

Improving Health Care for the Lesbian and Gay Communities

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On my 40th birthday, I made two important decisions regarding my health: I would finally see a physician on a routine basis, and I would be frank with my newly chosen doctor about being gay. This revelation might seem to have come late in life, but for me it was a major breakthrough. Although this physician had been recommended to me by colleagues, I was disappointed by the lack of discussion following my emotionally difficult statement about my sexual orientation. He did not discuss my sexual history or recommend that I be tested for HIV, nor did we discuss the need for hepatitis A or B immunizations.

More recently, I had a different but similarly off-putting interaction with the health care system. At the registration desk for a physician's practice at a nearby hospital, I was asked, rather publicly, whether I was married or single. When I replied that I had a partner, a second office worker sitting next to the registration clerk leaned over and loudly exclaimed, "He's single." Even as I tried to see the humor in this exchange, I remained disturbed by the ease with which a significant relationship could be dismissed, as well as by the chilling effect it had on my eagerness to be seen as a patient at this practice.

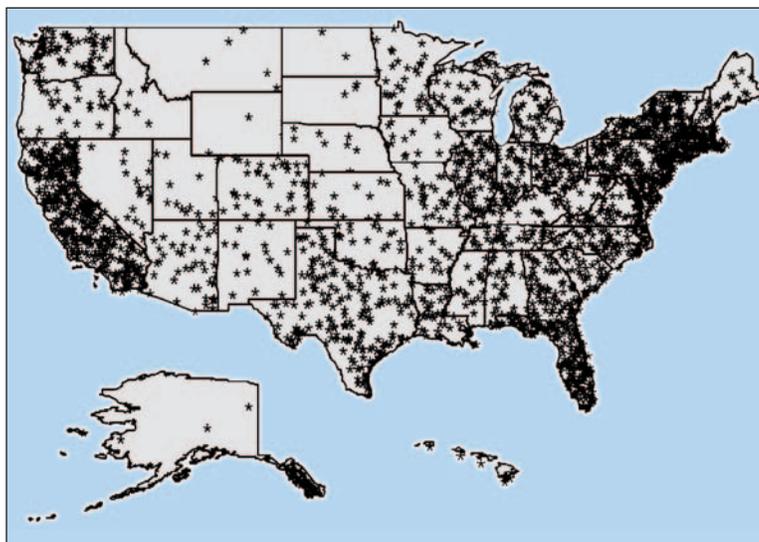
From my perspective as a clinician and teacher, these experiences were disappointing but not surprising. There is little formal education about sexual minority groups included in medical training. As a result, otherwise knowledgeable providers are often un-

informed about basic issues that are essential to providing high-quality care to this population. Indeed, when I discussed my dismay about the first encounter with one of my colleagues, she asked why I thought my physician should have discussed hepatitis A immunization — although since 1996 the Centers for Disease Control and Prevention (CDC) has formally recommended such preventive care in gay men. Would greater attention, during medical school, training, or continuing medical education, to gay men's health care have made such immunization more routine?

Such educational gaps persist despite the numerous reports indicating a need for greater attention to the health of the lesbian and gay communities. A 1999 report from the Institute of Medicine entitled "Lesbian Health:

Current Assessment and Directions for the Future" evaluated the strength of the existing research on the physical and mental health of lesbians. It reported a lack of lesbian-specific research and suggested that "misconceptions about risk . . . can negatively affect both the ability of lesbians to seek health care and access to treatment itself." Similarly, "Healthy People 2010," a 10-year plan developed by the Department of Health and Human Services in 2000, identified lesbian and gay Americans as one of six U.S. population groups affected by health disparities.

Despite such alerts, the medical resources that primary care providers commonly use in making treatment decisions pay little or no attention to issues of care for homosexuals and bisexuals. As an example, although *UpToDate*,



Same-Sex Couples in the United States.

Each star represents 250 households headed by a same-sex couple, as reported in the 2000 U.S. Census. The total number of such households was 594,391 in 2000. Map courtesy of Judith Bradford, Ph.D., and Kristen Barrett, Ph.D., Survey and Evaluation Research Laboratory, Virginia Commonwealth University.

an online resource for clinical information, has a comprehensive section on the gynecologic care of lesbians, it has no section presenting an organized approach to the care of gay men. The most recent edition of Branch's primary care textbook *The Office Practice of Medicine*, published in 2003, does not even mention the words "gay" and "lesbian" in its table of contents or index. Providers need easy access to information on how best to provide high-quality care to the lesbian and gay communities. No physician can know everything, but our routine sources of information should cover issues relevant to the care of this population.

Increasing the profession's awareness of the core medical issues for gay men and lesbians is the first step. Today, we are seeing a growing epidemic of sexually transmitted diseases among gay men, with a resurgence of gonorrhea, syphilis, and chlamydia, in addition to conditions such as lymphogranuloma venereum, that were previously less common.¹ All these diseases are easy to diagnose and treat, but if newer trends in prevalence are not acknowledged in medical education, physicians are unlikely to pay appropriate attention to necessary behavioral change and medical treatment when seeing patients in clinical settings.

Providers also need to be aware of related contributory and potentially hazardous trends, such as the current epidemic of crystal methamphetamine use, in order to effectively address these issues with patients. The CDC has suggested that HIV prevention also be addressed routinely during primary care visits in an effort to

reach populations in which the epidemic is growing.² Nevertheless, studies have consistently shown a considerable disparity between the attention paid to assessing the risk of HIV infection and other sexually transmitted diseases and that paid to assessing cardiovascular risk in office sessions.³ In both cases, changing potentially harmful behavior remains a challenge, but addressing the need for change is the first important step. What message do we as physicians send to our patients, gay or straight, when we ignore safety issues related to sexual behavior?

There are similar lacunae in most health care professionals' knowledge about appropriate cancer-prevention strategies for lesbians and gay men. It is recommended that cervical examinations be performed in lesbians according to the routine guidelines for all women, since studies of lesbians' sexual behavior reveal both great variability and substantial rates of sex with men, with the attendant risks of infection with the human papillomavirus (HPV) and the evolution of cervical carcinoma.⁴ Yet physicians frequently assume that lesbians have low or no risk of HPV infection and fail to perform both Papanicolaou (Pap) smears and pelvic examinations.

Similarly, there is a growing body of literature on the appropriateness of screening for anal dysplasia in men who have sex with men as a way of preventing the development of anal carcinoma. But there has been little effort to disseminate this information formally or to put systems in place to make the anal Pap smear part of clinical practice, at least

for patients with HIV infection, who have the highest risk of anal carcinoma.

Physicians can also play a critical part in helping lesbian and gay patients to confront questions or confusion about their sexuality — and about "coming out" to themselves and others. In this respect, the physician's role is no different from that of the primary care provider who assesses issues such as difficulty with relationships or domestic abuse and subsequently makes referrals for counseling. Whether the patient is an adolescent (who may be at risk for a suicide attempt⁵) or a middle-aged man or woman just beginning to identify as a homosexual after years of living a heterosexual life (who may feel isolated from family and friends), physicians should be aware of the issues that commonly arise in these circumstances. Nevertheless, guidelines for clinical practice can be very simple: ask the appropriate questions and be open and nonjudgmental about the answers. Few patients expect their providers to be expert on all aspects of gay and lesbian life. But it is important that providers inquire about life situations, be concerned about family and other important relationships, understand support systems, and make appropriate referrals for counseling and support when necessary.

Finally, we should consider how our practices could create an environment welcoming to homosexuals and bisexuals, helping to eliminate real or perceived barriers to care. The 2000 U.S. Census showed that this group makes up 5 to 7 percent of the population in major urban centers, and

it identified at least one household headed by a same-sex couple in more than 99 percent of U.S. counties (see map). If all health care providers reworded their forms to include lesbian and gay patients (asking, for instance, for the names of a child's parents rather than the mother and father), armed themselves with information about relevant resources available in the community, and ensured that all their staff were educated about relevant gay and lesbian issues, it would make a big difference.

Acting as individual clinicians, we may not be able to change national health care policy. Yet we must all be aware that we are most

likely seeing gay and lesbian patients, as well as patients who, although they do not consider themselves to be homosexual, are exploring their sexuality with same-sex partners. At the very least, we can adapt our own practices, and we can work with our medical schools and professional organizations to incorporate more information, at all educational levels, about the care of this population. We can also help our patients take steps toward leading open and healthy lives.

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