

Lesbian and bisexual health care

Straight talk about experiences with physicians

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ABSTRACT

OBJECTIVE To explore lesbian and bisexual women's experiences with their family physicians to learn about barriers to care and about how physicians can provide supportive care.

DESIGN Qualitative study that was part of a larger study of lesbian and bisexual women's health care.

SETTING The province of Nova Scotia, both urban and rural counties.

PARTICIPANTS Ninety-eight self-identified lesbian or bisexual women who volunteered through snowball sampling. Women were interviewed by lesbian, bisexual, or heterosexual female interviewers.

METHOD Semistructured, audiotaped, face-to-face interviews, exploring questions about demographic information, sexual orientation, general health care patterns, preferences for health care providers, disclosure issues, health care information, access issues, and important health care services. Transcription of audiotapes of interviews was followed by content, thematic, and discourse analyses. Thematic analysis is reported in this paper.

MAIN OUTCOME FINDINGS Three themes important for family physicians emerged: the importance of being gay positive, barriers to care, and strategies for providing appropriate care.

CONCLUSIONS Family physicians are in a pivotal position to ensure supportive care for lesbian and bisexual women. Physicians need to recognize barriers to care and to use gay-positive strategies, paying attention to self-education, health history, and clinic environment.

RÉSUMÉ

OBJECTIF Analyser l'expérience de femmes lesbiennes et bisexuelles avec leur médecin de famille afin d'en apprendre davantage sur les obstacles à surmonter pour obtenir des soins et sur les façons dont les médecins de famille peuvent dispenser des soins de soutien.

CONCEPTION Une étude qualitative qui faisait partie d'une analyse plus étendue des soins de santé dispensés aux femmes lesbiennes et bisexuelles.

CONTEXTE La province de la Nouvelle-Écosse, autant dans les comtés ruraux qu'urbains.

PARTICIPANTS Quatre-vingt-dix-huit lesbiennes et bisexuelles déclarées qui se sont portées volontaires à la suite d'un sondage en boule de neige. Les intervieweurs étaient des femmes lesbiennes, bisexuelles ou hétérosexuelles.

MÉTHODE Des entrevues face à face, semi-structurées, avec enregistrement sonore, dont les questions portaient sur des renseignements démographiques, l'orientation sexuelle, les tendances générales des soins de la santé, les préférences au chapitre des dispensateurs de soins, les enjeux liés à la divulgation, l'information sur les soins de santé, les problèmes d'accès et les services importants en matière de soins de santé. À la suite de la transcription des enregistrements sonores des entrevues, on a procédé à une analyse du contenu, des thèmes et de la linguistique textuelle. L'analyse thématique fait l'objet de la présente communication.

PRINCIPAUX RÉSULTATS Il s'est dégagé trois thèmes importants pour les médecins de famille : l'importance d'une attitude positive envers les gais, les obstacles à l'obtention de soins et les stratégies pour assurer des soins appropriés.

CONCLUSIONS Les médecins de famille occupent une situation privilégiée pour assurer des soins de soutien aux femmes lesbiennes et bisexuelles. Les médecins doivent reconnaître les obstacles à l'obtention de soins et avoir recours à des stratégies positives à l'endroit des gais, portant une attention particulière à l'auto-éducation, à l'anamnèse et à l'environnement clinique.

This article has been peer reviewed.

Cet article a fait l'objet d'une évaluation externe.

Can Fam Physician 1998;44:1634-1640.

How do lesbian and bisexual women perceive the role of their family physicians? Little research addresses this question for lesbian women and none addresses it for bisexual women.

What we do know suggests that providers' attitudes and behaviours can profoundly affect lesbians' health-seeking behaviours.¹⁻¹¹ In a review of the lesbian health care literature from 1970 to 1990, Stevens¹ located 28 studies, all of them conducted in the United States. Nine of these studies discussed providers' attitudes toward lesbian clients; the remainder reported lesbians' experiences and perceptions of their interactions with health care providers.

These findings do not present an optimistic picture. In general, health care providers hold negative attitudes toward lesbian and gay clients that can influence the quality of health care delivered and client health outcomes.²⁻⁷ Two related issues here are the assumption of heterosexuality¹²⁻¹⁵ and the negative effect of disclosing one's sexual orientation.¹⁶⁻²¹

Physicians appear to underestimate the numbers of lesbian and bisexual women in their practices.^{22,23} Simkin²⁴ suggests that lesbians do not receive good-quality health care because they are "invisible" to their health care providers. Trippet and Bain²⁵ found that lesbians did not seek traditional health care for common medical concerns because of marginalization. Lesbians often do not regularly attend gynecological clinics for reproductive health for fear of disclosure or because of negative experiences, placing them in an underscreened group.^{26,27} While no illnesses are unique to lesbians or bisexual women, their concerns could go unnoticed.^{22,23,26,27}

For primary care providers, such concerns include breast and cervical screening,²⁸ sexually transmitted infections, HIV, substance abuse, pregnancy, parenting concerns, lesbian battering,²⁹ alcohol problems,³⁰ and childbearing dilemmas.³¹ There is a concern that lesbians have been slow to adopt safer sex practices, presumably because of lack of readily available information and misinformation from health care professionals.³² The prevalence of sexually transmitted diseases is low among lesbians,¹¹ yet misinformation about STDs is often given (eg, use of condoms during intercourse, which assumes that the partner is male).

We lack Canadian data on these health care issues. During a larger study where we, the research

team, set out to explore these concerns, we were struck by the importance lesbian and bisexual women ascribed to family physicians. The objective of this paper was to explore in depth participants' experiences with their family physicians to learn about barriers to care and about how physicians can provide supportive care to their lesbian and bisexual patients.

METHOD

Setting

The study took place in the province of Nova Scotia. The larger study was designed to generate data about all facets of lesbian and bisexual participants' experiences of seeking health care. A qualitative component provided information about participants' interactions with health care workers and about individuals' personal experiences of barriers to care. The proposal for study, the informed consent form, and all accompanying recruitment advertisements were approved by a university-level ethics committee.

Sample

We publicized the study widely throughout the province at community organizations, at women's clinics, on radio, at appropriate cultural events, and at selected family physician practices. Given the constraints of studying an invisible population, snowball sampling (ie, word of mouth) was used to recruit participants.^{1,33} Building trust with participants was foremost. When participants were initially contacted, the informed consent procedure was detailed and explicit.

Ninety-eight women were interviewed in two waves. First we interviewed urban women, and second we purposely spread out to rural areas to capture the diversity of lesbian and bisexual women. More than a third of the participants were added to make sure that rural areas were included. Although qualitative approaches typically employ small sample sizes, this study was also designed to obtain simple descriptive quantitative data.

Interviews

Semistructured interviews were used for face-to-face, audiotaped interviewing. Some of the core questions were derived from articles on lesbian health.^{1,25,34-36} The interview guide was reviewed by key informants for validity and then revised through pilot testing. General areas were demographic information, sexual orientation, general health care patterns, preferences

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for health care providers, disclosure issues, health care information, access issues, and important health care services. The general trend in the categories of questions was to ask an open-ended one ("Can you tell me about your experiences as a lesbian or bisexual woman seeking health care?") followed by suggested prompts ("experiences with family physicians? specialists? emergency room personnel?") or any other individualized prompts deemed appropriate by the interviewer.

Average length of interviews was 1.4 hours (range 45 minutes to 3 hours). All interviews were audiotaped; participants received a copy of the tape if they wished.

Interviewing team

The interviewing team was composed of one lesbian, one bisexual woman, and two heterosexual women. All interviewers had Master's degrees and were chosen specifically for sensitivity and skills in interviewing. Participants were interviewed singly by their choice of interviewer. I met periodically with the interviewers to review progress, monitor taping, and discuss emerging themes and special problems. The team and I kept extensive field notes, which served several functions: a detailed accounting of the research process, direction for further discussion, organizing strategies for incoming data, and the basis for thematic codes.

Analysis

Tapes were transcribed verbatim to create a hard text, which I reviewed for accuracy. Several levels of analyses were conducted: content,³⁷ thematic,³⁸ and discourse.³⁹ The discussion in this paper is confined to thematic analysis. The analytic team reduced the interview material to several overarching themes. Working together, a research assistant and I started by locating all instances of talk about family physicians, further breaking the talk into several preliminary themes, or "start codes," with examples. The codes were discussed and developed, and the transcripts were reviewed until saturation was reached for each final theme.

This process is iterative, with researchers moving back and forth between text and analysis, creating the possibility of developing codes at any point. The procedure is aided by reviewing all field notes and by memos³⁸ in a separate researcher's journal outlining the progression of thinking about the content of the emerging themes. Quotes from each final code were then extracted from every transcript and collected in a separate quote file.

Participants were involved twice: through individual contact and by being invited to a closed group meeting to discuss the findings. Once the interviews were completed, participants received reports of the findings by mail and received a health care kit we designed with information about health and community services. The findings are supported with quotes for each theme.³⁹

MAIN OUTCOME FINDINGS

Participant characteristics are described in **Table 1**. Mean age was 37.2 years. Most respondents identified themselves as lesbian, and more than half reported being in cohabiting relationships. About two thirds of participants lived in urban regions. More than half had university degrees or higher, making the sample highly educated. We interviewed one vision-impaired woman, two hearing-impaired women, two physically challenged women, one black woman, and three Micmac women.

Importance of being gay positive

We asked participants, "How would you describe your ideal health care provider?" followed by "If you had to identify one category of health care provider who would care for your needs on a regular basis, who would that be?" Almost 70% of participants said that a family physician would be their ideal provider, compared with 49% who told us that their family physician was now their regular provider. Nearly all (94%) described being gay positive as the most important attribute of a family physician. This quality was cited more often than the ideal physician being a woman (71%), lesbian (20%), or a feminist (10%).

What is it to be gay positive? A gay-positive physician is open-minded, knowledgeable about lesbian and bisexual health care needs, and able to create and sustain a safe space for disclosure:

My ideal health care provider [would] be knowledgeable about health issues particular to lesbians, for example, breast cancer,... either lesbian, bisexual, or straight but not narrow.... If she has posters on the wall, they will include posters that depict lesbians.

One important feature about being gay positive is that the physician realizes that disclosure is not restricted to the health care interaction. This acknowledgment is not as simple as having a question about sexual orientation on the health history. Respect from physicians about a patient's decision to come out requires that providers have some

idea what it means in the outside world to be lesbian or bisexual:

[L]esbian women have to deal with things like invisibility, discrimination.... I don't see how keeping a whole part of yourself secret either with everyone or with some people at certain times could not affect your health. [There is] no acknowledgment of what it's like to live as a lesbian woman. [Physicians are] not concerned with society's views, how that is affecting my health.

Gay positive means that a provider is sensitive to the realities of being lesbian or bisexual in a fundamentally heterosexual world.

Barriers to care

Half the participants reported having forgone seeking health care of one type or another at least once because of their sexual orientation. A third said they had forgone seeking routine physical care, and roughly the same proportion reported they did *not* go for regular breast screening and Pap smears. But what exactly happens in health care interaction with a family physician that bars women from care? Barriers to adequate care included heterosexist assumptions, physicians' responses to disclosure, and the implicit responsibility for patients to educate providers.

More than two thirds of the sample reported being *always* aware of heterosexist assumptions. Three prominent cues were the health history, restrictive titles or categories on health care forms ("Mrs," "your spouse," etc), and the clinic or waiting room environment. The last two will be discussed under the section on strategies.

Examples of heterosexist assumptions in taking a health history—and subsequent inappropriate advice—were frequently mentioned in the interviews and seemed to follow a certain chain of events when a provider assumed heterosexuality. The prototype health history story in our interviews described family physicians asking such things as, "Do you have a boyfriend?" or "Are you married?" to start the sexual health history. Another variant was asking, "Are you sexually active?" and when the response was yes; assuming that this meant with men:

Next came his [her doctor's] intern who basically went through the same questions and why was I there and what were my symptoms and what was I using for birth control,... and I said, "I don't," and he kinda looked at me like "What?" Anyways, I kinda mouthed the words, "I'm gay,"... to him, and... he just couldn't get it, right?... So then, [I] just took the pen out of his hand and wrote it on the paper.... Once he regained his composure,... he was back and forth a couple of times with a couple of questions and one of them was, "Have you had an AIDS test?"

Even after disclosure, then, exploring the needs of patients can be precluded by practitioners' refusal or inability to engage with the disclosure:

After that, the sexual history stops in many ways. It's like, "Oh, okay, so you're not really sexually active. Yeah, but you're not having sex with men." "No, but I'm sexually active...." I guess people are thinking that, you know, we kiss a lot and hold hands... sorta like what my mom thinks, right?

Participants reported receiving inaccurate information after disclosure: for example, being told that lesbians are at low risk for HIV because their relationships are confined to women. However, some

Table 1. Participant characteristics (N = 98)

CHARACTERISTIC	N	%
AGE (Y) (MEAN 37; RANGE 18-64)		
≤30	23	23.5
31-39	36	36.7
40-49	33	33.7
≥50	6	6.1
ORIENTATION		
Lesbian	79	80.6
Bisexual	9	9.2
Prefer no label	10	10.2
GEOGRAPHICAL REGION*		
Urban	62	63.3
Rural	36	36.7
LEVEL OF EDUCATION		
Graduate	30	30.6
University	30	30.6
Partial university	23	23.5
High school	8	8.2
Partial high school	6	6.1
Elementary	1	1.0
RELATIONSHIP STATUS		
Cohabiting	54	55.1
Single	27	27.6
Dating one person	12	12.2
Married	3	3.1
Communal living	1	1.0
Multiple partners	1	1.0

*Rural—counties with populations 8000 to 60 000; urban—population total 350 000.

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women who currently live as lesbians have not always had women-exclusive relationships.⁴⁰ Consistent with Rankow's²² suggestion, some of the women in our study reported that they were told they did not need pelvic examinations or screening because as lesbians they were not at risk for cervical cancer or sexually transmitted infections. The issues around bisexuality seemed to present special problems for providers. Some bisexual participants thought that the whole concept of bisexuality posed enough difficulty that sexual health information was generally suspect anyway. They implied that their physicians were more comfortable with the notion of patients' relationships with men than with women:

[W]hen you go for your Pap smear, your regular checkups, ... sometimes your doctor will ask you about your sexual relationships, ... and when I told her... that I was bisexual, it seemed like she was more concerned about the men I was sleeping with [than] the women.

This restrictive focus could seriously skew a health history.

We heard some striking stories about physicians' reactions to disclosure. Fifteen women reported being told their sexuality was pathological; some were referred to psychiatric services. Seven women recalled having physically "rough" internal examinations after disclosure, and four women told us they were refused care. The wider context of these stories suggests that the behaviours of providers were important events around which women later made decisions to forgo seeking health care.

Finally, almost all our participants spontaneously articulated that providers need to take responsibility for educating themselves. The implicit expectation that lesbian and bisexual women will be patients and educators simultaneously in health care interactions is a barrier to adequate care:

I think it's really important for us to be honest about who we are and the kinds of things we do, because I think there's a lot of ramifications for our health. It's been frustrating at times because my doctor... wasn't homophobic, [but clearly] she doesn't have any kind of knowledge; it wasn't even [discomfort], but *any* kind of knowledge about sexual practices, so that's a huge problem... and I simply couldn't be responsible for trying to educate her.

Strategies for providing appropriate care

Participants suggested ways family physicians can provide appropriate care. In discussing such strategies, most participants included the notion of safety as a prerequisite for disclosure. For example, when

asked whether one should be approached about orientation during a health history, most respondents said yes, but this must be interpreted in terms of the ideal, where safety (eg, lack of discrimination, trust in professional uses of information) is unquestioned. One of the first steps has to be an honest evaluation of physicians' own biases:

[H]ere I am, you know, this lesbian physician and *I've* been caught making really... obvious assumptions about people... when they've said, "Oh well, I sleep with women," or something like that.... I can't believe... that I have made this assumption.

Educating gay-positive providers and re-educating others requires attitude change, the goal of which is the following:

To find a doctor, ... or any kind of health practitioner actually, ... to be able to say, "And this is my partner," and not have people do a double take, or [ask] "Excuse me," or "What do you mean?" or... even when we've said it... and it's not acknowledged, so we know that even though we've come out, the person on the other end of that is just not willing to accept our relationship in any kind of way.

Taking patient histories deserves immediate attention if health care providers are serious about addressing heterosexism. Birth control information provided under assumptions of heterosexuality can constrain taking a sexual history and misrepresent women's needs. Our participants drove home the point that the significance of the health history lies in validating the importance of relationships to health but that it also acts as an indicator of who one's patients are:

Yeah, I would love it if it were on the form.... I think it would be helpful if [physicians] understand how many lesbian and bisexual women were coming through their door;... they'd say, "Gee, there seems to be a lot of dykes comin' through the door, maybe we should look for a little literature, maybe we should be checkin' in to see how we could help these gals a little more."... If you don't even know we're there, if we're all invisible, then nothing can be done.... I'd love to see forms that were somehow a little more realistic about how relationships are formed.

Several participants suggested that physicians start history taking by asking such questions as, "Are you in a relationship?" and "Who is in that relationship you want to acknowledge?"

Participants described some immediate changes physicians could make in their waiting rooms and clinic areas to signal a gay-positive environment:

[T]hese health care posters... they're all definitely heterosexual and very oriented toward the nuclear family.... I don't go into a health care place and see... a thing about lesbians and AIDS, a poster on the wall, or a pamphlet.... They must be assuming that everyone coming in is straight or does not need to be acknowledged.

DISCUSSION

When patients are faced with the difficulties of disclosure, family physicians have a pivotal role. The data reported here extend previous work by Geddes⁴¹ on what factors (eg, attitude, sex) are important when lesbian or bisexual patients choose their physicians. Over and above this information, however, this study shows that lesbian and bisexual women must constantly monitor the effects of coming out to their health care providers. A family physician's reaction to disclosure can profoundly affect the quality of health care in the short term and, in the long term, the trajectory of health care.

Participants themselves provided concrete examples of, and suggestions for removal of, barriers to health care. In this way, these data contribute an empirical base to our understanding of the ramifications of lesbian and bisexual invisibility in the Canadian health care system. These ramifications have been discussed more in theory than in actual fact.^{24,26}

The interviews emphasized that providers must educate themselves about sexual orientation on two levels at once: in its application to specific health issues and in the overall stresses of living as lesbian or bisexual women. In this sense, HIV-prevention education for lesbians and bisexual women could prove particularly challenging. Half the participants said they had never discussed HIV risks with any physician. Women in general are an understudied group when it comes to HIV,^{42,43} but lesbian and bisexual women specifically are the least studied and most elusive population affected by HIV infection. In order to counsel women properly, we need information about women's risk-taking behaviours, constraints to activating safer sex practices, gaps in knowledge, and strategies employed in reducing risk.⁴⁴ Lacking a body of research on this topic, the onus is on health care providers to pursue these important issues individually with their patients.

This study was restricted to lesbian and bisexual women in one province and also to those who seemed to be relatively well educated, raising the issue of generalizing the findings. We have no suitable demographic data about lesbian and bisexual women against which to compare our findings, and are, therefore, hesitant to speculate whether members of a specialized group self-selected themselves for this study. At the same time, we have very few Canadian data of any sort on this topic.

Key points

- Lesbian and bisexual women wanted their family physicians to be "gay positive," that is, open-minded, knowledgeable about their health needs, and able to create and sustain a safe space for disclosure.
- A most important barrier to good care was the common heterosexist assumptions physicians reflected in their history taking and health advice, particularly in the areas of relationships and sexual behaviour.

Preliminary results have been presented in Ontario, Alberta, and British Columbia. Patients and health care providers have recognized the salient issues, especially about the role of the health history. Two questions that were reported to be especially useful were: "What do I need to know about your life or relationships that will help me to best meet your needs as your physician?" and "Are you having unprotected sex with men, with women, or with both?" Several chapters in *Women's Health Care: A Comprehensive Handbook*⁴⁵ are useful references. We believe that our findings have validity, having described experiences of women and of physicians in other parts of the country, whose own stories have been reflected to us during dissemination of our data.

Conclusion

Lesbian and bisexual women are receiving less than optimal health care in a Canadian health system that prides itself on equal access. Family physicians are in a position to address this problem by recognizing barriers to care and using gay-positive strategies. Practice patterns that promote heterosexism must be challenged and changed. This includes self-education, reviewing how we take health histories, and placing appropriate, supportive materials in clinics. Creating and sustaining a safe, professional space where women can disclose draws on the very principles of family medicine, that is, continuity of care in the context of a long-term relationship. ♣

Acknowledgment

This study was funded by the Medical Research Council of Canada through an operating grant to the author.

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