex attraction or experience.

Celia Kitzinger (1987) brought a lesbian feminist perspective to the debate by claiming that lesbian identity is not about personal needs but about socio-cultural and political goals to liberate women from patriarchal oppression, therefore shifting the emphasis from a personal and individual developmental process to a public and collective political act. She defines identity as “the set of meanings ascribed by a woman to whatever social, emotional, sexual, political or personal configuration she intends when she describes herself as a lesbian” (Kitzinger, 1987, p.90). She describes seven experiences or ‘accounts’ of being lesbian. Two of these accounts were by women who were not comfortable, one of whom experienced being lesbian as a ‘personal failing’ and the other felt being lesbian was ‘pathological’. The other accounts were:

1. lesbian as ‘sexual attraction’ only – this was a fluid attraction.
2. ‘person not the gender’ – these women said they fell in love with their partner who happened to be a woman. They had all been bisexually active, did not want to label themselves as lesbian, and considered it possible they could be with men in the future.
3. lesbian as a ‘minimal part’ of themselves – they regarded their lesbian identity as a private and personal matter, and they identified as people first.
4. lesbian as ‘personal fulfilment’ – they felt being lesbian was a discovery of their true self, they were not political about it, most had previously conformed to heterosexual expectations.
5. lesbian as a ‘socio-political statement’ – these women were radical feminists, they believed they had created their own lesbianism, and that it was not personal or private but a challenge to the dominant social system.
In contrast to Vivienne Cass’s (1979) stages, Kitzinger’s model allows for a variety of experiences of being a lesbian (or bisexual) woman and recognises that some women are very private while others are quite public about their sexual identity; some are apolitical and others politically motivated; some fluid and others fixed. However, missing from Kitzinger’s and Cass’s accounts is any sense that personal and public can coexist.

**Multiple Identity Models**

Identity theory has developed over the last decade to accommodate an understanding that we each maintain multiple identities (Jenkins, 2004). With regard to sexual identity, this was initiated by the postmodern ‘queer’ movement, which rejected the dualism of homosexuality and heterosexuality (Seidman, 1993). In fact, postmodernism rejected the concept of identity altogether (Butler, 1990), although it has since been reclaimed by leading theorists (Jenkins, 2004). I have deliberately chosen to use the concept of identity because it was a common way that women in my study understood their experience. I have also elected to use the lens of multiple identities as an emerging and exciting re-engagement with this concept in the field of sexual orientation. For example, research on the interplay between ethnic and minority sexual identity challenges us to remove assumptions that lesbian or gay identity would be the prime identity in ‘identity hierarchies’, in finding that ethnic identity may dominate (Markowé, 2002, p.225). So, from this perspective it is important to examine how minority sexual identity interacts with other more mainstream identities.

Multiple identity models show that most women (perhaps all) subscribe to multiple identities that are fluid and contingent on the context of their social interactions (Jenkins, 2004). For example, I currently identify as a lesbian woman, doctor, PhD student, academic, mother and musician, and the order in which I consider these identities important personally and present them publicly varies. These models fit most closely with Giddens’ concept of self identity, and particularly the interplay between the personal self
concept and the public presentation of identity. They also allow for fluidity, with identity changing as life circumstances alter. According to Giddens, we continuously produce and reproduce our self-identity, it is not a passive entity but a ‘reflexive project’ (Kaspersen, 2000, p.104).

Adam Fingerhut, Lelitia Peplau and Negin Ghavami (Fingerhut et al., 2005) from Los Angeles, USA have developed an identity framework that allows for fluid or fixed states, for coexisting multiple identities, and incorporates personal and public as simultaneous and legitimate components of sexual identity. Their ‘dual-identity framework’ identifies the variable social affiliations that lesbian women develop with lesbian and mainstream communities. They derived the model from the literature and then tested it in questionnaire based research with 116 lesbians recruited through lesbian organisations and gay pride marches in two large cities. One limitation of the model is that it does not directly include bisexual women’s experience. Fingerhut et al. (2005, p.130) describe four identity categories based on the intersection between lesbian and mainstream identities:

1. ‘Marginalised’ (may overlap with Kitzinger’s ‘pathological’ and ‘personal failing’ groups) – they feel socially isolated, not comfortable in either lesbian or mainstream community. Very sensitive to the stigma of lesbian identity.
2. ‘Assimilated’ (similar to Kitzinger’s ‘minimal part’) – these women prefer to be treated as an individual, being lesbian is of marginal significance to their identity. They have a low lesbian affiliation and high heterosexual affiliation socially.
3. ‘Integrated’ (same as Cass’s final identity synthesis stage) – they combine a strong lesbian identity with active involvement in mainstream community. This may change with their life stage, for example lesbian women who become parents tend to shift their affiliation toward the parenting community.
4. ‘Lesbian identified’ or separated (similar to Kitzinger’s ‘socio-political statement’ group, and Cass’s ‘identity pride’ stage) – being lesbian is central to their personal and social identity. They tend to separate from the mainstream and mostly socialise with the lesbian community.
I will next describe the identity experiences and preferred identity expression of the women in my study, or using Giddens’ (1991) terminology, their personal narrative and public practice. My main focus is on how different identity experiences influence disclosure of sexual orientation to GPs.

**Sexual Identity Experiences – The Personal Narrative**

I found that women’s experiences of their sexual identity fell into four distinct groups. The four groups contain elements of the dual identity framework, as well as of the models of Kitzinger (1987) and Cass (1979), which I will demonstrate throughout and summarise in Table 5 (p.188). To reach an understanding of the range of personal narratives, I analysed women’s discussion about sexual identity throughout their entire interview and took into account whether it applied to the present time or to other periods of their life course. A few women were in transition from one group to another, some had been in different groups previously, while others had remained in the same group throughout their adult life. Fluidity between groups was contingent upon the gender of their sexual partner or family structure or occasionally on their life-stage. Therefore, the four groups do not necessarily represent a hierarchy or progression of stages, as women had moved between groups in any direction. The four groups differed predominantly regarding the level of importance that women placed on their sexual identity compared with their other identities. Like Fingerhut and colleagues’ (2005) framework, they also differed according to whether women preferred social affiliation with lesbian or mainstream groups.

I have labelled the groups *attraction predominant, identity peripheral, identity integrated* and *identity defined*, and will continue to use italics when I use these labels. There is a fifth identity experience, which is one of identity confusion. The experiences of the women in my study suggested that this was a transitional phase for some women and was not experienced by others, so I have not included it as a group in its own right. First, I will describe each of the main four identity experiences and provide a pictorial representation.
using a multiple identities model. I will then describe identity confusion briefly before illustrating the other groups in more depth using examples.

1. **Attraction predominant** – seven women – “I’m same-sex attracted”
   These women did not generally assume a sexual identity for themselves, although some did use an identity label for the benefit of other people. They were bisexually attracted and had been bisexually active in the past or currently. Their same-sex attraction was not closely connected with other parts of their identity. They all had some affiliation with lesbian women, although most of those in their chosen social circle were heterosexual. They were unlikely to need to disclose their same-sex attraction publicly.
   Similar to Kitzinger’s ‘sexual attraction’ and ‘person not the gender’ groups.

2. **Identity peripheral** – 11 women – “I’m lesbian but it’s just another thing about me”
   These women identified as lesbian but this identity was of minimal importance to them. Like the **attraction predominant** group they regarded themselves as a woman or person first and felt they had chosen their sexual identity. They preferred heterosexual social interaction, although some valued lesbian friends. The key difference between this and the **attraction predominant** group was the pertinence of having a sexual identity. They were also more likely to find relevance in disclosing their sexual identity publicly.
   Similar to Kitzinger’s ‘minimal’ group and Fingerhut et al.’s ‘assimilated’ group.

3. **Identity integrated** – nine women – “It’s very important for who I am”
   These women regarded their lesbian identity as important but not predominant, they were comfortable in lesbian/bisexual and heterosexual social networks. They were generally happy to disclose their sexual identity if it was relevant to the recipient.
   Similar to Cass’s final stage of ‘synthesis’ and Fingerhut et al.’s ‘integrated’ group.
4. **Identity defined** – six women – “It’s my inner core”

These women felt their lesbian identity was central, they were likely to believe it was an inherent part of themselves and they preferred lesbian social interaction. Disclosure of their sexual identity publicly was important for their authenticity. Similar to Fingerhut et al.’s ‘lesbian identified’ group, Kitzinger’s ‘socio-political statement’ group, and Cass’s ‘identity pride’ stage.

In Figure 3, I have depicted the four identity experiences by displaying four women each with an arbitrary four identities (e.g. woman, artist, bisexual, mother). Each identity is represented by a hexagon and the size of each hexagon represents the relative importance of that identity in women’s lives. The bold hexagon represents the lesbian or bisexual identity, with the broken bold hexagon indicating the attraction predominant woman’s preference to avoid a sexual identity label. Sexual identity is either connected or disconnected from the woman’s core identities.

**Figure 3 - Pictorial representation of four types of identity experience**

<table>
<thead>
<tr>
<th>Identity defined</th>
<th>Identity integrated</th>
<th>Identity peripheral</th>
<th>Attraction predominant</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Identity defined" /></td>
<td><img src="image2" alt="Identity integrated" /></td>
<td><img src="image3" alt="Identity peripheral" /></td>
<td><img src="image4" alt="Attraction predominant" /></td>
</tr>
</tbody>
</table>
Identity Confusion

In my study, identity confusion occurred for some women, whereas others said they had never been confused. If confusion had occurred, it was a transitional phase towards one of the four sexual identity experiences. I will describe women’s experiences of confusion or lack of confusion here, so as to compare them with the identity confusion stage that is the first in the staged identity theories. For example, Vivienne Cass (1979) suggests that all lesbian and gay people go through this stage as they emerge from an assumed heterosexual identity.

In my study, 14 women (Angelina, Bear, Bee, Dora, Flo, George, Indigo, Kate, Jamie-Lee, Lesley, Lucy, Mae, Miranda and Robyn) described past experiences of identity confusion. Four of these women (Angelina, Bee, Flo and Kate) still felt some confusion, however these women still fitted into one of the other four identity experience groups. Thirteen women (Kirsti, Kiama, Betty, Anne, Nede, Sally, Madison, Mitzy, Jane, Sharon, Susan, Jill and Eileen) had never been confused. The other six women did not discuss confusion with me during their interviews. The presence or absence of confusion did not determine which identity group women were in at the time of the interview. For example, the 13 women who had never been confused represented all four of the sexual identity groups: Kirsti and Jane were attraction predominant; Madison, Betty, Sally, Susan and Sharon were identity peripheral; Kiama, Jill and Eileen were identity integrated; and Mitzy, Nede and Anne were identity defined. Eileen said she had felt “comfortable all along”, Betty and Susan both independently said they “just knew”. All of these women felt that their identity was fixed rather than fluid, it had always been part of themselves, which indicates that the staged identity models do not apply to all same-sex attracted women, and certainly not to Mitzy:

Mitzy (61): I know I can be myself, I can live the life, almost, that I want because I’m really comfortable with my identity and no-one’s going to change it, no matter what. [laughing] This is it.
The experience of confusion for many of the other 14 women was related to prevailing social attitudes and conditioning to be heterosexual. Robyn, Dora and Flo all described being surprised that they were not heterosexual as they had previously assumed:

    Flo (24, same-sex attracted): I think in the back of my mind I will always have that you should be with a man. Like I truly believe that I will probably have that for the rest of my life because… that’s twenty years of training.

Giddens’ (1991) theory of self-identity is helpful to understand why disrupted notions of heterosexuality are so confusing. He suggests that our existing knowledge must always be revised as we reflexively reproduce our identity, and that for a time, this creates uncertainty or doubt that the new knowledge is ‘true’. This is especially the case when traditional rituals and truths, such as the expectations of heterosexuality, do not fit the individual. He asserts the need for ontological security. Ontological security is initially based in the values learned from our parents (usually heterosexual values) and “constitutes the foundation of our own identity and confidence in the social and material world which appears before us” (Kaspersen, 2000, p.102). Challenging these values destabilises self-identity until a new set of values is learned and affirmed.

An awareness of the stigmatised nature of lesbian or bisexual identity also led to a sense of risk and the fear of being judged or discriminated against for the women in my study. This not only affected public expression, but for some women led to self denial of their sexual identity. Women described this using a range of phrases such as “swept it under the carpet” (Bear), “pushed it away” (Mae), “squashed it” (Jamie-Lee). Mae (53) realised that she was lesbian but suppressed it, so this was not so much confusion about her identity as confusion about its morality or acceptability. One manifestation of this denial was to form a long-term heterosexual relationship. As Jamie-Lee (47) said: “I knew I was gay before I got married, but then I just squashed it all and it was the done thing”. Eight women (Angelina, Betty, Gabrielle, Helen, Jamie-Lee, Lesley, Lucy and Nede) were married for a number of years before coming out and others had significant relationships with men including Bear, Susan and Indigo. Jill (50) said “I suppose I was doing what society
thought I should do in terms of going on the heterosexual path, even though I wasn’t really convinced”.

Identity confusion was not only about heterosexual expectations. For some of the bisexually attracted women it was related to their perceptions that a bisexual identity lacked legitimacy. Bisexuality is emerging as an authentic identity, however it remains quite marginal and many bisexual women describe feeling judged or ostracised within both lesbian and heterosexual communities (Pallotta-Chiarolli & Lubowitz, 2003). Clare Farquhar (Farquhar, 2000) found that various contested meanings of sexual identity, behaviour and attraction within the lesbian community have persisted since the 1970s, and she has labelled this ‘identity policing’. In her study, notions of lesbian authenticity had some currency, for example whether a woman could be a ‘real’ lesbian if she had sex with men.

Identity policing was the source of confusion for Indigo, Flo and Mina. Indigo (30) had initially identified as lesbian, then had a male partner, which created identity confusion. She only resolved her confusion when she realised that it was legitimate not to take on an identity and retain the possibility of having sex with either gender, hence her current attraction predominant identity experience. As she said “I was trying to work out what I was, and then all of a sudden….I can remember at the time someone saying ‘well you don’t have to be either’”. Mina described similar confusion about her identity when she was attraction predominant because she was having opposite sex behaviour:

Mina (23): It’s only been quite rare but there’s been occasional times I’ve slept with male friends and that sort of made me think, “Oh what am I really?” I would like for that question not to be important (…) but I feel like in the gay community you are expected to know what you are… as in like what I would identify as.

At the time of our interview, as an identity integrated woman, Mina had resolved this confusion by adopting a bisexual identity and embracing social affiliations with a diverse range of groups. Like Mina, most of the women had resolved their confusion and felt comfortable with their sexual identity. This comfort was associated with developing
confidence and self esteem and many women described their relief and well-being once they had resolved their identity. Women used very affirming phrases to signify this clarity such as it was “just an awakening” (Kirsti) and it was a “big relief” (Madison). Robyn, who was identity peripheral, spoke of her transition from suppression to comfort:

Robyn (31): Being a teenager and not really knowing and knowing you’re attracted to women but not knowing why or whatever, and just sort of suppressing it. (…) When you do finally realise and come out, then your general mental happiness…cause you know then and everything slots into place. “Oh, so that’s why and that’s why”. And then you feel comfortable in yourself enough to know that it’s not a big deal.

Lesley, who is now identity defined, had earlier been married in an abusive relationship for 17 years. When she began her first female relationship after she left the marriage she was attraction predominant:

Lesley (52): I think it was the [same-sex] relationship, it was denying it to yourself, we were saying things like, “Why do you have to be called a lesbian just because you’ve fallen in love with a woman? Why does everything have to have a label?” It’s all that stuff that you work through and then realise you have a label because you have to be able to recognise it yourself. And once you recognise it yourself and once you are able to admit it to yourself then you can talk to others.

So, during that stage of her life, Lesley had avoided adopting a lesbian or bisexual identity, however this was isolating as it prevented her from connecting publicly with other lesbian women. Later in the interview she described the difference for her identity comfort when she took on the ‘label’:

Lesley: Oh that was amazing, that was finding me, it was all around that. Yeah, I grew up in those years and became an adult that I could recognise and be comfortable with. (…) it was getting to know me and becoming comfortable with my sexuality.


**Attraction Predominant**

Seven women (Alice, Bee, Flo, Indigo, Jane, Jenny and Kirsti) described an *attraction predominant* identity experience. The common factor between all of these women, despite their range of ages from 21 to 72, was being same-sex attracted but not adopting a sexual identity for themselves. They described their attractions being to individuals, regardless of their gender, so were similar to Kitzinger’s (1987) ‘person not gender’ group. As Alice (43) said of her previous female partner of six years “I met someone and I fell in love with the person”. Jenny (72) spoke of her appreciation for her “close emotional link with women”. All women had connections with the lesbian and gay community, through websites, support groups or having lesbian friends. All but Jane had attractions to both women and men, either being equally attracted (Alice, Bee and Kirsti) or mostly attracted to men (Flo, Indigo and Jenny). Three women had a current male partner (Alice, Kirsti and Jenny) and Flo and Indigo had no partner, although both thought they could have male or female partners in the future.

In terms of sexual identity labelling, five of the seven women chose bisexual, although they all indicated that this was really a descriptor of their attractions or behaviour rather than an identity. Kirsti made this distinction clear:

Kirsti (53): I am a sexual person. I am not necessarily hetero or bi or attracted (...). If people need an identity… like a few of my gay friends need an identity from me then they know that I’m bisexual but I think it makes them more comfortable to know that they’re talking to somebody that does have same-sex as well. (...) I’m quite prepared to give them a label if they want one.

Indigo (30) and Jenny had selected ‘mainly heterosexual’ on the sexual identity question on the Diamond screening survey, however both said they had not been sure which category fitted them best, and Indigo had selected bisexual on my pre-interview survey, while Jenny had not chosen any identity label. Flo (24) preferred to use her own personal identity label, indicating her need to be an individual, however was starting to use bisexual
in lesbian circles. She stated that she did not think her sexual identity was an important part of her and “I don’t think it would ever be important”.

Jane, the youngest woman in the study at 21, was different to the other women in this group in being attracted only to women for the previous two years, although she had previously identified as heterosexual. She had selected lesbian as her identity on my pre-interview form, however would not have used that label for herself. She said “I don’t think about me being gay, I just think about me being me”. I asked how she would describe herself to a new GP and she said:

Jane: If they say “just can you give me a bit of a description?” [I would] just say “I live here, I’m 21, I come from a large family, I’m same-sex attracted”.

In terms of social affiliation, all of these women had been connected in some way to the lesbian community, although the majority of their social circle was heterosexual. All had lesbian friends, Bee was involved with an Asian lesbian group, and Flo and Jane attended a same-sex attracted youth group. Alice suggested that she and her previous female partner had actively sought out lesbian women for social support because they had been in a minority, particularly living in a small rural town. Indigo said that being bisexual was “not a big deal” and that “90% of my social network would have absolutely no idea that I’ve ever had any type of female liaison/relationship”.

**Identity Peripheral**

The common feature of the *identity peripheral* group was that they did adopt a lesbian identity, in contrast to the *attraction predominant* group, although described it as being of peripheral importance in their lives, and none were bisexualy attracted. Eleven women (Bear, Betty, Dora, Gabrielle, George, Kate, Madison, Robyn, Sally, Sharon and Susan) were in this group. They were aged from 21 to 56 and had a diverse range of economic and ethnic backgrounds but had a number of commonalities regarding their sexual orientation. Ten women were exclusively attracted to women and George was mostly
attracted to women. Eight had a female partner and three had no current partner. Most of the women in this group had been *identity peripheral* since they first recognised their same-sex attraction, so they were not in transition to another ‘stage’ as would be suggested by Cass’s (1979) model.

These women used very similar terms to describe the peripheral importance of their lesbian identity. Bear and Susan (43) said it was a “small part” of themselves, Robyn (31) that “it’s not a huge thing”, Sally (42) that she doesn’t “focus on it”, Sharon (40) that “it’s not that important”. Betty (41) said “I just think we’re all people, it doesn’t matter what your sexual orientation is”. Madison provided a typical example of her peripheral lesbian identity, as well as the interaction with her identity expression preferences:

> Madison (24): Asian would come before that and…female would come before that. So lesbian third, maybe even lower. No, it’s not that important to me. Um…it’s just another thing about me, like my race, which I hardly notice, unless someone points it out to me. Lately sexuality has been more on my mind because I think it’s not as openly accepted as my race so I’ve noticed that a bit more, but otherwise who I choose to be is my own business. For example work and personal life I keep very separate, at least I try to. (…) It just means I’m going to different night clubs [laugh], but that’s the only difference.

Social affiliations varied in this group, with four of the women (Betty, Gabrielle, George and Robyn) having no lesbian affiliations at all, and the rest having lesbian friends but also maintaining heterosexual social groupings. Betty (41) felt lesbian women could be “insular” and preferred having “a cross-section of people as friends”. For some of these women, lesbian social affiliations helped them to feel more comfortable with their sexual identity, to accept themselves through affirmation from or comparison with others. Susan and Madison had sought out “other people like me” (Madison) when they were first coming out, to “fit in” (Susan). Madison had found an Asian lesbian group, which “helped me accept myself” but she still felt “more comfortable in the straight community”. Robyn (31) also had connected peripherally with the “whole gay scene” but said “it’s not everything…but I’m just who I am.”
The *attraction predominant* and *identity peripheral* women were similar in that their sexual identity was somewhat disconnected or peripheral from their central or core identities. Another similarity was that they were apolitical, they did not want to “push boundaries and make statements” as Madison (24) said. Most of them also believed that being lesbian or bisexual was a choice. Bee (25) spoke of making a “methodical choice” when she was first seeing a woman, to judge whether her bisexual attractions were real for her. Alice specifically defined choice as an apolitical position:

Alice (43): I guess my view of sexuality is that it’s pretty fluid. I know there are political aspects of both gay men and lesbians who would say, it’s not a choice, it’s not a choice. For me it’s all a choice. [Laugh] And that’s my mind frame. I met someone and I fell in love with the person.

A further similarity between the *identity peripheral* and *attraction predominant* groups was that women felt attracted to particular people not to their gender. For example, Dora, George, Betty and Gabrielle all agreed that the gender of their partner was almost irrelevant. The main distinction between these groups was the lack of sexual identity for the *attraction predominant* women, which influenced their lack of desire to disclose their sexual orientation. Whereas, the *identity peripheral* women did feel they had a sexual identity, and were generally comfortable to disclose it. I will describe this in more depth in the identity expression section of the chapter.

**Identity Integrated**

This group described their sexual identity as being an important aspect of their overall identity, which was integrated with other aspects of their identity. Nine women (Angelina, Eileen, Esther, Jamie-Lee, Jill, Lucy, Miranda, Mina and Kiama) were in this group and they varied in age from 23 to 61. Seven women described themselves as lesbian and were exclusively attracted to women. Lucy (45) and Mina (23) selected bisexual on the pre-interview survey, although Mina referred to herself as gay during the interview. Both were
mostly attracted to women. Angelina (37) said her lesbian identity was “very important” and Lucy that her bisexuality was second behind her work identity. Miranda (61) used the word integrated when describing her identity and “all these little pieces of me”.

The two youngest women in this group were Kiama and Mina (both 23). Both felt being gay was connected with other aspects of their personal identity, in contrast to the previous two groups where sexual identity was somewhat disconnected. However, they had slightly different experiences in that Kiama’s various personal identities felt integrated but she was reluctant to express her sexual identity publicly, whereas Mina had integrated her personal and public identities. For Kiama, this was a form of impression management to avoid the risk of being discriminated against: “It [being lesbian] is a huge part of my life, it’s very important for who I am in my identity, but I don’t want people to treat me differently because of it”. Whereas, Mina had shifted from Kiama’s position to one of public authenticity:

Mina: I feel like it’s pretty balanced…it’s all pretty equal, like being a student and being a sister and daughter and being gay. (…) I sort of feel like this is who I am and I’m not going to hide that anymore. (…) It feels more accepting of me as a whole person too…I think that internal picture of myself is becoming more clear. And that everything can be connected.

Jill (50) and Jamie-Lee (47) felt that they had been identity integrated since they first recognised their same-sex attraction, while the others had moved to this understanding from a different group. Mina had been attraction predominant; while Miranda, Eileen (45) and Esther (36) had moved from being identity defined as younger women. Esther felt this was a maturing, saying “as I’ve gotten older there’s more to my identity than my sexuality... I feel so comfortable with it”. Therefore, in the sense that the identity integrated group is equivalent to the ‘identity synthesis’ final stage that Vivienne Cass (1979) described, these four women followed the staged identity model by moving from earlier stages, Mina from ‘identity comparison’ and the other three from ‘identity pride’.
The concept of integration also applied to a need amongst all of these women for both lesbian and mainstream social affiliations, suggesting that this component of their lifestyle reflected their integrated identity. This confirms Giddens’ assertion that “lifestyle gives material form to a particular narrative of self-identity” (Kaspersen, 2000, p.105). For example, Mina did not want to “only hang out with lesbians and just have a lesbian lifestyle” so that she could be true to her integrated identities. Similarly, as part of her transition from being identity defined to identity integrated Esther described her reconnection with heterosexual groups that Cass (1979) had described. For Esther this was largely about having acquired a new identity as a mother:

Esther (36): I think when you come out you kind of go through a process of moving away from those you know to kind of being more lesbian-identified and then kind of re-integrate I think with friendships based on likes and dislikes. And that’s happened heaps after having children, in fact I’ve probably increased my relationships with heterosexual friends or peers because there seems to be more in common around parenting than with lesbians without children who we know.

However, all of the identity integrated women maintained lesbian friends, which was partly about having a safe and culturally knowledgeable social space. Lucy described “that feeling of [a] secret with them [lesbian circle of friends], the whole world doesn’t know.” Mina felt lesbian contact enabled her own cultural awareness by helping her to feel more comfortable and proud of her lesbian identity and removing her sense of shame. Likewise, despite her shift towards heterosexual friends, Esther still needed lesbian contact:

Esther: At the moment in early parenting, although I can develop a relationship with other heterosexual parents, mainly mothers… I’m left wanting for supports and information on alternative models, in a really concrete, day-to-day ….. and you know it’s about our [lesbian] culture in a way.
Identity Defined

There were two main issues that distinguished the identity defined women from the identity integrated women. First, the identity defined women believed they had ‘always’ been exclusively lesbian, while most of the identity integrated women had moved to this place. Second, these women preferred to be connected with lesbian social networks, rather than finding benefits in diverse networks. Six women (Anne, Helen, Lesley, Mae, Mitzy and Nede) currently felt defined by being lesbian, and three women (Miranda, Esther and Eileen) had been so in the past. The six women who were currently identity defined were aged 49 to 61, were all exclusively attracted to women and most had not identified as heterosexual at all during their lives. Dr Debra, the lesbian psychiatrist, described observing this type of lesbian woman in her practice:

Dr Debra (56): There’s a certain sort of lesbian…(…) who, even if she gets socialised into some heterosexual experiences, particularly in adolescence and early twenties, essentially has some sort of lesbian identity, even if it was not formulated, from the age of four. [a little later] If we take it in terms of ease with living an out life, I do think some women have had a strong identity from the beginning.

Their lesbian identity was of central importance to these women. Miranda (61) still believed that being gay was her “inner core, gay firstly”; Lesley (52) that it “makes me who I am”, and a bit later “it’s just another big part of my life, it’s like I am a mother and I am not a wife but I am a lesbian”. Helen, Mae and Mitzy did not have a partner at the time of the interview, however this did not detract from the defining nature of their sexual identity. This is a major contrast with the women who were attraction predominant, whose identity was closely connected with the presence and gender of a current partner. As Helen (49) said “If I’m not having sex with women am I a lesbian? (…) well yes I am, absolutely”.

The identity defined women had been aware of their same-sex attraction from their childhood, as Dr Debra had observed, and they had a sense that this was innate. Eileen
(45) described feeling different during her adolescence and that “I actually learned that there was a lesbian label for what I was feeling…. I didn’t really know I had a name [laugh]”. Mae (53) said she had known about her same-sex attraction since she was in Grade 3 [about eight years old] and that she didn’t feel she had any choice. Jill (50) said she had always known and that it was “inside you”. Miranda believed that it must be inherent as “I wouldn’t choose to be different” as did Mitzy (61) who said “I’ve been gay all my life really”.

All of the identity defined women except Helen mentioned the importance of their lesbian friends over and above their heterosexual friends. Helen (49) was most comfortable with women in general and felt that “being lesbian is just a logical off shoot of the fact that I do like women”. Similarly to the identity integrated women, lesbian social contact created a safe and comfortable space indicating that being identity defined does not remove the vulnerability to negative social attitudes and lack of cultural awareness faced by same-sex attracted women. Lesley joined the local gay and lesbian choir and said “having all those friends out there in the world makes it so easy”. Most of Mae’s friends were heterosexual and knew about her sexual orientation, however she spoke of her comfort with other lesbian women:

Mae (53): I feel a bit more complete hanging around other lesbians. You're part of each other, although I feel good with my own heterosexual friends. I feel complete with them too in a sense, but (…) it’s not that same feeling. (…) Because I think you know that they [her lesbian friends] understand more about you.

**Summary of the Sexual Identity Experiences**

I have described four distinct groups of women according to their different sexual identity experiences. These groups differed in a number of ways. First, they differed according to the importance that women placed on their sexual identity, from being of no importance at all for the attraction predominant women, to of central importance for the identity defined women. Second, the degree of fluidity varied, from being a fluid situation for most
women, to being a fixed identity throughout their lives, particularly for most of the identity defined women. Third, the degree of choice differed, with most attraction predominant and identity peripheral women believing that they had control over identity as a choice, and many of the integrated and defined women believing their sexual identity to be innate. Finally, the chosen social affiliations varied, moving from a preference for heterosexual affiliation for the attraction predominant and peripheral women, to an integrated approach, and a preference for lesbian affiliation for the integrated and defined women respectively. Some of these women had experienced identity confusion during the realisation of their same-sex attraction and others had not, however confusion was a transitional phase rather than an ongoing experience.

Comparison of Identity Experiences with Existing Frameworks

My findings regarding women’s sexual identity experiences had similarities to and differences from the three existing frameworks I described at the start of the chapter. Table 5 (p.188) summarises the three frameworks and my findings. The experiences of the women in my study are most similar to those described by Fingerhut and colleagues (2005). The major difference is that the attraction predominant group that I found was not present in Fingerhut et al.’s study. Also the ‘marginalised’ group in their study was closest to the transitional confused stage that women in my study described, but none of these women remained marginalised or confused. These similarities and differences can potentially be explained by differences in method and sample. Fingerhut et al.’s dual identity model was drawn from the literature on lesbian identity and then tested with a sample of self-identified lesbians recruited through lesbian organisations. The identity literature and convenience sampling would have prioritised women who identify as lesbian and would have under-represented women who were attraction predominant. Recruitment of my sample in a general practice setting and using the ‘mainly heterosexual’ option on the sexual orientation question in the screening survey enabled the attraction predominant women to take part.
Table 5 - Comparing three identity frameworks with the study findings

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<td><strong>Confusion during identity formation</strong>&lt;br&gt;Not experienced by all women</td>
<td>‘Identity confusion’, ‘Identity comparison’ – feels alienated, and ‘Identity tolerance’ stages</td>
<td>‘Pathological’ and ‘Personal failing’ groups</td>
<td>‘Marginalised’&lt;br&gt;Socially isolated, not comfortable in either lesbian or mainstream community. Very sensitive to stigma</td>
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<td><strong>Attraction predominant</strong>&lt;br&gt;Do not ascribe to an identity. Apolitical, bisexually attracted. Sexual partner about the person, not gender. Some lesbian social networks</td>
<td>(Not represented)</td>
<td>‘Sexual attraction’ and ‘Person not the gender’ groups relating to choice of sexual partner, tend to be bisexual</td>
<td>(Not represented)</td>
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<tr>
<td><strong>Identity peripheral</strong>&lt;br&gt;Woman/person first, lesbian/bisexual identity of little importance. Low lesbian affiliation, prefer heterosexual social interactions</td>
<td>(Not really represented) Some similarity with ‘Identity acceptance’ - third last stage</td>
<td>‘Minimal part’ group</td>
<td>‘Assimilated’&lt;br&gt;Lesbian identity is of marginal significance. Low lesbian affiliation and high heterosexual affiliation</td>
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<td><strong>Identity integrated</strong>&lt;br&gt;Lesbian identity important but not central. Comfortable in lesbian/bisexual and heterosexual social networks</td>
<td>‘Identity synthesis’ - final stage</td>
<td>May include ‘Personal fulfilment’ group, however broader</td>
<td>‘Integrated’&lt;br&gt;Strong lesbian identity with active involvement in mainstream community</td>
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<td><strong>Identity defined</strong>&lt;br&gt;Lesbian identity is central and felt to be innate. High lesbian affiliation, tend to prefer lesbian social interaction</td>
<td>‘Identity pride’ - second last stage</td>
<td>May include ‘Socio-political statement’ group, but not necessarily</td>
<td>‘Lesbian identified’&lt;br&gt;Lesbian identity is central to their personal and social identity. Separate from the mainstream and mostly socialise with lesbian community</td>
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Randall Sell and Christian Petrulio (Sell & Petrulio, 1996) demonstrate the importance of inclusive sampling techniques in their review of 152 public health papers on lesbian, gay and bisexual people. They note that the common practice of only using self-identification as lesbian/gay or bisexual and recruiting through lesbian/gay/bisexual settings excludes same-sex attracted people who don’t identify. The attraction predominant and even perhaps the identity peripheral women that I identified in my study are likely to form a proportion of the 6.2% of young women who selected ‘mostly heterosexual’ in the Australian Longitudinal Study of Women’s Health (McNair et al., 2005), or of the 13.5% same-sex attracted women in the Sex in Australia Study (Smith et al., 2003). Considering the general practice setting that I am researching, it has been useful to have sampled a range of women with diverse identity experiences as they are more likely to represent the range of women that GPs encounter in practice.

Finally, Celia Kitzinger (1987) did describe the attraction predominant group, and found that women placed varied levels of importance on their sexual identity. Kitzinger aimed for a diverse sample “to understand how people construct, negotiate and interpret their [sexual identity] experience” (Kitzinger, 1987, p.71). Although she required that all participants define themselves as lesbian, she recruited through a wide range of settings including via friends, academic contacts, a gay counselling service, feminist groups and lesbian social groups in London and rural settings. This sampling clearly identified a broad range of women in a sample group which was similar to that in my study.

**Sexual Identity Expression – The Public Practice**

Sexual identity expression is the degree to which women present their sexual identity publicly. In this chapter, I have chosen to use Goffman’s (1971) term ‘expression’ rather than disclosure, as disclosure tends to indicate a discrete moment in time, whereas expression indicates an ongoing process. As Goffman suggested, this reflects the reality of
this public practice more clearly. The literature regarding sexual expression in relation to health care providers invariably uses the term disclosure, which I will also use when referring to that literature. I will describe the interaction between the personal identity experience and its public expression in the context of general practice. Giddens’ (1991) theory of self identity is helpful here as he suggests that the ability to maintain a unique narrative about one’s identity relies on having this reality recognised externally or publicly. He also asserts that we have control over this expression, so I have analysed levels of control that women perceived.

I will first critique the recent literature on disclosure of sexual orientation to health care providers. Then I will present the three expression approaches that women in my study used with their GPs, and the influences on these approaches.

**Literature on Disclosure to Health Care Providers**

Disclosure rates from 30% to over 70% by same-sex attracted women to primary care providers have been reported (A. E. Harrison, 1996). Recent studies from New Zealand, USA and UK report that at least half of lesbian and bisexual women disclose to their primary care provider (Diamant et al., 2000; Hunt & Fish, 2008; Neville & Henrickson, 2006). Just a few studies have examined demographic associations with disclosure, and most characteristics including age and education level are not associated with the likelihood of disclosure. The only consistent association seems to be sexual identity, with bisexual women being less likely to disclose than lesbian women (Cochran & Mays, 1988; Meckler et al., 2006; Polek et al., 2008). Carolee Polek and colleagues (2008) speculate that lower disclosure rates amongst the bisexual women in their study were related to the greater likelihood that these women were married and their husband might attend the same doctor, however the authors provided no empirical basis for this assumption.

The literature reveals active and passive methods for disclosure to health care providers. One of the most detailed descriptions comes from Janice Hitchcock and Holly Wilson’s
(Hitchcock & Wilson, 1992) interview study with 33 lesbian women in San Francisco using a grounded theory approach. This was a very homogenous sample of women who were all urban, most were white and all identified as lesbian. The authors describe four stances of disclosure to health care providers that were used by different participants: active disclosure (the women specifically stated their sexual orientation); passive disclosure (women provided a few obscure clues about sexual orientation); passive non-disclosure (women provided no clues as to their sexual orientation), and active non-disclosure (which “resembles a charade” (p.180), where women deliberately presented as heterosexual or did not correct the provider’s assumption of heterosexuality). Active disclosure was the least commonly used and both passive stances relied on the provider to ‘decipher’ the sexual orientation. Michele Eliason and Robert Schope (2001) applied Hitchcock and Wilson’s (1992) disclosure stances to their more diverse sample of 38 lesbian and 9 bisexual USA women. They found that 43% used active disclosure, 34% used passive non-disclosure, and 15% used passive disclosure, while no women used active non-disclosure. These studies do not distinguish between preferences of lesbian and bisexual women, nor do they consider identity experience as an influence on disclosure.

Hitchcock and Wilson (1992) found three areas of influence on disclosure to health care providers, which were personal influences, health care environment issues and relevance within the consultation. Personal factors included the woman’s comfort with her sexual orientation (increased comfort created more disclosure), her relationship status (being partnered increased disclosure), and her attitudes to health care (less episodic care increased disclosure). Environmental factors were the sensitivity of the health care provider, and inclusiveness of forms and waiting rooms, as well as past experiences of health care. Finally, relevance of sexual orientation to the consultation made disclosure more likely, although it was not clear whether this was about women’s perception of relevance to the health care provider or to themselves. Other studies have also found some or all of these influences including general openness about sexual orientation (Eliason & Schope, 2001; Meckler et al., 2006; Steele et al., 2006), and provider sensitivity (Eliason & Schope, 2001; Steele et al., 2006).
The existing literature fails to explore the direction of relevance, that is, whether women feel disclosure is relevant to themselves or to the provider. For example, Hitchcock and Wilson merely claim that “the perception of what is relevant is idiosyncratic to each individual” (Hitchcock & Wilson, 1992, p.182). A paper on a pilot study of six Swedish lesbian women did focus on relevance relating to the women themselves (Bjorkman & Malterud, 2007). Disclosure was important to these women for whole person care including being able to include their partner. More often, studies found that some participants disclosed because they felt providers should know for medical reasons (Meckler et al., 2006; Stein & Bonuck, 2001); or conversely, that some women did not disclose because they felt it was irrelevant to the provider (Boehmer & Case, 2004; Eliason & Schope, 2001; Meckler et al., 2006).

Several studies describe the risk of negative reactions as a major influence on non-disclosure. For example, in a New York study, 61% of women did not disclose because they were concerned about bad reactions or treatment (Stein & Bonuck, 2001). Hitchcock and Wilson (1992) found that disclosure to health care providers was a process of “personal risking” (p.179), as did Tamsin Wilton (Wilton, 2000). Patricia Stevens (Stevens, 1994b) also frames disclosure as risk and describes various protective strategies that lesbian women used with health care providers to reduce risk including screening providers, taking a support person, being vigilant, controlling disclosure and challenging negative treatment. Similarly, amongst 39 lesbian and bisexual women with a cancer diagnosis, 28% chose not to disclose to the cancer care provider, and for some this was because they feared homophobia and had no time to find a gay friendly provider due to their urgent need for treatment (Boehmer & Case, 2004).

**Three Identity Expression Approaches**

In my study, I discussed patterns of current and past sexual identity expression with each woman during our interview. I analysed the consistency of their presentation in various settings including to family and friends, work or study colleagues, and to GPs. I found that
there were three distinct approaches to identity expression that applied to all settings, which I have named open, passive and private. I had found three approaches in my study of lesbian parents’ interaction with health care providers, which I called proud, passive and private (McNair, Brown et al., 2008). I now feel that ‘proud’ is a problematic label as it might suggest that women with other forms of identity expression are not proud or that this form is superior. Open is a purely descriptive and value-free term and many women used this word to describe their approach.

In brief, women with an open approach wanted their GP to know about their sexual identity and usually preferred to inform GPs directly. Those with a passive approach were happy for their GP to know but generally would wait to be asked. Women with a private approach preferred not to disclose to their GP. In comparison to the stances described by Hitchcock and Wilson (1992), open was most similar to active disclosure, and private to the active non-disclosure. Passive included passive non-disclosure and passive disclosure, as this same approach by women in my study could result in either outcome. I will now provide examples of each of the three approaches and then discuss the major influences on these approaches. My findings regarding the influences answer a question arising from my previous lesbian parents’ study, which was why women chose particular expression approaches.

Open Approach - “It’s Always Relevant”

The open approach was very direct in that women preferred to tell most or all GPs about their sexual identity and even to correct an incorrect assumption. Thirteen women (Angelina, Anne, Alice, Bear, Esther, Mitzy, Jill, Nede, Helen, Kiama, Sharon, Susan and Mina) preferred this approach. For example, Mitzy (61, lesbian) has worn “a T-shirt saying I’m a lesbian”. Helen (49, lesbian) said if they “made the faux pas of assuming she’s [her partner] my friend I will correct them and say ‘no actually she’s my partner’”. Nine of the open women preferred to tell their GP rather than to be asked, which indicated
a preference to be in control of disclosure to the GP. The other four, Nede, Kiama, Jill and Mina, preferred to be asked, although each had directly told a GP at some stage.

**Passive Approach - “It Just Hasn’t Come Up”**

Women using this approach didn’t mind that their sexual identity became known to the GP, but would wait to be asked and would not explicitly raise the topic. Thirteen women (Jane, Lucy, Eileen, George, Robyn, Gabrielle, Kate, Betty, Dora, Jamie-Lee, Indigo, Jenny and Miranda) preferred a passive approach. They did not feel that they were hiding their identity, it “just hasn’t come up” as Miranda (61) and Lucy (45) both said. As Dora (41) said “I don’t say it…I don’t deny it, if somebody asks me outright I would say yes.”

Eileen told her GP in the context of contraceptive questions to assure her that she could not be pregnant:

> Eileen (45, lesbian): My current doctor knows that I’m gay, um…. but that wasn’t like Eileen walking in there and saying “Oh I’m a lesbian”. That was just in answers to questions that she had.

In general, these women were happy to answer if a GP directly inquired about their sexual orientation because this would indicate it might be relevant to the GP. Betty (41) said she would want to be asked by a GP “if it was pertinent to the visit”, although she believed that a GP wouldn’t ask because “it’s totally irrelevant to the treatment”. Kate (21) wanted to be asked in order to avoid assumptions of heterosexuality, and Jane (21) felt “the majority of the time it’s best that they know”.

**Private Approach - “There’s No Need”**

Women with a private approach did not overtly tell, nor did they respond to inquiries about their sexual identity, and some deliberately concealed their identity. Seven women (Bee, Sally, Kirsti, Lesley, Mae, Madison and Flo) preferred this approach. Women conceptualised this as displaying a façade (Sally), as hiding (Jamie-Lee and Mina in the
past), or as being silent (Bee). For example, Bee (25) and Madison (24) had both referred to their female partner as ‘he’ to avoid disclosure to the GP. All seven women felt their sexual orientation was not relevant from the GP’s perspective. None of these women could think of any medical reason for the GP to raise the subject and this was because they thought their health issues were the same as those of any other woman. As Kirsti said:

   Kirsti (53): I don’t think I’ve ever told a GP that I’m bisexual. (…) I’ve never ever found the need to. My sex life has got nothing to do with them examining my breasts or a lump or a skin rash or something.

Some women with an open approach with their usual GP were private with a casual GP, and again this was because they didn’t feel there was any clinical relevance and no need for whole person care. Helen, Esther, Jill, Sharon and Kiama all took this approach.

   Helen (49): The other doctors that I have seen in the interim … it wouldn’t have come up because I’ve seen them for something like a cold and you don’t really come out to someone with that.

**Influences on Identity Expression**

I have found three major influences on the identity expression approach that women preferred with their GPs. These were their identity experience, which determined the relative importance of their sexual identity to themselves; their perceived risk of disclosing, which related to negative social attitudes; and the degree of relational knowing within the patient-doctor relationship. The more important sexual identity was to women, the more likely they were to be open regardless of risk. Relational knowing between the woman and her GP had the capacity to allay the perceived risk and increased the likelihood of choosing an open approach. The relationship did not influence women who took the risk to disclose because their sexual identity is very important, or to avoid the risk because it was not important at all. Risk as an influence on disclosure most consistently appears in the literature, whereas the quality of the patient-doctor relationship is rarely
discussed. The nature of the sexual identity experience and its concomitant relevance to the woman has not previously been explored as an influence.

These influences relate, in turn, to the three theories that I have used to inform my analysis. Giddens’ (1991) theory of identity and modernity suggests that our self identity narrative gives rise to our chosen public lifestyle that expresses that identity. Giddens also contributes an understanding of the influence of risk on our self identity and the need to avoid risk if that identity is fragile or could be compromised. Goffman’s (1971) expression management theory accounts for socio-political barriers to our identity expression and the impact of risk that arises from negative social attitudes and the potential for discrimination. While Goffman does acknowledge the fact that the observer can influence the actions of the observed, he does not go as far as to appreciate the positive influence of true reciprocity in relationships on self presentation. So, feminist perspectives of relational interaction help to explain the influence of the patient-doctor relationship and its ability to overcome risk (Candib, 1995). The three influences that I have identified shed light on the reasons why different women have different identity expression approaches, rather than suggesting as Hitchcock and Wilson (1992) do, that whether disclosure is relevant to women or not is purely ‘idiosyncratic’.

I have developed a new model to depict the three influences on preferred identity expression to GPs, which I have called the Identity Disclosure Model. I have illustrated the model in Figure 4. I will now describe the three influences on identity expression in more detail.
Identity Experience Influencing Expression

The more important the woman’s sexual identity was to herself, the more important that she felt it was for GPs to know. So, identity defined and identity integrated women, whose sexual identity was important to them and connected to their other identities, tended to prefer disclosure and either had an open or passive approach with GPs. Conversely, women who were identity peripheral or attraction predominant were less likely to feel their sexual identity was important information for GPs because it was less important to
their overall identity. They tended to have a *passive* expression approach if they felt it was relevant from the GPs’ perspective, and a *private* approach if it did not seem clinically relevant at all.

In summary, of the 13 women who preferred to be *open* with their GP, nine were *identity defined* or *identity integrated*, three were *identity peripheral* and one was *attraction predominant*. Of the 13 women with a *passive* approach, nine were *identity peripheral* or *attraction predominant*, four were *identity integrated* and none were *identity defined*. Five of the seven women who had a *private* approach with their GP were *identity peripheral* or *attraction predominant*, none were *identity integrated*, and two were *identity defined*. I will first describe the women for whom their sexual identity strongly influenced their expression, then the women for whom it did not.

Many women who were *identity defined* or *identity integrated* spoke of their need to be authentic or honest, and not to hide their identity. As Nede (55, lesbian) said, who was *identity defined* with an *open* approach, “my relationship is always relevant. (…) . I mean like who’s at home to look after you”. She clarified that this was not just about having a partner, but about having a *female* partner. Helen, who was also *identity defined* was always *open* with GPs despite feeling that there was no clinical relevance to her disclosure:

Helen (49, lesbian): I would probably be more likely to [come out to a GP] as a blunt instrument in the way that I wouldn’t do it socially or at work or whatever you know. I’d be more likely to say, “Well by the way I am a lesbian or my partner is female,” or whatever rather than kind of just casually let it drip out, because I think it’s important. (…) I don’t actually see myself as having special health needs because I’m a lesbian. It’s an important piece of information that my doctor needs to know about me.

Conversely, Kate (21, lesbian) made a direct link between her peripheral lesbian identity and her *passive* approach with GPs, saying she would be happy to tell if she was asked directly, however “if they asked me about me [in general] I wouldn’t [say] I’m a lesbian,
because that doesn’t define me”. Eileen demonstrated this distinction between open and passive women and their different perspectives on the importance of their sexual identity. She had moved from being identity defined to identity integrated, and in parallel from being open to passive in her expression:

Eileen (45, lesbian): Probably 20 years ago I would have told them [GPs]. (...) [Now] it doesn’t bother me. My sexuality isn’t [such] a big part of my identity that I need to say “I’m a lesbian”. But when I was younger perhaps I would have. (...) Just that recognition factor, and I guess a lot of it back then was being different, and having a bit of a hot head about being different.

While the sexual identity experience was very influential on expression for most women, there were six women whose sexual identity experience did not influence their expression approach as much as perceived risk or the patient-doctor relationship. Mae (53) and Lesley (52) were both identity defined however had a private approach with their GP. This was related to wanting to avoid the risk that they perceived if their GP knew about their sexual orientation as I will demonstrate in the next section. Bear (25), Sharon (40) and Susan (43) were identity peripheral, and Alice (43) was attraction predominant, yet they were all open with their usual GP. These four women had a close professional friendship with their usual GP, which elevated their need for the GP to know them more fully as a person. Also, Alice did not regard her bisexual attractions as important, but did regard her family identity as being highly relevant to her GP, including the gender of her partner.

**Perceived Risk Influencing Expression**

Women’s preferred identity expression approach with their GP was influenced to varying degrees by their perceived risk of disclosure. So, risk had the capacity to override the importance of sexual identity in determining identity expression, as occurred for Mae and Lesley. This is referred to by Fingerhut and colleagues when they suggest that disclosure “is an imperfect indicator of a woman’s lesbian identity” (Fingerhut et al., 2005, p.133), because her desire to be open can be modified by her assessment of the likely response.
The risk of disclosure in the general practice setting is particularly related to the possibility of being judged by the GP. Miranda (61, lesbian) suggested this could occur if the GP was homophobic, resulting in being “treated differently with the wrong GP”. Some women were concerned that this might compromise the patient-doctor relationship and others that their care would be compromised. For example, Madison (24, lesbian) was private with Dr Michael because she feared that he might be “disgusted” and even “reject” her. This mirrors what Goffman (1971) refers to as “guarded disclosure” (p.188) as part of the impression management process, which is about assessing the safety or risk before disclosing. As Goffman describes:

When individuals are unfamiliar with each other’s opinions and statuses, a feeling out process occurs whereby one individual admits his views or statuses to another a little at a time. After dropping his guard just a little he waits for the other to show reason why it is safe for him to do this, and after this reassurance he can safely drop his guard a little bit more. (Goffman, 1971, p.189)

Risk management was an important influence on the identity expression approach for some women. A few women (Madison, Kirsti, Bee, Mae and Lesley) used a private approach to avoid the risk of negative consequences, regardless of the patient-doctor relationship. Other women incorporated the clinic environment or patient-doctor relationship into their decision about their identity expression approach, being selective as a risk management tool. Seventeen women discussed being selective in that they made careful decisions about whether to be open, passive or private with GPs. They made their decision, which Miranda and others suggested was largely intuitive, based on multiple cues such as the waiting room atmosphere, receptionist approach and GP manner. If they expected the GP to be positive or neutral they would be open or passive, and if they expected a negative response they would conceal their sexual identity by using a private approach. Esther described the subtle cues that women perceive in assessing risk:

Esther (36, lesbian): …if anyone’s in a position of disadvantage, [they] make a summary of the safety of that space. So it might be did eyes divert, up or down, or what’s on the wall, or how was I greeted, and all those things and maybe that’s not
thought about that people come into a practice and do that. It’s probably really rapid too, and they might not even be aware they are doing it.

By contrast, some of the *open* women were prepared to take the risk of negative reactions by being *open* regardless of their relationship with the GP, and did not need to use guarded disclosure. Their openness was not borne out of relational knowing and trust, but out of a commitment to the principle of being honest and transparent despite the risk this might pose. For example, Mitzy (61), who was *identity defined*, told her current GP that she was lesbian during the first consultation as a way to assess the GP’s attitude. Some of the *open* women (Mitzy, Jill, Mina and Esther) had developed a disregard for negative opinions, they were not concerned about what people thought of them. Esther, who was *identity integrated*, acknowledged the anxiety that could be present about potentially negative GP reactions and did choose not to tell “if I think that it would affect the treatment that I would get”. However, she was willing to take this risk with most GPs:

Esther (36, lesbian): I guess some people feel anxious or fearful of doctors and others don’t and I suppose depending on what I go in with I might have some trepidation or anxiety around what I need to reveal or what’s going to happen when I go, but largely I don’t. So, I feel confident that it’s safe enough that I can manage negative comments.

*Patient-Doctor Relationship Attenuating Risk*

As I presented in Chapter 4, a professional friendship between a woman and her GP helped to overcome the silencing of the lesbian lifeworld for some women. This was because the relational knowing that had developed attenuated the risk of disclosure. Greater relational knowing led to better understanding of the GPs’ values and attitudes, and a prediction of a positive reaction with reduced perceived risk. This was the case for Susan with Dr Olive, and Sharon and Dr Holly. Susan, Sharon and Bear were all *identity peripheral* yet had an *open* expression approach with their GPs. Bear explained that she was able to be “honest” with Dr Margaret because she knew Dr Margaret was non-judgemental, and this led to the most appropriate care:
Bear (25, lesbian): I mean that’s kind of why I keep going back to [Dr Margaret] because I can talk quite openly, quite honestly and it’s not a problem. If you can’t do that then there’s no point in going to a GP in the first place because you’re not going to get the level of care that you may need if you don’t say anything.

Dora was also identity peripheral and had an open approach with Dr Soula, however she had had a private approach with previous GPs and would return to being private with future GPs. This was dictated by her fear of being judged:

Dora (41, gay): If I had to see a new GP right now it would not be discussed, it would not ever be brought up, at least I don’t think it would be. Um…. as time goes on, I hope, it’s my wish that if I felt I needed to, I could. (…) It’s as if I’m scared to I think. There’s part of me that thinks I’d be a bit scared to and there’s a part of me that thinks I don’t need to.
Interviewer: What scares you about it?
Dora: It’s an acceptance thing. (…) I just feel very uncomfortable in the beginning and worried that people won’t accept who I am, and might judge me or something.

So, Dora’s past and future private approach would only be modified with ‘time’ and presumably the development of a close relationship. Her approach with Dr Soula had been different due to the close patient-doctor relationship that Dora’s partner already had developed with her as the family GP.

Therefore, patient-doctor relationships that can create trust and overcome risk for many women are both powerful and desired. The relationship in this regard assists to affirm women’s minority sexual identity by enabling disclosure, which resonates with Giddens’ (1991) concept of the pure relationship. He describes the elements of pure relationships as being mutual trust, respect, commitment, autonomy and mutual disclosure of an emotional nature. The professional friendship that I have described contains these elements and could therefore be regarded as a pure relationship, particularly when this enables identity expression.
Summary – A New Identity Disclosure Model

Central to the Identity Disclosure Model is the close relationship between the personal aspect of sexual identity, which is women’s identity experience; and the public aspect, which is their identity expression: the personal strongly influences the public. So, in answer to the first question of the chapter, women’s sexual identity experience commonly determines their preference for being open, passive or private about their sexual identity with their GP. This answers one of the quandaries in the disclosure literature regarding why bisexual women appear to be less likely to disclose. At least one factor is that some may be attraction predominant and therefore not regard their bisexual identity as important to themselves or to their GP. Alternatively, there may be other bisexual women, although not present in my study, who regard this identity as integral or defining and who may therefore prefer an open approach.

Identity experience was not the only influence on identity expression. The socio-political context of continuing discrimination against people of minority sexual orientation also played an important role in modifying public expression for many women. Whether women perceived that there was a risk of discrimination from their GP was determined by the issues raised in Chapter 4 including the level of relational knowing and trust. These additional influences explain the outliers in relation to the connection between identity experience and expression. So, there are women who are attraction predominant or identity peripheral and yet prefer being open due to their professional friendship with their GP, and women who are identity defined yet private due to the strong influence of risk.

GP Understanding of Sexual Identity

I will now address the second question of this chapter regarding how well GPs understood sexual identity. Overall, many GPs had little understanding of sexual identity in the sense of it being one of the multiple identities of women. As I described in Chapter 4, most GPs felt that they had insufficient knowledge about lesbian health, and this extended to poor
knowledge of sexual orientation as an identity. In addition, many GPs believed that women’s sexual orientation was generally not relevant to the consultation.

I will consider GPs’ understanding in the light of women’s expectations and needs that are revealed by the Identity Disclosure Model. My findings suggest that GPs would benefit from understanding minority sexual identity for three reasons:

1. To understand the association between women’s sexual identity experiences and their preferred approach to identity expression. This would help them to be aware of the varied disclosure preferences amongst same-sex attracted women, and to appreciate the relevance of sexual orientation within the consultation.

2. To understand the socio-political environment regarding minority sexual orientation and its influence on perceptions of disclosure as risk-taking. This would assist GPs to more overtly display their attitudes if they are non-judgemental and to know that some women are more resilient to risk than others in this regard.

3. To be available to women as a support during the sexual identity confusion transition. This requires awareness of the possibility, but not inevitability, of identity confusion and the range of supports women might need at that time.

Over-riding these issues is a need for awareness of the role that relational knowing in the patient-doctor relationship has in mitigating risk and enabling identity expression if desired. This is particularly pertinent for GPs to understand as they have some influence on the development of this relationship. I will expand on this within the next chapter on the process of disclosure. I will now examine each of the three levels of understanding about minority sexual identity from the GPs’ perspective.
Understanding the Relevance of Sexual Identity

Alice (43, bisexual): If someone was coming to a hypothetical GP, it’s not only up to the patient, but I guess to a certain extent the practitioner, to understand what their world view is and how important it is [for] the definition of their self.

Most GPs did not understand that many women, such as Alice, felt it was relevant for them to know about their sexual orientation from a holistic perspective, and to take some responsibility for gathering that information. GPs tended to view relevance from their own perspective in that sexual orientation wasn’t relevant to the ‘clinical’ presentation. For example, Dr Leon (34) said “if they’re coming in with a cold it just doesn’t really matter”. Drs Cahill, Cam, Elisabeth, Leon, Margaret, Olive, Pachy, Perry, Phoenix and Westy were all of this view, despite most of them being holistic, patient-centred practitioners and therefore ostensibly being accommodating of the patient’s social context and agenda. This disregards the possibility that sexual orientation can be relevant clinically if the woman’s sexual behaviour or identity is directly connected to her presenting health issue. Also, while this approach would not be a problem for women who had the same opinion of irrelevance (especially attraction predominant and identity peripheral women), it could prevent disclosure for women who believed sexual identity should be known as part of their holistic care. This approach reveals a lack of understanding of minority sexual orientation as an identity, as Dr Phoenix explained:

Dr Phoenix (57, outer urban): Look I don’t know that I really understand it [lesbian identity]. (...) I know a lot of them network together you know, like as [a] community…as one might with any particular interest, but I really don’t know what lesbians do or any special things.

To Dr Phoenix, sexual orientation was more an ‘interest’ than an integral part of women’s identity. Similarly, several GPs conceptualised sexual orientation narrowly as sexual behaviour, rather than perceiving the broader aspects of identity, which prevented inquiry about sexual orientation beyond the sexual history. For example, Drs Jackie, Joseph and Cahill all said they did not know many lesbian women in their practices because they
rarely took a sexual history. Dr Joseph (57) also described the female couples that he knew, but said he was not sure whether they had a sexual relationship, therefore whether they were ‘really’ lesbian.

By contrast, eight GPs (Drs Imogen, Jackie, Katie, Audrey, Olive, Harry, Rose and Soula) realised that women might prefer them to understand sexual identity from a more holistic perspective. Dr Katie (47) said of an openly lesbian patient: “I think she just wanted me to know…just as part of…knowing her I suppose”, which mirrors Alice’s perspective. Thinking about sexual orientation as a contextual or social phenomenon enabled them to consider broader issues such as women’s need for lesbian social networks and to use their existing skills of social history taking and supportive counselling. Dr Harry understood the concept of sexual identity more as an identity integrated or identity defined woman might:

Dr Harry (53): I think they would see their sexuality as an important part of them. And that then could be part of the broader encounter that they want the doctor to have knowledge of lots of their issues. (...) I think sexuality then would be part of that social history.

Dr Imogen (46) was the only heterosexual GP to realise that for some women “it may not be important that I know”. The other GPs, apart from Dr Holly, dichotomised the presumed preference of all lesbian women either to tell, or to conceal. So, even amongst the GPs with more understanding of sexual identity, there was virtually no awareness of the breadth of women’s sexual identity experiences, and therefore no possibility of understanding how these experiences would impact on disclosure preferences.

**Understanding Disclosure as Risk Taking for Women**

I reported in Chapter 3 that trust was a pre-condition to openness with GPs for some women. This need for trust becomes clearer when realising that many women perceived risks involved with disclosing to GPs. As I described in Chapter 4, a few GPs did understand that negative social attitudes might have an impact on the health of lesbian and
bisexual women. With regard to identity expression, I found that eight GPs (Drs Audrey, Imogen, Jackie, Soula, Pachy, Holly, Tyl and Perry) understood that risk management could be a disclosure modifier. They realised that women may not tell GPs about their sexual orientation due to a fear of being treated “prejudicially” (Dr Imogen), being “rejected” (Dr Jackie) or not knowing how the GP will respond. Dr Audrey realised that women might mistakenly assume she was not “tolerant”:

Dr Audrey (30): If it [sexual orientation] is at all related, or if they are going to see me on an ongoing basis it would be really nice if people could just say. But then I think that people can’t know how you are going to react.

So, Dr Audrey is capturing the women’s perspective of needing some reciprocal knowledge of the GP’s values and attitudes before disclosure might feel safe enough. Other GPs also assumed that women might feel more comfortable with a lesbian or gay specific environment because they would be able to predict positive reactions, just as the lesbian GP, Dr Holly had suggested. Dr Judy (48) felt that women would come to a lesbian-focused clinic because they could be more certain of a positive reaction, and Dr Lith, who worked in such a clinic, confirmed this:

Dr Lith (44): I think I would probably see quite a large proportion of lesbian patients. Most of the time they’re very open about their sexuality. I suppose they feel safe in our clinic so it’s not an issue.

Overall, 16 GPs (Drs Audrey, Pachy, Harry, Holly, Imogen, Jackie, Judy, Soula, Margaret, Michael, Phoenix, Elisabeth, Joseph, Leon, Rose and Westy) were aware of women’s need for rapport and trust to assist with disclosure. Dr Pachy (48) realised that women needed to trust her “to make them feel safe”. Dr Judy (48) knew that women would be observing her “reactions to them”. Dr Judy expected that some women might be concerned about compromising the patient-doctor relationship, but that building comfort should overcome that “fear”.

Therefore, many GPs had some understanding of the role of the patient-doctor relationship itself to allay perceptions of risk. However, they did not have the deeper level of
understanding that building such a relationship has the potential to support a woman’s sexual identity, as Giddens’ (1991) concept of the pure relationship would suggest. This could assist GPs to place a greater emphasis on building reciprocal knowing in the relationship in order to affirm sexual identity.

**Understanding Identity Confusion and Women’s Support Needs**

There is no literature on the role of the GP in supporting women with sexual identity confusion. Almost all papers about disclosure of sexual orientation to GPs address the importance of disclosure for health care or the patient-doctor relationship, but do not raise the possibility that disclosure might create the opportunity for identity support. There are a few papers on sexual identity support as a role of other health care professionals including nurses (Taylor, 1999), psychologists (Davies, 1994) and social workers (Larson, 2006). The skills and knowledge required for such support that these papers outline are very much part of the patient-centred GP repertoire including non-judgemental listening, empathy for experiences of discrimination, supportive counselling about life transitions, and referral where needed.

**Lack of Actual GP Support**

While GPs are well placed to provide coming out support, only one woman in my sample, Lesley (52), had experienced direct support from a GP during that time. I suggested to Madison that GPs could have a support role and she said “Oh, that’d be a great role for a GP to play”:

Madison (24): I mean even just asking “OK so you’re gay, how are you finding it?” and they could say good or bad, just give you that extra few minutes. Bad then refer on [laugh], if good, then good, put it in the file notes and see you next time.

Before discussing the GP perspective on this support role, I will describe the three main reasons women in my study had not seen GPs for support. First, many women relied on
friends or their female partner for support while they were coming out, and felt they did not need professional support. Robyn (31), Bear (25), Madison (24), Kate (21) and Jane (21) had all used lesbian social networks, which affirmed their sexual identity at that time, while none had considered seeing a GP. Likewise, Jill (50) said “once I accepted that [heterosexuality] was not for me I didn’t have an issue to talk to a doctor about (…) I didn’t feel uneasy”. Second and in contrast, several women felt they did have a need for professional support but were not aware that GPs could have offered this. Eight women (Sharon, Susan, Lucy, Jamie-Lee, Angelina, Alice, Sally and Flo) had seen counsellors for help with their sexual orientation during their coming out and all found this to be useful. However, other women did not find support such as Mae:

Mae (53): I had no idea where I could go. I did want to talk, yeah I did want to talk about it. I knew I couldn’t talk to my school friends or my friends as I got into my twenties.

Third, some women had not accessed GPs during their identity confusion because they perceived too much risk. They could not guarantee a supportive response and so could not take the risk of discussing their coming out issues during this very vulnerable period of their lives. Mina provided a typical example of the tendency to only disclose to GPs once she was no longer confused. Mina had felt she needed professional support during coming out but decided that the potential risks of disclosing to her GP outweighed any benefits. She had realised that a negative reaction at that stage could have further undermined her fragile sense of self-identity. She had since become comfortable with her sexual identity and built some resilience and was able to disclose to her GP once she knew she was strong enough to deal with any response.

Mina (23, bisexual): I guess if I’d known my GP had a lot of information, (…) if there had been something there [in the waiting room] about being gay or if my GP had something in her office that made me think ‘okay she’s queer-friendly’, I may have turned to her as a source of support. But I suppose I didn’t know what her reaction was going to be and once I’d been going for a year I felt pretty safe to tell her.
**GP Perspective on Having an Identity Support Role**

Twenty-four of the 27 GPs in my study had never seen a woman for coming out support. This lack of experience is not surprising given the reluctance demonstrated by most of the women in the study to seek coming out support from GPs. Three of the 24 GPs had supported family members of a young person who was coming out. Only Drs Alan, Holly and Joseph recalled having this role with lesbian women. Dr Alan (85) had discussed coming out with a number of young women “in their teens” and offered support, although he had not seen any older women in this group. He felt his role was to “allay their anxiety” and offer acceptance and understanding. Dr Holly (39) had seen several women at various ages, which she suggested was because she was known to be lesbian, and therefore predictably positive in her response. Dr Joseph had seen one woman for support after she separated from her male partner, who was also his patient. He used skills of empathy and support, which he felt were effective:

> Dr Joseph (57): I was very sympathetic to her situation and empathetic I hope, and supportive during that period and her change of sexual identification had no impact on the doctor-patient relationship. It wasn’t an issue. I mean, the grief that she was going through, at least initially, and then the happiness that she found. I was pleased, I was sympathetic to her and then I was happy for her.

Many GPs commented that they had only seen lesbian women who were comfortable with their sexual orientation. This supports Mina’s experience that she disclosed to a GP only after she felt comfortable with her sexual identity. Dr Imogen (46) said all of her lesbian patients seemed “completely comfortable with their sexual identity”, Dr Jackie (41) that they were all “established in their lesbian identity and relationship”, Dr Soula that they “haven’t had angst with it”. Dr Olive (43) realised that in the future she might “come across someone who might be questioning” but all of her current experiences were with “self assured” lesbian women. Dr Westy (49), who worked at a University clinic, realised that “the ones that are still confused about it tend not to bring it up or tend to avoid it”.

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**Note**: The text above is a natural representation of the document content. It has been reformatted for clarity and readability, ensuring that the original meaning and context are preserved. The natural text is read as if it were a continuous dialogue or narrative, without the need for further elaboration or questioning. The formatting adjustments have been made to enhance the readability and coherence of the text, ensuring that all relevant information is included and presented in an accessible manner.
While the majority of GPs had not experienced a coming out support role, all but Dr Normal agreed that it was an appropriate role for a GP. Dr Normal (70+) said he would merely emphasise that the gay lifestyle was not normal and it was their choice, a response feared by some of the women. Most GPs felt willing and able to transfer their supportive counselling skills to this area. However, Drs April, Cam and Rose wondered whether they had adequate skills to offer coming out support. For example, Dr Cam (50) felt that women would “probably come in desperate because they’d finally chosen you as the last resort”, and that she would feel out of her depth. All three GPs did go on to describe supportive roles they could play, and as Dr Rose suggested, while her lack of experience and unfamiliarity would hamper her, she would overcome this limitation:

Dr Rose (46): I’d certainly listen to all that she would have to tell me and I’d try and think about… I mean she’d know more than I would about any sort of support groups etc probably…and I would certainly ring you! [Laughs] or I would find… I would probably ring somewhere like [the local sexual health clinic] and say what support groups are needed? I mean I think I’d be all right actually, now that I think about it I would work out how to do it. But I wouldn’t be fantastic immediately because I’d have to think it through a little bit myself.

**Summary of GPs’ Understanding**

In answer to the final question of the chapter, only eight of the 27 GPs in the study understood sexual orientation as an identity, let alone the varied sexual identity experiences or preferences for identity expression that women described. This is not surprising given their very limited experience of seeing lesbian and bisexual women and the lack of education that was revealed in Chapter 4. Few GPs understood sexual orientation as an identity that could be important to women in itself, which impacted on their ability to perceive its relevance for women in the consultation. However, there was capacity amongst some GPs to appreciate this identity and its disclosure as a legitimate part of the holistic picture that GPs preferred to attain. Several GPs realised that disclosure was a risk for women and that building rapport and trust was important to facilitate
disclosure, however there was little understanding that a reciprocal relationship could be built that would facilitate women’s identity support. Although very few GPs had dealt with coming out support, all but one believed that this would be a suitable role. Therefore, while the level of understanding about minority sexual identity and its place in the consultation was low, the majority of GPs demonstrated willingness to improve their understanding and incorporate it into their day-to-day work.

Summary

The model of sexual identity expression that I have presented incorporates Giddens’ (1991) concept that personal and public self identities are linked. It also demonstrates the ‘internal-external dialectic’ regarding identity that Jenkins (2004) proposes. The model shows that identity experience influences the ways in which women publicly express their sexual identity to GPs, and in turn, that expression can affirm or destabilise the identity experience. Some women’s identity experience varies over their lifetime and with it their expression varies. Others have relatively fixed sexual identities. The model also incorporates the notion that perceptions of risk and the need to manage that risk can limit identity expression, while relational knowing in the patient-doctor relationship can overcome this risk to encourage expression. The risks inherent in identity expression are part of modern life as Giddens (1991) describes it, and negotiating such risks is required in order to be authentically present in the public space.

Authenticity is based on meanings of self, and these meanings varied amongst women. The sampling technique that I used in the study enabled a wide range of same-sex attracted women to participate and this range is likely to reflect the women that GPs see in their practices. The four experiences of sexual identity that I identify overlap sufficiently with those described in theories from different paradigms to suggest that these meanings represent those in the wider community of same-sex attracted women. Women who felt their sexual identity was of low or no importance (attraction predominant and identity peripheral groups) did not need to publicly express this part of their identity, and so non-
Disclosure to GPs did not compromise their public authenticity. Women for whom sexual identity was important (identity integrated and identity defined groups) were much more motivated to express this identity, and therefore barriers to disclosure such as perceived risk were more compromising to the presentation of their authentic selves.

GPs had a very limited understanding of these varied meanings of sexual identity, however some had capacity to perceive its relevance in the consultation. The willingness that almost all of the GPs displayed to improve their knowledge of minority sexual identity demonstrates that there is capacity to apply the Identity Disclosure Model in their everyday practice. For example, many agreed that they already had the range of skills that would be required to offer support for identity confusion during the coming out period. Also, most were holistic practitioners who preferred a patient-centred approach and so could easily enable relational knowing that included sexual orientation. In Chapter 7, I will explore the emancipatory potential of the model and whether using the model may help GPs to facilitate disclosure where it is desired by women.
CHAPTER 6 - MUTUAL RISK AND RESPONSIBILITY FOR DISCLOSURE

In this chapter I will illustrate the mechanics of disclosure of sexual orientation within the patient-doctor consultation. The Identity Disclosure Model is centred on women’s perspectives, and there are questions remaining regarding the GPs’ perspective, which I will present in this chapter. I will also consider why holistic GPs have allowed Habermas’s (2003 (1972)) ‘colonisation of the lifeworld’ to occur.

The theories of Habermas and Giddens that I have used throughout this thesis have contributed to my analysis of the process of disclosure. As I stated in Chapter 4, Habermas suggests in his Theory of Communicative Action that we are mutually obliged to reach a consensus in understanding the lifeworld of those with whom we converse (Habermas, 1984). In Chapter 5, I showed that women displayed considerable control in their decisions about sexual identity expression to their GP. There was a reciprocal motivation amongst some GPs to gather information about sexual orientation, however GPs had little understanding of how to enable disclosure or of the influence of sexual identity experiences on women’s disclosure preferences. So, there was little evidence of consensus building in relation to communication of women’s sexual identity to GPs.

Control is salient when discussing procedural issues such as how and why disclosure occurs and so I have theorised disclosure with this in mind. Giddens conceives of risk as being present when there is a loss of control (Kaspersen, 2000). The balance between risk and trust that Giddens highlights as central to our identity development in modern life certainly played out for women when considering disclosure. In this chapter, I will show that risk also underpins all of the barriers to facilitating disclosure that GPs raised and has a negative impact on GPs’ professional identity. I have already suggested that Giddens’ (1991) concept of the ‘pure relationship’ could apply to the sorts of professional friendship that some of the women and GPs experienced. This form of relationship requires various levels of reciprocity including mutual responsibility, so I have analysed
the disclosure experiences of women and GPs by considering where the responsibility for
disclosure lies. In summary, I will show that the themes associated with the how and why
of disclosure for women, GPs and their relationship are risk, control and responsibility.

I have posed two questions for this chapter:

1. How is disclosure negotiated between same-sex attracted women and their GP?
2. Who has control over disclosure and what are the expectations of where the
   responsibility for disclosure lies?

Gaps and Assumptions within the Disclosure Literature

I consider that there are two major limitations within the literature on disclosure of sexual
orientation to health care providers. The first is that disclosure of minority sexual
orientation is mostly presented as essential to achieving the best possible health care and
patient-provider relationship; and the second is that there are very few studies which
present the health care provider perspective on facilitation of disclosure. My work
challenges the first and addresses the second limitation. I will summarise the essentialising
arguments here, and will present the few available studies on health care provider
perspectives later in the chapter. In short, literature on the GP perspective reveals that
while risk is commonly discussed in terms of being a disclosure barrier for women, it is
rarely considered as a barrier for doctors.

Much of the literature on disclosure of sexual orientation assumes that disclosure is
essential for adequate health care (Eliason & Schope, 2001; Mravcak, 2006; Neville &
Henrickson, 2006). For example, lesbian health guidelines for the Society of Obstetrics
and Gynecology in Canada make the following claim: “For the lesbian patient to receive
appropriate care, her sexual orientation and lifestyle must be known and understood by her
health care providers” (italics added) (V. Davis, 2000, p.202). Similarly, Gary Remafedi
(Remafedi, 2006) states that health care providers should inquire about the sexual
orientation of adolescents as a necessary act to improve the health inequalities of same-sex
attracted young people. Again, Kathleen Bonvicini and Michael Perlin assert that “eliciting accurate sexual orientation and relationship status of the patient is crucial” (Bonvicini & Perlin, 2003, p.118). This narrative fails to recognise the variability of women’s desire for disclosure that I outlined in Chapter 5.

A related assumption, which I presented briefly in Chapter 3, is that non-disclosure leads to poorer health care access and reduced continuity of care (Wilton, 2000), and dissatisfaction with health care (Bonvicini & Perlin, 2003). Amy Harrison’s article on primary care for lesbians and gay men has been widely cited, and she says “most lesbians and gays believe that their health care would be of a higher quality if they could safely disclose their homosexuality identities” (A. E. Harrison, 1996, p.12), however she does not provide evidence for this statement. One study revealed that 58% of lesbians had disclosed without prompting to their health care provider, which was viewed as evidence that women believe it is important (van Dam et al., 2001). However the authors failed to discuss the motives of the 42% of women who did not disclose, apart from assuming that they feared a negative reaction. When authors do acknowledge that non-disclosure is a choice for some women it is almost always assumed to be a strategy to avoid discrimination and negative attitudes of health care providers, rather than a positive choice.

Carol McDonald (2006) provides an alternative and more nuanced perspective of disclosure, arising from her qualitative study with 15 self-identified lesbian women. She examines the experience of disclosure in a heteronormative society from a feminist perspective:

An essentialising of disclosure as always the ‘right thing to do’, whether in the name of health or of political ideology negates the individual circumstances and experiences of each lesbian life and removes from the woman the opportunity to exercise agency in her own life. (McDonald, 2006, p.44)

McDonald (2006) raises concerns that such valorising of disclosure can lead to a view by health care providers that non-disclosure is pathological, for example that it indicates low
self-esteem or heightened anxiety. In my study, this belief did arise as an important influence on barriers to GPs facilitating disclosure that I will present below.

**Literature on Patterns of Disclosure**

Disclosure can only occur in the consultation if the woman or the doctor or both take responsibility for it. The woman must tell, the doctor must ask, or there must be a shared process where the doctor establishes the conditions under which disclosure by the woman is possible. Disclosure rarely occurs as a subtext or assumption because, as I showed in Chapter 4, the majority of GPs assume that their female patients are heterosexual. There is very little discussion in the literature about who should have responsibility for disclosure. The majority of authors assume that women should tell, and they focus on the attributes of the provider that encourage women's disclosure. Having a sensitive provider has been found to facilitate disclosure (Eliason & Schope, 2001). Attributes of sensitivity included having specific knowledge and actively involving the same-sex partner (Bjorkman & Malterud, 2007; Bonvicini & Perlin, 2003; Klitzman & Greenberg, 2002), understanding the social context (Schilder et al., 2001), and being accepting and affirming (Saulnier, 2002). Conversely, I have found just three papers that suggest facilitation of disclosure is the health care provider’s responsibility (Bjorkman & Malterud, 2007; Boehmer & Case, 2004; Remafedi, 2006), and none that recommend shared responsibility. However, Gary Remafedi does problematise this by stating that simply asking about sexual orientation “might not work” with adolescents because the young person might be afraid to answer or might not have built adequate trust (Remafedi, 2006, p.1303).

The literature demonstrates that women are much more likely to tell than are doctors to ask. Consistently, less than one quarter of lesbian women report being asked about their sexual orientation in the consultation (Steele et al., 2006; Stein & Bonuck, 2001). Lack of provider inquiry is found to be a barrier to disclosure. For example, amongst 131 adolescents, 65% said their main doctor did not know their sexual orientation, and 33% had not disclosed because they had not been asked (Meckler et al., 2006). Only 21% had
been asked by the doctor, and 64% felt that if a doctor asked them disclosure would be easier. The same pattern is found in the sexual health literature, in that most patients want to discuss sexual issues but prefer not to raise them, but few are asked by GPs (Gott, Galena, Hinchliff, & Elford, 2004). Ulrike Boehmer and Patricia Case (2004) suggest that having the full responsibility for disclosure is a burden for women and often results in disclosure not occurring. Their study involved interviews with 33 lesbian and six bisexual women who had had breast cancer and they found that “cancer providers’ lack of inquiry of sexual orientation allowed women to passively refuse disclosure of their sexual orientation” (Boehmer & Case, 2004, p.1885). This would apply to those women in my study who had a passive approach to their identity expression, where they would wait to be asked and rarely be asked. However, I wouldn’t suggest this was ‘refusal’, but rather resignation to the habitual silence on this topic.

Preferences Regarding Who Is Responsible For Disclosure

I asked women and GPs their preference as to whether the GP should ask or the woman should tell about her sexual orientation. Twenty women preferred the GP to ask and 13 preferred to tell; whereas just six GPs believed that it was their role to ask, while 21 preferred the patient to tell them. Clearly, there was a disparity between women’s and GPs’ preferences, and I will describe the outcome of this disparity in the following pages. This is similar to the findings in the literature, suggesting that GPs mostly prefer to defer responsibility for disclosure of sexual orientation to women.

Women’s Preferences for the Method of Disclosure

The reasons women gave for their preferences were related to their identity experience and preferred expression approach, their need to be in control of disclosure, or their perception of the relevance to the GP of their sexual orientation within the consultation. Women’s preferred expression approach (open, passive or private) did not entirely dictate their
preference for telling or being asked and therefore there was some discrepancy between
the preferred expression approach and preferred disclosure method. In addition, women’s
preferences did not relate to their life-stage, as all life-stages were represented amongst
women who preferred to tell or to be asked.

Amongst the 13 women who preferred to tell, the major reason was to be in control of
their disclosure. This complies with Habermas’s theory regarding control being one of the
three human interests, in that women’s level of interest in their sexual orientation matched
their required level of control (Crossley, 2005). It also follows liberal feminist principles
that women prefer to control the degree to which personal information is made public
(Candib, 1995). Eight of these women had an open identity expression approach (Bear,
Sharon, Anne, Esther, Helen, Mitzy, Susan and Angelina), five had a passive approach
(George, Jamie-Lee, Jane, Miranda and Robyn), and none were private. Most of the open
women preferred to tell to avoid assumptions (Esther, Helen, Angelina, and Mitzy)
because their sexual identity was important to them, as all of these women were identity
defined or identity integrated. They wanted to present an authentic self to the GP inclusive
of their sexual identity. Sharon (40) also linked disclosure with her decision to continue
seeing the same GP. The passive women preferred to tell because they wanted to control
the timing of disclosure and to ensure that the GP would be receptive or sensitive. For
example, Jamie-Lee (47) said that if there was some form of ‘gay friendly’ sign at the
clinic, then she “wouldn’t think twice about it [telling]”. George (56) wanted to build
rapport first and so did Bear:

Bear (25, lesbian, inner urban): Generally I prefer to tell because then it lets me do
it in my own time when I’m comfortable (…). So yeah I prefer to tell because it
kind of lets me gauge the GP before I’ll say anything. I didn’t tell [Current female
GP] until about a year ago and I’ve been going to her for two and a half years. (…)
I just wanted to make sure that I’d seen her a couple of times and I knew how she
approached health care and how she treated her patients.

Dr Margaret (Bear’s GP) reiterated Bear’s position:
Dr Margaret (51, inner urban): Well I guess people wouldn’t say it if they didn’t know the GP well enough. You know, it wouldn’t be the sort of thing you come in on your first visit and say “oh look at this”. It would be more something that you’d get to trust someone enough and get to know them enough before you’d say it I would think. Maybe there would be people in society who would judge them. Yes okay, but I don’t.

This desired level of control amongst the women who preferred to tell had developed over time. Many of these women had earlier had a *private* approach to their identity expression due to their fear of negative GP attitudes. For example, as I discussed in Chapter 5, they deliberately had not disclosed to GPs during their coming out period. So, their preference to tell GPs had only developed since they had become secure in their sexual identity and had developed the resilience to deal with potentially negative responses. Mitzy (now *identity defined*) described this transition in her life:

Mitzy (61, lesbian): I wouldn’t have felt strong enough to come out and say “I’m a lesbian”. I don’t know what I thought the reaction would be but certainly at work, you’d probably get the sack, [or at least] be treated differently. (...) It was only when I became a strong woman. Or stronger. (...) I still feel that oppression but in terms of GPs, I can choose. That’s a major leap for me, huge.

Conversely, amongst the 20 women who preferred to be asked, the main reasons were either that they found telling too difficult, or they relied on GP inquiry as an indication of GP attitudes. Needing to be in control was less important than for the group who preferred to tell because generally their sexual identity was less important to them. Of the 20 women, six were *attraction predominant* (Bee, Flo, Kirsti, Indigo, Jenny and Alice), and six were *identity peripheral* (Madison, Sally, Betty, Gabrielle, Kate and Dora).

Many of the women preferred being asked because disclosure was difficult. Dora (41) and Sally (42) said they did not like telling, Bee (25) said she “wouldn’t know where to begin”, and Indigo felt it would be “easier” to be asked. Even Nede (55) preferred to be asked, despite being *identity defined* with an *open* approach, because she realised that disclosure can be mutually difficult, saying “I don’t know how to bring it up and maybe
they [GPs] don’t know how to bring it up either”. Miranda had not disclosed to a previous 
GP but had hoped that he would ask because her identity was important to her. In 
retrospect she felt she should have taken some of the responsibility, but did not as it was 
too difficult, which reiterates the claim in the literature that disclosure is a burden for 
women:

Miranda (61, lesbian, *identity integrated, passive* approach): I mean maybe that’s 
it, maybe they see only one aspect of me, and it’s been because I’ve been guarded 
also, or I haven’t felt it necessary, or they haven’t asked, there’s a combination of 
all these three. Perhaps my needs haven’t been met, and they would have been met, 
but then perhaps I should have done something about it. But it’s very difficult to 
do something about it.

Most of the women also preferred GPs to ask as this would indicate the GP’s attitudes;
either their level of interest in, or their approach to, minority sexual orientation. As Lucy 
(45, bisexual, *identity integrated, passive* approach) said “I would prefer her to know, and 
yet I haven’t told her. But it’s only because I don’t like to do the announcement thing. If 
you haven’t asked me, you’re not interested”. While this preference would be expected of 
the eight *passive* women, it was also the reason that some of the *open* women preferred to 
be asked. For example, Mina (23, bisexual) would have preferred to disclose on an intake 
form “to get it out there straight away” and then she would know that the GP was 
interested and “okay with it”. Connected to sexual orientation being relevant to the GP, 
some women were happy to be asked if the way the question was asked indicated minority 
sexual orientation was, as Lesley (52) said, “one of the normal things in life”. Jill (50) also 
pREFERRED to be asked as part of “the general scheme of things”. Madison reiterated this:

Madison (24, lesbian, *identity peripheral, private* approach): When they ask, and if 
they present it in a nice way then it normalises the situation, for me it’s not 
something that’s taboo or something I should feel ashamed of or embarrassed 
about. If the GP were to ask, then that would be an open invitation to let him or her 
know about things I think.
A normalising question would indicate something very important about the GPs’ underlying attitudes towards minority sexual orientation. This again raises the risk of potential negative attitudes as a constraint on women’s identity expression. Being asked allows women not only to know that the GP perceives some relevance, but also to ascertain the GP attitudes as part of their risk assessment and decision about how to answer. Mina described this interrogation of the way the question is asked:

Mina: If I went to a doctor and they said “are you heterosexual?” I’d feel like saying “No I’m homosexual” would almost be a bit of an embarrassment, but if they say “Are you homosexual or heterosexual?” or the other way round it’s just like obviously they are open to both answers.

**GP Preferences for the Method of Disclosure**

The majority of GPs (21 of 27) definitively preferred the patient to disclose rather than to ask women themselves. Many suggested that being told was “easier” (Dr April) or “more efficient” (Dr Leon), contrasting with women’s perception that it was easier being asked than telling. There were two over-riding reasons GPs gave for preferring this approach, one being that they assumed women would tell them if they really wanted to, and the other was to avoid being intrusive to women. The assumption that women would tell generally arose from a lack of understanding of the many barriers to disclosure that women perceived. As Dr Soula (62, outer urban) said “I don’t know what would stop them from telling me” referring to her regular patients, and Dr Cahill (54, inner urban) believed that “if they want to tell me they’ll tell me”. However, eight of these 21 GPs (Drs Audrey, Judy, Jackie, Katie, Margaret, Pachy, Perry and April) did understand some of the barriers and believed that their role was to establish the conditions under which women would feel comfortable to tell. This position recognised women’s fear of negative reactions and their need to feel secure in the patient-doctor relationship before disclosing. As Dr Audrey (30, outer urban) said “if it is at all related, or if they are going to see me on an ongoing basis it would be really nice if people could just say, but then I think that people can’t know how you are going to react”. All of these GPs had a holistic, patient-centred approach and
focused on building a good relationship as the central factor in creating the right conditions. As Dr Katie (47, regional) said “You just hope that you have a good enough relationship that they’d be happy just to tell you and know that you wouldn’t take it against them”.

Several GPs (Drs Cam, Harry, Lith, Normal, Rose, Westy, Cahill and Michael) preferred patients to tell because they believed that asking was too intrusive. Dr Rose felt it would be uncomfortable for the patient to be directly questioned about her sexual orientation, which would be the case for those women I reported who preferred to tell in their own time once they were sure of the GP reactions. However, this approach would not suit the many women who were merely waiting to be asked. Four GPs (Drs Alan, Normal, Judy and Michael) went further in believing that lesbian women should not reveal their orientation in any context to avoid opening themselves to discrimination:

Dr Normal (70+, inner urban): If they keep it to themselves, I mean… that matter would never be brought up, nobody knows, it’s their own business. That’s why I choose you might say a blind eye [laughing]. (…) They would be accepted if they just live their lives without saying anything. I mean who’s going to say that they’re not normal [then].

As demonstrated in the literature, it was also rare for GPs in my study to take responsibility for disclosure. Six GPs (Drs Alan, Holly, Imogen, Phoenix, Joseph and Elisabeth) preferred to ask patients and actually did so in practice. For example, Dr Joseph estimated that of those lesbian women he knew, about 30% had told him and 70% had responded to his question. They differed only in that Drs Phoenix, Joseph and Elisabeth would ask women when they felt it was relevant, whereas Drs Alan, Holly and Imogen routinely asked as part of their social history. These last three GPs all realised that disclosure can be very difficult for women and that being asked would be easier for the patient, as Alan said “the homosexual patient would be grateful for it”. Dr Phoenix (57, outer urban) related this to other difficult disclosures when saying “I think ultimately as professionals we have to accept that people have things that they’re not going to talk about unless we raise them”.

Dr Holly probably had the most experience of asking women about their sexual orientation, having had “truck loads” of lesbian patients, and was also able to understand women’s perspectives of disclosure from her personal experiences as a lesbian woman. She acknowledged the need to create the right environment for disclosure, however described going a step further and directly asking women in a normalising way when needed, just as many of the women preferred:

Dr Holly (39, lesbian, inner urban): I think it’s probably easier if I ask them [pause].
Interviewer: Why is that?
Dr Holly: (…) It’s not just about sexuality, it’s about anything, about making the environment right that people can say stuff that they’ve obviously been wondering about saying for a long time, they’ve probably rehearsed the discussion in their heads for a long period of time and are doing that gaze at you about what’s your reaction going to be. It’s possibly easier and a bit kinder to the patient to take that out of the equation and just make it a “give me a fact” rather than that sense of having to almost look for a justification.

**Congruence of Disclosure Preferences within Woman-GP Pairs**

I analysed the disclosure preferences of the 24 woman-GP pairs and the association between congruent or incongruent preferences and actual disclosure. Amongst the pairs, 14 GPs were aware of the woman’s sexual orientation and 10 were not. I regarded congruent preferences to be either when the GP preferred patients to tell and the woman preferred to tell, or when the GP preferred to ask and the patient preferred to be asked or to tell. Logically, I would expect these forms of congruence to lead to disclosure. Incongruent preferences occurred when the GP preferred to be told and the woman preferred to be asked, which I would expect to form a barrier to disclosure. Eleven pairs were congruent and 13 were incongruent.
Amongst the 11 congruent pairs, eight of the women believed that their GP knew about their sexual orientation, as I expected, and three women believed the GP did not know. George and Dr Harry were an example of congruence enabling disclosure because George wanted to tell only once rapport had developed, and Dr Harry waited to be told to ensure the patient was comfortable to tell him. Likewise, while Dr Elisabeth asked when relevant, Esther preferred to tell to avoid assumptions and had told Dr Elisabeth in the context of needing a referral for reproductive services. In the three congruent pairs in which the GPs did not know the women’s sexual orientation, each woman had not disclosed for different reasons. Dr Joseph preferred to ask, but only in certain circumstances, and had not asked Jamie-Lee. While Jamie-Lee preferred to tell, she had not told Dr Joseph due to her concern about his reaction and having seen him when she was previously married. So the risk of compromising the patient-doctor relationship had overcome preference for Jamie-Lee. Dr Phoenix preferred to ask and Kirsti preferred to be asked, but both had specified this was only when sexual orientation was relevant, which Kirsti felt it had not been when she was seeing Dr Phoenix. Finally, Lucy had not told Dr Imogen because she had not been asked by her. She had started seeing her well before Dr Imogen had started routinely asking new patients about their sexual orientation. Lucy (45, bisexual, outer urban) was annoyed by this apparent lack of initiative from Dr Imogen saying “I don’t think that that’s my role to drive the relationship with my GP. I want her to work it”.

Amongst the 13 incongruent pairs, seven GPs were not aware as I predicted and six were aware. Many of the women in these pairs would have been happy to disclose if asked and did not feel a question would be intrusive, while their GPs were convinced that such a question would be intrusive. This applied to Gabrielle and Dr Fred, Mae and Dr Katie, Indigo and Dr Leon, and Sally and Dr Normal. Madison and Dr Michael are a typical example of incongruence leading to a lack of disclosure, with Dr Michael waiting to be told and Madison waiting to be asked. Just as Nede had suggested, initiating disclosure can be mutually uncomfortable, and Madison also realised this was a barrier:

Madison (24, lesbian outer urban): I think it’s because the topic itself is still…um both parties aren’t very comfortable discussing it in that setting, so each would want the other to approach it to make it easier on themselves.
More surprising amongst the incongruent pairs were the six women who had disclosed despite the incongruence. All of them (Jill, Alice, Nede, Betty, Dora and Eileen) had told their GP and not waited to be asked, despite preferring to be asked, because they believed it was important for the GP to know about their sexual orientation. This was about presenting themselves authentically to the GP, just as it was for some of the women who preferred to tell. Jill, Nede and Eileen needed authenticity because they were identity integrated or defined; and Dora, Alice and Betty because their same-sex partner attended the same GP. These women were prepared to take some reciprocal responsibility for informing the GP to enable this authenticity. Jill (50, lesbian) said she would raise her sexual orientation with a new GP because “I guess it’s sort of like asking for somebody’s help but only telling them half the story, I think I’d have to say ‘look this is who I am’ (…) I can’t expect them to give me a good answer if I don’t tell them everything”. Dora had a similar perspective on needing to be ‘honest’:

Dora (41, gay, identity peripheral): Maybe when I have to move to a new GP, maybe I might consider… I need to be a little bit more honest with this doctor because if I don’t give a bit then how can I expect them to know. Try and be a bit more understanding, and that it’s a two-way thing. The doctor can only…they haven’t got a crystal ball.

**Summary of Preferences**

Some women preferred to tell about their sexual orientation and this was predominantly to have control over disclosure. Other women prefer to be asked, either because they would only disclose if it was relevant to the GP, or to ascertain GP attitudes. The majority of GPs preferred not to ask, due to a belief that women would tell if they wanted to, or because they believed that asking was intrusive. The disclosure preferences highlight that disclosure of sexual orientation is regarded as difficult by both women and GPs, with a majority of people in both groups believing it is ‘easier’ for the other to initiate the
process. Only three GPs routinely asked, believing it was “easier and kinder” to ask, as Dr Holly said.

The large number of incongruent pairs is not surprising given the discrepancy between the many women who preferred to be asked and the very few GPs who preferred to ask. The preference to pass responsibility to the other often resulted in a lack of disclosure, although some women were prepared to share that responsibility to be more authentically present in the consultation. Deflecting responsibility resulted in relinquishing control over disclosure. While it is not surprising to see women doing this because it is a common occurrence within the consultation where the power so readily diverts to the doctor, it is curious to see doctors being so willing to defer control. I will address the reasons for this when presenting GPs’ barriers to facilitating disclosure, which focus on risk perceptions.

Habermas’s Theory of Communicative Action (1984) offers some insights into GPs’ possible motivations for or against facilitating disclosure. Direct inquiry about sexual orientation could be seen either as a communicative action if it was motivated by a desire to understand the woman’s lifeworld or as a strategic action if it was used to control the information exchange. Conversely, a lack of inquiry could be the result of GPs using strategic action for other purposes such as to achieve the biomedical purpose of the consultation in the desired time. As discussed in Chapter 4, strategic action can also be motivated by perceptions that minority sexual orientation is not relevant to the consultation. These examples display evidence that failure to facilitate disclosure of minority sexual orientation is a strategic action by GPs that leads to colonisation of the lifeworld.

I will now describe the actual experiences of how disclosure occurred, which did not always satisfy women’s preferences.
Experiences of Disclosure

Six of the 33 women in my study had never disclosed to a GP (Bee, Flo, Jamie-Lee, Jenny, Lucy and Madison), and 27 had disclosed, although six of these had not disclosed to their current GP. I will outline the disclosure experiences of the women who had ever disclosed, both how this had occurred and the context in which sexual orientation had arisen. All but two of the 27 GPs (Drs Normal and Michael) could recall disclosure from same-sex attracted women.

How – Who Told and Who Asked

The experiences of the 27 women who had disclosed indicated that their preferred method of disclosure was often not realised. Twenty-four women had told a GP and three women (Gabrielle, Kiama and Sally) had been asked. Gabrielle had been asked at a women’s clinic but not by her current GP (Dr Fred), and Sally was asked by Dr Normal when he was entering her demographic details into his new computer program, although he did not recall this. Kiama had been asked recently by the GP she had seen since childhood recalling that “I didn’t tell her, she just knew” and believed that her mother had told the GP:

Kiama (23, lesbian, inner urban): She probably said “have you slept with males before?” and I said no and she said “have you slept with females?” and I’ve gone yeah. (…..) It was pretty easy.

The actual experiences of disclosure that the GPs recalled mostly corresponded with their preferences. Fifteen GPs had never asked a woman about her sexual orientation and all of these GPs preferred not to ask. Twelve GPs had asked women and six of these preferred to ask, although as I discussed previously only three (Imogen, Holly and Alan) did so routinely. Six of the 12 GPs who had asked (Drs April, Phoenix, Lith, Michael, Joseph and Cam) did so only rarely; and Drs Audrey (30), Leon (34) and Elisabeth (39) asked “occasionally” in relation to their sexual history taking. As I described in Chapter 4, the
more recent training of these three GPs assisted them with skills of sexual history taking, in particular to ask specifically about the gender of sexual partners, as Kiama’s GP had done in the previous example.

The perception of minority sexual orientation by GPs was often subtle and based on women’s cues rather than direct disclosure. Various cues were noted by GPs including dress code and appearance (“butch” or masculine indicators such as “cropped hair”, dangling chains, multiple piercings or tattoos), or mannerisms (such as “brashness” or assertiveness). For example, Dr Fred obtained a “slight impression” based on women’s mannerisms and Dr Alan said that he used “ESP”. This corresponds with Goffman’s forming of ‘impressions’ by observation of a person (Goffman, 1971), and was similarly described in another Australian study in that GPs used appearance to assess socio-economic status (Furler et al., 2005). These visual cues were based on stereotypes of a lesbian woman and would therefore not have detected women without such presentations. Other GP assumptions were based on more situational cues such as Dr Lith’s experience that it was often “obvious” when women attended with a same-sex partner. Dr Joseph used a living arrangement as a cue in the following example and had not clarified the issue as he did not feel there was any medical relevance to do so:

Dr Joseph (57, outer urban): There is a very elderly couple where one of the partners has died recently, but they lived….I don’t know whether it was a sexual relationship or a relationship of friends, elderly women who lived together, but they’d lived together for 30 or 40 years and I think it would have been a sexual relationship. You know…they were…well that’s an assumption.

A few women expected that cues would be used by GPs in making an assessment of their sexual orientation, and, as Goffman (1971) suggests, some women used their appearance as a form of impression management with GPs. I mentioned in Chapter 4 that some women encouraged heterosexual assumptions through their feminine presentation. Conversely, Jamie-Lee, Kate, Mitzy and Miranda expected GPs to assume they were lesbian by their non-feminine appearance, although in my opinion only Kate conformed to GPs’ stereotypical descriptions. Other women had experienced possible GP assumptions
that were not clarified by the GP. For example, Dora’s previous GP knew that she lived with a woman but did not clarify that relationship. Likewise, Gabrielle had attended doctors with her partner and had never been asked who she was. These women felt that clarification would have been preferable to be sure the assumptions were correct. GPs tended not to clarify these cues by directly asking women about the gender of their partner or their sexual orientation, as Dr Joseph showed. Fifteen GPs (Drs Alan, Audrey, Cam, Elisabeth, Fred, Joseph, Imogen, Jackie, Leon, Katie, Leon, Lith, Olive, Rose and Tyl) described speculating that some of their female patients might be lesbian. Only Drs Alan and Elisabeth followed up their assumption and asked women. So, while assumption rather than direct disclosure can be a useful tool, it requires clarification and would not be useful or possible with all women. GPs’ failure to clarify their assumptions points to a form of habitual silencing, although as I described in Chapter 4 this could be intentional or unintentional.

I compared the recollections of disclosure or non-disclosure amongst the 24 woman-GP pairs within that particular relationship. All but one pair described consistent versions of events in that the woman described her particular experience with that GP, and the GP described how he or she usually experienced women’s disclosure. For example Eileen had disclosed when Dr Tyl asked about her sexual history related to a gynaecological problem, and Dr Tyl told me that disclosure mostly occurred in the context of gynaecological care and that it is “usually an indication from the patient that I pick up on”. Miranda said Dr Jackie had asked her what her partner thought about her breast cancer treatment decision and Miranda had then referred to her partner as “she” for the first time. Dr Jackie said that she never directly asked women, but usually discovered sexual orientation when women revealed that their partner was female. Similarly, Dora, Alice, Esther and Sharon all told their GP in the context of mentioning their female partner, and their respective GPs, Drs Soula, Judy, Elisabeth and Holly all felt sexual orientation tended to arise when they asked about women’s partners. Drs Elisabeth, Imogen and Holly tended to probe for the partner’s gender if needed, which is an example of the clarification of cues that women hoped for:
Dr Holly (39, lesbian, inner urban): It usually comes up when I ask directly about partners and then “what’s your partner’s name and what does he or she do?” (…) So it’s always picking up “tell me about your partner”, “he works as a panel beater”, right. [Or] “my partner is a university academic”, well still haven’t answered [so] I’ll keep coming back to that [asking the gender].

The only pair not to have consistent disclosure recollections was Sally and Dr Normal. Dr Normal did not remember any women disclosing to him despite Sally saying that she responded to his question while he was entering her details into his new computer-based medical software. He had asked whether she was “heterosexual, homosexual or bisexual” in order to fill in the demographic section of this software package. He had indicated to her that he felt forced to ask this question, which he otherwise would not ask, because he had to complete all questions in the file. Sally clearly recalled this as Dr Normal had looked surprised when she said homosexual and went on to seem quite voyeuristic by asking her several related questions.

There were also a few exact versions of events where the GP actually recalled the disclosure of the woman I had interviewed. This was the case between Alice and Dr Judy, Angelina and Dr April, George and Dr Harry, and Susan and Dr Olive. For example, Alice said she and her female partner started seeing Dr Judy when they first moved to Australia and presented together as a couple “like a family”. Dr Judy recalled seeing such a couple who “indicated that they were in a same-sex relationship right at the start”, which helped her to understand the “dynamics” of their “family life”. Susan disclosed to Dr Olive when she was going through depression related to a same-sex relationship break-up. Susan (43, gay) said “I told her. I think it was when I went through a really dark patch. I’d been seeing her for about a year, but I felt comfortable”. And Dr Olive recalled Susan’s disclosure:

Dr Olive (43, inner urban): The patient I’ve known for twelve, fourteen years. She started to see me [regularly] and at some point in the next twelve months, two years, she came to see me very upset and basically said “I have broken up with my
partner, I was in a gay relationship” and just told me. (…) Yeah so that was quite easy because she actually said.

Therefore, multiple methods were used for disclosure including cues provided by women in the hope that GPs would ask clarifying questions, women presenting as a couple, indirect inquiry by GPs via sexual or social history that triggered women to disclose or, rarely, direct questions from GPs. Most disclosures were initiated by women. Although the majority of GPs recalled seeing only a few lesbian patients, they could accurately recall the disclosure methods. The ease and apparent accuracy with which most women and GPs were able to recall disclosure methods is indicative of the importance and sensitivity of this event to women and GPs.

**Why – Context for Disclosure**

There were three main contexts in which sexual orientation arose in the consultation: a) most commonly related to a same-sex relationship, b) related to sexual or gynaecological health, and c) in the context of a health crisis.

Sixteen women and 22 GPs had experienced disclosure as a result of a same-sex partner being discussed. Several women saw the same GP as their partner and either openly attended together or told the GP they were partners. Mostly this was disclosed as contextual information for the GP, however Miranda, Mitzy and Lesley described situations where GPs needed to know because their partners were involved in supporting them during a serious illness. Five GPs remembered women attending with their same-sex partner. Dr Westy realised that there might be “a certain amount of relief that they’re able to be open about their relationship”, which reflects his awareness of the importance of authenticity for some women. Six women disclosed to their GP in order to obtain support with same-sex relationship problems or break-up. Seven GPs also recalled this context and Dr Tyl was perceptive in realising that one woman had told her about her relationship break-up because “she wanted someone to acknowledge it”. In almost all cases the women
had initiated the disclosure by mentioning the name of their partner, although as I discussed previously, Drs Elisabeth, Holly and Imogen had all asked about partners and then probed for their gender.

Sexual health was experienced as the context for disclosure by 13 women and nine GPs. The possibility of a sexually transmissible infection from a female partner led to disclosure for Bear, Esther, Indigo, Mae, Mina, Dr Lith and Dr Westy. A Pap smear and general sexual history had initiated disclosure for Jill, Kiama, Robyn and Sally; and been the trigger for inquiry by Drs Audrey, Cahill, Elisabeth, Katie and Leon. Four women (Eileen, Jane, Kate and Mina) had disclosed when GPs assumed they needed contraception, and Drs Audrey, Fred, Holly, Pachy and Westy experienced disclosures in this way. For example, Jane (21, lesbian, regional) said “I went to get my Pap smear done and (…) she was asking me about protection and I’m like ‘I’m not on the Pill, I’m gay’ and she says ‘OK’… and that was it”. Dr Fred described a similar scenario:

Dr Fred (65, regional): I must have asked her about pregnancy, no, I must have asked her about her periods and perhaps contraception and she said “oh not me doc, I’m not the type, I’m ….I’m gay” or something like that. Which probably confirmed what I was suspecting I think [laugh]. But she was quite open about it and she always has been.

So, Dr Fred’s heterosexual assumption in his method of sexual history taking was effective in this instance in leading to a disclosure because he was seeing a woman who was comfortable enough to correct his assumption, as Jane described. However, this would not be the case for many women as I showed in Chapter 4, where GP assumptions of the need for contraception prevented them from disclosing.

Finally, six women disclosed to a GP as a result of a social or medical ‘crisis’. This was a coming out crisis for Angelina (37) and Eileen (45), whose parents had instructed them to disclose. Angelina had also disclosed to another GP in her 20s about experiencing partner abuse in her marriage and being same-sex attracted. As I reported in Chapter 5, these disclosures rarely resulted in a caring or therapeutic response. Conversely, Indigo and
George had both disclosed to GPs due to significant same-sex relationship problems and found excellent support. Indigo (30) remembered feeling in “quite a desperate situation” and her GP being “great”. George had been seeing Dr Harry for a number of years when she was virtually forced to disclose to him. She had assaulted her female partner and been charged and her lawyer suggested obtaining a character reference from her GP. She described her extreme vulnerability in this situation as she did not know how Dr Harry would respond to her double disclosure of having a same-sex partner and being abusive:

George (56, lesbian, rural): So I went to my GP and I said to him, like it just happened yesterday, I said to him “You have been my GP for a long time. After I tell you this you may no longer want to be my GP”. And I told him that I was homosexual. [later] I was just amazed at how many people [including Dr Harry] just accepted it.

Anne (60, lesbian, outer urban) told her current GP (Dr Cam) when she developed uterine cancer, and Mitzy disclosed to a previous GP when diagnosed with breast cancer. Again, both of these situations were fraught, as this was a time when the women needed the most support, from their partner and their GP, and fortunately both had resulted in supportive responses. Mitzy and her partner had both been seeing the same GP in their rural town and had not previously disclosed in order to protect her partner who worked in health.

Interviewer: Had you ever been to see her together before that?
Mitzy (61, lesbian): No, we didn’t have any need to I suppose. But this was really a crisis, and …. [Previous female partner] picked up the lump actually, and then of course…on her advice “You’re coming to the doctors, come on”.

Two women had crises but felt relieved that they had already disclosed to their GPs, so unlike George, Anne and Mitzy, they could obtain support without the added burden of disclosure at such a difficult time. Dr Debra, the lesbian psychiatrist, had attended her GP with her female partner when she coughed up some blood and Helen received support following separation from a same-sex partner:

Helen (49, lesbian, outer urban): I would have hated if, let’s just say I hadn’t been out to my GP at that point, and I’d been like a blubbering mess and in addition to
actually having to go in there and say “my relationship has broken down and by the way”… you know, it would have been really hard. I didn’t have any of that and so that’s why I think I’m really glad that I was out to my GP (…), you can cut to the chase of what’s actually important right then.

### Summary of Experiences

The majority of women had told their GPs and the majority of GPs had been told, replicating the disclosure literature. Many GPs had wondered whether women were lesbian but it was rare for any of them to have confirmed this with women, despite women preferring this. So, women largely took responsibility for disclosure and GPs were passive recipients of the information. These experiences generally satisfied the preferences of GPs, while women’s preferences were often not fulfilled, particularly if they preferred to be asked but had actually told to ensure authenticity. Declaring a same-sex relationship was a very common method of disclosure used by women. Another common method was related to sexual history, and while some women were willing to disclose in the face of GPs’ heterosexual assumptions, GPs could not rely on this as many other women were silenced by these assumptions. Finally, the most vulnerable context for disclosure was a social or medical crisis, and some women felt it was far preferable to have already disclosed before such an event occurred.

### GP Reactions to Disclosure

The literature has shifted over the past decade from focusing on homophobic or negative GP reactions to revealing that excessively neutral responses can be almost as problematic for some women. While I found that some GPs did not clarify their assumptions based on visual or subtle verbal cues from women, the literature reveals women’s experiences of providers who do not acknowledge even their direct disclosure. Ignoring a disclosure was experienced by 11% of women in a national New Zealand study (Neville & Henrickson,
2006) and 10% of those in a national UK lesbian health study (Hunt & Fish, 2008).
Likewise, in Boehmer and Case’s (2004) study few of 39 women attending cancer
providers had experienced a homophobic response, but “many providers’ reactions were
so neutral that their reaction was perceived negatively” (Boehmer & Case, 2004, p.1887).
This resulted in ongoing vigilance by women as they could not ascertain the providers’
recommend that providers should openly acknowledge disclosure and integrate the
information into the consultation. In their study of 33 lesbian women, Janice Hitchcock
and Holly Wilson found that women wanted at least “a verbal response (to disclosure) that
acknowledges an awareness of the risk taken” (Hitchcock & Wilson, 1992, p.181). So
these women wanted more than a neutral or non-committal response. Conversely,
excessively focusing on sexual orientation can be equally disturbing for women as it can
tend to suggest that minority sexual orientation is the underlying issue rather than it purely
being demographic information (Bjorkman & Malterud, 2007).

I found very little in the literature that describes experiences of optimal reactions to
disclosure of minority sexual orientation. The most useful study was by Christine Saulnier
(2002), who describes a “continuum of provider reactions” (p.355), being homophobia,
heterosexism (including negative stereotyping), tolerance (provider has some knowledge
and awareness), lesbian sensitivity (lesbianism is regarded as normal, the health care
provider is comfortable and receptive), and finally lesbian affirmation (celebrating
lesbianism). Otherwise, authors tend to focus on and report the negative reactions, even
when the paper is ostensibly about health care experiences overall, such as Patricia
Stevens’ work (Stevens, 1998).

There is some literature on provider responses to disclosure of intimate partner abuse
(IPA), which provides useful additional insights as this form of disclosure has significant
parallels with disclosure of minority sexual orientation. For example, in one Australian
study, 88% of women had never been asked about abuse by a GP, while about a third had
ever told a GP (Hegarty & Taft, 2001). They were more likely to have told if they had
been asked. Gene Feder and colleagues (2006) conducted a meta-analysis of 25 qualitative
studies on IPA (n = 847) and examined women’s experiences of provider reactions to their disclosure, and their preferred responses. Women wanted providers to raise abuse as long as they were sensitive in their response to disclosure. If disclosure had not occurred initially, women also wanted providers to continue to inquire about abuse to provide time to build trust that would enable a later disclosure. Providers were perceived to be sensitive if their responses were non-judgemental, compassionate and supportive, and if they understood the complexity of abuse and knew about referral networks. Finally, women wanted providers to understand the social and psychological issues and not to regard abuse as a medical issue. So, like same-sex attracted women, women experiencing IPA preferred providers to take an active role in facilitating and responding to disclosure (Feder, Hutson, Ramsay, & Taket, 2006).

In my study, as for women experiencing IPA, the success of a disclosure was partly dependent on receiving a sensitive reaction from the GP. As I explained in Chapter 4, women were adept at detecting very subtle responses from GPs that may have indicated discomfort or surprise. I have found that there were three categories of GP reaction to disclosure that women described, and these in turn had the effect of pathologising, minimising, or normalising their sexual orientation. I have outlined pathologising and minimising responses in Chapter 4 when discussing the ways in which GPs tend to silence the lesbian and bisexual lifeworld within the consultation. I will briefly expand on women’s experiences and GPs’ explanations for the minimising responses before a more detailed discussion on the range of normalising responses that women experienced.

Minimising Responses

Fourteen women described GP reactions to their disclosure having the effect of minimising or silencing their sexual orientation. For example, Esther told one GP that she was lesbian and she noted that he “went a bit more poker-faced” but he said nothing. Ten women (Esther, Eileen, Alice, Jill, Miranda, Jane, Kate, Lesley, Sally and Mitzy) said that the GP did not raise sexual orientation again after their initial disclosure, which had been
years before in some cases. Many of these women were not bothered by this, suggesting that they were simply happy that the GP was aware. For example, Jill (50, lesbian) had a response of silence from Dr Cahill and described the same response from her 80 year old mother, saying she was “not going to push it down her throat out of respect for her”.

Several women had similar experiences with their own families, which may have reduced the impact of the response from their GPs as they were as protective of their GP as of their family. Similarly, Eileen, believed that her GP, Dr Tyl, did not remember her sexual orientation from visit to visit. Dr Tyl told me that she did not record a woman’s sexual orientation for confidentiality reasons and that this would make it difficult for her to remember. Like Jill, Eileen did not expect her GP to remember:

   Interviewer: So there are some signs that you get that she doesn’t quite remember?
   Eileen (45, lesbian, rural): Well, yeah. Does she need to anyway?
   Interviewer: What do you think?
   Eileen: Oh, probably not. It doesn’t matter to me. (…) I wouldn’t be offended that she didn’t remember.(…) God, how many people does she see in one day.

Alice and Miranda were more intrigued by the silence. Miranda found it “amazing” that GPs can know and never mention it. Alice had presented with her female partner and been open about their relationship when they initially saw Dr Judy. Dr Judy had not raised the issue of sexual orientation again, despite Alice now having a male partner, who also sees Dr Judy as a patient. Alice took the full responsibility for the ongoing silence:

   Interviewer: Has she [Dr Judy] ever said anything to you, or asked you about the transition [from having a female to a male partner]?
   Alice (43, bisexual, rural): No! And maybe that, I’d never thought about that, but maybe that’s kind of strange. I guess she assumed I’d talk to her about it if there were issues. I guess it’s not strange that she didn’t ask. [Silence] I think she probably would have if I’d been hinting at issues or brought up the subject, she would have been right there with me about discussing it.

Just a few GPs described reactions that I consider would be minimising to women. Dr Michael (55, outer urban) said he deliberately applied a “flat facial expression” to “be
normal” so as not to reveal his negative attitude. Others deliberately did not probe when women evaded certain questions such as those about contraception or pregnancy, which was an extension of the failure of GPs to respond to women’s cues regarding sexual orientation that I described previously. GPs understood women’s evasion to mean that they wanted to avoid disclosure, however it is just as likely that they were silenced by assumptions of heterosexuality. For example, Dr Pachy described this scenario leading to delayed disclosure:

Pachy: (48, outer urban): Sometimes I may have seen people and it’s down the track that it comes out, that yes they are in a same-sex relationship and that they may have not answered [earlier questions]. I would have said something about do you need contraception and it will just be “well no I don’t”. But just the hesitation or the way it’s said or things like that, I just wonder whether they don’t need it because they’re with a same-sex partner, not because they are not sexually active.

In summary, although many women preferred GPs to ask about sexual orientation, most were not surprised or offended when their GP did not continue to acknowledge it following disclosure. This indicates that the major hurdle for these women was that their sexual orientation had become known to the GP and the risk had passed when the GPs reaction had not been negative. In many cases the GP and woman subsequently continued to build their relationship without needing to refer again to this now tacit knowledge. It also indicates the low level of expectation that many women had for the possibilities that ongoing acknowledgement, where relevant, could offer in further deepening their professional relationship.

**Normalising Responses**

In Chapter 3 I showed that many women particularly hoped for humane interpersonal values including non-judgementalism and acceptance of their sexual orientation. They also wanted caring empathy from their GP incorporating a genuine understanding of themselves as lesbian or bisexual women. This is very similar to abused women’s
preferences for GP responses to be sensitive (Feder et al., 2006). Women’s descriptions of positive reactions to their disclosure by GPs corresponded with these two expectations. They experienced reactions that indicated acceptance as being normal and acknowledgement of the relevance of sexual orientation in the consultation. Some of these responses were more overtly accepting, while others were very similar to the neutral responses I discussed previously, however these women perceived them to be normalising rather than minimising. I have labelled all of these positive responses as normalising.

Acceptance as normal was expressed to women in different ways. For 12 women this was about a neutral response, which indicated a lack of judgementalism, and all of these women declared that this was the type of response that they preferred. Alice and Nede both said their respective GPs (Dr Judy and Dr Lith) “didn’t bat an eyelid”, Eileen’s (Dr Tyl) “didn’t miss a beat”, and Miranda found her GP (Dr Jackie) “didn’t react at all, which I was very tuned in to”. Angelina said Dr April had “no reaction whatsoever” and then said this was “fantastic…she treated me as a human being”. Dr April recalled Angelina’s disclosure and felt that Angelina had wanted her to react “without being too effusive”. Sharon and Jill felt their disclosure had been a “non-issue”, as Jill said her GP seemed to regard it as “just another fact” about her. Some women gauged this neutral yet accepting response literally by their GP’s facial expression on disclosure. Mina (23) recalled her GP “had the same expression as she always does, which is a very concerned look …very understanding and no judgement in it at all”. Esther recalled her GP’s response in this way:

Esther (36, lesbian): I think that what made it really good was it was just normalised, so there wasn’t sort of triple blinking or you know, facial surprise or anything, but I didn’t see it. There was certainly nothing negative about the experience.

Other women experienced more overt expressions of acceptance from GPs. The first GP Eileen had seen on her mother’s request was very clear in saying to Eileen “being lesbian is not a problem”. Eileen also recalled Dr Tyl’s reaction that “she was not disinterested or gazing around” and similarly Tyl said she was careful not to “denigrate or dismiss” a
disclosure. Dr George had prepared her GP, Dr Harry, for the ‘bad news’ and so was surprised by his positive reaction. She recalled him saying “I’ve got many homosexual patients and it makes no difference to me”, which, in Dr George’s subsequent experience it had not. Two other women, Eileen and Robyn believed the fact that their GPs continued to treat them with respect was a marker of acceptance and also professionalism. Mitzy and Lesley had both been thanked by their GP for telling them when they disclosed, which was another respectful gesture.

A few GPs realised that women wanted to feel accepted by them and made efforts to ensure that their reactions expressed this. Dr April (38, inner urban) hoped that she didn’t look “surprised or disapproving” when she was told. She said “I suppose I’m just worried about how they’ll perceive my reaction”. Dr Imogen wanted to show “it’s no big deal to me” and also that “it’s a normal part of life”. Similarly, Dr Elisabeth hoped she “send(s) out signals that it would be OK” and Dr Debra (the lesbian psychiatrist) felt responsibility to affirm that being lesbian is normal. Dr Audrey thanked women just as Mitzy and Lesley had appreciated, by “making affirmative statements such as ‘I’m glad you told me’”. Like Dr Harry, Dr Joseph believed it was important to reassure women that their sexual orientation “has no effect on my relationship with them or treatment or my respect”. Some GPs were aware of the need not to over-react, as many women had said, but for Dr Audrey it was difficult to find the correct balance between not reacting and over-reacting:

Audrey (30, outer urban): I think sometimes we try to show that we are tolerant by pretending somebody hasn’t said… not pretending they haven’t said it but not … just saying “oh yeah” and then they might not feel that they were really acknowledged. Or they might think “did she do that because she’s not really comfortable?”.

Interviewer: So you would want to demonstrate in some way that you are comfortable?
Audrey: Comfortable without being really patronising. That’s the thing, if you don’t want to be sounding like “what an achievement”.
A further GP reaction was to acknowledge women’s sexual orientation in an ongoing way within consultations. So, unlike the minimising approach in which women disclosed and GPs did not raise the subject again, some women appreciated GPs continuing to acknowledge their sexual orientation where relevant. This particularly arose as recognition of women’s same-sex relationship and reflects the preference that I outlined in Chapter 3 for a holistic approach from GPs. For example, Angelina, Dora, Bear and Betty liked the fact that their GPs periodically inquired about their female partner. Betty (41, lesbian) said this “takes the visit to a personal level sometimes, she actually asks the question”.

Angelina’s GP (Dr April) regularly asked after her same-sex partner, which Angelina regarded as a sign of acceptance, especially as Dr April was responding just as she had when Angelina had a male partner:

Angelina (37, lesbian, inner urban): I think she had seen me so unhappy for such a long time when I was married, that now she has seen me, sometimes happy, sometimes unhappy [laugh] with my current [female] partner. That’s probably why she asks. But she used to ask with my husband as well.

Interviewer: So she’s just treating it as a partnership, as a relationship.

Angelina: Yes, whatever they do affects me and vice versa. So, “is everything okay at home?”

Indigo and Jamie-Lee had experienced acknowledgement of a same-sex relationship breakdown. Indigo by her usual GP at that time, and Jamie-Lee by a GP colleague. The pertinent issue for each of them here was that commonly such an event might be passed off as unimportant, as Jamie-Lee explained:

Jamie-Lee (47, gay): He acknowledged it’s pretty tough splitting up, whereas other people just go “oh yeah it’s just a relationship, it’s not even really a relationship because it’s gay”. He was really in tune.

Dr Elisabeth was the only GP who referred to the need for ongoing acknowledgement. She felt it was useful to send “signals” that she was okay with women’s sexual orientation by “just dropping into the conversation every now and then that I’m aware that they’re same-sex attracted and that it’s not a problem”.
Summary of Patterns of Disclosure

Unlike the predominant tone of negativity regarding health providers’ attitudes and behaviour regarding disclosure in the literature, I have described many positive disclosure experiences amongst the participants in my study. First, several women had experienced normalising GP responses to disclosure that were respectful and revealed accepting GP attitudes. Second, there were several congruent woman-GP pairs, including women who preferred not to disclose and GPs who preferred not to ask. These pairs contradict the essentialising of disclosure found in the literature by being perfectly satisfied with their non-disclosure. A more subtle finding was women’s acceptance of neutral or minimising GP responses, which resulted in relative satisfaction. However, I contend that this reflects the low expectations of health care providers that many women also revealed in Christine Saulnier’s (2002) study, and while not being particularly detrimental to the patient-doctor relationship, could be improved. Similarly, while many women achieved disclosure when desired, others were constrained by a lack of GP inquiry or by GPs’ lack of acknowledgement of cues to disclosure.

In answer to the second question of the chapter regarding control of disclosure, I have found that most GPs hand control of disclosure to women and most women accept the control, although some would prefer GPs to take more responsibility than they generally do to share the burden of disclosure. GPs do not commonly relinquish control to this extent. Even the strongest proponents of the patient-centred clinical method maintain that the GP should preserve a firm grip on the content of the consultation, facilitating patients’ agendas to be present while insuring that the work of the consultation is achieved (Stewart, 1995). Likewise, GPs who are holistic and patient-centred would be expected to preserve and utilise personal information about patients in an ongoing and meaningful way within their relationship with patients.
So, it is surprising on two levels that most GPs held the particular knowledge of sexual minority status at such a distance. The relinquishing of control and the absence of ongoing acknowledgement by GPs suggest that disclosure is not negotiated as much as tolerated and then consigned to an archive of facts that are not required for patient care. This approach is accepted by those women who also believe their sexual orientation is of peripheral importance to their identity. However, it is disrespectful to women whose sexual orientation is much more central to their identity or who need support in relation to it. Why is sexual orientation distanced by so many GPs to the extent that most other personal characteristics of patients are not? This is answered by the many barriers to facilitating disclosure that GPs described and the perceived risk that underpinned them, which I will now describe. This is assisted by understanding Giddens’ theory that control and risk are dialectically interwoven (Kaspersen, 2000).

**GP Barriers to Facilitating Disclosure**

There is very little literature on the provider perspective regarding disclosure of sexual orientation, although there is some recognition that this is a challenging area for doctors. Mari Bjorkman and Kirsti Malterud are both lesbian GP researchers in Norway and say that their rationale for conducting a pilot study with lesbian women on disclosure was that they themselves had found it difficult to “encourage and respond to disclosure” in their practices (Bjorkman & Malterud, 2007, p.59). I have also found this challenging in my clinical work and I would expect it to be even more difficult for heterosexual GPs with little experience or knowledge in the area. In response to the literature demonstrating how few same-sex attracted people are directly asked about sexual orientation by health care providers, Gary Remafedi (2006) cites three American medical academies that recommend asking all adolescents about their sexual orientation. He questions why providers do not ask and calls for more research on the provider perspective.

I have found only three studies that explore health care providers’ perspectives on barriers to facilitating disclosure of sexual orientation: a) a survey of 79 Swedish GPs (response
rate of 52%) and follow-up focus group with 10 GPs (Westerstahl & Bjorkelund, 2003; Westerstahl et al., 2002); b) an interview study with 22 UK GPs (Hinchliff et al., 2005); and c) a survey of 114 Australian providers of aged care (response rate just 19%) (Tolley & Ranzijn, 2006). The barriers that providers in all studies identified were a lack of knowledge of the relevant issues and of how to ask, which created embarrassment; fear of offending heterosexual patients; and assuming that patients do not want to disclose, so not wanting to be intrusive. The UK GPs also identified lack of time as their main barrier, assuming that sexual orientation would necessarily be accompanied by difficult issues requiring support (Hinchliff et al., 2005). Conversely, the Swedish GPs generally assumed there were no relevant health issues to justify knowing about sexual orientation (Westerstahl et al., 2002). Amongst these GPs, 37% (28) were aware of having lesbian patients, and only 5% (four) of these had specifically asked any patients about their sexual orientation. Of the 48 who did not know any lesbian patients, none had ever asked directly. Anna Westerstahl and colleagues (2002) considered the issue of the lack of perceived relevance to be their most interesting finding in view of research evidence that there are several lesbian health issues relevant to GPs, which I outlined in Chapter 3. They also found that GPs leave the responsibility for disclosure to the patient. Finally, the UK GPs also discussed their own personal discomfort and prejudice, for example believing that gay relationships are dysfunctional, which prevented them from asking about these relationships.

Similar barriers have been reported regarding facilitation of disclosure of other sensitive areas. In a sexual health study, UK GPs preferred not to discuss sexual issues in general as they did not have time and felt it was none of their business, and non-heterosexual people were identified as being more of a barrier to this (Gott et al., 2004). GPs are also reluctant to facilitate disclosure of intimate partner abuse (IPA) because they believe they don’t have the skills or time, which women perceive as GPs not caring about the issue (Hegarty & Taft, 2001). Another central barrier in the IPA literature is a lack of medical knowledge, meaning that GPs rely on “common cultural myths” which leads to “express neglect of domestic abuse as a problem in general practice” (McKie, Fennell, & Mildorf, 2002,
p.344). I have demonstrated a similar lack of education regarding minority sexual orientation amongst GPs in my study.

In the previous two chapters I raised several barriers to disclosure that were perceived by women. In summary, these were GP assumptions of heterosexuality, minimising differences, limited knowledge and occasionally negative attitudes. Also, related to sexual identity, barriers for women included a lack of trust and rapport with particular GPs resulting in perceptions of risk. Barriers from the GP perspective that I have already discussed include a lack of understanding of women’s sexual identity and their varying preferences for disclosure, a failure to understand disclosure as risk-taking, and feeling that sexual orientation was not relevant to the consultation. I will now discuss other barriers that GPs raised, which were similar to those raised in the limited existing literature, including their need to avoid offending either heterosexual or lesbian patients, lack of skills, lack of time, and feeling embarrassed or uncomfortable. Some GPs had encountered evasiveness, which they believed indicated that women were reluctant to disclose their sexual orientation. I will argue that these GP barriers are collectively about risk to the GP.

**Fear of Causing Offence**

The barrier to facilitating disclosure that was most commonly raised by GPs in my study was the risk that they would offend or insult patients by asking about sexual orientation. This was about offending heterosexual patients for nine GPs and about offending lesbian or bisexual patients for 13 GPs. No GPs perceived that offence could be taken by both groups. Whether the concern was about reactions of heterosexual or same-sex attracted patients, the effect was that these GPs rarely or never asked about sexual orientation. Regarding offending heterosexual patients, most GPs did not elaborate on what would actually cause offence, however Dr Alan (85, inner urban) suggested that “a lot of people [including GPs] are frightened of homosexuality” and others intimated that the stigmatised
nature of homosexuality might make an inquiry about sexual orientation seem like an accusation to patients. As Dr Pachy said:

Dr Pachy (48, outer urban): I would get the feeling that straight people are perhaps more likely to be offended… they seem to find it very important that people are aware they’re straight and any hint that they may not be (…) they overcompensate I think.

Nine GPs (Drs Alan, April, Cahill, Cam, Harry, Katie, Pachy, Soula and Westy) were concerned about insulting heterosexual patients. Dr Cam and Dr Katie framed asking heterosexual patients about sexual orientation as a mistake, suggesting they would only ask patients when they were fairly certain they were lesbian. Dr Cam (50, outer urban) was concerned that causing offence in this way, by asking a “direct question and you’re wrong” might mean the patient would “never come back to you”. Dr Harry also raised this issue as one of risk:

Dr Harry (53, regional): I’m not going to ask them “are you gay?” because it may be extremely offensive for some people if they’re not, it may be a relief for those that are. But I’m not prepared to take the risk to be open I suppose or confronting.

Like Dr Harry, Dr Cahill (54, inner urban) also acknowledged the benefits of asking however he was driven by a ‘majority rules’ approach. I let him know that many lesbian and bisexual women are waiting for GPs to ask and he said “yeah but the other 80% of women who aren’t lesbians may get either offended or surprised if we do ask them. So rather than upset them we are going with the greater majority.” These GPs were concerned that heterosexual patients would be so offended that they would not return to the GP.

Six women (Jill, Mina, Madison, Alice, George and Lesley) realised that a barrier to GPs asking might be their perceived risk of offending a heterosexual woman. This was mostly phrased as a possibility rather than a certainty. Madison (24, lesbian, outer urban) said “in an attempt to build rapport doctors might be afraid to broach the topic if it offends someone who is heterosexual”. Lesley (52, lesbian, inner urban) was also sensitive to the GPs’ perspective in saying “once somebody has snapped someone’s head off they’re not
going to ask again are they?” George was the only woman to relate an actual example of a heterosexual friend taking offence:

George (56, lesbian rural): The girl [female GP] said to her, “Do you have a partner?” and she said, “Yes” and [the doctor] said, “Would that be male or female?” And [female friend] was quite insulted about that, it was a really strange question she said, “My name is Mrs [Surname], yes I do have a partner and he happens to be my husband”. And [my friend] is really a broad-minded person.

Apparently, the GP had asked the question in a way that is currently taught as appropriate and sensitive, by asking about the gender of the sexual partner, however even this created offence. George’s use of the word ‘girl’ to describe the GP implies that her friend now had a lower opinion of that GP, reducing her to a young woman, rather than a professional GP. This reflects another element of the risk that GPs believed they are taking, a risk to their professionalism and status.

The expectation of offence being taken by heterosexual patients was often not experienced in practice. Many GPs could not comment on the reality as they had not actually asked any female patients directly about their sexual orientation. Of the 12 GPs who had asked, only one (Dr Audrey) recalled a woman being offended. Dr Lith (44, gay, inner urban) had experienced straight men seeming offended but never women. Dr Imogen (46, outer urban) said “possibly there have been occasions when they [heterosexual women] might have looked a bit surprised”. Dr Holly was a rare GP who regularly asked about sexual orientation and said, if anything, women would be unaware “not picking up on why you would ask”:

Dr Holly (39, inner urban): The main reaction is usually one of “I’d never thought about that” (…) So there hasn’t been anyone who’s stood up and said “how dare you think that I’m a lesbian” and stormed out of the room.

Dr Holly felt the lack of negative reactions may have reflected her inner urban patient demographic. Just Dr Audrey had experienced negative reactions, and she worked in an
outer urban location with many patients who she felt had conservative values. Her experience also comes closer to revealing the underlying reasons for GPs’ concerns:

Dr Audrey (30): Well, I often ask for sexual history, and I always use the term partner and then ask male or female. And in [outer Western suburb] what I normally get is a complete look of disbelief [laughing] that I would even need to ask. And I think people kind of stare at you and they go “male of course” or “female” as if you’re some kind of freak for asking. (…..) I find it hard to ask because I so often get the completely blank “why are you asking me this stupid question”.

Dr Audrey’s perception of the patient reactions exactly mirrored that described by George’s friend. For Dr Audrey, the risk posed by offending heterosexual women was that they would regard her own behaviour as ‘stupid’ or offensive. This was a very personal reflection and shows that GPs are vulnerable to the opinions of their patients, and that GPs’ professional identity can be compromised by patients’ negative opinions of them.

Regarding the risk of offending lesbian or bisexual women, 13 GPs (Drs Cam, Elisabeth, Jackie, Joseph, Katie, Normal, Olive, Pachy, Phoenix, Rose, Lith, Tyl and Westy) felt reticent to ask about sexual orientation because lesbian or bisexual women might find this too ‘intrusive’. I have previously raised this as one of the main reasons GPs gave for preferring women to disclose rather than to ask women about their sexual orientation. None of the GPs interviewed had actually experienced a lesbian or bisexual woman taking offence, although Dr Pachy (48, outer urban) had seen a few gay men who had asked why she needed to know, which had “put the wind up me”. Drs Cam and Pachy both felt it would be too “confronting” for lesbian women to be asked, Dr Joseph believed that women might be “uncomfortable”, Dr Normal that it would be “embarrassing”, and Dr Tyl that it might be “threatening” for women. Even the gay male GP, Dr Lith, who felt that it was often irrelevant to know about women’s sexual orientation, was less likely to ask women if he thought they would take offence:
Dr Lith (44, inner urban): I think you should make them as comfortable as possible, you don’t just come out and say “are you gay?”, I mean what’s the point, and then they say “oh, do I look gay?” … they could get a bit defensive.

Inherent in GPs’ belief that women would find a question intrusive was an assumption that women would not want the GP to know about their sexual orientation because they would then be stigmatised. During the later GP interviews, when it was clear that a significant disparity was emerging between preferred disclosure methods, I mentioned that many patients wanted them to know and preferred them to ask. In response to this, Dr Olive reflected on why she might have made that assumption. She felt she was being influenced by societal attitudes and concluded that “we probably should really be moving to just asking people... just like you can ask them what medications they are on”:

Dr Olive (43, inner urban): So that comes back to should we just ask all women, which we probably should, because really (...) across society it shouldn’t be a problem, you should be able to say to someone “are you gay or are you heterosexual?” and they should be able to say “I’m gay” without taking any offence. So we should be able to ask everyone, because really (...) there’s no way a doctor can know about someone’s sexuality based on appearance.

Dr Jackie (41, rural) also wondered throughout our interview whether it really was intrusive or not. Like Dr Olive, by the end of the interview she had convinced herself that she should be asking about sexual orientation, that it is her responsibility, and again this was largely about her need to overcome her own discomfort and assumptions of stigma. Drs Olive and Jackie’s reflections revealed that, in the absence of adequate knowledge about the normality of minority sexual identity, they had relied on ‘common cultural myths’ that the majority of same-sex attracted women would be embarrassed. This prevented them from facilitating disclosure just as Linda McKie and colleagues (McKie et al., 2002) found occurred in preventing disclosure of IPA within general practice. There is excellent evidence in the abuse literature that women are not offended to be asked (Feder et al., 2006), just as most same-sex attracted women in my study were happy to be asked.
Dr Phoenix and Dr Rose were both aware that the way they asked about sexual orientation might be offensive. Dr Debra, the lesbian psychiatrist, expressed concern that some GPs might ask about sexual orientation “like an interrogation” and therefore cause offence. Dr Phoenix (57, outer urban) felt it was easy to say the wrong thing but better to ask and then apologise if it seemed “clumsy”. Dr Rose was more confined by this concern:

Dr Rose (46, inner urban): I must admit, particularly with [lesbian] women who are very overtly ‘this is a big part of their persona’ I’m probably a bit more wary because I’m trying hard not to be offensive. (…) So even just being very careful with the sort of words you use. I probably am much more alert to that.

Interviewer: Why do you think you’re more alert?
Rose: Oh I don’t want to offend them or…say alienate them I suppose because it’s easy to have a consultation where everyone’s at ease instead of using terms that you know might be uncomfortable for them I guess.

There were two methods that GPs in the study used to reduce the risk of offending patients, one was to normalise the question and the second to discuss why they were asking. Dr Imogen (46, outer urban) spoke of “just quietly asking, without any big deal, about male or female partner” and that if someone looked surprised she would say “just a routine question, that’s life”. Likewise, Dr Phoenix (57, outer urban) said he would ask whether a woman was in a same-sex or opposite sex relationship and felt that “you’ve got to have the right throw away words…in a way that can quickly roll off without being obtrusive”. Dr Westy (49, inner urban) raised a parallel situation of asking about Aboriginality: “There are a number of people who are offended at being asked if they are Aboriginal. [So] we try to train people that you respond to that by saying ‘look I ask the question of everybody’”. Dr Holly had considered the issue of intrusiveness and overcame it by making the relevance of her inquiry overt to women:

Dr Holly (39, inner urban): I guess that’s the difficulty about trying to make sure that it’s not just an intrusive question but it is actually handled sensitively, but also just fits into that overall sense of yeah this is good to know about you because this fits in with this and it’s not just an obsessive interest.
Inadequate Skills

Unlike Drs Imogen, Holly and Phoenix, several GPs did not know how to ask effectively, which formed a barrier to facilitating disclosure. Dr Holly believed that asking about sensitive issues such as sexual orientation were “fundamental GP skills” rather than being confined to specialists, which mirrors Gary Remafedi’s (2006) assertion that they are readily teachable skills. Some GPs asserted that the opportunities to ask the question were rare, which prevented experiential learning, as I described in Chapter 4. For example, Dr Soula (62, outer urban) felt that any question she asked was awkward because the situation arose so infrequently, and similarly Dr Phoenix (57, outer urban) said “I don’t ask comfortably about sexuality, it’s not something I do routinely”. As cited above, Dr Rose was very uncertain about what the correct words might be, and Dr Tyl said “how to ask, that’s one of the biggest things”. Drs Rose, Jackie, Pachy, April and Tyl all asked me for guidance as to the best way to phrase a question regarding sexual orientation.

Six GPs preferred to use indirect questions to ascertain women’s sexual orientation. While this is acceptable to women, these GPs felt it was not ideal. Dr Olive described this method as “sneaky”, Dr Rose as “wafty”, Dr April as “a round about way”, Dr Tyl as “without being too direct”. For example, Dr Pachy and Dr Olive asked whether the woman needed contraception. Drs April and Rose asked about the sex or name of the partner, which Dr April felt was “not very courageous”, which again framed facilitation of disclosure as a risk-taking activity. Dr Westy felt that asking a more direct question such as “are you same-sex attracted?” could be “very intrusive”. Alice (43, bisexual, rural) actually preferred this more indirect method of questioning, although this was for GPs’ sake rather than her own. She recognised that for GPs “it would be hard to ask specifically” and suggested they could ask an open question such as “tell me about the relationships in your life” or “how you define your family?”. Alice was representative of a number of women in the study in this regard, and given that the context of disclosure for many women was revealing their same-sex partner, GPs asking about the sex of the partner rather than directly about sexual orientation would be appropriate. Conversely, Mina (23, bisexual, inner urban) said “the way GPs ask” was an important indicator of
openness and she wanted “a list of options [of sexual orientation] or an open ended question”.

**Personal Discomfort**

Dr Joseph (57, outer urban): Do I ask everybody what their sexual identification is, no I don’t. Um…and why, because I probably don’t feel completely comfortable in doing that.

Some GPs admitted that another barrier to raising sexual orientation was their own discomfort, rather than transferring the source of discomfort to the patient. GPs experienced discomfort for four main reasons. The first was their own awkwardness accompanying their lack of skills and practice in asking as I described previously; second their embarrassment if they discovered that they had incorrectly made a heterosexual assumption; third, not knowing how to display their accepting attitudes to counteract possible assumptions by lesbian patients that their attitudes would be negative; and finally, a few were uncomfortable with lesbian sexual orientation from a moral perspective.

Six GPs were uncomfortable when it became clear they had made heterosexual assumptions. Dr Audrey felt “awkward”, “stupid” and “bad”; Drs Cam, Jackie and Judy were “embarrassed”; Dr Katie felt “terribly guilty” and apologised to the woman; and Dr Rose felt “a bit of a fool” because she hadn’t “worked it out”. Dr Judy also had experienced not remembering a woman’s disclosure, which later became “a problem”.

GPs lacked skills in demonstrating their accepting attitudes, which created discomfort as some assumed that same-sex attracted women would perceive them to be judgemental or unapproachable due to certain personal characteristics. Older age was one such characteristic. I asked Dr Phoenix (57) why he felt lesbian women do not disclose to him and he said “I’m an old bloke and they might look at me as being in an era when there weren’t many gay and lesbian issues [laughing heartily] in my day!”. Indeed, Dr
Phoenix’s patient Kirsti (53) confirmed this perception saying she thought he was “old fashioned” and therefore judgemental. Kirsti’s assumption was interesting given they were of a very similar age. Jamie-Lee also expected that younger GPs would be more comfortable. Age was not the only personal characteristic that GPs felt would ostracise patients. Dr Audrey (30, inner urban) felt that if patients knew she was married, and therefore heterosexual, it might “make them think” that she was “bothered” by homosexuality.

I demonstrated in Chapter 3 that women did not feel GP gender was a barrier to lesbian and bisexual sensitivity. However, gender was perceived to be a significant barrier by a few of the male GPs. Drs Phoenix, Cahill, Perry, Michael and Westy all believed that it was more difficult for them to raise sexual orientation with female patients (particularly young women), assuming these patients would prefer to disclose to a female GP. Conversely, Dr Fred (65, regional) did not find this to be a barrier saying “I hope it’s no bar to seeing lesbian patients…I certainly would feel comfortable seeing gay women”.

The gender barrier was not confined to male GPs, with Dr Katie and Dr Elisabeth both feeling slightly uncomfortable doing Pap smears for lesbian patients due to fears of crossing sexual boundaries. Dr Elisabeth (39, outer urban) felt this “could be sexually confronting” for the patient, and Dr Katie (47, regional) agreed that the same issue “crosses my mind”. Dr Elisabeth’s patient Esther actually wondered whether Elisabeth was “uncomfortable” regarding Esther’s lesbian orientation, however could not explain why she felt this. There is little logic in this fear as lesbian women should theoretically feel safer with a heterosexual female GP than with a male or lesbian GP as there would be little risk of this GP being sexually attracted to the patient.

Finally, as I have described in Chapter 4, some GPs actually were not comfortable with lesbian sexual orientation *per se*. For example, Dr Rose said “I think I need to be a bit broader and a bit more accepting of difference”. Drs Normal, Joseph and Tyl all did not ask women for this reason. Dr Tyl (61, regional) said she was uncomfortable because “probably you are scared that you’re not going to see the other person’s point of view so much. It’s a difference and particularly if you are strongly heterosexual yourself”. I did
not explore heterosexual GPs' own sexual identity within our interviews and it is possible that a further source of personal discomfort may have been ambivalence regarding their own sexual orientation. This is possibly an area of exploration for future studies.

Evasive Patients

Fourteen GPs said they did not facilitate disclosure because they believed that women did not want them to know. This indicated an assumption that non-disclosure meant women were uncomfortable about their sexual orientation, which was also described by Carol McDonald (McDonald, 2006). GPs perceived this evasiveness in a number of ways. For those GPs who felt it was entirely the patient’s responsibility to tell, merely not being told was enough to assume women did not want to tell. This applied to Drs Margaret, Michael, Leon, Judy, Joseph, Rose and Phoenix. This belief was associated with the assumption that patients would find inquiry about their sexual orientation intrusive. Some GPs perceived that women did not want to tell through various verbal or non-verbal cues such as seeming “aggressive” (Dr Leon), seeming not to like the GP (Dr Lith) or presenting a certain “bravado” (Dr Elisabeth). A further cue was women avoiding the use of a gender pronoun when referring to their partner. Indeed, Alice described using this method if she preferred not to disclose: “I probably would have been skirting around pronouns all the time if I really hadn’t wanted her to know”. Drs Harry, Judy and Perry all felt that this was a deliberate sign that they should avoid disclosure, believing that the women were being “secretive” or evasive. As Dr Perry said: “I’m very careful to use the word partner, and many, many consultations end up with undefined gender, it just ends up and you never know. So I just leave it, that’s fine”. So, while Dr Perry believed the patients were being evasive, he was equally avoiding disclosure by electing not to probe for the partner’s gender.

Just three GPs (Drs Holly, Elisabeth and Imogen) realised that women’s avoidance of disclosure was not because they did not want to disclose, but potentially because there was
a lack of adequate rapport. Dr Elisabeth described this, while also referring to two of the central GP barriers of the fear of causing offence and her perceived lack of relevance:

Dr Elisabeth (39, outer urban): When somebody walks in the door and they’re giving off all the signs that they’re gay, you think “is it intrusive of me to actually acknowledge that?”, particularly if it’s not relevant. But then again you want to send the message that it doesn’t bother you and that you are quite comfortable, particularly for the young women. I think that’s part of the bravado is that they walk in sending off signals saying “don’t even go there” when really actually what they want is somebody that they feel comfortable with.

Drs Holly, Imogen and Pachy also realised that disclosure avoidance by women early in the patient-doctor relationship can leave the GP with the impression of heterosexuality, which can then be harder to undo later. Dr Holly described her approach to this, indicating her sensitivity to a range of patients, from those who do not need to disclose, to those who do but in their own time, and those who need encouragement to disclose:

Dr Holly (39, inner urban): [I ask] “are you in a relationship, tell me about your partner?” And if I’m getting the cues that they don’t particularly want to [answer] then I’ll just absolutely pull back on that because it’s not crucial.

[a little later]
There are the ones where you kind of know and you’re sort of half amused with when are we actually going to have this discussion, when’s it going to come out. And they’re the ones that are quite happy, where the health issues aren’t directly related to sexuality and it really is a by the way, “oh surprise me”. And then there is the group for whom disclosure is therapeutic and they’re the ones where you end up getting a little bit, frustrated is not the right word, but it’s this sense of “I wish she’d tell me”, but you can’t ever push it cause that just doesn’t work.

Dr Holly is acknowledging here that same-sex attracted women can be ‘evasive’ regarding disclosure, however that this relates to a lack of relevance on their part or waiting for adequate rapport, rather than avoiding stigma. She describes a sensitive approach to facilitation of disclosure, where biding her time can be useful to allow the woman to gain
confidence. However, this is not an endless waiting game as her ultimate motivation was to enable a disclosure.

**Summary – Facilitation of Disclosure as Risk for GPs**

In Chapter 5 I presented the fact that disclosure was a risk taking activity for many women and that risk could play a role in preventing women’s desired identity expression. This included the risk that the patient-doctor relationship might be compromised or that sexual orientation might be ignored. It became apparent when analysing GPs’ perceived barriers to disclosure that facilitating disclosure was also a risk taking activity for GPs. These perceived and potential risks were multiple, including the risk of offending patients, of exposing their inadequate skills or knowledge, of highlighting their own discomfort, or the risk of ascertaining minority sexual orientation against a woman’s wishes. These risks fall into the areas of the professional and personal; professional risk being a threat to GPs’ standing as a knowledgeable and effective GP, and personal risk being a threat to GPs’ personal sense of self and integrity. Regardless of the fact that the perceived risks were rarely, if ever, experienced, these risks frequently prevented the facilitation of disclosure by GPs, just as the risk perceived by women prevented their identity expression if the patient-doctor relationship was not optimal. Therefore, there was mutual risk, which in some cases synergistically created mutual silence about minority sexual orientation within the patient-doctor relationship.

Giddens suggests that individuals take personal responsibility for risk in modern life, as distinct from previously held perceptions of risk being an act of God or fate (Lupton & Tulloch, 2002). Deborah Lupton and John Tulloch (2002) applied Giddens’ concept to the Australian setting and interviewed 74 people about their definition of risk. A common definition was “risk as an action or decision with an uncertain outcome” and that risk involved “loss of control, resulting in uncertainty or fear...where your wellbeing is in the hands of someone you don't know” (Lupton & Tulloch, 2002, p.323). These definitions readily apply to the risks revealed by GPs. Many GPs felt that facilitation of disclosure
could lead to a precarious outcome, including loss of or irrevocable damage to the patient-
doctor relationship, which they were not willing to compromise. A further outcome was
the potential for compromising their own professional standing in patients’ eyes by
revealing their inadequacies in this area. This constituted a loss of control of their
professional identity. In describing the ways they managed this risk, GPs were really
describing a form of impression management regarding their professional identity, just as
women managed their sexual identity expression. However, while many women were able
to overcome the risk they felt by developing enough trust within their relationship with the
GP to disclose, many GPs did not reciprocate and trust women enough to reveal their own
vulnerability in this area.

This brings me back to the issue of the medical system colonising the sexual minority
lifeworld. GPs were aware that their level of knowledge and skills in this area was low
and some realised that they were relying on lay concepts of minority sexual orientation,
and in some cases on myths regarding women’s need to hide this information. However,
as I outlined in Chapter 4, GPs either did not know how or did not feel compelled to
gather this information and surmount these deficiencies. This issue can be theorised using
both Habermas and Giddens. Habermas suggests that one of the influences on the
colonisation of the lifeworld is “the increasing encapsulation of learning processes in
various areas within specialist cultures that are split off from everyday communicative
practice” (Cooke, 1994, p.16). This may legitimately apply to the silence regarding
minority sexual orientation within medical learning. For Giddens, ontological security is
maintained for adults through largely unconscious, day-to-day routines that are often
embedded within the system in which we operate (Kaspersen, 2000). The medical system
has not created opportunities to learn about minority sexual orientation, and therefore has
not instilled unconscious routines regarding this topic. The lack of routines and failure to
legitimise learning about minority sexual orientation has left GPs feeling insecure and has
compromised their professional identity. Controlling their environment was achieved by
avoiding facilitation of disclosure, therefore reverting to the system world of medicine and
to knowledge in which they did feel secure. In doing so, they ignored the patient’s agenda
and lifeworld that they would usually attempt to incorporate.
Summary

I have addressed two gaps in the literature on disclosure of minority sexual orientation, namely challenging the concept that disclosure is essential within the patient-doctor relationship, and revealing GP perspectives on disclosure. My Identity Disclosure Model explained that disclosure is not universally desired or needed by women, and yet this is generally not understood by GPs. While many GPs believe that women prefer to avoid disclosure due to the embarrassment of stigma, most women do not disclose for other reasons. They either make an active choice not to disclose because their sexual orientation is not very important to their identity, or they delay disclosure waiting for adequate relational knowing with their GP or simply waiting to be asked.

In answer to the first question of the chapter on how disclosure is negotiated, I have found that very often it was not negotiated in the sense of a mutual process. Rather, it was very one-sided in that most women who wanted to disclose actively informed their GP and most GPs waited to be informed. Further, many GPs deliberately avoided clarifying sometimes quite explicit cues from women, either because they adhered to a cultural myth that women preferred not to disclose, or they wanted to avoid risk to themselves that disclosure posed. However, the risks that GPs perceived were not salient to most women. While outcomes for women varied, a significant proportion of the women in my study were satisfied with the fact that they had disclosed or not. Conversely, GPs began their interviews satisfied with their passive approach to disclosure, but the more reflective they became, the more they challenged this stance. Some GPs realised that their lack of initiative regarding disclosure of minority sexual orientation was at odds with their otherwise patient-centred approach.

For both women and GPs there was perceived risk towards their own identity and to the integrity of the patient-doctor relationship. However, each group dealt with the risk in very different ways. As my Identity Disclosure Model reveals, some women did not
disclose due to risk, while others were able to disclose by developing enough trust in the GP to overcome the risk. Conversely, the majority of GPs tended to avoid the perceived risk to their professional identity by handing control of disclosure to the patient, or by covertly controlling through silencing. So, while there was mutual risk perceived by women and GPs, there was not mutual trust. For GPs to have taken the risk of displaying vulnerability would have involved a level of trust that their patients would continue to respect their professionalism. Ironically, this would actually have been the case with many women. Many women hoped for inquiry about their sexual orientation by their usual GP, and did not have high expectations for GPs to have specific skills or knowledge in this area. If GPs were aware of this they might be willing to take the perceived risk of facilitating disclosure.

The end result was that disclosure often occurred if women desired because women took most of the responsibility for it. Holding the control was enabling for some women as they were free to exercise their choice of identity expression and were unlikely to be required to disclose when they did not believe it necessary. However, the uneven responsibility did not work for those women with a passive approach to disclosure who were waiting to be asked by their GP. At the very least women believed that GPs should have a responsibility to ensure that their reaction to disclosure was not pathologising or minimising, but preferably normalising, and this was achieved by most GPs in the study.

The optimal approach would be shared responsibility for disclosure, which is how Lupton and Tulloch (2002) interpret Giddens’ concept of risk as requiring a shared responsibility with others to overcome risk. This was described by just one GP (Dr Holly) who had the benefit of understanding lesbian identity from her personal perspective, as well as the experience of multiple disclosures in her practice. This involved the GP creating the environment for disclosure including building rapport and some reciprocal sharing of personal information to develop trustworthiness, while being sensitive to cues if women were not ready to disclose. Then trusting the patient sufficiently to probe their cues rather than ignore them, to treat their sexual orientation as factual rather than stigmatised information, and to directly ask if needed.
CHAPTER 7 - CAPACITY FOR TRANSFORMATION

In this chapter, I will briefly summarise the key findings of my study that answer the first two questions of the thesis: a) how the clinical relationship is experienced, and b) how disclosure of sexual orientation is negotiated. A number of problems emerged, which were overt or covert to women and GPs and can be summarised around concepts of silencing and risk. I will then focus on the intentional and unintentional motivations for silencing and theorise these using Giddens’ (Giddens, 1987) concept of practical and discursive consciousness.

Next, I will answer the final question of the thesis, which addresses how the Australian general practice consultation can be changed to improve the health care experience for same-sex attracted women and their GP. In my analysis here, I will use the critical theory principle that change can arise from understanding and critiquing social systems, including uncovering tacit power dynamics (Alvesson & Sköldberg, 2000). I will demonstrate that as some women and GPs became more sensitive to each other’s respective cultures and needs through reciprocal knowing in their relationship, they were able to overcome the habitual silencing when desired and so transform the general practice experience. This illustrates that general practice can effectively accommodate the needs of same-sex attracted women. Through my findings, I have modified the original frameworks I chose, suggesting that GP training and research in this area should move from patient-centredness to relationship-centredness, and from cultural competence to cultural sensitivity. My Identity Disclosure Model combines these two frameworks, as well as modifying existing theories on sexual identity experience and expression. I will apply Habermas’s (2003 (1972)) three human interests of understanding, control and emancipation to this model and demonstrate that the model has a role in further transforming general practice care. I will describe how the model could be applied to medical education.
Finally, I will reflect on the strengths and limitations of my study, my personal role in applying the findings, and consider future research that arises from my work. I will finish by concluding the whole thesis.

Summary of Findings

How the Clinical Relationship is Experienced

The first question of the thesis was how do same-sex attracted women and their GPs experience their clinical relationship, which I answered within Chapters 3 and 4. Women expressed a range of preferences for care from focused care of convenience to holistic care of continuity. Focused versus holistic preferences were partly determined by women’s life-stage, whereas continuity was influenced by sexual orientation in terms of reducing health care needs, particularly contraceptive and pregnancy care. A theme that was central to most of the women’s preferences for ongoing care was relational knowing, which was an expectation that their usual GP would know them humanely, empathically and culturally. Many women felt this knowing was achieved through the development of an optimal patient-doctor relationship. For some women, this also included limited reciprocal knowing about the GP themselves.

An important deviation from the current literature that presumes disclosure to be essential (Neville & Henrickson, 2006) was that some women preferred that their sexual orientation was not part of the knowing by their GP, although these women still valued GP attributes of humaneness, empathy and cultural awareness that created the potential for disclosure if needed. Conversely, other women preferred that their sexual orientation was known by their usual GP, and they were very forgiving of the generally low level of specific knowledge that their GPs displayed. While some would have preferred care that was more tailored to their minority sexual orientation, most were satisfied because they had developed trust that overcame the potential risks of being open.
Almost all of the GP participants described their style of care as being holistic and patient-centred in that they valued getting to know their regular patients from a biopsychosocial perspective. While most did not deliberately encourage reciprocal knowing by patients of themselves, many acknowledged that this did occur with certain patients, and that it assisted in enhancing the patient-doctor relationship. The broader concept of professional friendship that some women described and appreciated was also recognised by some GPs as enabling a more trusting patient-doctor relationship. Trust was a pre-requisite for disclosure for many women. Similarly, reciprocal trust by GPs of women enabled some openness by GPs about their insecurities and lack of knowledge of minority sexual orientation. This indicated that broadening the focus from patient-centredness to relationship-centredness might assist in creating an environment that enables disclosure in both directions.

The major problem that emerged in relation to the experience of the clinical relationship was habitual silencing of the sexual minority lifeworld within the consultation. There were also a few experiences of pathologising, which were devastating for women, however largely resulted in these women terminating contact with the GP involved, and by taking control they avoided the risk of further pathologisation. By contrast, all women described experiences of silencing of their sexual orientation, even with their usual GP. There were negative effects of silencing for women and GPs. From the women’s perspective, some were not affected as non-disclosure was their preference anyway, so they utilised it to mutually avoid raising their lifeworld. However, other women were troubled by the silencing because it either excluded their lifeworld against their wishes or increased their sense of risk if they raised it, especially where they could not predict the GP’s response. From the GPs’ perspective, there was a common assumption that sexual orientation was irrelevant to the consultation or that women would prefer that it not be raised.

Additionally, some GPs recognised their very limited knowledge and skill in the area of minority sexual orientation. This was incongruent for those GPs who otherwise valued their own holistic approach but were not able to offer the same level of holism with regard to minority sexual orientation.
This study offers a new contribution to the field by exploring GP perspectives and motivations regarding the silencing. It also compares the relative contributions of women and their GPs to the silencing, as both women and GPs could be agents in silencing. For women, this was either motivated by a lack of need to disclose or by the need to avoid risk to their identity if they were not able to ascertain the GP’s likely response. This finding confirmed Hitchcock and Wilson’s (1992) formulation of disclosure as risk taking for women. For GPs, silencing arose predominantly from heteronormative practices. These practices were either heterosexual assumptions that were largely unintentional due to failing to explore the ‘negative space’ of the unspoken lifeworld, or more deliberate claims of irrelevance which revealed a lack of knowledge. The literature has explained GPs’ lack of inquiry about sexual orientation as being due to heterosexual assumptions (Hunt & Fish, 2008), however my findings also revealed that intentional silencing was often motivated by GPs’ need to avoid risk. The risk was to their professional identity if they recognised their inadequate preparation throughout their medical education, so they attempted to avoid embarrassment by excluding this aspect of their patients’ lifeworld. Other GPs felt there was a risk to the patient-doctor relationship if they stumbled into territory that was troublingly unfamiliar. Therefore, risk could be perceived by women and GPs, which had the potential to lead to mutual silence, particularly when the patient-doctor relationship was not sufficiently mature to overcome the risk.

I will now briefly compare my findings with those from the UK study by Christine Barry and colleagues that I summarised in Chapter 4 (Barry et al., 2000; Barry et al., 2001). They used a similar method in interviewing patients (62) and their usual GPs (20), however they also added observation via the use of videotaped consultations. They applied Habermas’s (1984) Theory of Communicative Action to understanding communication in the patient-doctor relationship, and used patient-centredness as the basis for assessing effectiveness of communication. Their starting point was evidence from the literature that the social context was one of the most commonly unvoiced agendas in the medical consultation. This was similar to the background to my study that sexual orientation (as a social issue) was rarely included in the consultation. Barry et al. (2001) describe four patterns of communication, and in three of them (‘strictly medicine’,
‘lifeworld blocked’ and ‘lifeworld ignored’) the patients’ lifeworld was silenced in some way. They suggested that patients found the silencing in the ‘lifeworld blocked’ and ‘lifeworld ignored’ patterns “a painful threat to their identity” (Barry et al., 2001, p.491). My findings were similar but more focused on the particular aspect of the social lifeworld of sexual orientation. In particular, I was able to describe variations in identity and levels of risk, and also delineate why the lifeworld was silenced by understanding the risk posed to both women and GPs.

The main difference between Barry et al.’s (2001) findings and mine was in the fourth pattern of the ‘mutual lifeworld’ consultations, in which the patient’s social lifeworld was voiced. They found that in these consultations doctors used natural conversational techniques including humour, empathic statements and open questions about the lifeworld, and in which patient emotions were allowed and validated. They suggest that this approaches Habermas’s ideal, consensus-driven dialogue, and that it is more natural because the doctor relied on their own life skills rather than a medical formula (Barry et al., 2001). They focused entirely on the patient’s lifeworld and did not suggest that the doctor’s lifeworld played any part in the consultation.

My findings differed from Barry and colleagues in two ways. First, I found that the doctor’s lifeworld did become part of the mutual understanding for some woman-GP pairs. Second, while I did find that many of the woman-GP pairs achieved openness in terms of knowing the woman’s sexual orientation, the level of understanding by the GPs was very limited. Habermas’s definition of consensus suggests that each person in the conversation can mutually understand the objective, subjective and normative perspectives of the other: “the speaker enters into an interpersonal relationship of mutual obligations with the hearer” (Cooke, 1994, p.12). Doctors were unable to fully understand women’s subjective and normative perspectives of minority sexual orientation as their own lifeworld experiences in the area were so limited. They had little personal knowledge unless they happened to be lesbian or gay themselves, and even then, their identity experience may have been very different from that of their patients. They had to rely on minimal experiences of friends or family or less than a handful of other known lesbian
patients. So, because the context of minority sexual orientation was so foreign to the lifeworlds of most GPs, and the impact of negative social attitudes was so intrusive compared with other aspects of the social lifeworld, my findings revealed quite a different solution. Rather than relying on mutual understanding, women and doctors used their trusting relationship to achieve consensus.

**How Disclosure of Sexual Orientation is Negotiated**

The second question of the thesis addressed how disclosure of minority sexual orientation is negotiated between same-sex attracted women and their GP. I answered this within Chapters 5 and 6. The Identity Disclosure Model that I have developed explains the influences on identity expression (disclosure preference) to GPs. In particular, it offers an explanation as to why some women preferred not to disclose, despite their GPs seeming to fulfil the often described criteria for disclosure of non-judgementalism and empathy (Klitzman & Greenberg, 2002; Saulnier, 2002). In summary, there were three approaches to the public practice of identity expression, which were to be open (preferring to tell), passive (waiting to be asked) or private (preferring not to tell). The three main influences on women’s approach in the general practice setting were their private narrative of their identity experience, their perceptions of risk, and trust in the patient-doctor relationship.

Women’s identity experience influenced their preferred identity expression approach through determining the level of importance of sexual identity to the woman. There were four types of sexual identity experience, which I label attraction predominant, identity peripheral, identity integrated and identity defined. These were fixed for some women and fluid for others, and some of the women had experienced identity confusion prior to taking one of the four stances. Most of the attraction predominant group selected the label bisexual for the purposes of the study, and so this finding has helped to fill a gap within the disclosure literature by providing one explanation as to why bisexual women are less likely to disclose to health care providers than lesbian women (Meckler et al., 2006).
Alongside identity experience, perceived risk of disclosure and relational knowing within the patient-doctor relationship counter-balanced each other in influencing disclosure. The process of disclosure was experienced as burdensome and risk taking for both women and GPs. Rather than sharing responsibility for initiating disclosure, almost all GPs handed the control to women, which replicated the literature findings that few doctors ask about sexual orientation (Steele et al., 2006; Stein & Bonuck, 2001). While many women took control and told GPs, those with a passive approach would have preferred to be asked. Alternatively, relational knowing overcame the perceived risk to enable disclosure for some women but for few GPs. As a result of habitual silencing, few GPs understood the range of sexual identity experiences or the variation in disclosure preference. This lack of understanding contributed to preventing the development of reciprocal trust of women by GPs, which might have assisted GPs to take more risk yet more responsibility for disclosure.

In terms of Habermas’s Theory of Communicative Action (1984), the ways that disclosure of sexual orientation was negotiated by women and GPs demonstrate a balance between communicative and strategic action. I have found that some GPs used strategic action by choosing not to facilitate disclosure with a purpose of avoiding risk or focusing on biomedical issues that they considered to be more relevant. Some women also used strategic action in avoiding disclosure through reinforcing GPs’ heterosexual assumptions. This was also to avoid risk or to fulfil their own belief that their sexual orientation was not pertinent to the consultation. Alternatively, as the trusting patient-doctor relationship developed, some of these same GPs and women shifted to a communicative action in which disclosure became possible through attempts at a shared understanding of the place of minority sexual orientation in the consultation. Graham Scambler has critiqued the assumption that doctors tend to be agents of strategic action and patients of communicative action, which the work of Mishler and Barry and colleagues tends to support (Scambler, 2002). He argues that “most doctor-patient encounters represent a dynamic and negotiated mix of communicative and strategic action” (p.125) and my work supports this viewpoint. Both GPs and same-sex attracted women were capable of either action.
Theorising Silencing Using Giddens’ Levels of Consciousness

I have found that the habitual silencing of women’s sexual minority status in the general practice consultation could result from intentional or unintentional actions of GPs. I will theorise these positions by applying Anthony Giddens’ (1987) premise that there are two types of consciousness. I will also demonstrate that either stimulus is problematic for GPs and for those women who would prefer disclosure. Finally, I will present the opposing view, that silencing can enhance the patient-doctor relationship in some circumstances.

Giddens’ Theory of Structuration provides a framework for analysing how the behaviour of an individual (in this context a doctor or a patient) is influenced by the broader socio-political system, and how the system is influenced by the individual (Giddens, 1987). The theory recognises that individuals have agency, that is, they are at least partially in control of their actions and can partially explain them. Individuals operate within systems, which contain sets of rules that are designed to maintain these systems (such as the ‘rules’ of medical consultations). Many individuals cannot fully explain their actions as they are operating according to rules that they do not recognise. So, knowledge has boundaries including unconscious actions and unintended consequences of action. Giddens (1987) claims that people are knowledgeable through two separate types of consciousness: discursive consciousness in which they can provide reasons for their actions; and practical consciousness, which is the taken-for-granted knowledge that we cannot always explain. He suggests that most of our knowledge is practical, including that within institutional practices such as the medical consultation. An important strategy that he says we must use is to reflexively monitor our actions and the reactions of others in order to become more discursively conscious.

My research suggests that GPs have flawed practical and discursive consciousness with regard to women’s minority sexual orientation, leading to unintended and intended silencing. Practically, GPs had little taken-for-granted knowledge about minority sexual
orientation due to heteronormative silencing within the medical system. This also reflects the broader silencing in society, with a concomitant failure to recognise lesbian and bisexual women as full citizens (Richardson, 2004). Social examples in Australia are the lack of recognition of same-sex couples in almost all pieces of federal law until 2008, and the ongoing exclusion of a sexual orientation question from the periodic national household census (Australian Bureau of Statistics, personal communication).

Discursively, GPs justified their lack of focus in this area by arguing that minority sexual orientation is irrelevant to the consultation. The combination of a lack of tacit knowledge and assumptions of irrelevance prevented any real reflexivity as to the consequences of silencing on women. It also meant that GPs were not stimulated to learn more as they were unaware of the gaps in their knowledge. There was an absence of even informal discussion about same-sex attracted women’s health amongst the participating GPs in their practices. Most said that they had never discussed the issue with their colleagues and only one, Dr Jackie, felt discussion would be useful. However, during the course of my interviews, many GPs openly reflected about these assumptions and their possible effects on same-sex attracted women.

Intentional silencing by GPs was equally problematic because it created a false consensus and created conflict with an otherwise holistic philosophical position. In this setting, the false consensus occurred where both GPs and some women (those with passive or private identity expression approaches) tacitly agreed that minority sexual orientation was irrelevant to the consultation. This is what Habermas calls ‘pseudo communication’ where people cannot recognise their misunderstandings and so generate a false consensus (Crossley, 2005). Habermas says this occurs especially in the context of domination, where there is no real dialogue. Christine Barry and colleagues (2001) refer to this as collusion between patient and doctor to silence the lifeworld, however I regard the word collusion to indicate a guilty or intentional motivation. Consensus indicates a more innocent or unintentional motivation, even though the outcomes can be just as negative. In my study, the false consensus that sexual orientation was irrelevant in the consultation did occasionally prevent women’s health issues being raised. The literature and my experience suggest that there are many areas of women’s health in which sexual orientation is directly
relevant, as I outlined in the introductory chapter (Hunt & Fish, 2008; Leonard, 2002). Many of the women I interviewed were not aware of how their own health issues could differ from those of heterosexual women. So, a deliberate scheme not to raise sexual orientation can lead to less than ideal health care. I suggest that in this situation, it is the GP’s responsibility to at least consider the possibility of minority sexual orientation and its potentially attendant health issues.

The second problem with intentional silencing of minority sexual orientation is that it created a conflict for many of the GPs who were otherwise patient-centred practitioners. This was a problem for women, who perceived their GP as holistic and interested in them as a person, but then found that the GP did not follow through and acknowledge sexual orientation as integral to that knowledge. It was also a problem for GPs if they realised that their exclusionary approach to sexual orientation had prevented them from fulfilling their goal of knowing their patients as well as they could. They also neglected to follow another of the five dimensions of patient-centredness, which is sharing power and responsibility with patients. In failing to take mutual responsibility for disclosure they burdened women and potentially compromised their health care.

An opposing view on silencing is that it may be protective for women and GPs, and even beneficial. It is important not to focus entirely on the negative consequences, as I did find that some women were very satisfied with this approach. This was the case for women who preferred focused care rather than holistic care, and for women with a *private* approach to their identity expression. It also suited those GPs whose personal beliefs were negative towards minority sexual orientation but who were committed to concealing these views from women. In acknowledging these benefits, it raises the challenge of how GPs who become more aware that they need to change their silencing approach will know when they are seeing women who are *private*. I will discuss this when I demonstrate the application of the Identity Disclosure Model later in the chapter.
Transformative Moves

My analysis reveals that general practice can be transformed to accommodate the diverse needs of same-sex attracted women. Some women and GP participants in my study used methods to overcome the habitual silencing at the level of the consultation through building their relationship, and also at the broader cultural level by understanding the impact of risk mediated by socio-political influences. These methods were embedded within the models of relationship-centred care and cultural sensitivity. My Identity Disclosure Model draws these existing models together to present an integrated understanding of the key influences on disclosure. I claim that these models can be transformative to both the practice and research of general practice. They are transformative in a critical hermeneutic sense in that they each build on pre-existing theoretical models in the research field, and on pre-existing knowledge and skills in the practice field. This process brings to life two definitions of critical sociology that Giddens has cited, namely that “no social process is governed by unalterable laws” and that “we must be conscious of the alternative futures that are potentially open to us” (Giddens, 1986, p.22). While the system of medicine can seem intransigent to change, I have found that it is very amenable to an alternative present and future with regard to accommodating minority sexual orientation.

I will now discuss each of the three models, demonstrating how my work has enhanced these models from a theoretical point of view, and how they can improve general practice care for same-sex attracted women. This will answer the question of how women and GPs can be liberated from the habitual silencing of the sexual minority lifeworld, where desired. Through the course of my study women have asked how they can know when a GP is culturally aware, empathic and humane in order to feel safe enough to disclose. Similarly, GPs have asked how they can know when women feel the need to disclose. The answers to these questions are central to overcoming the silence and are found within the three models.
I argued in Chapter 3 that patient-centredness theoretically applies well to seeing same-sex attracted women as it is designed to enable doctors to understand the impact of diverse cultural backgrounds on patients’ health (Stewart, 1995). Equally, it was the philosophy of the majority of the GPs in this study, as it has been the philosophical basis of general practice training (McWhinney, 1997). However, it alone has been inadequate to open GPs to the possibility of accommodating sexual minority. So, while understanding the patient’s agenda is a pre-requisite of this method, many GPs in my study justified ignoring this particular agenda. On the other hand, where building relational knowing was central to women and the GP, the silencing was overcome amongst many of the woman-GP pairs. I contend that this is because building a relationship unequivocally requires both parties to participate. This focus encouraged women to take some control and to overcome the traditional power imbalance that is embedded in the medical consultation and that would have had them waiting passively to be asked. So, women were able to overcome the potential risks of disclosure and the heteronormativity of GPs to raise their sexual orientation. This relates back to Lucy Candib’s (1995) claim that medicine can be transformed by shifting the patient-doctor encounter from a contract to a relationship. It was possible to determine that the relationship was central to creating openness in my study because my method enabled a comparison of women’s and GPs’ perspectives of the relationship within woman-GP pairs. This is a unique contribution to the field as it has not been done to date.

Relationship-centred care (Beach & Inui, 2006) is just one of many types of centredness that have appeared in the literature over the last 50 years. Julian Hughes and colleagues (Hughes, Bamford, & May, 2008) have reviewed the literature on client-, family-, patient-, person- and relationship-centred care to compare the concepts and determine their individual versus collective value. They conclude that conceptually each type of centredness contains the same themes and achieves the same aims to make biomedicine more humanistic and to focus on care as a “mutual endeavour” (p.461). However they also advocate maintaining each type because they each apply to a different context or setting of
health care. Traditionally, patient-centredness emerged within the family medicine context (McWhinney, 1997), as did relationship-centredness 20 years later (Beach & Inui, 2006). Relationship-centred care adds elements of reciprocity and even mutual friendship, and in my study, it was these elements that enabled some women to be open with their GP where otherwise they would have been passive. So, I have added evidence to the argument that relationship-centredness could replace patient-centredness as more enabling for some patients in the general practice context.

I have considered three possible counter-arguments to focusing on relationship-centred care. The first is an ethical consideration regarding control, the second is that a reciprocal relationship is not desired by all same-sex attracted women or GPs, and the third is the claim that relationship-centredness is not enabling for GPs. With regard to the issue of control, Richard Street and colleagues (Street, Krupat, Bell, Kravitz, & Haidet, 2003) highlight that patient-centredness can create an ethical dilemma for doctors when seeing patients who prefer a biomedical focus and a high level of doctor control. An equivalent issue for my study in terms of relationship-centredness is how GPs should respond to patients who do not want to disclose, given the evidence from the literature and my findings that disclosure enhances trust and the relationship overall. Should GPs encourage disclosure even with women who prefer not to disclose? This is a matter for discernment at the individual consultation level. GPs require flexibility and judgement in terms of applying particular models of care, and I concur with the view that GPs should ultimately respect the preferences of individual patients (Teal & Street, 2009).

A similar limitation to using relationship-centredness as the philosophical centre of general practice care for same-sex attracted women is that not all women in my study wanted a reciprocal relationship with their GP. They preferred to leave the responsibility for disclosure to the GP, and described wanting more of a business transaction than a relationship. General practice needs to accommodate these women too, and can do so if GPs fully understand the diversity of needs within this cultural group. Similarly, Carolyn Chew-Graham, Carl May and Martin Roland (Chew-Graham et al., 2004) controversially claim that suggesting that enhancing the patient-doctor relationship is a goal or ‘outcome’
of every consultation is flawed and ‘demoralising’ for GPs who cannot achieve this with certain patients. However, again my findings indicate that flexibility is needed in adopting a relationship-centred approach, which will not be suitable or possible with every patient.

Can relationship-centredness be enabling for GPs as well as for women? The central problem that I found from the GPs’ perspective was the risk that facilitating disclosure posed for them. While optimal patient-doctor relationships did overcome some of the risk for women, they did not usually overcome GPs’ perceived risk. Even those GPs who had developed reciprocal relationships and professional friendships with their lesbian patients still relied on women to disclose their sexual orientation. Tulloch and Lupton (Tulloch & Lupton, 2003) have challenged traditional understandings of risk taking as irrational and driven by ignorance by finding that many people deliberately take risks based on knowledge. They also claim that “if successfully undertaken without disaster striking, voluntary risk-taking can lead to a greater sense of control resulting in a feeling of accomplishment and agency” (p.133). This was certainly the case for most of the women who had risked disclosure and I suggest would enhance agency for GPs too. So, instead of attempting to take control by avoiding disclosure, GPs could take the risk of facilitating disclosure and thereby gain control by enhancing their relational knowing of the patient and improving the patient-doctor relationship.

If the patient-doctor relationship were to approach Giddens’ ‘pure relationship’, each person in the relationship would need to be prepared to trust reciprocally and reveal themselves emotionally (Kaspersen, 2000). I contend that GPs can learn from the ways in which some women overcame their perceived risk by trusting their GP. If GPs can trust women in a similar way, this could overcome their own perceived risk and enable GPs to take some responsibility for disclosure. This would add to the relationship-centredness model by suggesting that reciprocal risk can be counterbalanced by reciprocal trust and lead to reciprocal responsibility. In this way, GPs are enabled by relationship-centredness. Even in the absence of full reciprocity, broadening GPs’ understanding of sexual minority culture is a way to surmount some of the risk, which I will discuss in the next section.
Cultural Sensitivity

I have suggested that GPs should accommodate individual patients’ preferences regarding relationship-centredness. Similarly, I dispute the assumption that all same-sex attracted women would want their ‘culture’ affirmed by GPs and suggest that a more flexible approach is also required in this regard. I believe that the term cultural sensitivity encompasses this imperative, replacing cultural competence, which is a more global and generic concept. Cultural sensitivity is apt when applied to a cultural group such as same-sex attracted women who display a wide diversity of identity and disclosure needs. It also mirrors calls that social citizenship should be based on individual differences rather than sameness, and on a “recognition of citizens in ways that are authentic to our own self definitions” (Moosa-Mitha, 2006, p.206). Equally, same-sex attracted women need to understand the diversity of aptitude for cultural sensitivity amongst GPs.

I found that GPs and same-sex attracted women had a mutual lack of understanding regarding each other’s cultural milieu, which inhibited the potential to fully develop a truly authentic conversation. Most GPs did not appreciate that minority sexual orientation can inhabit a cultural space, nor did they understand the diversity within that space. Few patients comprehended that a truly patient-centred GP wants and needs to know about their social context, or that the general practice system is designed to accommodate culturally-specific care. Conversely, I found a few examples of women or GPs who did have a better cultural understanding of each other through relational knowing, which helped to build trust. So, I have surmised that improving the cultural sensitivity of both GPs and same-sex attracted women would enhance the clinical experience. I will show how this can be beneficial when I demonstrate the application of the Identity Disclosure Model. I have added to the cultural competence literature by providing insight into what knowledge and skills GPs and women need to become more culturally sensitive towards each other, which I will now outline.
**Culturally Sensitive GPs**

My findings show that it can be beneficial for GPs to understand sexual minorities as a cultural group because this challenges the silencing of women’s sexual orientation in the consultation. A cultural perspective would counteract GP assumptions that minority sexual orientation is only relevant when it is a problem for women, or when related to sexual issues. This is because the patient-centred philosophy requires that GPs understand the culture of all of their patients. It also suggests to GPs that this is an area that is part of their role, rather than a specialist role that requires referral. This confirms the assertion of Greta Bauer and Linda Wayne that cultural sensitivity regarding sexual minorities must become a “practical necessity” and not just a “buzzword” (Bauer & Wayne, 2005, p.47). However, while it should be practised by every GP, it is not necessarily needed by every patient.

As to the specific knowledge and skills that GPs need to be culturally sensitive, in part I have replicated the existing literature that suggests providers should be comfortable when seeing same-sex attracted women, should not assume heterosexuality, and should accommodate the same-sex partner in decisions and consultations if women prefer (Saulnier & Wheeler, 2000; Stevens, 1992). GPs should have specific knowledge, which includes the experiences, norms and values of same-sex attracted women; and their historical, environmental and social context (Bauer & Wayne, 2005). In terms of social context, they need to understand the health impacts of minority stress that may or may not be present (Schilder et al., 2001). However, there are significant gaps in the lesbian sensitive care literature, and in particular very limited or lack of guidance for clinicians on disclosure of sexual orientation. There is also little practical advice on the need to respect the patient’s choice not to disclose.

My findings contribute a more detailed understanding of the knowledge, skills and attitudes a culturally sensitive GP would need to have. First and foremost from women’s perspectives, GPs need to have non-judgemental and preferably accepting attitudes towards minority sexual orientation. Some women would also benefit from in-practice
advocacy regarding their sexual orientation, particularly if their health is being adversely affected by sexuality-based discrimination. Second, GPs’ knowledge should include an understanding of the diversity of sexual identity experiences that women can have. This includes whether a woman might call herself lesbian, bisexual or prefer no identity label; and an understanding of the range of preferred social affiliations from predominantly lesbian through to entirely heterosexual social networks. This knowledge has an impact on the sexual orientation terms that GPs would use within the consultation and on the choice of referral to heterosexual, lesbian or bisexually centred support groups.

Third, culturally sensitive GPs should have skills in facilitating disclosure of sexual orientation. Many of the GPs in my study felt inadequately prepared in this area, being unsure of the correct language to use, how direct to be, and when to initiate the discussion. They did not recognise that they already use similar skills to encourage disclosure of other sensitive issues such as domestic violence or substance use. The skills include removing assumptions of heterosexuality by using terms for partners that are generic and value free; acknowledging a woman’s direct disclosure; responding to less direct patient cues by probing or clarification; and asking questions that become increasingly focused as needed, moving from living arrangements, to the gender of the domestic partner, to the sexual identity.

An important additional requirement of culturally sensitive GPs is that they should overtly demonstrate these attributes to women. Some women in my study were seeing GPs with many of these attributes however were not aware of this and therefore were reluctant to disclose to them. As I mentioned earlier in this chapter, many women wondered how they would know that a GP was sensitive. One method for displaying cultural sensitivity detailed in the literature is making the clinical environment comfortable and accommodating of sexual minority, which is said to alert women that the GP may be sensitive (Eliason & Schope, 2001; Hutchinson et al., 2006; Stevens, 1994b). Methods include displaying a small rainbow sign (a universal gay and lesbian symbol), having lesbian-specific patient materials, displaying a clinic non-discrimination policy that includes sexual orientation, training reception staff to use inclusive language, and having
specific sexual orientation questions on the clinic intake forms (Gay and Lesbian Medical Association, 2002).

I have found that these environmental signs are of limited value. Only a few of the women in my study deliberately observed the waiting room and receptionist behaviour for signs of sensitivity, while most women did not. In addition, some women realised that the presence of these signs would not guarantee that a specific GP in that clinic would be culturally sensitive. So, while clinics can choose to use these methods as cues to sensitivity for women, it is still incumbent upon individual GPs to make their own sensitivity clear to women. The main method that emerged from my study was to recognise that minority sexual orientation has a legitimate presence in the consultation through demonstrating acceptance, shared responsibility for disclosure and ongoing acknowledgement. Reassuringly for GPs, displaying these sensitive attitudes, alongside a commitment to relationship building, are readily achievable and should not create a burden.

To become fully culturally competent in this area most GPs require additional specific knowledge. My study revealed that attaining this knowledge is a challenge for GPs, given the dearth of currently available education in the area. Younger GPs at least had received education regarding sexual orientation as a social phenomenon, rather than as merely a sexual or psychological issue; and had learned specific skills in detailed social and sexual history taking. They also understood the fact that patients from diverse cultural groups have diverse values and beliefs that impact on their health, which is now being explicitly taught in fields such as adolescent, indigenous, and migrant health. Theoretically then, this younger group of GPs would just need to transfer this knowledge to the field of minority sexual orientation by learning about appropriate language and other specific cultural issues. However, most of the GPs in my study were still relying on experiential learning from the few same-sex attracted patients they were aware of seeing, which is clearly insufficient. I hope that through disseminating my findings and persuading GPs of the importance of attaining knowledge in this area, they will be stimulated to take an active role in seeking professional development, as well as realising they can transfer their existing skills.
There are possible objections to my claim that cultural sensitivity applies well to sexual minority health care. For example, in the literature these objections come from the postmodernist queer theorists who reject sexual identity as a cultural issue and claim that the presentation of the self is a performance, rather than an identity (Sullivan, 2003). It also arises amongst adolescent health (Hillier & Harrison, 2004) and sexual health (Bailey, Farquhar, Owen, & Mangtani, 2004) researchers who focus on sexual behaviour or attraction rather than sexual identity and culture. I have previously justified my focus on sexual identity and rejected the postmodernist framework. However, I concede that the tension has some weight in my study sample, given that the attraction predominant women and perhaps some of the identity peripheral women, did not take on a sexual identity and/or did not socially affiliate with lesbian or bisexual women or groups. So, asking GPs to be culturally sensitive could indicate that all same-sex attracted women see their sexual orientation as being part of a broad cultural phenomenon. Instead GPs need to build in to that sensitivity ways to ascertain women’s sexual identity experience if identity appears to be relevant.

However, I can justify the cultural sensitivity approach as applying to any of the women in my study. For example, the attraction predominant women would be accommodated well by a GP who approached their sexual orientation in the graduated way that I suggest for disclosure facilitation. At a more systemic level, as Bauer and Wayne (2005) suggest, GPs cannot ignore the broader socio-political perspective on sexual orientation, and a cultural sensitivity approach encourages this level of sensitivity. Whether women hold to lesbian or bisexual culture or not, they are still affected by social attitudes towards their sexual orientation. Without understanding the socio-political context, there is a risk that GPs could simply view each sexual minority person as an individual who has chosen a particular lifestyle. They would not understand the risk posed to their health and wellbeing, even to women without a sexual identity, of living in a society that continues to express negative attitudes.
Culturally Sensitive Same-sex Attracted Women

There is nothing in the literature regarding the need for same-sex attracted women to understand the culture of general practice. Yet, I found simple gaps in women’s understanding of general practice that I consider could be overcome to create a more empowering experience. For example, some of the younger women in my study who preferred focused care, had not experienced any other form of general practice care and therefore were surprised to learn that many GPs preferred to offer holistic care. Also, to realise that general practice may offer a safe place for support with coming out would provide an accessible resource that is currently desperately needed by many women during that particular period of their lives. However, this must be tempered with being able to discern when a GP is not able to offer sensitive care. This could be done by picking up heterosexual assumptions made by GPs or sensing judgementalism regarding other minority issues or even regarding gender. Women would learn about the culture of general practice through GPs being more explicit about their role with their patients. There is also a place for peak bodies such as the Royal Australian College of General Practitioners to more effectively promote these areas of general practice care to the community.

I also assert that it would be helpful for women to understand that GPs can feel vulnerable and at risk in the area of sexual minority care. This would help to change the persisting view of the culture of medicine as all-powerful and all-knowing to one that is more realistic. I agree with the assertion of both Kirsti Malterud (1993) and Lucy Candib (1995) that one goal of the patient-doctor interaction is empowerment of the woman patient. For example, Kirsti Malterud (1993) suggests that doctors should ask women about their expectations of medical care, and Lucy Candib says that “empowerment includes letting patients in on how little may be known with certainty about their problem” (Candib, 1995, p.262). Same-sex attracted women in my study have already shown that they are willing to take control when they have a lot to gain by doing so, in particular to actively tell GPs about their sexual orientation when it is very important to them despite GPs’ silence. Some GPs in my study also revealed their vulnerability to women by declaring their lack
of knowledge and seeking information from their patients. Raising women’s awareness that they have a role in sharing their own cultural beliefs with their GP would help them to reframe their responses to being silenced. This would encourage women to continue to take an active role in overcoming this silence and to shift some of the power balance towards themselves.

Suggesting that women take some responsibility for educating doctors about their sexual minority culture is controversial. Critics would say that surely it is the responsibility of the medical system and the doctors themselves to ensure they have this education. Also, the literature points to resentment of this role amongst some women (Platzer & James, 2000; Stevens, 1992), although other studies infer that women are comfortable with that role (Mulligan & Heath, 2007). Kirsti Malterud (1993) highlights that the health care interaction retains an inherent power imbalance as evidenced by the ways in which doctors either medicalise or ignore women’s health issues. However, if relationship-centredness and cultural sensitivity is to be truly transforming, then this requires not only reciprocal knowing but power sharing, and my findings suggest that many women are more than willing to take up the challenge. This does not remove responsibility from the medical education system itself to improve its sexual minority content, nor does it suggest that all women must educate GPs. However, the fact that most GPs in my study had learnt most of their knowledge in this area from so few same-sex attracted women patients demonstrates the influence of this method.

**Applying the Identity Disclosure Model**

The Identity Disclosure Model demonstrates that same-sex attracted women have varying approaches to their sexual identity expression to GPs and that these are influenced by their identity experience, patient-doctor relationship and levels of risk. I assert that understanding this model can assist GPs to understand whether women need to disclose their sexual orientation in the consultation. This was a central concern to GPs in my study,
that they did not know whether women wanted them to know or not, nor did they know how that preference could be determined.

I consider that this model can add knowledge to each of Habermas’s (2003 (1972) three human interests of understanding, control and emancipation in the context of GPs providing optimal care for same-sex attracted women. Through becoming aware of the concept of multiple identities and its application to sexual orientation, GPs can understand women’s underlying rationale for disclosure or not. Through considering women’s perceived risk and the contribution this makes to women’s selective approach to identity expression, this can enlighten GPs as to the importance of women having control over disclosure. Knowing the social contributors to these perceptions of risk will also enlighten GPs regarding the burden that disclosure can be to women, and the need to share that burden through culturally sensitive skills of disclosure facilitation.

Finally, focusing on the power of the reciprocal nature of the patient-doctor relationship can be liberating from the traditional biomedical approaches that GPs revert to when in a vulnerable position of inadequate knowledge. Paolo Freire, an educationalist and critical theorist, reconceptualised power as being reciprocal and mutual, evidenced by dialogue being an important emancipatory strategy: “the oppressed gain their own voice and collaborate in transforming their own culture” (Christians, 2003, p.233). The transformation in the general practice culture would be that GPs would be willing to reveal their vulnerability and sense of risk, and equally that they would trust patients enough to overcome that risk through building an optimal patient-doctor relationship. It would also replace GPs’ reliance on cultural myths and assumptions about sexual orientation with an incentive to gain adequate knowledge and skills in this area. Perceptions of sexual minority culture could also be transformed by making it known as a normal social fact rather than a stigmatised and hidden sexual phenomenon. So, women can be free to reveal or not reveal their sexual orientation as they wish, and contribute to overcoming both the essentialising of disclosure that dominates the current literature, and the minimising of its importance that dominates GPs’ thinking.
I will now illustrate the application of the Identity Disclosure Model using seven woman-GP pairs from my study in order to support my hypothesis that an awareness of the model would assist understanding, control and emancipation for the individuals within the pairs. Each of the pairs characterises an ongoing patient-doctor relationship, at least as they were intended at the time of our interviews. I have chosen the seven pairs for their representation of each of the identity experiences and expression types in the model, with outcomes of disclosure or non-disclosure. I have presented where the pairs fit into the Identity Disclosure Model in Figure 5.

**Figure 5 - Seven woman-GP pairs illustrating the Identity Disclosure Model**
Kirsti (53, bisexual) was an attraction predominant woman with a private approach to identity expression. She started seeing Dr Phoenix (57) three years before our interview when he was caring for her sister during her final illness. She had not told Dr Phoenix about her bisexual attractions and behaviour despite having an excellent relationship with him. Her two main reasons for not disclosing were that she believed her sexual orientation made no difference to her health care or self identity, and she preferred to avoid risk to their relationship as she believed that Dr Phoenix would have conservative attitudes. On the contrary, Dr Phoenix had a very open, non-judgemental attitude towards minority sexual orientation, and was one of the few GPs in the study who believed it was his role to ask women when relevant. He had clearly not communicated his openness to Kirsti. The relationship could stand as it is and continue to be helpful or an understanding of the model might help Dr Phoenix to make loose inquiry about Kirsti’s living arrangements, gender of partner, but then respect her expected silence as a possible indicator of a private approach (or indeed, that she might be heterosexual).

A complicating factor here was that Kirsti had recurrent vaginal thrush and had wondered whether this might be related to sex with female partners. Transmission of thrush between female sexual partners is likely although hasn’t yet been empirically proven (Bailey et al., 2004). Most doctors would not have this knowledge. This is an example of the intersection of sexual orientation as a social and biomedical issue in that Kirsti’s sexual behaviour in the context of her general practice care was medically relevant. Two crucial elements to accommodating Kirsti’s sexual behaviour and medical issue might be Dr Phoenix improving his display of non-judgementalism to overcome Kirsti’s false assumption, and Dr Phoenix gaining up-to-date knowledge on STIs between women. Kirsti might then be willing to raise the thrush and her question about a sexual connection despite her private approach, and Dr Phoenix would then have capacity to respond with an appropriate
management plan. So, applying the model might assist in improved understanding between Kirsti and Dr Phoenix.

**Gabrielle and Dr Fred**

Gabrielle (46, gay) was an *identity peripheral* woman with a *passive* approach to disclosure. She had a female partner but no lesbian social affiliations at all. She had not disclosed to Dr Fred (65). He had been her usual GP for 20 years when she was married, and she had returned to him two years before our interview because she remembered how caring he was. Dr Fred believed that asking about sexual orientation was intrusive so he had not asked, while Gabrielle was happy to disclose if asked, although was quite happy for Dr Fred not to know as she did not believe it was at all relevant to her life or health. Dr Fred had learned over the years that sharing personal details with patients was helpful to them, and had done so with Gabrielle. She, in turn, believed that if she did tell Dr Fred, his reaction would be positive, so she had accurately determined his overall attitude. This is an example of a non-disclosure situation that suited both people and that neither adversely impacted on Gabrielle’s health care, nor affected their relationship. The model in this situation would be useful if and when Dr Fred included sexual orientation in his holistic approach to health care. It would help him to be aware of the limited importance of sexual orientation to women such as Gabrielle, and respect her lack of disclosure and desire to retain control over this information.

**Dora and Dr Soula**

Dora (41, gay) was similar to Gabrielle in being *identity peripheral* and having a *passive* approach to her identity expression. Her GP of three years, Dr Soula (62), knew that Dora was in a same-sex relationship as Dora had disclosed in the context that her partner was an existing patient of Dr Soula’s. In the past, Dora had not believed her sexual orientation was relevant to GPs at all, however through her relationship with Dr Soula she had become more aware of the holistic nature of general practice. She was very aware of Dr
Soula’s non-judgemental or ‘unshockable’ attitude. She had been scared of being judged by GPs in the past and had found in Dr Soula the acceptance of her sexual orientation that she needed. She was very concerned about finding a new GP when Dr Soula eventually retired, and had started to realise that it was partly her responsibility to be ‘more honest’ about her sexual orientation, while still hoping the new GP would ask. So the model would help Dora by helping her to focus on the professional friendship that is possible with a usual GP and the need for mutual responsibility for disclosure. Dr Soula had some awareness of the mental health impacts of negative social attitudes, however had not applied this to same-sex attracted women seeing GPs, as she believed that there would be no reason for these women not to tell her. The model would enlighten Dr Soula regarding the perceived risks that can prevent disclosure for some women.

**Lucy and Dr Imogen**

Lucy (45, bisexual) was an identity integrated woman with a passive approach to her expression. She had seen Dr Imogen (46) for ten years, having started seeing her just after her marriage break-up and entering her same-sex relationship. I have previously described the incongruence between their disclosure strategies in that now Dr Imogen prefers to ask all of her new patients about the gender of their partner, however had not been doing this at the time when she first saw Lucy. There were a number of misunderstandings between them that would be easily clarified using the model. Lucy wanted holistic care but did not believe that GPs could realistically offer this due to time constraints. Ironically, Dr Imogen was a thoroughly holistic practitioner who provided long consultations under several circumstances, and clearly needed to communicate this more overtly to patients such as Lucy. Lucy perceived considerable risk in the possibility of disclosing to Dr Imogen, which prevented her disclosure despite her increasing need to do so. Dr Imogen was one of the most normalising of GPs in my study regarding sexual orientation and would certainly have been accepting of Lucy’s sexual orientation. So, again, if Dr Imogen made her attitudes and approach more transparent to Lucy by building that aspect of the knowing within their relationship, Lucy may have felt more comfortable with her. Dr
Imogen had also acknowledged that a lack of disclosure at the beginning of a patient-doctor relationship could result in her assumption that the patient was heterosexual. If Dr Imogen were to occasionally probe for partner’s gender even with long-standing patients, she would over-rule these assumptions. Finally, Lucy could overcome her false assumption of general practice by learning about the holistic nature of Dr Imogen’s practice.

**Eileen and Dr Tyl**

Similar to Lucy, Eileen (45, lesbian) was *identity integrated* with a *passive* approach, although had told Dr Tyl (61) about her sexual orientation in the context of sexual health questions that Dr Tyl had asked. Eileen had seen Dr Tyl for about 10 years and was very happy with their relationship. Eileen believed that the GP role is to provide physical health care, and had sought grief counselling elsewhere because she would never have considered seeing her GP for that. Yet, Dr Tyl was a non-judgemental GP who took a special interest in the emotional care of her patients, so theoretically could have provided support to Eileen at that time. Eileen perceived that Dr Tyl did not remember about her sexual orientation from visit to visit, and felt that this was not important overall. On the other hand, Dr Tyl developed a growing awareness during our interview that her lack of recall due to her decision not to record sexual orientation in her medical notes could be problematic and even offensive for women. She also began to realise that asking women about their sexual orientation could be useful, however declared that she did not know how to ask, and was somewhat constrained by her focus on the stigmatised nature of minority sexual orientation. The model may liberate Dr Tyl from these constraints by helping her to realise that minority sexual identity is a normal part of women’s other identities, enabling her to ask about sexual orientation and record it without fear of offending her patients.

**Angelina and Dr April**
Angelina (37, lesbian) is *identity integrated* with an *open* approach to identity expression. She had been seeing Dr April (38) for 11 years, over the period of her transition from married life to having a same-sex partner. Angelina had not sought Dr April’s help during her coming out period, rather had sought counselling support elsewhere. However, once she was secure in her lesbian identity, Angelina had told Dr April about her same-sex partner to gain support with relationship difficulties. Her disclosure at that time, despite having had very negative experiences of disclosure to GPs earlier in her life, was due to the professional friendship and the associated trust that she had developed during the first four years of her time with Dr April. Angelina was particularly grateful that Dr April occasionally asked about her partner in an ongoing acknowledgement of the relationship. Despite her obvious lesbian-sensitivity and success with Angelina, Dr April was concerned that she had inadequate skills to support women during coming out, or to ask about sexual orientation generally. This meant that she had rarely asked women, and so had not been in the position of initiating support for women who may have been confused at that time. The challenge for Dr April was to develop these skills so that she could provide the full support that future patients in Angelina’s position would need.

**Nede and Dr Lith**

Nede (55, lesbian) was *identity defined* with an *open* approach, and had only recently started to see Dr Lith (44, gay), having sought out a GP in a lesbian and gay-focused clinic. The openness of her disclosure approach was evidenced by having told Dr Lith that she was lesbian at only her second visit with him, before the relationship had really developed. She had a pattern of using GPs for her needs although recently had decided that an ongoing relationship was preferable due to the onset of chronic medical conditions. Nede was already knowledgeable that GPs could be holistic because her partner was a GP, so she was in a better position than many women to understand the culture of general practice. Dr Lith was a recent medical graduate, having previously worked in another health profession. He believed that women should tell him about their sexual orientation if desired and did not ask women routinely, often making assumptions that women were
lesbian that he tended not to confirm with them. Despite his own gay orientation, his medical training had not prepared him to understand the specific health issues that exist for same-sex attracted women. He was beginning to recognise the gaps in his knowledge since he had commenced work in the lesbian and gay focused clinic, and was realising that most of the time sexual orientation was relevant to him as the GP. However, he had not taken the logical next step of taking responsibility for facilitating disclosure. Understanding the model for Dr Lith could open this possibility and share the control for disclosure that he had passed on to patients.

Application to Other Cultural Minority Groups

I consider that the Identity Disclosure Model could be applied to other cultural minority groups whose members have similar multiple identity experiences and similar challenges with disclosure to GPs. This potential was endorsed by several participants during my PhD completion seminar and also by the completion panel members. There are several examples of such groups, however it is important to consider them in distinct sub-groups according to the nature of identity. For example, some people have minority identities related to their health status, such as people with blood-borne viruses such as hepatitis C, or experiences of abuse, or disability. These identities will be more medicalised due to the need for treatment. Others have minority identities relating to a particular lifestyle such as being an intravenous drug user or a sex worker, which again require specific medical care. Finally, others have identities of pride, such as indigenous people, people who were adopted, or people with certain religious affiliations. This last group is closest to minority sexual orientation. There are also several areas of overlap between groups, for example a lesbian woman may be an abuse survivor, or a hearing impaired person may consider this an identity of pride. The identity experiences in any of these groups are likely to correlate with the four experiences that I have described, as are the approaches to identity expression. This potential application to other groups requires empirical research with each group to ascertain areas of similarity and difference with my findings.
Summary of the Transformative Potential

I have demonstrated that women and GPs can be liberated where desired from the habitual silencing of the sexual minority lifeworld through prioritising relationship-centred care, developing reciprocal cultural sensitivity, and applying the Identity Disclosure Model. These methods would enhance women’s ability to discern GP attributes that indicate safety to disclose, through their enhanced knowledge of GP culture, and through GPs’ improved openness to revealing their attitudes to patients. They would also enhance GPs’ awareness of which women prefer to disclose, because GPs would be less likely to assume heterosexuality and more likely to take the risk to open the discussion. Control over the information of sexual orientation should be retained by women, however women and GPs could share the burden of disclosure through GPs becoming willing to create a sensitive environment and take some of the responsibility for enabling disclosure. These changes would be emancipatory as they would alter the conditions under which GPs engage with same-sex attracted women. It would also encourage GPs to subtly alter the culture of general practice by bringing more of themselves into the consultation with certain patients and within appropriate boundaries. Self-disclosure by GPs is just one of the tools that they can use with selected patients to enhance the patient-doctor relationship. While improving knowledge is important, I assert that focusing on improving the relationship and achieving culturally sensitive attitudes and behaviours are achievable for GPs and women.

My work also has transformative potential for the theoretical basis for general practice education and research. It suggests the need for a shift from patient-centredness to relationship-centredness. It describes the benefits of developing professional friendship as a way to enhance long-term patient-doctor relationships. It also calls for a broadening of the concept of culture to include minority sexual orientation and an understanding of sexual identity, rather than being restricted to the current cultural attributes of race, ethnicity, religion, and perhaps age and gender. I will now move to a discussion of the educational implications of this change.
Educational Implications

Specific medical education has been raised as an important method to overcome health care provider barriers to facilitating disclosure with same-sex attracted people. Gary Remafedi (2006) asserts that disclosure skills can be taught, including making the environment sensitive, understanding confidentiality and how to ask open and non-judgmental questions. Sharron Hinchliff and colleagues (2005) also believe that training in communication skills should be “prioritised”, as do Carolyn Tolley and Rob Ranzijn (Tolley & Ranzijn, 2006), who state that exposure to non-heterosexual people would be beneficial. While theoretically this education would be useful, there is little evidence for such education programs resulting in sustained behaviour and attitudinal change amongst GPs (McNair, 2003). With this limitation in mind, I will describe two ways in which GP education could be enhanced using the findings of my study. First, I will touch on the development of guidelines for GPs that I have commenced, and second on a possible method for GPs to understand multiple identities. I will then outline the existing tensions and limitations that will form a barrier to these innovations.

Guidelines on Sensitive Care for Same-sex Attracted Women

One of the outcomes of my study is the development of guidelines for GPs on sensitive care for same-sex attracted women. There are currently no specific Australian guidelines, which is in keeping with the silence in this area that is endemic within the medical system. Indeed this is the case more generally. The Canadian authors of one of the few textbooks dedicated to lesbian and gay health state that there is a “non-existence of up-to-date standards of care for gay and lesbian patients” (Peterkin & Risdon, 2003, p.8). The majority of GPs in my study had agreed during our initial interview that guidelines would be useful for their work, so I proceeded with this plan. I decided not to include the guidelines in this thesis so that I could focus instead on the theoretical and practical findings and implications of the study. However, I will briefly outline the process of
guideline development and list what the guidelines will contain. I have written a paper on this process and submitted it for publication.

My initial step was a systematic review of existing guidelines on lesbian, gay and bisexual (LGB) health for primary care providers in Australia, New Zealand, UK, Republic of Ireland, Canada and the USA. I included gay and bisexual men in the review as there were almost no guidelines focused purely on women, and many of the issues are similar. I found 26 existing guidelines and from these selected the nine most applicable and rigorously developed guidelines. One of my supervisors and I then appraised these using the AGREE instrument to assess the quality of reporting, the quality of the recommendations and their predicted validity (The AGREE Collaboration, 2003). I then compared the recommendations from these nine documents and found they contained consistent items, which could be applied to the Australian general practice setting. I formulated these items into draft guidelines under the following headings: creating an inclusive clinical environment; achieving standards for effective provider-patient communication; sensitive documentation of sexual orientation; attaining special knowledge for LGB cultural awareness and appropriate referral and resources; staff training; encompassing LGB personnel in the workplace; and addressing LGB population health issues.

I identified new knowledge from my study that I could add to the draft guidelines. This included a summary of the identity-disclosure model, guidance for clinicians on how to facilitate disclosure of sexual orientation, referral and documentation issues, and understanding legislation that impacts on health. I then sent the draft guidelines to 18 of the participant GPs who had agreed to be involved in a follow-up interview, and subsequently conducted a telephone interview with 12 of these GPs to discuss the guidelines. The GPs provided detailed and constructive feedback that enabled improvement of the draft document. I have included the current version of the guidelines in Appendix 7. I have received a grant to conduct the next phase of the project, which I have described as part of my dissemination strategy in Appendix 6. In brief, I will consult with a wide range of GPs about the current version of the guidelines and seek
endorsement of the final version by the Royal Australian College of General Practitioners. Finally, I intend to disseminate the guidelines widely to GPs as both a web-based and paper resource, bearing in mind that unless this is embedded in multiple educational strategies, guidelines can be limited (Grol et al., 1998).

Understanding Multiple Identities

I have considered the challenge of educating GPs about the place of sexual identity within women’s multiple identities and its impact on identity expression. This will be challenging first because GPs have very little education or personal knowledge in the area, and second because the commonsense understanding of sexual orientation is largely about sexual behaviour or attraction, rather than identity. At this stage, I plan to use an analogy with which GPs will be most familiar, which is the relative importance of their own personal identities. This is in keeping with the reflexivity that I am suggesting within the Identity Disclosure Model, and which is encouraged by relationship-centred proponents (Beach & Inui, 2006). Relationship-centredness suggests that GPs should be constantly monitoring their role and place within the patient-doctor relationship and the degree to which they reveal aspects of themselves to selected regular patients.

My analogy is that all GPs could reflect on their own identity as a GP and where this fits within the other parts of themselves. From personal experience and observation of friends and colleagues, I can see that GP identity is very much like sexual identity in the sense that it can range from being extremely marginal to absolutely central to our overall identity. For example, some GPs would regard it as role-predominant, which is equivalent to attraction predominant sexual identity. It is not important to their self identity, and they would never tell anyone they were a GP in a social setting. Conversely, other GPs are completely defined by their professional role and rarely, if ever, interact with anyone outside of the GP sphere. Being a GP would be the first, and possibly, the only thing they would tell anyone about themselves. I believe that if GPs understand this application of
identity experience to their own life, they will be able to understand the diversity within women’s minority sexual orientation.

Tensions

GPs consistently raise the problem of multiple and conflicting demands on their skills and time (Marjoribanks & Lewis, 2003). There are also enormous pressures on GPs to maintain up-to-date knowledge in every field of biomedicine, creating competing demands on the limited amount of time for professional development (D. Davis, 2006). Asking GPs to add another area of knowledge to their professional development may be difficult, particularly as it relates to such a small group of patients. The minority issue is pertinent, as GPs are driven to learn particularly when they are repeatedly confronted by gaps in their knowledge. However, as many GPs in my study confessed, being aware of gaps that related to just a handful of patients is not an adequate trigger. Similarly, competing demands are increasingly problematic from the beginning of medical education. From my experience, I have confronted this in undergraduate medical curriculum development in attempting to add issues of minority sexual orientation to sexual history taking tutorials that had been allocated limited time. One solution that educators and GPs have raised is to teach from a generic cultural competence or social justice perspective, on the assumption that students will transfer knowledge from one minority group to another. However, as I have found, there is a need for specific knowledge and skills regarding sexual minority as well as general principles. A generic approach can also result in a subliminal message that we should just treat everyone equally, which simply exacerbates the silence regarding same-sex attracted women.

The ongoing dominance of biomedicine over the social aspects of health is a further tension. This dominance impacts at all educational levels. Medical students are acculturated in the biomedical model during early training and can tend to fall back on this model of thinking when they feel uncertain or vulnerable. General practice training does apply a social model of care and a patient-centred approach; however there is very little
content specific to same-sex attracted women. There is also a dearth of resources available to GPs, with minimal peer-reviewed papers, no local guidelines, and few internet-based resources, so making it very difficult to access the knowledge. Finally, there is an ongoing unwillingness amongst GPs to humanise themselves within the patient-doctor relationship. While I have found that many patients appreciate some reciprocal knowledge of the GP as a person, GPs have had to disavow their training to achieve this. Many of the GPs in my study did reveal themselves as people to some patients, but they admitted this to me almost apologetically. So, overcoming these inherent limitations to encourage GPs to be more reciprocal will be challenging.

**Personal Reflections and Praxis**

I will reflect here on my study in two ways. First, my reflections relate to the effect of the study on myself, particularly in terms of my position as a partial insider to the two groups of participants. Second, I will discuss how I might be involved in translating my study findings into practice and influencing change for women and GPs. This is in keeping with the praxis orientation that Patti Lather (1986), which encourages self-reflection regarding my role in the study outcomes.

Conducting this study has influenced me personally and professionally. I have contemplated my own relationships as a GP with my regular patients and the degree to which we have achieved a professional friendship. Like some of the GP participants, I have gradually moved to overcome the imposed silencing of my subjectivity within consultations and have chosen to reveal more of myself to selected patients. I can now more clearly see the impact of my medical training on this constraint and the added freedom I have gained from being more authentic and open. I have also come to understand my same-sex attracted patients more clearly and the range of sexual identity experiences they might have had. I have become more aware of the subtleties of sexual identity expression and that I actually see a much broader range of women encompassing the whole spectrum of sexual minority than I had previously recognised. I have become
more inquisitive as a practitioner to understand the preferences and expectations my patients might have of me regarding disclosure, not just of sexual orientation, but of other sensitive issues.

Similarly, my perspective within the study has altered. I began the study with particular preconceptions that I outlined in Chapter 1, which included an assumption that women should disclose their sexual orientation to their GP. I have shifted to understand the diversity of needs and that disclosure is neither essential nor helpful for some women. As a researcher, I have also moved from being an activist with certain biases, to being more reflexive and open.

I uphold a belief that the general practice system and culture can change. In my commitment to praxis, I will now reflect on how my study findings might generate change for this culture, individual women and GPs. I have been influenced by Paolo Freire (Freire, 1970) and his concept of ‘intentionality of consciousness’, a process of increasing discursive awareness by reflection and action. Freire (1970) says that “human activity consists of action and reflection: it is praxis; it is transformation of the world” (p.106). He suggests that for transformation to occur, this must occur collectively, not individually, and must involve the oppressed. He describes a culture of silence in which the oppressed have no voice or control, and more importantly may have no awareness that they have no voice, which can lead to apathy and loss of self-esteem. This fits with the habitual silencing of minority sexual orientation within general practice, although in a way it is the supposed ‘oppressor’ in the GP who is disenfranchised by devolving control for disclosure, just as much as the ‘oppressed’ woman is silenced sometimes beyond her control. I argue that the oppressor in this setting is really the tradition of biomedicine. So, the process of liberation from this oppressive system would require the active participation and consent of women and GPs, as well as engagement with the medical system itself.

I can play an active role in engaging same-sex attracted women and GPs in this process of change. First, I intend to present my findings to lesbian and bisexual women’s groups and to GPs and will consult widely regarding the development of guidelines. I have already
discussed the process of GP guidelines development. The guidelines for same-sex attracted women may take a number of forms, but centrally they will include guidance on the culture of general practice, and on how to determine whether a GP is culturally sensitive. The repeated inquiries both to Gay and Lesbian Health Victoria and to the Australian Lesbian Medical Association from lesbian and bisexual women to find a sensitive GP make this need very clear. Beyond that, I see the need to remove some of the cultural myths amongst some women and GPs regarding lesbian health being no different to women’s health. This would involve specific health promotion initiatives to same-sex attracted women. This has been commenced in New South Wales but is needed in each state as well as nationally. For GPs, it would involve improving their access to existing resources on lesbian and bisexual women’s health, which will be part of the web-based guidelines. It also requires a policy commitment to ensure that women’s health contains specific information on minority sexual orientation rather than a broad-brush minorities approach. There will be an opportunity in this area as the Federal Government has announced the development of a new National Women’s Health Policy, with a call for submissions during 2009, to which I will respond.

Creating change within the broader medical system will be more challenging. However, I see room for optimism in view of very recent changes within the state and federal political arena. The year of 2008 was momentous in the Australian gay and lesbian movement for bringing legislative change that recognises many rights of sexual minority people. The federal parliament passed several laws that now recognise same-sex relationships in areas such as medical treatment, superannuation, taxation, family law and social security. Two state parliaments of Australia (Victoria and New South Wales) passed laws recognising the parenting rights of non-biological parents in same-sex couples, and Victoria introduced a registration scheme for same-sex relationships. This followed over a decade of conservative federal leadership, which, for example, passed a law defining marriage as between a man and a woman, specifically to exclude same-sex couples. Several of the women who participated in my study made reference to this heterosexist (if not homophobic) leadership and the negative impact that this was having on their own social
standing and self esteem. One of these women had been a lesbian activist in her youth, and just a few were politically motivated, but all found this political environment oppressive.

It has become clear to me that where social change occurs, legislation follows and eventually the most conservative amongst our social systems are influenced to change (Bowers & Minichiello, 2001). Therefore, it is only a matter of time before the social and political transformation for the rights of people of minority sexual orientation moves into the medical system and assists in enabling recognition of sexual minority issues as legitimate and important. Researchers Randolph Bowers and Victor Minichiello have set this challenge:

Medicine, like our legal, political, religious and education systems, has both an opportunity and a responsibility to reverse the history of pathologising homosexuality by fostering healthy and positive views of being gay, thereby creating a society that allows gay people to live their lives as accepted and valued citizens, and not as the defective biological and social “other”. (Bowers & Minichiello, 2001, p.154-5)

The change that is required of the medical system is to overcome heteronormative approaches in practice, education and research; and by doing so support individual doctors in their endeavours to be humane, empathic and culturally sensitive.

**Strengths and Limitations**

I have recognised various limitations of my study. These relate to issues of sampling, method and generalisability. I am using the term ‘generalisable’ in the way that Jeanne Daly (2007) recommended as the most rigorous level of qualitative research, which I outlined in Chapter 2 (Table 2).

The sample of same-sex attracted women was drawn from women attending randomly selected general practices (17 women), as well as snowball sampling via the initial women
(5) and from the lesbian/bisexual community (11). Previously, I have discussed that this resulted in women with a diverse range of sexual identity experiences, and that, at least with regard to lesbian women attending Australian general practice, the findings are likely to be generalisable. One caveat to this generalisability however is that there were only six women who identified as bisexual, compared with 25 women who identified as lesbian (or gay). According to population based studies, the number of bisexual women would be expected to be equal to or higher than lesbian women (Smith et al., 2003), and equally I would expect there to be just as many or more bisexual women attending general practice. Also, none of the bisexual women in my study were *identity defined* in their identity experience, whereas I would expect these women to be present within the population. Further, few women were in their coming out phase of identity confusion, which is not surprising as it would be unlikely for these women to volunteer to be in a study at this difficult time. Therefore, the generalisability of findings with regard to bisexual women and those who are coming out is very limited.

A further sampling issue occurred in relation to recruitment via another study. I drew my general practice sample from women recruited for the Diamond study, and did not recruit any woman who fulfilled screening criteria for current depression, as these women were to be recruited to Diamond. So, it is likely that my sample of women may have had better mental health than the full range of same-sex attracted women attending general practice. However, many of the women in my study did discuss current or past feelings of depression, so there was a presence of women with poorer mental health.

Another limitation regarding sampling was that most of the GPs (22) were recruited via the same-sex attracted women participants, and only six from the general medical community. This may have created a selection bias in that, having been deliberately chosen as the GP of a sexual minority woman, they may have been more non-judgemental and lesbian sensitive than the general population of GPs. Unfortunately, I have no way of comparing their attitudes against Australian GPs in general as this has not been studied. So, any findings regarding GP attitudes are not generalisable.
My analysis of the patient-doctor relationship was restricted to the women’s and doctors’ perspectives as I did not include an observational component in my research method. This was deliberate as I was prioritising the lived experience of each participant consistent with the phenomenological approach. However, in view of the importance of the patient-doctor relationship that emerged, triangulation of findings using observation may have been useful. The lack of observation limited my ability to verify the quality of the patient-doctor encounter other than by using comparison within woman-GP pairs.

Finally, I consider that my Identity Disclosure Model requires testing to ascertain its perceived soundness amongst same-sex attracted women and GPs. In the spirit of Paolo Freire’s (1970) requirement to involve the oppressed in any application of research that anticipates change, as well as a feminist desire to engage, I would not claim that the model is fully formed without such corroboration.

In contrast, I believe that my study has a number of strengths. While I have outlined the limitations of my sampling method, it was also a strength in being derived from a general practice sample rather than the much more commonly derived lesbian community-based sample. This enabled inclusion of a number of women who are usually not represented in lesbian health studies, in particular identity peripheral and attraction predominant women. My sampling method was the first to involve women-GP pairs that I am aware of, which meant that direct comparison of their perspectives was possible. In this way, I could compare women’s and GPs’ responses to perceived risk and see the benefit of relationship-centredness for both. My insider status as both a lesbian woman and GP generated a number of advantages including assisting with my perceived trustworthiness during recruitment, and creating depth during interviews because I often shared tacit cultural understandings with participants. It will be particularly helpful during the next phase of my research in translation of my findings into practice.
Further Research Needed

The question of whether the Identity Disclosure Model would actually be transformative in the day-to-day relationships of same-sex attracted women and their GPs could only be answered by applying the model and evaluating the outcomes. I intend to do this as part of my GP guidelines development and dissemination of research findings to the lesbian and bisexual communities. Observation of the patient-doctor relationship in action may be a useful component of this evaluation, as I previously suggested.

To date there has been no equivalent study of the perspectives of Australian gay and bisexual men of general practice care. There has been one study in which 16 GPs were interviewed regarding the care of gay men with depression (Newman, Kippax, Mao, Saltman, & Kidd, 2008). While there will be some similarities with the perspectives of same-sex attracted women, there are likely to be significant gender-based differences that would require independent research. Finally, similar qualitative research with other silenced minority groups attending general practice would be important to understand whether the Identity Disclosure Model could be applied to these groups.

Conclusion

I saw a single lesbian woman in my general practice recently who was seeking support to conceive a child. She had a regular male GP in another practice who she “loved to bits” however he was away so she came to see me. She had never told him about her sexual orientation, and typically, he assumed that she was heterosexual. Recently, he had started to give her advice about on-line heterosexual dating sites, and this had prompted her to realise that she would “eventually have to tell him” about being lesbian. She told me that she had just not got around to her disclosure yet. This simple story encapsulates the problem that I have been addressing throughout the thesis. Despite an excellent patient-doctor relationship including trust and relational knowing that this woman and her GP had achieved, one piece of information was unspoken. The version of the problem outlined in
the literature depicts disenfranchised lesbian patients with uncaring and possibly homphobic GPs. I have found that the problem is much more subtle yet no less challenging. Predominantly it involves women who are satisfied with their patient-centred GPs but are sustaining an awkward silence arising from waiting for the right moment or inquiry to tell in the face of heteronormative assumptions.

The aim of my study was to understand what constitutes an optimal patient-doctor relationship between same-sex attracted women and their usual GP, and how this can be achieved. A few women and GPs in my study had achieved such a relationship using different methods. For some, the answer was in the relationship itself and its ability to overcome perceived risks that disclosure of sexual orientation entailed. For women, this was assisted by knowing the GP and being able to predict their responses. For GPs, it involved being able to decipher the code of preferred sexual identity expression and therefore the desired place of sexual orientation within the patient-doctor relationship. Some women and GPs described relationships as professional friendships, which approached Giddens’ (1991) concept of the ‘pure relationship’ in that they involved the reciprocity of mutual care, mutual trust and, rarely, mutual responsibility for disclosure.

However, relationship building did not overcome the silencing of sexual orientation for some of the women and GPs in my study. Some women took the risk and disclosed even when they could not predict the GP’s reaction. Others chose not to disclose, therefore avoiding the risk, either because they felt no need for their GP to know about their sexual orientation, or needed to tell but could not take the risk. GPs’ usual patient-centred approach was compromised by their lack of preparedness regarding women’s minority sexual orientation due to the silence within medical education and the lack of tacit knowledge within broader society. It was also compromised by the traditionally objective nature of doctors’ interactions with patients, which resulted in their reluctance to reveal the vulnerability of their ignorance by risking facilitating disclosure. By contrast, some GPs had overcome the silencing by developing limited cultural awareness through experiential learning, either with known lesbian patients or, more commonly, friends and family.
Disclosure of minority sexual orientation within general practice represents a spectrum from being insignificant to being essential. Within this continuum is variation according to whether it is a choice or it is a given; it is a process over time or it is a moment in time; it is contingent on relational knowing, or it is pursued regardless of the relationship. GPs need to understand this complexity, just as they must understand the variability in presentations of heart disease or depression, or the wide range of effects of minority ethnicity on health. So, the answer to achieving an optimal relationship does not entirely rest on sexual orientation being revealed, as it can be irrelevant to the woman and the GP, although this is uncommon. Nor does the answer rely on satisfying individual preferences for disclosure, particularly when sexual orientation is relevant to the presenting health issue. Using my opening example, for the lesbian woman seeking conception advice, her male GP would need to know her situation completely to be able to offer the most appropriate medical advice, regardless of her disclosure preference. The answer, as with any centredness approach, is for each individual within the patient-doctor relationship to communicate, learn, acknowledge, risk and trust according to the needs at the time. By doing so, each optimal relationship is working to transform general practice.

I have proposed, as part of the solution to the habitual silencing, that education of GPs and women will assist to transform the nature of the patient-doctor relationship. Therefore, I have focused the next steps of the project on creating guidelines for GPs and taking my findings to the lesbian and bisexual communities. These educational processes would enhance the clinical encounter for a wider group of people than those fortunate enough to have stumbled across each other and the relevant information. The education would need to be very specific, to be accessible across the spectrum of medical training, and available to a wide range of women. Educating GPs about sexual minority culture and women about the holistic potential of GP culture could and should create openness and reduce perceived risk. The knowledge and skills required for such cultural sensitivity are eminently learnable. However, they can seem intangible, particularly for GPs, as even instituting the search for such knowledge relies on valuing something that was previously overlooked.
due to the tacit rules within medical culture and the socio-political environment which are based on heteronormative assumptions.

While I have suggested that both women and GPs should take responsibility for becoming culturally sensitive, in truth this is largely about transforming the culture of general practice. Women are already taking the burden of the responsibility for disclosure of their sexual orientation. To transform general practice to be sensitive to same-sex attracted women, GPs need to be less careful, less avoidant when the topic is potentially sensitive, and less sensitive to criticism by patients when knowledge or skills are inadequate. They need to connect with and enjoy the diversity of their patients, and in the spirit of reciprocal trust need to share responsibility with women for disclosure. In opening up the possibilities beyond the heteronormative, they can then become truly reflexive and transform the system from within to be optimal for the full range of same-sex attracted women who attend.
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APPENDIX 1 – PLAIN LANGUAGE STATEMENTS

I sent the following plain language statements respectively to women and GPs who had agreed to participate in my study. The study was titled “Disclosure and attitudes to lesbians: outcomes in general practice (DIALOG)”.

Plain Language Statement for Same-sex Attracted Women

DISCLOSURE AND ATTITUDES TO LESBIANS: OUTCOMES IN GENERAL PRACTICE (DIALOG)
INFORMATION SHEET FOR SAME-SEX ATTRACTED WOMEN

What is the study about?

DIALOG is designed to develop an understanding of the doctor-patient relationship that forms between same-sex attracted women and their general practitioner (GP). One aspect of the relationship that will be explored in depth is whether women tell their GP about their sexuality, and whether telling or not affects the perceived quality of the doctor-patient relationship and the resulting health care. The research will contribute to PhD studies of Dr Ruth McNair.

It is hoped that the new understanding achieved will help to inform education programs for doctors and their same-sex attracted patients regarding methods for enhancing the doctor-patient relationship.

What will you be asked to do?

You will participate in an interview with Dr Ruth McNair. The interview will take place at a convenient location and time and will take approximately one hour. If you consent, the
interview will be audio-taped and later transcribed. You can stop the interview at any time before or during the interview, without any penalty. Any information that has been collected from you will be destroyed if you withdraw your consent up to the time of publication. Transcripts of the interviews will be sent to you to check and confirm their accuracy if you wish. If you wish, you will be sent a final report summarising key findings of the project.

You will be asked to nominate whether you would be willing to be interviewed a second time by the same researcher within the following 12 months. Second interviews may be conducted with some participants on an individual basis to explore whether there was any influence on the doctor-patient relationship of having participated in the first interview, particularly on behaviours that might effect disclosure. This will also provide an opportunity to explore themes that have arisen from the first set of interviews in more depth.

**Are there any possible advantages or disadvantages for you?**

All GPs and same-sex attracted women in the study will be provided with information regarding specific health issues for lesbians and bisexual women for your information. You will also be provided with a list of lesbian-sensitive health resources.

Some participants may reveal negative experiences with health care providers or in life in general that is related to their sexuality during the interview. Dr Ruth McNair will be conducting all interviews. She is an experienced general practitioner who has experience in lesbian health. She knows a wide range of health and counselling services that are available for lesbian and bisexual women in Victoria.

You may have already given permission for your GP to be invited to participate in the study. If you have, although your GP will be aware that one or more of her/his patients will have been interviewed, details of your identity will not be revealed to your GP. You will also not be told whether your GP has agreed to be interviewed.
Confidentiality

Your identity will be removed from the transcripts of your interview. Your name will be replaced with a pseudonym and other identifying information will be altered. If information from your interview is to be used in any publication arising from the project, every attempt will be made to prevent you from being recognised. However, this study involves just a small number of people, so it is possible that you could be recognised.

What will happen to the information collected from you during the interview?

The interview transcripts will be analysed to understand the attitudes, behaviours and beliefs of each person interviewed and of the group as a whole. This information will be used in reports to the funding body, the lesbian/bisexual community and the medical community. Academic papers and articles outlining the results will be published. The tapes of the interviews will be stored in a locked filing cabinet at the Department of General practice for 5 years and then destroyed. Codes that identify participants will be kept in a separate locked location. Transcripts and any identifying information will be kept in a computer file that will be password protected.

Investigators:
Dr Ruth McNair Phone: 8344 6077, Mobile: 0419 120 663, Fax: 9347 6136
Associate Professor Kelsey Hegarty Phone: 8344 4992, Fax: 9347 6136
Dr Angela Taft Phone: 8341 8571

For concerns contact:
Executive Officer, Human Research Ethics, University of Melbourne
Phone 8344 2073, fax 9347 6739

Funding:
Dr McNair has been funded by the National Health and Medical Research Council of Australia, and by a Family Medical Care Education and Research Grant in 2004.
Plain Language Statement for GPs

DISCLOSURE AND ATTITUDES TO LESBIANS: OUTCOMES IN GENERAL PRACTICE (DIALOG)
INFORMATION FOR GPs

What is the study about?

DIALOG is designed to develop an understanding of the experience of GPs seeing same-sex attracted women. One aspect of the doctor-patient relationship that will be explored in depth is whether women tell their GP about their sexuality, and whether disclosure or non-disclosure affects the perceived quality of the doctor-patient relationship and the resulting health care. The research will contribute to the PhD studies of Dr Ruth McNair.

It is hoped that the new understanding achieved will help to inform guidelines and education programs for doctors and same-sex attracted consumers regarding methods for enhancing the doctor-patient relationship.

What will you be asked to do?

You will participate in an interview with Dr McNair. The interview will take place at a convenient location and time and will take up to one hour. If you consent, the interview will be audio-taped and later transcribed. You can stop the interview at any time before or during the interview, without any penalty. Dr McNair will also ask your permission to observe your practice environment and take notes. Any information that has been collected from you and about your practice will be destroyed if you withdraw your consent up to the time of publication. Transcripts of the interviews will be sent to you to check and confirm their accuracy if you wish. If you wish, you will be sent a final report summarising key findings of the project.

You will be asked to nominate whether you would be willing to be interviewed a second time by the same researcher within the following 12 months. Second interviews may be conducted with some participants on an individual basis to explore whether there was any
influence on the doctor-patient relationship of having participated in the first interview, particularly on behaviours that might effect disclosure. This will also provide an opportunity to explore themes that have arisen from the first set of interviews in more depth.

**Are there any possible advantages or disadvantages for you?**

All GPs and same-sex attracted women in the study will be provided with information regarding specific health issues for lesbians and bisexual women, upon which you could base discussions in future consultations. You will also be provided with a list of lesbian-sensitive health resources, for referral purposes.

Dr Ruth McNair will be conducting all interviews. She is an experienced general practitioner who has experience in lesbian health. She knows a wide range of health and counselling services that are available for lesbian and bisexual women in Victoria.

Your patient(s) has given permission for you to be invited to participate in the study, however she/they will not be told whether you have agreed to be interviewed or not. Details of the identity of the patients will not be revealed to you.

**Confidentiality**

Your identity will be removed from the transcripts of your interview. Your name will be replaced with a pseudonym and other identifying information will be altered. If information from your interview is to be used in any publication arising from the project, every attempt will be made to prevent you from being recognised. However, this study involves just a small number of people, so it is possible that you could be recognised.

**What will happen to the information collected from you during the interview?**
The interview transcripts will be analysed to understand the attitudes, behaviours and beliefs of each person interviewed and of the group as a whole. This information will be used in reports to the funding body, the lesbian/bisexual community and the medical community. Academic papers and articles outlining the results will be published. The tapes of the interviews will be stored in a locked filing cabinet at the Department of General practice for 5 years and then destroyed. Codes that identify participants will be kept in a separate locked location. Transcripts and any identifying information will be kept in a computer file that will be password protected.

**Investigators:**
Dr Ruth McNair - Phone: 8344 6077, Mobile: 0419 120 663, Fax: 9347 6136
Associate Professor Kelsey Hegarty -Phone: 8344 4992, Fax: 9347 6136
Dr Angela Taft - Phone: 8341 8571

**For concerns contact:**
Executive Officer, Human Research Ethics, University of Melbourne
Phone 8344 2073, fax 9347 6739

**Funding:**
Dr McNair has been funded by the National Health and Medical Research Council of Australia, and by a Family Medical Care Education and Research Grant from the RACGP 2004.
APPENDIX 2 – CONSENT FORM

I used the same consent form for all participants, which was based on the template recommended by the University of Melbourne Human Research Ethics Committee.

CONSENT FORM
DISCLOSURE AND ATTITUDES TO LESBIANS:
OUTCOMES IN GENERAL PRACTICE (DIALOG)

Name of participant:

Name of researcher: Ruth McNair

1. I consent to participate in the DIALOG project, the details of which have been explained to me including details of the interview process. A written copy of the information has been given to me to keep.

2. I authorise the researcher to interview me.

3. I acknowledge that:

   (a) The possible effects of the interview have been explained to me to my satisfaction;

   (b) I have been informed that I am free to stop the interview or withdraw from the project at any time without explanation or prejudice and to withdraw any unprocessed data that I have previously supplied;

   (c) The project is for the purpose of research and not for treatment;
(d) I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements.

(e) I understand that this study involves just a small number of people, so there is a small possibility that I could be recognised within the project reports.

4. I consent to the interview being audio-taped and later transcribed and acknowledge that:

(a) I am aware that a copy of the transcript will be sent to me to verify that the information is correct;

(b) That my name will be altered to a pseudonym and other identifying details altered if my information is used in any publications.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
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<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>(Participant)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>(Witness to consent)</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 3 – PRE-INTERVIEW SURVEYS

All participants completed a brief survey prior to, or soon after, their initial interview.

Same-sex Attracted Women’s Survey

DIALOG

PARTICIPANT SURVEY – NON-HETEROSEXUAL WOMEN

This survey is for women who are taking part in the DIALOG study. The information within the survey will mostly be an addition to the areas to be covered within the interview.

It contains 3 sections:
Section A is about your background and some personal details
Section B is about your sexual orientation, social connections and relationships
Section C is about your current health and health care.

Your answers will be seen only by Dr Ruth McNair, who will treat all information confidentially. Any presentation of this information will not contain anything that could identify you. These questions are important to know a little bit about you, and to build a picture overall of the women participating in the study.

You are welcome to leave questions out if you would prefer not to answer them. We estimate that it will take about 5 to 10 minutes to complete.

Please bring the completed survey with you to your interview
or post it to Dr Ruth McNair
The Department of General Practice, 200 Berkeley St, Carlton, 3053

If you have any queries, please ring Ruth McNair on 0419 120 663
Your name_________________

Section A: Your personal details

A.1 What is the suburb/town in which you live? ______________

A.2 Which best describes the area in which you live?

<table>
<thead>
<tr>
<th>Inner suburban or urban (within 5 km of city)</th>
<th>Outer Suburban</th>
<th>Regional centre (50,000 or more)</th>
<th>Rural area (5,000 to 50,000)</th>
<th>Rural area (less than 5,000)</th>
</tr>
</thead>
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</tr>
</tbody>
</table>

A.3 What is your age in years? ____________years old

A.4 In which country were you born? ____________

A.5 Are you of Aboriginal or Torres Strait Islander origin?

<table>
<thead>
<tr>
<th>Aboriginal</th>
<th>Torres Strait Islander</th>
<th>Both Aboriginal and Torres Strait Islander</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A.6 Do you speak a language other than English at home?

☐ No    ☐ Yes   If yes, please specify which language_________

A.7 What is the highest education level you have completed? (please tick one)

<table>
<thead>
<tr>
<th>Primary School</th>
<th>Up to Year 10 or equivalent</th>
<th>Up to Year 12 or equivalent</th>
<th>Diploma, Trade, Certificate, TAFE</th>
<th>University degree</th>
<th>Higher University degree (Grad Dip, Masters, PhD)</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>
A.8 What is your work or study pattern? (please tick any that apply)

<table>
<thead>
<tr>
<th>Working full-time</th>
<th>Working part-time</th>
<th>Unemployed looking for work</th>
<th>Not in the paid workforce (retired, home duties)</th>
<th>Studying full-time</th>
<th>Studying part-time</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

A.9 What is your gross annual income (before tax)? (please tick one)

<table>
<thead>
<tr>
<th>No income</th>
<th>Up to $26,000 per year</th>
<th>$26,000 to $78,000 per year</th>
<th>Over $78,000 per year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

A.10 Do you receive a pension or benefit?

For example unemployment benefits, a pension, a student allowance, family allowance

☐ No    ☐ Yes

Section B: Your sexuality and relationships

B.1 Which of the following best describes your sexual identity? (please tick one)

<table>
<thead>
<tr>
<th>Lesbian</th>
<th>Gay/homosexual</th>
<th>Bisexual</th>
<th>Queer</th>
<th>Heterosexual/straight</th>
<th>I don’t describe my sexual identity</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

B.2 For how long have you identified in this way?__________ years

B.3 Have you identified with another sexual identity in the past?

☐ No    ☐ Yes If yes, which identities?___ How long ago was that?___
B.4 Are you in a relationship currently?

☐ No  If no, go to B.6  ☐ Yes

B.5 What is the sex of your partner?

☐ Female   ☐ Male

B.6 What is your current marital status with regard to a heterosexual marriage recognised by Australian law? (please tick one)

<table>
<thead>
<tr>
<th>De facto</th>
<th>Married</th>
<th>Divorced</th>
<th>Separated but not divorced</th>
<th>Widowed</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

B.7 What is your sexual attraction? (please tick one)

<table>
<thead>
<tr>
<th>Attracted only to women</th>
<th>Attracted only to men</th>
<th>Attracted mostly to women</th>
<th>Attracted mostly to men</th>
<th>Attracted equally to women and men</th>
</tr>
</thead>
<tbody>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

B.8 What was the sex of your sexual partner(s) in the last 12 months? (please tick one)

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
<th>Female and Male</th>
<th>No partners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

B.9 What was the sex of your sexual partner(s) over your lifetime? (please tick one)

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
<th>Female and Male</th>
<th>No partners</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
B.10  Do you have children? *(please tick any that apply)*

<table>
<thead>
<tr>
<th>Biological child/children</th>
<th>Non-biological child/children</th>
<th>Pregnant</th>
<th>Planning to have children</th>
<th>No children</th>
</tr>
</thead>
</table>

B.11  Do you have any connections with the lesbian, bisexual, gay, transgender (LBGT) communities?

☐ No  If no, go to C.1  ☐ Yes  If yes, please answer the following:

B.12  Which parts of the lesbian, bisexual, gay, transgender (LBGT) communities do you connect with? *(please tick any that apply)*

<table>
<thead>
<tr>
<th>Lesbian/bisexual support group</th>
<th>Lesbian/bisexual specific magazines</th>
<th>LGBT radio (JOY-FM) and/or TV (Bent-TV)</th>
<th>Lesbian/bisexual Web sites</th>
<th>Lesbian/bisexual businesses</th>
<th>Lesbian/bisexual health services</th>
</tr>
</thead>
</table>

Other (Please specify) ___________________________ __________

Section C: Your health and health care

C.1  How do you rate your current general health? *(please tick one)*

<table>
<thead>
<tr>
<th>Excellent</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
</table>

C.2  Do you have any current medical problems requiring regular medical review?

☐ No  ☐ Yes

C.3  Are you on any regular prescribed medications?

☐ No  ☐ Yes

C.4  Approximately how many regular GPs have you seen as an adult?__________
C.5 Do you see health care providers apart from GPs for your health care?

☐ No If no, go to C.7  ☐ Yes If yes, please answer the following:

C.6 Please list other providers you have seen regularly (including complementary health providers)

__________________________________________________________

C.7 What is the longest time you have ever consistently seen one GP as an adult?
(please tick one)

<table>
<thead>
<tr>
<th>Less than 1 month</th>
<th>1 to 6 months</th>
<th>6 to 12 months</th>
<th>1 to 3 years</th>
<th>3 to 5 years</th>
<th>5 to 10 years</th>
<th>More than 10 years</th>
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</table>

C.8 Where do you find information about your health? (please tick any that apply)

<table>
<thead>
<tr>
<th>Friends</th>
<th>Family members</th>
<th>Media (TV, magazines, radio, newspaper)</th>
<th>Internet</th>
<th>Books</th>
<th>Your GP</th>
<th>Other health care provider</th>
<th>Please specify</th>
</tr>
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</table>

Other (Please specify)  ________________________________

Thank you very much for completing this survey.
GPs’ Survey

DIALOG - DISCLOSURE AND ATTITUDES TOWARDS LESBIANS:
OUTCOMES IN GENERAL PRACTICE

PARTICIPANT SURVEY – GENERAL PRACTITIONERS

This survey is for GPs who are taking part in the DIALOG study. The information within the survey will mostly be an addition to the areas to be covered within the interview.

It contains 3 sections:
Section A is about your current practice details
Section B is about caring for lesbian and bisexual women
Section C is about your personal details

Your identity will only be known by Dr Ruth McNair, who will treat all information confidentially. Any presentation of this information will not contain anything that could identify you. These questions are important to know a little bit about you, and to build a picture overall of the GPs participating in the study.

You are welcome to leave questions out if you would prefer not to answer them. We estimate that it will take about 5 to 10 minutes to complete.

Please bring the completed survey with you to your interview
or post it to Dr Ruth McNair
The Department of General Practice
200 Berkeley St, Carlton, 3053

If you have any queries, please ring Ruth McNair on 0419 120 663
A.1 What is the suburb/town in which you practice? ______________

A.2 Which best describes the area in which you practice?

<table>
<thead>
<tr>
<th>Inner suburban or urban (within 5 km of city)</th>
<th>Outer Suburban</th>
<th>Regional centre (50,000 or more)</th>
<th>Rural area (5,000 to 50,000)</th>
<th>Rural area (less than 5,000)</th>
</tr>
</thead>
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</tr>
</tbody>
</table>

A.3 How would you best describe your main practice setting? (please tick one)

<table>
<thead>
<tr>
<th>Private general practice</th>
<th>Corporatised general practice</th>
<th>Community Health Centre</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

A.4 Who do you work with in your practice?

<table>
<thead>
<tr>
<th>Female GPs (state the number)</th>
<th>Male GPs (state the number)</th>
<th>Practice nurses</th>
<th>Psychologists/counsellors</th>
<th>Other (please specify)</th>
</tr>
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</table>

A.5 How many sessions per week do you work?________

A.6 In a usual week, how many patients would you consult with? ________

A.7 In a usual week what proportion of your patient consultations are with adult females (>18 years old): ________%

A.8 In a usual week what proportion of your patient consultations are:

<table>
<thead>
<tr>
<th>Less than 6 minutes (level A)</th>
<th>6 to 20 minutes (level B)</th>
<th>20 to 40 minutes (level C)</th>
<th>Greater than 40 minutes (level D)</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>
A.9 **Which of the following patients do you routinely bulk-bill?** *(please tick any that apply)*

<table>
<thead>
<tr>
<th>All patients</th>
<th>Pensioners</th>
<th>Non-pension health care card holders</th>
<th>Children</th>
<th>Adolescents</th>
<th>None</th>
</tr>
</thead>
</table>

A.10 **What are your areas of interest within general practice?**

__________________________________________________

__________________________________________________

**Section B: Caring for lesbian and bisexual women**

B.1 **Can you recall seeing any patients in general practice who identify as lesbian or bisexual or are same-sex attracted?**

☐ No If no, go to B.3 ☐ Yes If yes, please answer the following:

B.2 **What proportion of your adult female patients are not exclusively heterosexual? __%**

B.3 **How would you rate your knowledge of lesbian/bisexual women’s health issues?** *(please tick one)*

<table>
<thead>
<tr>
<th>Very knowledgeable</th>
<th>Moderately knowledgeable</th>
<th>Somewhat knowledgeable</th>
<th>Not very knowledgeable</th>
<th>No knowledge</th>
</tr>
</thead>
</table>

B.4 **How much training have you had in health issues for non-heterosexual women?** *(please estimate the number of hours at each level)*

<table>
<thead>
<tr>
<th>Undergraduate (medical school)</th>
<th>Hospital training</th>
<th>GP training</th>
<th>GP professional development</th>
<th>Other <em>(Please specify)</em></th>
</tr>
</thead>
</table>


B.5 Do you know any health care providers with lesbian-specific knowledge to whom you could refer a non-heterosexual woman if needed?

☐ No    ☐ Yes

B.6 Which of the following referral networks catering to lesbian, bisexual, same-sex attracted women are you aware of? *(please tick any that apply)*

<table>
<thead>
<tr>
<th>Lesbian/ bisexual support groups</th>
<th>Women’s health services</th>
<th>General Practices specialising in lesbian health</th>
<th>Youth health services</th>
<th>Gay and Lesbian Switchboard</th>
<th>P-Flag (parents and friends of lesbians and gays)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other *(please specify)*__________________________

Section C: Your personal details

C.1 What is your age in years? ___________years old

C.2 In which country were you born? ___________

C.3 Do you speak a language other than English in your practice?

☐ No    ☐ Yes If yes, please specify which language_________

C.4 In what year did you complete your medical degree? _______

C.5 In which country did you graduate? ___________

C.6 What are your other qualifications? *(please tick any that apply)*

<table>
<thead>
<tr>
<th>Vocational Registration</th>
<th>FRACGP</th>
<th>FACRRM</th>
<th>Higher University degree (Grad Dip, Masters, PhD)</th>
<th>Clinical Diploma(s)</th>
<th>Other <em>(please specify)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C.7 How many years have you worked in general practice?

In Australia _______ yrs; Overseas _______ yrs
The following questions in this section are more personal. You may prefer not to answer them.

C.8 What is your current marital status with regard to a heterosexual marriage recognised by Australian law? *(please tick one)*

<table>
<thead>
<tr>
<th>De facto</th>
<th>Married</th>
<th>Divorced</th>
<th>Separated but not divorced</th>
<th>Widowed</th>
<th>Not applicable</th>
</tr>
</thead>
</table>

C.9 Which of the following best describes your sexual identity? *(please tick one)*

<table>
<thead>
<tr>
<th>Heterosexual /straight</th>
<th>Gay/ Lesbian homosexual</th>
<th>Bisexual</th>
<th>Prefer not to answer</th>
<th>I don’t describe my sexual identity</th>
<th>Other <em>(please specify)</em></th>
</tr>
</thead>
</table>

C.10 Are you in a relationship currently?

☐ No  If no, go to C.12  ☐ Yes

C.11 What is the sex of your partner?

☐ Female  ☐ Male

C.12 What is your sexual attraction? *(please tick one)*

<table>
<thead>
<tr>
<th>Attracted only to women</th>
<th>Attracted only to men</th>
<th>Attracted mostly to women</th>
<th>Attracted mostly to men</th>
<th>Attracted equally to women and men</th>
<th>Prefer not to answer</th>
</tr>
</thead>
</table>

*Thank you very much for completing this survey.*

Some questions in this survey have been used with permission from the DIAMOND GP survey.
I matched items where possible within the women’s and GPs’ interview schedules. The following schedules are the final versions of each, having been modified slightly following the early interviews. I did not always use the same order of questions during interviews. Each section starts with a stem question and is followed by a number of probing questions, which I asked only if needed.

**Same-sex Attracted Women’s Initial Interview Schedule**

Name ________  Preferred Pseudonym ________  Interview Date ________

**Before starting the tape**

Plain language statement  Demographics survey - completed  Consent form
Permission to audio-tape  GP invitation

**Introduction**

I am interested in same-sex attracted women’s experience of seeing GPs, what works and doesn’t work, whether their needs are being met.

I am aiming to interview a number of women and GPs separately.

Ultimately, I hope to help women to know how to get the most out of seeing their GP, and create some guidelines for GPs in this area.

Anything you would like to ask about the project overall?

How long have you got today – finish time?

**Opening Question – seeing GPs**

Can you tell me what it has been like for you going to see GPs over the years? (apart from your current GP)

- what sorts of things would you go about, what wouldn’t you go about
- would anything stop you going
- were your needs met/satisfied, how have you felt
- do you prefer a woman or a man
- have your experiences changed over time- how
- can you give me specific examples, what would have improved the experience

Can you tell me about your current GP? (gender, age group) – what is she/he like
- how did you choose to see him/her, why
- how well do you know him/her , how well does he/she know you
- does she/he know about your sexuality
- is she/he sensitive to your needs as a lesbian
- is it important for you to know her/his sexuality
- how does she/he compare to other GPs you have seen
- what is his/her practice environment like
- do you feel comfortable as a lesbian going to her/his practice –why/not
- do you trust her/him

Health care
For your health care, what do you need from your GP?
- who do you think should make decisions about your health- you/GP/ shared
- do you prefer self-care or HCP care
- do you think seeing the same GP over time is important, consistency

How has it been seeing other health care providers, apart from GPs?
- do they provide for different health care needs particularly with regard to your sexual orientation
- does your GP know, who do you regard as your main health care provider

Disclosure
Disclosure: Do you think your sexuality is important for your health care? (and for children’s health care if relevant)
Do you think your GP should know about your sexual orientation? Do GPs think they need to know?
- why, when, why not,
- how does she/he know – should you tell, should she ask; - if she/he knows – what was her/his response, how did that make you feel
- When do you think your sexual orientation is relevant for the GP, has a GP ever assumed you were lesbian, have you ever been asked
- medical notes and referral letters – should your sexuality be written down
- did you consider talking with a GP when you were first coming out
- Identity: how important is your identity as a lesbian to you, compared with your other identities, is that changing for you

Social Environment

Social: What do think the public attitude is about women who are not heterosexual?
- now, in the past, changes- what
- rural/urban, older/younger people

Discrimination: Have you had any personal experience of negative attitudes (or positive)?
- can you give an example?
- strangers, people you know, friends, family
- negative attitudes from GPs/ what about overtly positive attitudes
Did these experiences affect your health?
Does being lesbian/bi affect your health?

Close

What is your wish list for an excellent GP, what is important to you generally and as a lesbian/bi woman?
Is there anything else you would like to say/add?
How do you feel having talked about these issues?
Why did you decide to participate in the interview? Has participating changed anything for you? in the way you might interact with GPs?
Post interview after turning off the audiotape recorder
Invitation to contact me if you would like to add something.
Can I contact you when transcribing to clarify an issue?

Yes  No

Would you like to read the transcript and have an opportunity to comment and suggest changes?

Yes  No

Follow up
Would you like to participate in a follow-up interview or group discussion to hear about the early findings?

Yes  No

Other contacts
Can you think of anyone else who may be interested in being part of this study?

Yes  No

Permission to interview GP
Can I contact your usual GP to invite them to be interviewed?
I will not identify you when I am speaking with them.

Yes  No

If Yes: Obtain GP’s name, practice name and location.

Health resource
Would you like a copy of a resource I have developed containing information and referral resources?

Yes  No
GPs’ Initial Interview Schedule

Name __________   Preferred Pseudonym __________   Interview Date ________

Before starting the tape
Plain language statement   Demographics survey - completed
Consent form   Permission for audio-taping

Introduction
I am interested in GPs’ experience of seeing same-sex attracted women in their practice.
I am aiming to interview a number of same-sex attracted women and GPs separately.
I hope to create some guidelines for GPs in this area, and help women to know how to get
the most out of seeing their GP.

Anything you would like to ask about the project overall?
How long have they got today – finish time?

Opening Question – the general practice
What sort of practice do you work in? Including going through the survey briefly with
them
  - range of patients seen, % of women, estimate of SSA women, practice type,
  - do you have many long-term patients
  - how well do you know your regular patients

How do you think your patients perceive your practice/your style as a doctor?
  - what do expect or hope for from your patients? What would you want as a patient?
  - how well do you think your patients know you? Is this important?
  - [- who do you think should make decisions about your patients’ health- you/her/
    shared between you]
  - [- what is your opinion of your patients seeing other health care providers]
  - how do you help your patients build their trust in you
**Seeing SSA women [start here if the GP has little time]**

How do you think a same-sex attracted woman would feel as a patient in your practice, including in the waiting room, with the receptionists?

Do you know what the receptionists attitudes are towards lesbian/bisexual patients?

Do you know anything about the attitudes of the other doctors in your practice?

Can you tell me about a time when you saw a same-sex attracted/lesbian/bisexual woman?

- how did you know she was lesbian/bi -if negative experience – what would have improved it
- do you think you met her needs
- how did you feel when you were seeing her
- is your gender important, your sexuality, have your experiences changed over time- how

If no known experience:

Comments on two vignettes – a lesbian attending for a Pap smear and woman with a same-sex partner attending for donor insemination access advice

**Disclosure**

Do you think it is important for you to know your female patients’ sexual orientation?

When, why, relevance

- assumptions – have you ever assumed a woman was lesbian- why, does her appearance/manner influence you?
- medical notes and referral letters- do you record the sexual orientation
- have you ever asked, what happened
- is sexual orientation relevant to her health care

Do you think some women want you to know their sexual orientation? Why?

- has anyone disclosed to you, what happened, how did you feel
- would you expect a lesbian to tell you about her sexuality or not to tell, would you hope that she would tell you
- have you ever been surprised when told – what situations would be a surprise
- do you have an understanding of the meaning of lesbian/bi identity to these women

Consequence/outcome of disclosure/non-disclosure? For her / you / health care / pt-dr rel.

Social Environment
What do think the public attitude is about women who are not heterosexual?
- now, in the past, changes, the laws, rural/urban, older/younger people

What are your beliefs about the underlying basis of lesbian sexual orientation?
What has influenced your understanding of lesbian/bisexual culture/identity?
Have your own lesbian patients had any influence on your knowledge or awareness?
Do you know anyone in your own life who is non-heterosexual? Friends / family / colleagues
Are you aware of their experience of social attitudes?

How does being non-heterosexual affect women’s health?

What is your understanding of the influence of discrimination on health for non-heterosexual women Can you give an example?
- do you have a role in advocacy for patients in general / who have experienced discrimination - examples
- have you had any experience of discrimination in your own life? Has that influenced the way you practice?

Close
Why did you decide to participate in the interview?
Has participating changed anything for you?
Is there anything you could change to improve your practice for non-heterosexual women? - within the practice environment, personally
Is there anything else you would like to say/add?
How do you feel having talked about these issues?

**Post interview after turning off the audiotape recorder**
Invitation to contact me if you would like to add something.
Can I contact you when transcribing to clarify an issue
    Yes    No
Would you like to read the transcript and have opportunity to comment and suggest changes?    Yes    No

**Follow up**
Would you like to participate in a follow-up interview to hear about the early findings?
    Yes    No

**Other contacts**
Can you think of anyone else who may be interested in being part of this study?
    Yes    No

**Non-heterosexual women’s health resource**
Would you like a copy of a resource I have developed containing information and referral resources?    Yes    No

A copy of Gay and Lesbian Health Victoria waiting room poster?    Yes    No
APPENDIX 5 – CODING FRAMEWORK

The codes that I present here represent the final coding tree after allocation of codes to all transcripts.

Codes For Same-sex Attracted Women

Some of the codes were derived from the literature:
* Continuum of provider responses by Saulnier et al (2002)
** Patient-centred characteristics within Mead and Bower (2000)

<table>
<thead>
<tr>
<th>Preferred gender of GP</th>
<th>Expectations of GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefer female</td>
<td>Type of care- physical,</td>
</tr>
<tr>
<td>Prefer male</td>
<td>emotional, holistic²</td>
</tr>
<tr>
<td>No preference</td>
<td>Knowledge of lesbian health</td>
</tr>
<tr>
<td>Preferred sexuality of GP</td>
<td>Professionalism³</td>
</tr>
<tr>
<td>Prefer lesbian or gay</td>
<td>Attitudes⁴</td>
</tr>
<tr>
<td>Prefer straight</td>
<td>Increasing the breadth⁵</td>
</tr>
<tr>
<td>No preference</td>
<td>Advocacy⁶ - Dr or Pt initiated</td>
</tr>
<tr>
<td>Knowing GP sexual orientation</td>
<td>Shared decision making</td>
</tr>
</tbody>
</table>

Reasons for gender preference

<table>
<thead>
<tr>
<th>Reasons for gender preference</th>
<th>Patient directed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female – connection, embodiment</td>
<td>What influences the expectations</td>
</tr>
<tr>
<td>Male – boundaries</td>
<td>Own profession- health, other</td>
</tr>
<tr>
<td>Positive attitude to lesbians</td>
<td>Lifestage</td>
</tr>
</tbody>
</table>

General attitudes to GPs

<table>
<thead>
<tr>
<th>General attitudes to GPs</th>
<th>Own coming out experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Past experience with GP</td>
</tr>
<tr>
<td>Negative</td>
<td>Past experience with specialist</td>
</tr>
</tbody>
</table>

Experience of GP system

<table>
<thead>
<tr>
<th>Experience of GP system</th>
<th>Women’s assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial – as barrier, as control</td>
<td>Health care needs</td>
</tr>
<tr>
<td>Access – distance</td>
<td></td>
</tr>
<tr>
<td>Appointments - waiting</td>
<td>Having regular GP</td>
</tr>
<tr>
<td>Choice of GP</td>
<td>Using GPs⁷</td>
</tr>
<tr>
<td>Time</td>
<td>Willing to travel</td>
</tr>
</tbody>
</table>

Experience of seeing GPs

<table>
<thead>
<tr>
<th>Experience of seeing GPs</th>
<th>Triggers to needing regular GP</th>
</tr>
</thead>
</table>

² Dealing with everything – social, psych, spiritual, physical
³ e.g. ‘professional’, ethical, confidential
⁴ E.g. ‘will be non-judgemental’, ‘might not approve of lesbians’
⁵ The GP will explore more than what the person presents with
⁶ GP will speak up for pt needs e.g. with specialist, with lawyer, write a letter of support
⁷ Seeing GPs for a service only e.g. Medical certificate, pragmatic
| Good experience | Finding usual GP\(^8\) -friend, |
| Bad experience | choice, family, chance |
| Changes with time | Relationship lacking\(^9\) |

**Partner and GP**
- Non attendance
- Prefer same GP as partner
- GP knowing medical history
- Prefer different GP to partner
- Convenience over continuity
- Attend GP with/without partner
- Continuity important

---

**Current and past GP experiences**

<table>
<thead>
<tr>
<th>Pt-Dr Relationship</th>
<th>Clinic environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boundaries-who sets, why</td>
<td>Receptionists</td>
</tr>
<tr>
<td>Continuity</td>
<td>Other doctors</td>
</tr>
<tr>
<td>Trust Pt to Dr</td>
<td>Representations of diversity</td>
</tr>
<tr>
<td>Trust Dr to Pt</td>
<td>Overt signs of acceptance</td>
</tr>
<tr>
<td>Knowing Pt re Dr(^10)</td>
<td>Family environment</td>
</tr>
<tr>
<td>Knowing Dr re Pt(^11)</td>
<td>Neutral</td>
</tr>
<tr>
<td>Friendship (connection***)</td>
<td>Not noticed</td>
</tr>
<tr>
<td>Professional relationship</td>
<td>Medical</td>
</tr>
<tr>
<td>Intimacy</td>
<td></td>
</tr>
<tr>
<td>Dynamic (changes with time)</td>
<td></td>
</tr>
<tr>
<td>Reciprocity (mutual sharing/care)</td>
<td>Non-verbal, listening**, explains</td>
</tr>
<tr>
<td>Transference</td>
<td>Genuine interest, gives time**</td>
</tr>
<tr>
<td>Control/Agency</td>
<td>Understanding</td>
</tr>
<tr>
<td>Power (sharing***)(^12)</td>
<td>Caring empathy***</td>
</tr>
<tr>
<td>Termination</td>
<td>Perceptive/Intuitive**</td>
</tr>
<tr>
<td>Honesty</td>
<td></td>
</tr>
<tr>
<td>Rapport</td>
<td></td>
</tr>
<tr>
<td><strong>GP attributes valued</strong></td>
<td></td>
</tr>
<tr>
<td>Good communication</td>
<td></td>
</tr>
<tr>
<td>Positive attitudes/values</td>
<td></td>
</tr>
<tr>
<td><strong>GP attributes disliked</strong></td>
<td>Engages Pt agenda**</td>
</tr>
<tr>
<td>Poor communication</td>
<td>Knowing context(^13)**</td>
</tr>
<tr>
<td>Insensitive</td>
<td>Non judgemental</td>
</tr>
<tr>
<td>Dismissive</td>
<td>Respectful</td>
</tr>
<tr>
<td>Doesn’t listen</td>
<td>Honest</td>
</tr>
<tr>
<td>Make assumptions</td>
<td>Competence</td>
</tr>
<tr>
<td>Time poor</td>
<td>Up to date</td>
</tr>
<tr>
<td>No people skills</td>
<td>Open to wide range of treatments</td>
</tr>
<tr>
<td>Negative attitudes/values-not humane</td>
<td>Thorough</td>
</tr>
<tr>
<td>Lack respect</td>
<td>Follow up**</td>
</tr>
<tr>
<td>Breaks confidentiality</td>
<td>Remembers</td>
</tr>
</tbody>
</table>

---

\(^8\) How they started seeing GP – e.g. via a friend
\(^9\) Not having a usual GP – reasons, outcomes
\(^10\) How well does the woman know her GP
\(^11\) How well does the doctor know the patient (from women’s perspective)
\(^12\) e.g. shared decision making or not
\(^13\) i.e. woman’s social context – family, culture, sexual orientation
| Judgemental | Would find out if didn’t know |
| Stuffy/old fashioned | **Humanity** |
| Arrogant | Personal |
| Poor boundaries | Funny |
| **Incompetence** | Balanced, well rounded |
| Lack of knowledge | Relaxed |
| Cursory | Comfortable |
| **Lack humanity** | |
| No empathy | **Wishlist of ideal GP** |
| Arrogant | Applies to own GP |

**Disclosure**

<table>
<thead>
<tr>
<th>Actual GP reactions to disclosure</th>
<th>Expected GP reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pathologise</strong></td>
<td></td>
</tr>
<tr>
<td>GP Embarrassment</td>
<td>Positive</td>
</tr>
<tr>
<td>Homophobia*</td>
<td>Negative</td>
</tr>
<tr>
<td>Negative GP reaction</td>
<td>Unsure of possible reaction</td>
</tr>
<tr>
<td>GP Uncomfortable</td>
<td>Conceal negative attitude</td>
</tr>
<tr>
<td><strong>Minimise</strong></td>
<td></td>
</tr>
<tr>
<td>Forgetting</td>
<td>Why GP should know</td>
</tr>
<tr>
<td>Neutral/no reaction to minimise</td>
<td>Relevance to health</td>
</tr>
<tr>
<td>Heterosexism*</td>
<td>Coming out issues</td>
</tr>
<tr>
<td>Silence</td>
<td>Sexual health/physical health issues</td>
</tr>
<tr>
<td>Never raised or made relevant</td>
<td>Understand context/person</td>
</tr>
<tr>
<td><strong>Normalise</strong></td>
<td></td>
</tr>
<tr>
<td>Acknowledgment</td>
<td>Why GP not told</td>
</tr>
<tr>
<td>Positive reaction</td>
<td>Don’t know why – no reason</td>
</tr>
<tr>
<td>Neutral as a positive reaction</td>
<td>Risk (judged/rejected/to pt-dr rel.)</td>
</tr>
<tr>
<td>Tolerance*</td>
<td>To avoid stereotyping</td>
</tr>
<tr>
<td>Sensitive*</td>
<td>Confidentiality</td>
</tr>
<tr>
<td>Affirming*</td>
<td>Lack relevance (no need)</td>
</tr>
<tr>
<td><strong>Disclosure method</strong></td>
<td></td>
</tr>
<tr>
<td>GP told or not</td>
<td>Lack rapport/trust</td>
</tr>
<tr>
<td>GP asked or not</td>
<td>Assumption of heterosexuality</td>
</tr>
<tr>
<td>GP already knew/guessed</td>
<td>To protect GP</td>
</tr>
<tr>
<td>Prefer GP ask Pt</td>
<td>Race, ethnicity issue</td>
</tr>
<tr>
<td>Prefer Pt tell GP</td>
<td>Gender/age/race of GP</td>
</tr>
<tr>
<td><strong>Disclosure timing</strong></td>
<td></td>
</tr>
<tr>
<td>At beginning of GP relationship</td>
<td>Conflict avoidance</td>
</tr>
<tr>
<td>Later in GP relationship</td>
<td>GP responsibility (not asked)</td>
</tr>
<tr>
<td><strong>Disclosure context</strong></td>
<td></td>
</tr>
<tr>
<td>Related to partner</td>
<td>Pt-Dr relationship – end, improved</td>
</tr>
<tr>
<td>Related to a crisis</td>
<td>Partner involvement</td>
</tr>
<tr>
<td>When comfortable with sexual</td>
<td>Authenticity</td>
</tr>
<tr>
<td></td>
<td>Openness to say anything</td>
</tr>
<tr>
<td>orientation</td>
<td>Health care – worse/better</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>When coming out/questioning</td>
<td></td>
</tr>
<tr>
<td>When asked general history</td>
<td>Mental health – worse/better</td>
</tr>
<tr>
<td>When comfortable with GP</td>
<td>Satisfaction/comfort</td>
</tr>
<tr>
<td>Sexual health issue</td>
<td>Discomfort</td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td></td>
</tr>
<tr>
<td>Medical notes</td>
<td>Support and acceptance/lack</td>
</tr>
<tr>
<td>Referral letters</td>
<td>Question identity</td>
</tr>
<tr>
<td>Intake forms</td>
<td>Advice appropriate/inappropriate</td>
</tr>
<tr>
<td><strong>Disclosure modifiers</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Disclosure to GP versus other</strong></td>
<td>Safety with GP</td>
</tr>
<tr>
<td>Consistent</td>
<td>Sexual identity experience</td>
</tr>
<tr>
<td>Inconsistent</td>
<td>Protecting others</td>
</tr>
<tr>
<td></td>
<td>Internalised homophobia</td>
</tr>
<tr>
<td></td>
<td>Fear of negative reaction</td>
</tr>
</tbody>
</table>

| **Sexual identity**                  |                                    |
| **Identity experience**              |                                    |
| Defined (social with lesbians)       | Partner                            |
| Integrated (social with L & Het)     | Being single                       |
| Peripheral/ Minimal (social w. het)  | Family                             |
| Isolation (no social network)        | Social                             |
| Confusion                            | Friends                            |
| Guilt about identity                 | Lifestage                           |
| Attraction predominates              | Health care provider               |
| Behaviour predominates               | Political e.g. feminism            |
| Fluid                                | Apolitical/personal                |
| Static                               | Race, ethnicity                    |
| Denial to self                       | Gender ideas/impact                |
| Multiple identities                  | Anti-label/anti-stereotype         |
| **Identity expression**             | Confidence/self esteem/lack        |
| Public/visible                       | Belief is inherent                 |
| - Honesty                            | Belief is a choice                 |
| Private/invisible                    | Outsider status                    |
| - Silence                            | Connections with lesbian scene     |
| - Façade                             | Same as anyone else                |
| - Secrecy/hiding                     | Assumptions about sexual identity  |

14 The personal or internal sexual self-identity relative to other areas (Fingerhut et al, 2005).
15 Being lesbian is central ‘core’
16 E.g. has no partner but still identifies as lesbian, or female partner defines her identity
17 Level of importance varies with the situation, or identity experience varies over time
18 Public identity
19 ‘I realised who I really am’, born this way
20 Had been ‘living a lie’ George
21 Keeps were lesbian identity to herself (some regard this as hiding), some do this for greater public acceptance
Passive Appearance
Selective Activities and interests

Social connections Manner
Heterosexual Sexualised
Lesbian and heterosexual Stereotypes
Lesbian and bisexual women
Women more than men

Social Environment

<table>
<thead>
<tr>
<th>Social attitudes</th>
<th>Personal experiences of attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative - stigma</td>
<td>Family - silence, reject, accept</td>
</tr>
<tr>
<td>Positive</td>
<td>Children</td>
</tr>
<tr>
<td>Improving</td>
<td>Friends</td>
</tr>
<tr>
<td>Not improving</td>
<td>Neighbours</td>
</tr>
<tr>
<td>Lesbians vs. gay men vs. bisexuals</td>
<td>Work</td>
</tr>
<tr>
<td>Promiscuity/sexualised</td>
<td>Partner</td>
</tr>
<tr>
<td></td>
<td>Strangers</td>
</tr>
</tbody>
</table>

Influences on social attitudes

<table>
<thead>
<tr>
<th>Experience</th>
<th>Systemic discrimination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media</td>
<td>Health effects of being Same-sex attr.</td>
</tr>
<tr>
<td>Location</td>
<td>Positive</td>
</tr>
<tr>
<td>Age, generation</td>
<td>Negative</td>
</tr>
<tr>
<td>Gender</td>
<td>Physical, sexual, emotional</td>
</tr>
<tr>
<td>Religion</td>
<td>Partner-related</td>
</tr>
<tr>
<td>Ethnicity/culture</td>
<td>Effects not recognised</td>
</tr>
<tr>
<td>Political</td>
<td>Isolation/social exclusion</td>
</tr>
<tr>
<td>Other minority</td>
<td>Self doubt</td>
</tr>
<tr>
<td>Exposure: Celebrities, role models</td>
<td>No health effects- personal, general</td>
</tr>
<tr>
<td>Education</td>
<td>Discrimination – physical, emotional, health care effects, vigilance/fear</td>
</tr>
</tbody>
</table>

Impact of involvement in Dialog

<table>
<thead>
<tr>
<th>Effect of interview</th>
<th>Health and wellbeing history</th>
</tr>
</thead>
<tbody>
<tr>
<td>On identity</td>
<td>Depression</td>
</tr>
<tr>
<td>On disclosure</td>
<td>Anxiety/stress</td>
</tr>
<tr>
<td>Therapeutic</td>
<td>Physical illness</td>
</tr>
<tr>
<td>No effect on planned behaviour</td>
<td>Drug or alcohol history</td>
</tr>
<tr>
<td>Increased likelihood of disclosure</td>
<td>Intimate partner abuse</td>
</tr>
<tr>
<td>Chance to reflect</td>
<td>female partner, male partner</td>
</tr>
</tbody>
</table>

22 ‘different faces’ Kirsti
23 What do they think the current social attitudes towards lesbian and bi women are?
<table>
<thead>
<tr>
<th>Reasons to participate</th>
<th>perpetrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help others/share GP experiences</td>
<td></td>
</tr>
<tr>
<td>Knowledge gathering</td>
<td>Confidentiality</td>
</tr>
<tr>
<td>Inquisitive</td>
<td>Self Care</td>
</tr>
<tr>
<td>Belief in research</td>
<td>Guidelines</td>
</tr>
<tr>
<td>Did not think could help</td>
<td>For GPs</td>
</tr>
<tr>
<td>Trust researcher</td>
<td>For same-sex attracted women</td>
</tr>
</tbody>
</table>
Codes for GPs

Many of the codes are the same as the women’s codes, however a few are unique.
Some of the codes are derived from the literature:
** Habermas Theory of Communicative Action (1972)

Practice Style

<table>
<thead>
<tr>
<th>Expectations of own role</th>
<th>Clinic environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>For whole person care –integrated*</td>
<td>Receptionists</td>
</tr>
<tr>
<td>For family</td>
<td>Other doctors</td>
</tr>
<tr>
<td>Mutual agendas**</td>
<td>Representations of diversity</td>
</tr>
<tr>
<td>Type of care- physical, emotional</td>
<td>Overt signs of acceptance</td>
</tr>
<tr>
<td>Advocacy24- Dr or Pt initiated</td>
<td>Family environment</td>
</tr>
<tr>
<td>Knowledge of lesbian health</td>
<td>Neutral</td>
</tr>
<tr>
<td>Professionalism25</td>
<td>Medical</td>
</tr>
<tr>
<td>Shared decision making</td>
<td>Influences on own style/attitudes</td>
</tr>
<tr>
<td>Patient directed</td>
<td>Gender/ Age</td>
</tr>
</tbody>
</table>

Other health care providers
- Sexual orientation
- Own past history – health, social
- Experience in practice

Self care
- Medical education
- Patients

How perceived as a doctor

<table>
<thead>
<tr>
<th>Pt-Dr Relationship</th>
<th>GP attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boundaries-who sets, why</td>
<td>Good communication</td>
</tr>
<tr>
<td>Continuity</td>
<td>Non-verbal, listening**, explains</td>
</tr>
<tr>
<td>Trust Pt to Dr</td>
<td>Genuine interest, gives time**</td>
</tr>
<tr>
<td>Trust Dr to Pt</td>
<td>Understanding</td>
</tr>
<tr>
<td>Knowing Pt re Dr26</td>
<td>Caring empathy***</td>
</tr>
<tr>
<td>Knowing Dr re Pt27</td>
<td>Perceptive/ Intuitive**</td>
</tr>
<tr>
<td>Friendship (connection***</td>
<td>Positive attitudes/values</td>
</tr>
<tr>
<td>Professional relationship</td>
<td>Shared decision making**</td>
</tr>
<tr>
<td>Intimacy</td>
<td>Engages Pt agenda**</td>
</tr>
</tbody>
</table>

24 GP will speak up for patient needs e.g. with specialist, with lawyer, write a letter of support
25 e.g. ‘professional’, ethical, confidential
26 How well does the woman know her GP
27 How well does the doctor know the patient (from GP perspective)
Dynamic (changes with time)  Knowing context
Reciprocity (mutual sharing/care)  Non judgemental
Transference  Respectful
Control/Agency  Honest
Power (sharing***)
Termination  Up to date
Honesty  Open to wide range of treatments
Rapport  Thorough
**Reciprocity (mutual sharing/care)**
Non judgemental
Transference  Respectful
Control/Agency  Honest

**GP expectations of patients**
Follow up**
Remembers
Would find out if didn’t know

**Termination**
Honesty  Open to wide range of treatments
Rapport  Thorough

**Honesty**
Would find out if didn’t know

**Rapport**
Thorough

**Honesty**
Open to wide range of treatments

**Dynamic (changes with time)**
Knowing context

<table>
<thead>
<tr>
<th><strong>GP expectations of patients</strong></th>
<th><strong>Why GP should know</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pathologise</strong></td>
<td>Relevance to health</td>
</tr>
<tr>
<td>GP Embarrassment</td>
<td>Coming out issues</td>
</tr>
<tr>
<td>Homophobia*</td>
<td>Sexual health/physical health issues</td>
</tr>
<tr>
<td>Negative GP reaction</td>
<td>Understand context/ person</td>
</tr>
<tr>
<td>GP Uncomfortable</td>
<td>Holistic care</td>
</tr>
<tr>
<td><strong>Minimise</strong></td>
<td>To avoid assumptions</td>
</tr>
<tr>
<td>Forgetting</td>
<td>Don’t know why – no reason</td>
</tr>
<tr>
<td>Neutral/ no reaction to minimise</td>
<td>GP barriers to asking</td>
</tr>
<tr>
<td>Heterosexism*</td>
<td><strong>Attitudinal barriers</strong></td>
</tr>
<tr>
<td>Silence</td>
<td>Intrusive, ‘none of my business’</td>
</tr>
<tr>
<td>Never raised or made relevant</td>
<td>Assumptions of heterosexuality</td>
</tr>
<tr>
<td><strong>Normalise</strong></td>
<td><strong>Educational barriers</strong></td>
</tr>
<tr>
<td>Acknowledgment</td>
<td>Over stigmatisation</td>
</tr>
<tr>
<td>Positive reaction</td>
<td></td>
</tr>
<tr>
<td>Neutral as a positive reaction</td>
<td></td>
</tr>
<tr>
<td>Tolerance*</td>
<td>Lack knowledge</td>
</tr>
<tr>
<td>Sensitive*</td>
<td>Lack skills (e.g. how to ask)</td>
</tr>
<tr>
<td>Affirming*</td>
<td>Lack relevance</td>
</tr>
<tr>
<td></td>
<td>Sexualisation</td>
</tr>
</tbody>
</table>

28 i.e. woman’s social context – family, culture
29 e.g. shared decision making or not
30 Would only ask when topic is sex
<table>
<thead>
<tr>
<th>Disclosure method</th>
<th>Habitual silence – not considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP told or not</td>
<td>Personal barriers</td>
</tr>
<tr>
<td>GP asked or not</td>
<td>Fear of offending</td>
</tr>
<tr>
<td>GP already knew/guessed</td>
<td>Embarrassment – should know</td>
</tr>
<tr>
<td>Prefer GP ask Pt</td>
<td>Avoid seeming judgemental</td>
</tr>
<tr>
<td>Prefer Pt tell GP</td>
<td>Own culture/ethnicity/age/gender</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disclosure timing</th>
<th>System barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>At beginning of GP relationship</td>
<td>Sexual boundaries</td>
</tr>
<tr>
<td>Later in GP relationship</td>
<td>Time restriction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disclosure context</th>
<th>Patient related barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related to partner</td>
<td>Evasive /pt doesn’t raise SO</td>
</tr>
<tr>
<td>Related to a crisis</td>
<td>Pt would be offended to be asked</td>
</tr>
<tr>
<td>When comfortable with SO</td>
<td>Lack rapport</td>
</tr>
<tr>
<td>When coming out/questioning</td>
<td>Age extremes</td>
</tr>
<tr>
<td>When asked general history</td>
<td></td>
</tr>
<tr>
<td>When comfortable with GP</td>
<td>Experience of seeing SSA women</td>
</tr>
<tr>
<td>Sexual health issue</td>
<td>Awareness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disclosure consequences</th>
<th>Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pt-Dr relationship – end, improved</td>
<td>Knowledge</td>
</tr>
<tr>
<td>Partner involvement</td>
<td>Own gender</td>
</tr>
<tr>
<td>Authenticity</td>
<td>Own sexual orientation</td>
</tr>
<tr>
<td>Openness to say anything</td>
<td></td>
</tr>
<tr>
<td>Health care – worse/better</td>
<td>Medical notes</td>
</tr>
<tr>
<td>Mental health – worse/better</td>
<td>Referral letters</td>
</tr>
<tr>
<td>Satisfaction/comfort</td>
<td>Intake forms</td>
</tr>
<tr>
<td>Discomfort</td>
<td>Sensitive areas similar to sexual orient.</td>
</tr>
<tr>
<td>Support and acceptance/lack</td>
<td>Physical issues</td>
</tr>
<tr>
<td>Question identity</td>
<td>Sexual issues</td>
</tr>
<tr>
<td>Advice appropriate/inappropriate</td>
<td>Emotional issues</td>
</tr>
<tr>
<td></td>
<td>Lifestyle/cultural/lifestage</td>
</tr>
</tbody>
</table>

## Social environment

<table>
<thead>
<tr>
<th>Social attitudes</th>
<th>Influences on personal attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative - stigma</td>
<td>Family of origin</td>
</tr>
<tr>
<td>Positive</td>
<td>Children</td>
</tr>
<tr>
<td>Improving</td>
<td>Friends</td>
</tr>
<tr>
<td>Not improving</td>
<td>Neighbours</td>
</tr>
<tr>
<td>Lesbians vs. gay men vs. bisexuals</td>
<td>Work</td>
</tr>
<tr>
<td>Promiscuity/sexualised</td>
<td>Partner</td>
</tr>
</tbody>
</table>

| Influences on social attitudes | Experiences of discrimination |

---

31 What do they think the current social attitudes towards lesbian and bi women are?
<table>
<thead>
<tr>
<th>Experience</th>
<th>Culture/ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Media</td>
<td>GP attitudes to SSA women</td>
</tr>
</tbody>
</table>
| Location   | Age, generation  | Same as other women 
| Gender     | Different health issues  |
| Religion   | Different lifestyle issues  |
| Ethnicity/culture | Homophobic   |
| Political  | Pathologise      |
| Other minority | Normalise       |
| Exposure: Celebrities, role models | Should keep SO private |
| Education  |                  |

**Sexual identity**

<table>
<thead>
<tr>
<th>Assumptions about sexual identity</th>
<th>Health effects of being Same-sex attr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Positive</td>
</tr>
<tr>
<td>Activities and interests</td>
<td>Negative</td>
</tr>
<tr>
<td>Manner</td>
<td>Physical, sexual, emotional</td>
</tr>
<tr>
<td>Sexualised</td>
<td>Partner-related</td>
</tr>
<tr>
<td>Stereotypes</td>
<td>Effects not recognised</td>
</tr>
<tr>
<td><strong>Understanding of identity experience</strong></td>
<td>Isolation/social exclusion</td>
</tr>
<tr>
<td>Defining</td>
<td>Self doubt</td>
</tr>
<tr>
<td>Integrated</td>
<td>No health effects- personal, general</td>
</tr>
<tr>
<td>Peripheral/ Minimal</td>
<td>Discrimination – physical, emotional, health care effects, vigilance/fear</td>
</tr>
</tbody>
</table>

| Isolation (no social network)    | **Belief in cause of female homosexuality** |
| Confusion                       | Genetic                               |
| Attraction/Behav predominates    | Hormonal                              |
| Fluid                           | Environmental                         |
| Static                          | Choice                                |
|                                 | Innate                                |
|                                 | Unknown                               |

**Impact of involvement in Dialog**

<table>
<thead>
<tr>
<th>Effect of interview</th>
<th>Reasons to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>On GP understanding</td>
<td>Help others</td>
</tr>
<tr>
<td>On facilitating disclosure</td>
<td>Knowledge gathering</td>
</tr>
<tr>
<td>No effect on planned behaviour</td>
<td>Inquisitive</td>
</tr>
<tr>
<td>Chance to reflect</td>
<td>Belief in research</td>
</tr>
</tbody>
</table>

---

32 Should treat everyone the same, just people
<table>
<thead>
<tr>
<th>Guidelines</th>
<th>Did not think could help</th>
</tr>
</thead>
<tbody>
<tr>
<td>For GPs</td>
<td>Trust researcher</td>
</tr>
<tr>
<td>For same-sex attracted women</td>
<td>Own patient involved</td>
</tr>
<tr>
<td></td>
<td><strong>Self Care</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Confidentiality issues</strong></td>
</tr>
</tbody>
</table>
APPENDIX 6 – DISSEMINATION

I will present a summary of the various methods of dissemination of my study findings that I have completed and planned. This process will continue over the next few months and involves the following methods:

1. Study website.
2. List of professional conference presentations including abstracts.
3. List of community presentations.
4. List of academic publications.
6. Grant for the development of GP guidelines on the sensitive care of lesbian and bisexual women.

Website

I created the website very early in the study for two purposes: a) to inform consumers and health care providers of key issues in lesbian and bisexual women’s health, and b) to outline the Dialog study and disseminate findings. As of the end of March 2009, the site has had 3,418 unique users. I have displayed the home page of the website at Figure 6. The sections in the health area of the website are sexual orientation & coming out; health issues; fertility, pregnancy & parenting issues; guidelines for health care; resources and support; research; and links. The sections in the study area are summary and aims, advisory group, progress, findings, presentations and papers, McNair publications, and links. The URL for the website is www.dialog.unimelb.edu.au.
Figure 6 - Home page for the study website

Health & health care for lesbian, bisexual and same sex attracted women

Women who are lesbian, bisexual and same sex attracted (SSA) have some unique and important health issues and health care needs. This site is dedicated to providing information about these issues and needs from an Australian perspective for women, for health care providers and for health researchers. Research about the health of these women can be difficult to access. This site showcases one Australian research project (DIALOG) on the experiences of general practice care, as well as providing links to other research.

Lesbian, bisexual and SSA women’s health

Health issues for lesbian, bisexual and SSA women particularly include those related to specific lifestyles, and the health effects of living in a world that can be homophobic or can assume that every woman is heterosexual.

DIALOG PhD project

DIALOG (disclosure and attitudes towards lesbians: outcomes in general practice) is an interview-based study exploring the patient-doctor relationship between lesbian, bisexual and SSA women and their GP from both perspectives.

About Ruth McNair – the site author

Ruth is a general practitioner in Carlton, specialising in lesbian and women’s health. She is also a Senior Lecturer at the Department of General Practice, University of Melbourne. She is currently undertaking the DIALOG PhD research project. She is a member of several Victorian government advisory committees on lesbian health. She was the founding Convener of the Fertility Access Rights Lobby from 1999 to 2004. She is immediate past Convener of the Australian Lesbian Medical Association from 2001-2005.
Professional Conferences

Presented

I have presented study findings to health care professional and research communities at nine conferences. I will list each conference and then provide their abstracts. The first three conferences were presentations from my previous study on lesbian parents negotiating the health care system, which was a precursor to the current study.

Title: Lesbian parents negotiating the health care system: control and safety.

Title: Lesbian parents negotiating the health care system: implications for policy and practice.

Title: Lesbian and gay parenting in the public space: supporting a creative force for change.

Title: Effective patient-doctor relationships: a right or a privilege.

Title: Professional relationships between GPs and same-sex attracted women.

6. Royal Australian College of GPs Annual Scientific Convention, Brisbane, 5-8 October 2006.  
Title: Giving voice to the silence: researching the professional relationships between GPs and same-sex attracted women.

I received the Alan Chancellor Medal for Best First Presenter for this paper.

Title: The Socio-Political Climate, Identity And Disclosure In Health Care For Same-sex Attracted Women.

   Title: General practice guidelines for culturally competent care of lesbian, gay and bisexual (LGB) patients.

   Title: In-practice advocacy for sexual minority women: a good idea in theory.

Abstracts

1. National Women’s Health Conference, 2005
Title: Lesbian parents negotiating the health care system: control and safety
Authors: Dr Ruth McNair, Rhonda Brown, Amaryll Perlesz

Lesbian-parented families have unique healthcare concerns and have been under-researched to date. We present findings from a qualitative research study in which 20 lesbian-parented families were interviewed about their public and private worlds. This paper will particularly examine the health care experiences of these families. Experiences of the health care bureaucracy were largely difficult, with participants facing inflexibility and lack of recognition of their family structure. Experiences with individual health care providers were more positive. Many had found providers to be approachable, caring and interested in their family, and welcomed the opportunity to educate providers. The most difficult situation faced was the silencing of the non-birth mother within the health care setting at all levels.

Almost all parents described their strategies for disclosure of their sexual orientation and family structure when interfacing with the health care system. Disclosure for lesbian families is different than for individual lesbians. The potential repercussions of disclosure become more salient when the children may be affected, and while it may be an option for single or even coupled lesbians to avoid or delay health care to minimise negative
reactions, this is not possible when it concerns a child’s health. Avoidance of disclosure is also not ideal if the non-birth mother is to have a recognised place in the health care of her child/ren. We found four distinct approaches to disclosure by lesbian parents within the health system. Our findings indicate that most lesbian parents made very active decisions regarding disclosure, whether they chose to disclose or not. The level of satisfaction with health care seems to relate, in part, to the level of control parents had over their disclosure, rather than to disclosure itself.

2. General Practice and Primary Health Care Conference, 2005
Title: Lesbian parents negotiating the health care system: implications for policy and practice
Authors: McNair, Brown, Perlesz, Lindsay, De Vaus, Pitts

Objectives
This study explored how lesbian parents and their families experience public systems including primary health care.

Methods
Twenty 20 lesbian-parented families in Victoria participated in an in-depth interview lasting up to 5 hours. The interviews were analysed by a multi-disciplinary research team using a grounded theory approach.

Principal findings
Experiences of the health care bureaucracy were largely difficult, with participants facing inflexibility and lack of recognition of their family structure, whereas individual health care providers were often described as approachable, caring and interested in their family. The most difficult situation faced was the silencing of the non-biological mother within the health care setting at all levels. Almost all parents described their strategies for disclosure of their sexual orientation and family structure. Most made very active decisions regarding disclosure, whether they chose to disclose or not.

Discussion
There is international evidence that most lesbians would prefer to disclose their family structure to their primary care provider if at all possible, however we have found that
some did not wish to disclose. The level of satisfaction with health care seemed to relate, in part, to the level of control parents had over their disclosure, rather than to disclosure itself.

*Implications for policy, delivery or practice*

This study provides rich evidence for the need to improve the health care system to incorporate diverse population groups such as lesbians. In particular, policy is currently almost silent on lesbian health and lesbian families, despite significant health disparities within this group. Primary health care practice can be improved by recognising diverse family structures on practice forms and within consultations. Providers need to include the non-biological mother in decision making if desired by the parents.


Title: Lesbian and gay parenting in the public space: supporting a creative force for change

Over the last decade there has been a growing visibility of the reality of lesbian and gay parented families. Access to fertility services for lesbians, adoption for lesbians and gay men, and surrogacy for gay men have been the subject of at times fierce public debate, with the Victorian Equal Opportunity Commission finding it 'the most contentious of all issues’ in 1998. Even within some areas of the lesbian and gay community, parenting has been marginalised. I will present the perspective of these parents and their children. How they respond to being political scapegoats, to the lack of recognition of non-birth parents, to the public scrutiny of their lives. There is no doubt that being change agents creates stress and vulnerability for these parents. For example, lesbian and gay parents are intensely protective of their children, not wanting to subject them to negative attitudes. I will then focus on the implications of this context for the health care professions including psychology. How do we create a safe environment for these families, maintaining their dignity and self-determination? We have a role in supporting the change agents so that they can continue to be a creative force in our society.
Findings from an Australian interview-based PhD study of same-sex attracted women and their general practitioners will be presented.

Study background:
The Australian primary care context is centred around contact with a regular general practitioner (GP). The GP provides care to individuals and families, coordination of care in the community and referral to specialist medical care. Therefore, the effectiveness of the patient-GP relationship is crucial to the quality of health care delivered and received. Australian lesbian and bisexual women, when compared with heterosexual women, are shown to have experienced higher levels of abuse, are more likely to use illicit drugs and to suffer with depression and anxiety. Much of this difference relates to homophobic societal pressures. So, these women have pressing needs for a GP that they trust and can be open with about their sexual orientation. While Northern American and UK studies reveal that lesbians and bisexual women are less likely to attend primary care and have lower levels of satisfaction, this has not been studied to date in Australia.

Method:
In-depth semi-structured interviews were conducted with a wide range of same-sex attracted women in rural and urban locations. With the participants’ permission, their usual GPs were subsequently interviewed. Interviews were conducted by a researcher who is both a GP and a lesbian. Transcripts were analysed and cross-coded by the research team including a GP and a social scientist.

Findings:
This presentation will focus on experiences of the quality of patient-GP relationships. Many women were highly satisfied with their regular GP, having developed a trusting relationship. The various reasons for this satisfaction will be explored as will the influence of the need to disclose sexual orientation to the GP. The need to disclose or not emerged as a complex and variable issue. The GP perspective will also be discussed, in particular their level of preparedness to deal with disclosure and issues specific to same-sex attracted women. GP participants were highly motivated to learn more about these issues.
Conclusion:
While an effective and honest relationship with a GP is a right in a country with universal health care such as Australia, many of the participants regarded this as a privilege for them. Finding an appropriate GP was neither easy nor possible for some women. Strategies to improve the effectiveness of general practice care to lesbian and bisexual women that are relevant to their needs and achievable will be discussed.

Title: Professional relationships between GPs and same-sex attracted women
No abstract.

Title: Giving voice to the silence: researching the professional relationships between GPs and same-sex attracted women
Authors: Ruth McNair, Kelsey Hegarty, Angela Taft

Objectives
1. To describe some of the challenges in researching a topic that is rarely discussed and can be difficult for GPs, and how these challenges were tackled.
2. To provide some of the emerging findings about the relationship between same-sex attracted women and their GPs from both perspectives and why sexual orientation does or does not enter into the consultation.

Method
This PhD study has used qualitative methodology. In-depth individual interviews have been conducted with over 30 same-sex attracted women and over 20 GPs, using semi-structured interview schedules. Most women were recruited from a large general practice based survey and most GPs were the regular GP of the participating women. The theoretical framework was chosen to understand the experiences of the patient-doctor relationship for each participant in the context of their knowledge and expectations (hermeneutic phenomenology), and the impact of gender and power on these experiences (feminism). Critical theory was also used to incorporate the socio-political context of
same-sex attraction and identity and enable a change agenda for the research. Analysis for this paper has focused on a comparison of the patient-doctor relationship as experienced by women and their regular GP.

**Findings**

Sampling stigmatised populations is notoriously difficult and often results in samples that are homogenous. Recruitment through a general practice based survey has resulted in a much more diverse group of same-sex attracted women than is usually obtained, most of which had a regular GP. Most of their GPs were also willing to be involved. Women and GPs offered insights into factors that enhanced their inter-relationships. Disclosure of sexual orientation was influenced particularly by the nature of the woman’s sexual identity and understandings of its perceived relevance to health care.

**Discussion**

The relevance of sexual orientation within the consultation will be discussed in terms of the patient-centred clinical method.

**Implications for practice**

There is a clear need for increased exposure to knowledge and skills development for GPs to enhance their work with same-sex attracted women.

7. **International Women’s Health Conference, 2006.**

Title: The Socio-Political Climate, Identity And Disclosure In Health Care For Same-sex Attracted Women.

All general practitioners (GPs) see same-sex attracted women in their practices, although many of these women have not disclosed their sexual orientation to the GP. Disclosure is thought to enhance the patient-doctor relationship and improve the quality of health care. However the issue has been found to be much more complex in the PhD study that will be presented here. In-depth, semi-structured individual interviews were conducted with over 30 same-sex attracted women and over 20 GPs. Most women were recruited from a large general practice based survey and most GPs were the regular GP of the participating women. The interviews explored the experiences of the patient-doctor relationship for each participant in the context of their knowledge and expectations (using hermeneutic
phenomenology), the impact of gender and power (using feminism), and the socio-political environment (using critical theory) with regard to sexual orientation.

The social and political understandings of each participant about lesbian and bisexual female sexual orientation had a bearing on perceptions of sexual identity. Is it a lifestyle choice or an innate characteristic, is it defining and central or merely a sexual behaviour, should it be openly displayed or concealed? These understandings in turn heavily influenced decisions regarding the place of disclosure of sexual orientation in the consultation. Further influences on disclosure were considerations of relevance, trust and risk.

The paper will present these various influences on disclosure and their impact on the patient-doctor relationship. The implications for GP education will be presented including the need for GPs to understand the impact of the socio-political climate on their same-sex attracted patients’ identity. This will more fully equip GPs to provide patient-centred care that is tailored to the individual woman’s needs.


Title: General practice guidelines for culturally competent care of lesbian, gay and bisexual (LGB) patients

Background

No Australian guidelines currently exist for GPs to understand best practice standards for LGB patients. Yet this is a minority group with significant health disparities and difficulties accessing primary care. LGB people have consistently called for improved culturally sensitive care. GPs receive little specific training in this area and most struggle to meet the specific needs of their LGB patients.

Aims

To develop evidence-based guidelines for culturally competent care of LGB patients attending Australian general practices.

Methods

First, a literature review was conducted of existing LGB clinical practice guidelines. The search strategy included peer-reviewed literature and guidelines published by international
government, consumer and health care provider organisations. Existing guidelines were appraised using the AGREE instrument and summarised into a draft guidelines framework.

Second, 33 same-sex attracted women (SSAW) and 27 GPs were interviewed about their experiences within general practice care. Women’s preferences for care were analysed and added to the draft guidelines. Selected participants received draft guidelines for comment, and the feedback was used for further refinement.

Results

The resulting general practice guidelines will be presented. SSAW research participants agreed that the guidelines represented issues of importance to their primary care. The GP research participants found the guidelines to be helpful in improving their understanding of cultural issues pertaining to LGB status.

Conclusion

Australian general practice provides excellent standards of care for a diverse range of patients. The draft guidelines for LGB care will assist in improving cultural competence of general practices for another underserved population group.

Title: In-practice advocacy for sexual minority women: a good idea in theory.

Background

Advocacy is a role that many doctors find daunting however there are increasing calls for doctors to take on ‘public roles that redress social inequalities’. This role can start within the consultation, including the recognition of social causes of patient’s suffering. Lucy Candib has suggested a three stage approach to empowerment through advocacy: first, recognising oppression of patients; second, empathically acknowledging inequalities; and third, working with patients towards emancipation. People of minority sexual orientation are subject to health inequalities due to negative social attitudes and some desperately need our advocacy.

Aims
This paper aims to discuss issues that restrict practice-based advocacy with same-sex attracted women patients.

**Methods**
The study involved in-depth interviews with 33 same-sex attracted women (SSAW) and 27 GPs about the patient doctor relationship in relation to sexual orientation.

**Results**
Almost half of the GPs agreed that they had a role in practice-based advocacy, a commitment ranging from contemplating it occasionally to strongly believing in the role. They distinguished between patient-initiated or ‘passive advocacy’, which felt more comfortable to many, and doctor-initiated or ‘active advocacy’. GPs’ theoretical support of in-practice advocacy with SSAW was rarely enacted because they lacked awareness of social inequalities for SSAW, lacked confidence in the role, or relied on passive advocacy, which was ineffective as SSAW were not aware of this GP role.

**Conclusion**
We recommend inclusion of sexual orientation in education on health inequalities and specific training for advocacy skills so that doctors can follow Candib’s three-step model with SSAW.

**Planned**

1. **Women in Medicine Conference, Provincetown, USA, July 2009.**  
   Title: Reciprocal disclosure of sexual orientation in the patient doctor relationship: all risk and no responsibility.

Disclosure of sexual orientation by women to their physician has been presented as one-way from patient to doctor, and as desirable for better health outcomes. The presentation will include findings from a PhD study exploring the patient-doctor relationship, which show a much more complex picture of disclosure, in which reciprocity and identity play key roles, and where multiple preferences for disclosure exist.
In-depth, semi-structured individual interviews were conducted with 33 same-sex attracted women and 28 physicians. One of the research questions was ‘How is disclosure of sexual orientation negotiated between same-sex attracted women and their GP?’ Analysis was framed by the theory of relationship-centredness and considered the relevance of feminist perspectives including empathy, reciprocity and agency. Findings were that reciprocity, where the physician revealed personal (albeit limited) details about themselves, was valued by many women. However opinions varied as to whether physicians should disclose their sexual orientation. Similarly, disclosure was not a universal need for women but depended on the salience of their sexual identity in their lives. Disclosure of sexual orientation was perceived as a risk by women and their physicians alike, and responsibility for disclosure was often deflected to the other.

Title: A new model on disclosure of minority sexual orientation in general practice.

Aims and rationale
The aim was to develop a model to assist the process of disclosure of minority sexual orientation to GPs. Disclosure is a considered risk for many same-sex attracted women, and GPs rarely take responsibility to ask about sexual orientation.

Methods
Using a critical hermeneutic approach I conducted in-depth interviews with 33 same-sex attracted women and 27 GPs, including 24 woman-GP pairs, regarding the patient-doctor relationship.

Findings
The identity disclosure model explained the influences on women’s disclosure preferences to their GPs. Women's approaches to disclosure were to be open (preferring to tell), passive (waiting to be asked) or private (preferring not to tell). The three main influences on women’s approach were their sexual identity experience, their perceptions of risk, and trust in the patient-doctor relationship. The identity experience determined the level of importance of sexual identity, and the more important it was, the more likely she was to disclose. Perceived risk motivated silence, and relational knowing within the patient-doctor relationship could overcome perceived risk to encourage disclosure.
**Benefits to the community**

The identity disclosure model would assist GPs to facilitate disclosure while realising that not all women need to do so. This would overcome both the essentialising of disclosure that dominates the current literature, and the lack of relevance that dominates GP thinking. This model could be used within GP education to create greater cultural sensitivity and more focus on relationship-centredness with this minority group, and may be transferable to other minority groups.

I also plan to present study findings at the National Women’s Health Conference in Hobart in May 2010.

**Community Presentations**

I have presented study findings at three gay, lesbian, bisexual and transgender (GLBT) community events and conferences:

1. **Health in Difference Conference, Melbourne, 21-23 January 2005.**
   
   Title: Lesbian health research methods.
   
   Co-authors: Rhonda Brown (La Trobe Uni), Melanie Gleitzman (Uni NSW), Jo Harrison (Uni SA), Lynne Hillier (La Trobe Uni)
   
   No abstract.

2. **Lesbian Health Across the Lifespan conference, Melbourne, 7-10 October 2005.**

   Title: Human Rights and Lesbian Health: Victoria and Beyond.
   
   Co-author: Barbary Clarke
   
   No abstract.


   Title: For better or worse. Various impacts of culturally diverse backgrounds of same-sex attracted women and general practitioners on the health care encounter.
Cultural and linguistic diversity (CALD) of lesbian and bisexual women has been the subject of some research, with evidence that their marginalisation within health care is compounded. There has been little attention paid to the effects of CALD background of the health care provider on the lesbian or bisexual client. This is important in the current climate in which increasing numbers of overseas trained doctors are entering Australian general practice. Ruth will present findings from her PhD study for which she conducted in-depth individual interviews with over 30 same-sex attracted women and over 20 general practitioners (GPs). A number of the women discussed experiences of seeing GPs from CALD backgrounds and some of the women were of CALD background themselves. Some GPs discussed the influence of their cultural background on their role in caring for SSA women. The experiences suggest a wide range of impacts on the patient-doctor relationship, from complete misunderstanding to enhancement. Overall, this part of the study highlights the need to consider issues of diversity from both consumer and health care provider perspectives.

I plan to publish articles on same-sex attracted women’s health in lesbian publications and newsletters over the coming months. These will have a particular emphasis on recommendations for enhancing the patient-doctor relationship, and guidelines for finding a sensitive general practitioner. I also hope to present the study findings at the biennial national GLBT health conference Health in Difference in 2010.
Academic Publications

My supervisors and I have had three papers published in peer-reviewed journals and have submitted a fourth. I will list the papers here and have included a copy of the full papers in Appendix 9.

Published Papers


McNair R, Taft A, Hegarty K. Using reflexivity to enhance in-depth interviewing skills for the clinician researcher. BMC Medical Research Methodology 2008, 8:73
Unofficial Impact Factor – 1.99

Journal Impact Factor - pending

Submitted Paper

McNair R, Hegarty K. A systematic review of guidelines for the care of lesbian, gay and bisexual people in primary care settings. Submitted to Family Practice
Journal Impact Factor – 1.3
Planned Papers

I have planned the following papers with my supervisors and the Advisory group:
1. Risk taking and GPs facilitating disclosure of minority sexual orientation.
   To Family Practice or Annals of Family Medicine
2. Lesbian and bisexual cultural sensitivity rather than cultural competence.
   To Family Practice
3. Identity diversity and disclosure as a choice and non essential.
   To Women’s Health or Women’s Health Issues
4. The Identity disclosure model – theoretical and practical issues.
   To Social Science and Medicine
5. GP Guidelines for the sensitive care of lesbian and bisexual women.
   To Australian Family Physician

Guide For GLBTI Inclusive Practice

I am chairing a working group of the Ministerial Advisory Committee on Gay, Lesbian, Bisexual, Transgender and Intersex Health and Wellbeing, which is developing a ‘Guide for GLBTI Inclusive Practice’. This is designed for use by all DHS-funded services in Victoria, which includes hospitals, community health services, mental health services, drug and alcohol services, housing, disability and community aged care services. The first draft of the guide was based on my systematic review of guidelines and PhD study findings. We are now developing the next draft based on feedback from state-wide consultations with DHS Directors, service managers and providers. This will include reference to the health care standards with which DHS services must comply. The final product should be available on-line and as hard copy to all DHS services by the end of 2009. This will be the first guide for GLBTI sensitivity produced in Australia for any health service. Once in use, it will be evaluated and revised.
GP Guidelines On The Sensitive Care Of Lesbian And Bisexual Women.

I have received a research grant from the Australian Lesbian Medical Association to produce GP guidelines for the sensitive care of lesbian and bisexual women. The project aims to consult with key stakeholders to improve on the current draft guidelines (in Appendix 8) and then to make them readily accessible to Australian GPs. Specific project objectives are:

1. To format the guidelines to be presented in the most user-friendly way and be accessible both as a laminated card and web-based material.
2. To consult with the RACGP to review and endorse the guidelines.
3. To circulate the guidelines to GPs in selected Divisions of General Practice in Victoria.
4. To evaluate the usefulness of the guidelines.

I will then disseminate the guidelines widely to GPs as both a web-based and paper resource, as well as submit papers to peer-reviewed journals and conferences during 2009/2010. I hope that the resulting guidelines will improve the primary health care experience of lesbian and bisexual women and their GPs.
APPENDIX 7 – DRAFT GP GUIDELINES

I have developed the current draft of the GP guidelines using a systematic literature review, feedback from 12 GPs in the study during the follow-up interview, and feedback from members of the Advisory group.

DIALOG GUIDELINES ON SENSITIVE CARE FOR LESBIAN AND BISEXUAL WOMEN

These guidelines have been designed to assist GPs and their practice staff to provide culturally sensitive care to lesbian, bisexual and same-sex attracted women. They were developed using existing clinical guidelines and from findings of the DIALOG study, which involved interviews with 33 lesbian, bisexual and same-sex attracted women and 27 GPs.

How many lesbian and bisexual women would be attending my practice?

• Approximately 2% of Australian adult women identify as lesbian or bisexual. Another 5-8% of women report same-sex attraction or behaviour. Lesbian and bisexual women attend general practice slightly more frequently than heterosexual women.

• Around 50% of these women will not have disclosed their sexual orientation to their GP.

Is being lesbian and bisexual a cultural issue?

• Yes, some women’s sexual identity includes specific values and beliefs including preferred social affiliation with lesbian or bisexual groups. This is similar to ethnic or racial identity.

• Other same-sex attracted or partnered women do not identify as lesbian or bisexual and have values that align more closely with heterosexual women, including their social networks.
• Many women have multiple identities and cultural affiliations including sexual orientation, race, ethnicity, family, religion/spirituality or disability

**What are specific health issues for lesbian women?**

In comparison to heterosexual women, lesbian women *may* be different in the following ways:

- **Discrimination** and stigma can lead to various health issues
  - Marginalisation and social exclusion, including from family of origin
  - Higher levels of depression and anxiety
  - Experiences of violence or harassment
  - Lack of continuity with one GP and/or reluctance to disclose to the GP

- **Coming out** can be difficult for some women at any age, requiring support of their GP

- **Same-sex relationships** – lower level of legal recognition, the rate of intimate partner violence is about the same as heterosexual relationships

- **Conception** may require medical guidance and referral

- Lack of legal and social recognition of the non-biological parent

- Lesbian women are more likely to smoke, have higher intake of alcohol and illicit drugs

- **Sexual health** – specific safe sex methods, same prevalence of STIs overall, lower blood borne viruses, higher bacterial vaginosis and genital herpes

- More likely to have experienced child and/or adult sexual abuse

- More likely to have risk factors for breast, ovarian and bowel cancer due to lower rates of pregnancy and contraceptive pill use, higher rates of smoking, lower rates of screening

**What are specific health issues for bisexual women?**

Bisexual women can have all of the same health issues as lesbian women, however are even more likely to be affected by:

- **Social exclusion**, potentially not belonging to lesbian or heterosexual networks

- Lack of understanding of bisexuality as an identity rather than just an attraction
• Higher levels of **depression and anxiety**

• Higher levels of **sexually transmissible infections** than lesbian and heterosexual women

**What do lesbian and bisexual women expect of general practice care?**

• That minority sexual orientation is regarded as a **normal** variation

• An **inclusive practice environment** that serves to normalise their sexual orientation

• **Awareness** that lesbian and bisexual women attend and avoidance of assumptions of heterosexuality

• **Attitudes** that are at least openly non-judgemental, accepting and affirming; some hope for advocacy regarding their sexual orientation

• **Knowledge** of specific health issues and sensitive referral networks

**How can I make my practice inclusive of lesbian and bisexual women?**

• Having **discrete signs** in the waiting room that indicate inclusivity and safety e.g. a rainbow sticker, lesbian/bisexual specific posters or pamphlets

• Ensuring all staff including receptionists use **inclusive language** and display non-judgemental attitudes

• Providing **inclusive intake forms**, which include a number of options regarding sexual orientation and relationship status (see Box 1)

**How would I know I am sensitive to lesbian and bisexual women in my consultations?**

Many of these skills can be transferred from other areas of sensitive practice that you may be more familiar with such as adolescent health or migrant health

• Using culturally aware **language**
  
  e.g. using a gender-neutral word for partner until gender of partner is known, using the word the woman herself uses for her sexual orientation (lesbian, gay, bisexual, not straight)

• Facilitating **disclosure** of sexual orientation (see Box 2)
• Acknowledging the role of same-sex partner and/or chosen family in the woman’s life
• Clarifying the relevance, if any, of sexual orientation to health and social networks e.g. experiences of discrimination, connection with family of origin
• Recognising women’s sexual orientation can change over time
• Recognising that sexual identity may not correlate with sexual attraction or behaviour, e.g. a bisexual-identified woman may have a monogamous same-sex relationship, a lesbian-identified woman may have sex with men
• Assuring confidentiality if required
• Documenting sexual orientation and/or partner’s name in the medical notes
• Asking permission to include sexual orientation in referral letters if it is relevant

How can I facilitate disclosure of sexual orientation?
Women have diverse views on whether they want to disclose, whether this should occur early in the relationship or once rapport has developed, and whether they prefer to tell or be asked by their GP.

In general, women expect GPs to ask and do not feel it is an invasion of privacy.
• All of the preceding steps in lesbian-sensitive care will assist women to disclose
• Regard disclosure as a shared responsibility between yourself and the woman

If women tell:
• Normalise your response e.g. don’t appear surprised or concerned
• Respond to women’s subtle cues by probing e.g. if women use ‘they’ regarding a partner

If you ask:
• Why to ask: a holistic approach, part of social history, in relation to partner, in relation to determining sources of stress, relevance to other health issues
• When to ask: early in the relationship, however if women give a neutral answer or have not completed the intake form they may need more time
• How to ask: may require direct questions (see Box 2)
How do I find out about referral networks?
Referring to lesbian-specific or lesbian sensitive groups and providers is necessary where sexual orientation is relevant to the health issue they will deal with, or where women prefer to associate predominantly with lesbian or bisexual networks.

- Health care providers who are sensitive to lesbian and bisexual women:
  - this is mostly through word-of-mouth from other lesbian or bisexual patients
  - some community health centres have lesbian-sensitive referral lists
- Lesbian and bisexual specific support groups and social groups
  - The ALSO Directory (based in Victoria)

Where can I find up to date lesbian and bisexual women’s health information?
Gay and Lesbian Health Victoria Clearinghouse: www.glhv.org.au
ALSO Directory for gay, lesbian and bisexual sensitive service providers: www.also.org.au
Lesbian and bisexual women’s sexual health: www.lesbianstd.com
Lesbian parenting: www.rainbowfamilies.org.au
General lesbian health: www.mautnerproject.org

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<th>Preferred contact for emergencies</th>
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<td>(rather than marital status)</td>
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<td>Separated</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>Divorced</td>
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Box 1: Intake form questions
Box 2: Discussing sexual orientation

It can be helpful to introduce this topic by explaining why you are asking these questions:
e.g. I ask all of my new patients about their living arrangements.
I need to know something about your sexual history as it may be relevant to your symptoms.
I need to ask about how you define your sexual orientation to determine the best referral.

Demographic questions about partner and living arrangements
Do you have a partner? (rather than are you married)
What is your partner’s name?
Is your partner male or female? (if answer to the previous question not clear)
Do you live with anyone?
Who do you regard as your close family?
Are you co-parenting your children with anyone?
Who is the biological parent/mother? (rather than who is the real parent/mother)

Then clarify documentation in the medical record:
I usually record significant relationships in the medical record. Are you comfortable with me recording your relationship?

Sexual history
Do you have a current sexual partner or partners?
Do you have sex with men, women or both?
Do you need any information about safer sex?
Do you have any need for contraception?
Do you feel safe with your partner?

Other direct questions about sexual orientation
If not partnered, or if relevant to understand preferred social networks:
How do you describe your sexual orientation?

To probe for discrimination related health issues:
Have you had any negative experiences relating to your sexual orientation?

If referring to a support group:
Would you prefer a lesbian-specific or general support group?
APPENDIX 8 – PUBLISHED PEER-REVIEWED PAPERS


McNair R, Taft A, Hegarty K. Using reflexivity to enhance in-depth interviewing skills for the clinician researcher. BMC Medical Research Methodology 2008, 8:73

Unofficial Impact Factor – 1.99

Author/s: 
McNair, Ruth Patricia

Title: 
Same-sex attracted women and their relationship with GPs: identity, risk and disclosure

Date: 
2009

Citation: 

Publication Status: 
Unpublished

Persistent Link: 
http://hdl.handle.net/11343/35417

File Description: 
Same-sex attracted women and their relationship with GPs: identity, risk and disclosure

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