The Gay–Lesbian Patient and the Family Physician

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Denver, Colorado

DR. RICHARD ANSTETT (*Family Physician*): Today we have the opportunity to learn from gay and lesbian individuals what the primary care physician needs to know to care for the homosexual patient. This forum is intended to allow an open discussion between the panel and the audience, who are students, family practice residents, and faculty at the St. Joseph Family Practice Residency Program in Denver, Colorado. Let us begin by introducing the panelists:

RICHARD BROWN (*Member, Board of Directors, Gay and Lesbian Community Center of Denver*): We appreciate the opportunity to speak to professionals because our main goal is to break stereotypes and to improve understanding between the heterosexual and the gay community. Please do not hesitate to ask us any questions. There are no questions in this forum that we feel to be out of bounds.

MS. L.S. (*Legal Secretary*): I am a legal secretary in Denver. I am here to answer any of your questions.

DR. C.C. (*Resident in Psychiatry, University of Colorado, Health Sciences Center*): I am happy to have the chance to talk to people about the way I see the gay–lesbian community interface with health care professionals.

DR. CHUCK STEPHENS (*Family Physician*): I am a gay physician with a large percentage of gay and lesbian patients. I find that these patients are willing to come to me because I'm not judgmental about their lifestyles. I am especially interested in the "coming out" experience and working with gay and lesbian youth.

DR. C.M. (*Resident Physician, University of Colorado Health Sciences Center*): As a physician and a lesbian, I believe the primary thing that gay patients want from their physicians is good medical care, not interference from the physician's prejudices about their sexual practices.

Submitted, revised, June 15, 1987.

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MR. BROWN: I would like this discussion to focus on the relationship between the gay or lesbian patient and the physician, and how physicians can enhance the care of that particular population.

Could we start out by talking about experiences that gays have had that have not been successful in terms of finding a physician who is sympathetic to their needs.

DR. C.C.: I believe it is the responsibility of the health care professional to set the tone that will determine the patient's comfort in letting the physician know that the patient is gay. Personally, I was leery about telling any of my physicians that I was gay. As a medical student, I had to be sure that my physician would not hold it against me, or that his knowledge of it would not hinder my career plans, such as finding a high-quality residency. A major part of the "coming out" process involves knowing what the consequences are, and whom you can trust with this process.

DR. ANSTETT: How important is it for the gay patient to convey his sexual preference to his or her physician?

DR. C.C.: It is important because, as you all know, a patient's sexual practices can dramatically influence his or her health. Physicians may adjust the differential diagnosis of a symptom knowing that the patient has a homosexual preference. For example, oral gonorrhea might be considered for the patient with a sore throat.

DR. STEPHENS: A good history is important regardless of whether it concerns sexuality or some other aspect of the patient's life. The history taking establishes a rapport between the patient and the physician. Getting information about somebody's sexual preference is a highly developed skill. One does not just walk in and ask the patient about his or her sexual preference. The sexual history is particularly critical whether a patient is heterosexual or homosexual.

MS. L.S.: Let me speak from a personal experience. If a physician sees a female patient who has not used birth control since 1968, this is an obvious clue about a female patient's sexual preference. As a lesbian, my family is going to have a different configuration than a heterosexual's family, but that does not mean that I do not have a family.

It is important also to remember that the gay or lesbian patient may have had or continue to have heterosexual experiences, just as the predominately heterosexual patient may occasionally have a homosexual experience.

DR. NEAL SULLIVAN (*Family Physician*): As a family physician with a busy gay practice, I would like to reinforce that a given patient's sexual life may be quite diverse. Homosexual patients have occasional heterosexual encounters and heterosexual patients have occasional homosexual encounters. Eliciting this type of sexual information from a patient can be very complicated.

DR. ANSTETT: Let us get back to the question of obtaining information about a patient's sexual preference or practices. How do the panelists recommend doing this in a way that will be acceptable to the patient?

DR. C.M.: When I am obtaining a sexual history from women, I eventually ask them if they're sexually active with men, women, or both. This gives patients the opportunity to answer with any of the options, and lets people know that I am not shocked or upset by any answer they might give. If patients have symptoms that may be related to their sexuality, it is important for them to know that their sexual practices are an important part of the history taking, which will lead to high-quality medical care. I recall, for example, a 15-year-old girl I saw in the emergency room who told me at the outset that she was homosexual, but she never mentioned having heterosexual encounters. In fact, her real concern for her visit was the possibility of a pregnancy.

I think that the quality of the history can also be improved with the type of forms that are used for patients to complete. For example, a form that includes a checkoff for not only a spouse but also a significant other or partner breaks down some walls of discomfort between the physician and the patient.

DR. STEPHENS: I like to ask patients early in my getting to know them a question, such as, "Do you have a sexual partner?" I hope this conveys to my patients that I am open and comfortable in hearing whatever answer they give.

It is important for me to know whether a patient has a significant other, not only in terms of sexual orientation, but also in terms of that patient's social support system. The details of a patient's sexuality are less important to me at first, until symptoms occur that may involve a patient's sexual practices, such as a sore throat or genital or rectal complaints.

DR. C.C.: I have been concerned that most medical forms make the assumption that patients are heterosexual by asking such questions as whether they are married, divorced, widowed, or single. If a patient checks off the category of single, not much information is conveyed about the patient's sexual preference, or whether the patient has a social support system or anybody who cares about what happens to him or her. Significant others are very important in supporting an ill patient. An important physician role with a gay or lesbian patient is to support and be an advocate for the patient's own social support system. For instance, there are certain places in hospitals, such as intensive care units, that allow only family visitation.

The gay or lesbian patient might ask, "As my family physician, will you support my desire to have my lover with me if I become seriously ill?" The family physician may find out this information by asking such questions as, "Is there anybody who needs to be included in your care?" and "Who do you want me to share important information with concerning your health?"

DR. MARTIN KIERNAN (*Director, Family Practice Residency, St. Joseph Hospital*): Let me take this discussion in another direction for a moment. I dealt with a young man, 26 years old, Midwestern, and Catholic, who wanted to determine whether or not he was gay. I was very unsure about where to go with this. Could the panel address this question?

MR. BROWN: Since I represent the gay and lesbian community, I can tell you that there is a place to go in Denver and in almost every large American city to find assistance with this question. We have a program called Peer Support, which primarily deals with people who are "coming out" or who have the kind of questions that this man probably had.

Peer Support is an excellent place for people to start. The interested person can call and use a first name: he or she will be assigned to a counselor who will talk in a nonthreatening way about the situation. They may meet if the individual chooses to do so. Let me mention that when I first came out, it took me at least ten years to do so, and when I finally did, there was a lot of confusion in my life. I was a football coach, played basketball, and had no particular interest in cutting hair or decorating homes. I sought some counseling at this time that helped me get in touch with some of my concerns. The first "coming out" experience I had was with a gay men's outdoor group. This group made me feel more relaxed and gave me a resource. We do not expect physicians to be able to address all of these issues, but we do expect them to know what resources are available in the community for dealing with such individuals.

DR. STEPHENS: I "came out" to my family physician who had been my physician since second grade. He was the only physician in town, and I told him about my homosexuality when I was 32 years old. He was our family's best friend; I grew up with his son, roomed with his son in college, and had sexual experiences with his son as an adolescent. His son is now happily married with a large family.

I had a major concern all my life that if I were to mention to somebody in that small town that I had these thoughts concerning my homosexuality, I would have

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been branded as "sick," and would have been encouraged to dismiss these thoughts. Communities as such do not give adolescents in doubt an opportunity to experiment with even thinking about their sexuality. I wish that I had a program like the one here in Denver, called Outright, which is a youth program for gay, lesbian, and bisexual youth. It provides an opportunity for these youngsters to make decisions about their sexual orientation in a free and open atmosphere.

DR. MARK ROJEC (*Resident in Family Practice*): Are there other ways that a person who is not sure of his or her sexuality will present to physicians with perhaps nonspecific symptoms or other changes in their lives? What other clues would we have that somebody may be gay, and how could we approach that?

MR. BROWN: Some clues might cause you to consider the possibility of the sexual confusion in a younger individual. Foremost are signs of depression, doing poorly in school, or failing to perform in general. Children who seem to have everything going for them but are depressed or perhaps involved in substance abuse may be dealing with problems surrounding sexual identity confusion.

DR. C.M.: As a psychiatric resident, I primarily see children who are already in some trouble. However, children or adults with sexual identity concerns may present in a variety of different ways, especially with substance abuse, major depression, or bizarre behavior. As a general rule, it is safe to say that most people do not tell you in a forthright way just what the problem is.

DR. C.C.: Let me talk about some of the problems of a nonsexual nature that are frequent within the gay population. I see a significant amount of depression and substance abuse. This is understandable to the extent that gay patients make up a minority group and deal with many of the social issues that accompany being unaccepted in many cases by the majority of the population.

DR. STEPHENS: I would also include suicidal ideation or attempted suicide, especially in adolescents, as a clue to concerns about sexuality. We often associate teenage suicide with family disruption or low self-esteem, but may not think about sexual identity issues as perhaps contributing to the increase in teenage suicide in this country.

WALT SHREIBMAN (*Psychologist, Family Practice Residency, St. Joseph Hospital*): Could you tell us the things that peer counselors work with in helping young people explore their sexuality? Also, what sort of questions would be the best for a family physician to ask?

MR. BROWN: For the most part I would help the patient prepare to talk to a trained counselor about these issues. You can tell the individual that the counselor will simply discuss his lifestyle concerns, and that the patient should be free to ask any questions he or she chooses.

DR. C.C.: There are several issues related to whether a family physician might decide to care for the needs of the gay or lesbian patient. First, does that physician have

the time to take care of the special needs of this population? Does that physician have the time and motivation to ask questions related to the patient's lifestyle, particularly his sexuality? For a patient with sexual identity crisis or one who proclaims homosexuality, is that physician comfortable meeting that patient's needs and using the resources within the community to deal with those needs?

DR. RICHARD NANNA (*Resident in Family Practice, St. Joseph Hospital*): I would like to address the question of promiscuity to the panel. Many of us believe that gay individuals are more promiscuous than the straight population. Could you comment on this?

MR. BROWN: The data that I have available to me show that gay men between the ages of 15 and 21 years are very promiscuous, as is the case with heterosexual men in this age group. One problem with answering your question is that there is substantial diversity within the homosexual population. It appears that there is a promiscuous component to the homosexual population at all ages; however, as with the heterosexual population, there is a strong component of monogamy within many homosexual relationships.

DR. STEPHENS: The stereotype that gay people are promiscuous may come from the fact that the gay people most visible to the rest of the world are promiscuous. It took me a long time as a gay person to realize that most of us are "married" to our significant others, function as professionals within the community, and get together with each other without the need for "sex orgies." My own opinion is that promiscuity is highly overrated as a gay issue. I think of it as an adolescent issue, as Mr. Brown stated.

DR. ANSTETT: Let me ask you about the social relationships of homosexuals. As a family physician, we think of the family unit as consisting of a mother, father, and some children. How do we go about evaluating the quality of homosexual social relationships or the quality of the resource system of the gay or lesbian patient?

DR. C.C.: In my mind, there is no significant difference in evaluating the family or social resource system of the heterosexual or homosexual patient. The issues are the same: "Do you have someone else in your life?" "Do you have other people around who care about you?" and "Are the important people around you supportive?"

DR. C.M.: There are a significant number of lesbians who have been married and have children. Thus, a lot of families are composed of two or three children and a pair of female lovers.

DR. STEPHENS: I think it may be important to redefine the term *family.* Many gay men in Denver also have children and continue to raise those children. Most of the gay patients in my practice have both a nuclear family, which includes a significant other, friends, and perhaps children, and an extended family. Consequently, many gay patients have two social support systems that do not mesh: their extended blood family, and their support system that includes a lover and typically a number of gay and lesbian friends. When the gay or lesbian patient becomes ill and is in the hospital, the physician is asked to mesh in a tactful way the needs of the patient's extended family and his gay social support system.

DR. NANNA: How well does the legal community support your concept of family?

DR. STEPHENS: Somewhat better than it used to; however, the gay or lesbian relationship must have airtight rules. Gay couples have found themselves in major conflict with one partner's family of origin. One such problem that may arise when a gay patient dies is determining the legal rights around such issues as the gay patient's will.

MS. L.S.: As you know, currently in Denver there is a major lawsuit dealing with the right of the gay partnership in owning a home in Denver proper, where only family dwellings are allowed. As a personal comment, my lover and I have owned our house jointly and are in the process of drawing up legal documents for ownership. I think that physicians and all health care professionals should be aware that these types of conflicts occur every day with the gay or lesbian relationship.

DR. C.C.: I want to raise the question of confidentiality within the physician-patient relationship as it relates to the gay or lesbian patient. The gay man especially has cause for significant concern these days regarding his medical record, in particular the extent to which information about antibody testing for human immunodeficiency virus (HIV) is to be reported and to whom. These concerns make it even more difficult for the gay patient to discuss his sexual orientation with his physician. Such information has implications for access to insurance as well as future employment. The gay patient needs an absolute assurance that the information he shares with his physician is confidential.

DR. SULLIVAN: I have had several patients declined for disability and life insurance over the past few years. When I reviewed their charts, I noticed references I had made, such as, "the patient had pain with rectal intercourse," which in itself was enough for the insurance companies to deny applications. I have requested explanations from these insurance companies, but they would only give vague excuses, such as abnormality of a liver function test. I strongly suspect that any kind of reference to a male gay lifestyle is enough for an insurance company to decline the application. This creates a major ethical problem for me with respect to how much information I should divulge to insurance companies.

MR. BROWN: Before we conclude, I would like physicians to know there is good reading material available that they might recommend to patients dealing with some of these issues we discussed. Examples of excellent titles include, *Now That You Know* and *Coming Out to Parents.*

DR. ANSTETT: It is now time for us to conclude the panel. Thank you all for your contributions.

Suggested Reading

Alexander RW: Seeking God's Wisdom About Christian Homosexuality, privately published. (Copies available through: Robert W. Alexander, PO Box 328, Laguna Beach, CA 92652-0328)

Bell AP, Weinberg MS, Hammersmith SK: Sexual Preference: Its Development in Men and Women. Bloomington, Ind, Indiana University Press, 1981

Borhek M: Coming Out to Parents. New York, The Pilgrim Press, 1983

Clark D: Loving Someone Gay. New York, New American Library, 1982

Fairchild B, Hayward N: Now That You Know. New York, Harcourt, Brace Jovanovich, 1979

Gong V, Rudnick N (eds): AIDS: Facts and Issues. London, NJ, Rutgers University Press, 1987

Holbrook S: Fighting Back: The Struggle for Gay Rights. New York, Lodestar Books, 1987

Pennington S: But Lord They're Gay. Hawthorne, California, Lambda Christian Fellowship, 1982