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## Sexual Identity, Identity Disclosure, and Health Care Experiences: Is There Evidence for Differential Homophobia in Primary Care Practice?

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### Abstract

**Background**—Given extant health disparities among women who belong to the sexual minority, we must understand the ways in which access to and satisfaction with health care contribute to such disparities. The purpose of this study was to explore how sexual minority women’s (SMW) health care experiences compared with those of their heterosexually identified counterparts. We also sought to investigate whether there were differences within SMW in this regard. Finally, we explored whether participant satisfaction and comfort with health care providers (HCPs) differed depending upon HCP knowledge of participants’ sexual orientation.

**Methods**—We administered surveys to 420 women including lesbian, gay, bisexual, or other “queer” identified women ( $n = 354$ ) and heterosexually identified women ( $n = 66$ ).

**Findings**—Contrary to our expectations, we found that SMW were as likely to have had a recent health care appointment, to have been recommended and to have received similar diagnostic and preventive care, and to feel comfortable discussing their sexual health with their HCPs. They were, however, less likely to report being satisfied with their HCPs. We found no differences between lesbian SMW and non-lesbian SMW with respect to these indicators. We found important differences with respect to sexual orientation disclosure and health care satisfaction, however. Those participants whose HCPs purportedly knew of their minority sexual orientation reported greater satisfaction with their HCPs and greater comfort discussing their sexual health than those whose providers were presumably unaware.

**Conclusion**—We discuss important clinical and research implications of these findings.

Women in the sexual minority, including women who identify as lesbian, bisexual, or who have another “queer” status (e.g., those who identify as pansexual, same-gender-loving, etc.) have been found to have poorer health outcomes than their heterosexual counterparts. For example, sexual minority women (SMW) may be at elevated risk for overweight and cardiovascular disease and may be more likely to engage in deleterious behaviors, such as

smoking and heavy drinking, that contribute to morbidity (Cochran, 2001; Drabble & Trocki, 2005; Gruskin & Gorden, 2006). Health care providers (HCPs) have a unique opportunity to effect change among these patient populations. However, discriminatory practices within the health care context, patient perceptions of provider prejudice (e.g., heterosexism), and even internalized homophobia (i.e., the devaluing of self, conscious or not, based on one's sexual orientation) likely serve as barriers to regular health care receipt and reinforce negative attitudes toward the health care system (Hutchinson, Thompson, & Cederbaum, 2006; Stevens, 1995; Williamson, 2000). Moreover, SMW's engagement in care and perceptions of health care quality are predicated on the perception of provider prejudice (Bergeron & Senn, 2003; Dehart, 2008; Mathieson, Bailey, & Gurevish, 2002; Stevens, 1995).

Some have argued that there are differential degrees of stigma associated with various sexual minority and gender identity groups (Finlon, 2002; Gay and Lesbian Medical Association and LGBT Health Experts, 2001). For instance, Hiestand, Horne, and Levitt (2007) examined the health care experiences of lesbian and bisexual women who identified as being either more "butch" or "femme." Indeed, they found that butch women had fewer regular gynecologic examinations and reported poorer treatment in health care settings, despite being more likely to be "out" with HCPs than femme women. Others have found that queer women whose self-reported orientation was more heterosexual than exclusively homosexual, were less likely to disclose their sexual orientation to HCPs than lesbian-identified women (Polek, Hardie, & Crowley, 2008). Similarly, Meckler, Elliott, Kanouse, Beals, and Schuster (2006) found that bisexual youth were less likely to disclose to HCPs than gay- or lesbian-identified youth.

Although researchers have begun to examine the nature of health care experiences among SMW and some have explored differential treatment and perceptions of stigma within SMW populations, we could find no contemporary research that examined whether health care experiences and actual health care receipt differed by sexual orientation status. To that end, we had three primary objectives for this study. First, we wanted to investigate whether there would be differences between heterosexually identified women (herein referred to as HW) and SMW in terms of the degree to which they receive regular health care, are recommended and/or receive similar preventive screenings, and how satisfied they are with their HCPs. Second, we wanted to examine whether there would be any differences on these indices among SMW who identify as lesbian (herein referred to as "lesbian SMW") and other queer-identified women (including those who identify as bisexual, pansexual, queer, etc.; herein referred to as "non-lesbian SMW"). Third, we aimed to explore whether provider knowledge of sexual orientation would be associated with positive health care experiences (i.e., satisfaction with HCPs and comfort discussing sexual health issues with HCPs) among all SMW.

Based on our review of the literature, we proposed the following hypotheses: 1) compared with HW, SMW will have received health care less recently, will have been less likely to have been given recommendations for preventive care and to have received preventive care, and will report poorer health care experiences; 2) compared with lesbian SMW, non-lesbian SMW will have received health care less recently, will be less likely to have been given

recommendations for preventive care and to have received preventive care, and will report poorer health care experiences; and 3) HCP knowledge of patient sexual orientation will be associated with health care experiences in the following ways: 3a) compared with SMW who believe that their HCPs are unaware of their sexual orientation, SMW who believe their HCPs know their sexual orientation (regardless of the manner in which HCPs arrived at this awareness) will report better health care experiences, 3b) compared with SMW who have not explicitly disclosed their status, those who have disclosed their status will report better health care experiences, and 3c) among the subsample of those whose providers are aware of their sexual orientation, SMW who have explicitly disclosed will report better health care experiences than SMW whose providers found out through other means.

## Methods

### Study Procedures

Participant recruitment took place at a Lesbian, Gay, Bisexual and Transgender (LGBT) PRIDE festival held annually in a large, Midwestern city. Trained research assistants were stationed at a festival booth and invited festival attendees to participate in a survey regarding their health care experiences. Persons who were at least 18 years of age and who reported seeing a primary HCP (e.g., family practice, internal medicine specialties) within the past 5 years were eligible to participate in the study. Once eligibility was established, participants were escorted to a semiprivate area in which they provided informed consent and completed an anonymous, self-administered, written survey. Upon completion of the survey, participants dropped their surveys into a secured collection box and received a small gift valued at \$5 in exchange for their time, approximately 10 minutes. In total, 420 women—354 women who identified as being lesbian, gay, bisexual, or another “queer” identity (e.g., pansexual) and 66 women who identified as being heterosexual—participated in the survey. All procedures were approved by appropriate institutional review boards.

### Measures Participant demographics

We collected participant gender, sexual orientation, age, education, ethnicity, income, residency, and HIV status data. With respect to sexual orientation, participants were asked to report their sexual orientation according to the following response options: Gay/lesbian/homosexual, bisexual, straight/heterosexual, questioning/uncertain, or other. We operationalized HW as women who self-identified as straight/heterosexual and SMW as those who self-identified as lesbian/homosexual, bisexual, questioning/uncertain, and other. For the purposes of some analyses, the SMW group was subdivided between lesbian SMW and non-lesbian SMW.

### Time since last primary health care visit

We asked each participant when she last had an appointment with her current HCP. Participants responded to one of five options ranging from “less than 1 month ago” to “more than 2 years but less than 5 years ago.” For the purposes of the current study, we recoded the five responses to represent a dichotomous measure of “less than a year ago” and “1 year or more ago.” Recent health care receipt was operationalized as having an appointment with a HCP during the year before the interview date.

### Quality of health care experiences

To assess perceived quality of health care experiences, we asked participants about the degree of comfort they felt discussing their sexual health with their HCP and general satisfaction with their HCP. Specifically, participants were asked to respond on a 4-point Likert-type scale (from “very comfortable” to “very uncomfortable”) to the question, “How comfortable are you with discussing sexual health with your doctor?” To assess satisfaction, participants were asked, “How satisfied are you with your doctor?” A 4-point Likert-type scale was used with options ranging from “very satisfied” to “very unsatisfied.” For the purposes of this study, two dichotomous variables were created such that very/somewhat comfortable and very/somewhat satisfied were recoded as comfortable and satisfied, respectively, and very/somewhat uncomfortable and unsatisfied were recoded as uncomfortable and dissatisfied, respectively.

### Preventive health care recommendations and receipt

Each participant was asked whether her HCP had ever recommended a cervical pap smear or mammogram. Participants were also asked whether they ever had a cervical pap smear (ever and in the past 2 years) or if they have ever had a mammogram.

### HCP knowledge of participant sexual orientation

Each participant was asked, “Do you believe your doctor knows what your sexual orientation is?” Those who responded affirmatively were asked how their HCPs knew their sexual orientation. Response options included: “I disclosed without being asked,” “I disclosed because my doctor asked,” “S/he probably assumes it,” or “Someone else told him/her.” For the purposes of this study, we examined differences between SMW who believed their HCPs were aware versus those who believe they were unaware of their sexual orientation and between SMW who disclosed their orientation versus those who did not (i.e., all SMW data were included in the analyses). For SMW whose providers ostensibly knew of their sexual orientation, we examined whether there were differences in outcome indices depending on the manner by which HCPs came to be aware of the participants’ minority sexual orientation.

### Data Analyses

Statistical analyses were performed using SPSS 20.0 (SPSS Inc., Chicago, IL). Frequencies and descriptive statistics were calculated. To test hypothesis 1, that SMW will have received health care less recently, will be less likely to have been given recommendations for and to have received preventive care, and will report poorer health care experiences than HW, we conducted a series of chi square analyses. We controlled for age (i.e., <40 vs. 40 years of age) when examining mammogram recommendation and receipt. To test hypothesis 2, that compared with lesbian SMW, non-lesbian SMW will have received health care less recently, will be less likely to have been given recommendations for and to have received preventive care, and will report poorer health care experiences, we conducted a series of chi square analyses and controlling for age as we did with the analyses for hypothesis 1. Finally, to test hypothesis 3, that HCP knowledge of patient sexual orientation will be associated with health care experiences, we conducted a series of chi square analyses.

## Results

The total sample consisted of 420 women whose mean age was 31.44 years ( $SD = 11.32$ ; range, 18–78). Approximately half of the women (55.7%;  $n = 234$ ) identified as lesbian; 28.6% ( $n = 120$ ) identified themselves as another sexual minority (e.g., bisexual, pansexual, queer, etc.), and 15.7% ( $n = 66$ ) reported being heterosexual. Most women reported being White (69.8%); 7.6% were Latino and 12.1% were African-American. Over half (55.5%) had finished college and 96% had finished high school. The majority (58.6%) reported living in an urban area, and 30.2% and 11% reported living in suburban or rural areas, respectively. Over one third (37.6%) earned more than \$30,000 annually. Among SMW ( $n = 351$ ), the majority (66.1%) were referred to their providers from people in their own personal social networks or other providers; only 2% reported selecting their providers from a “gay-friendly” resource list. Also among SMW ( $n = 354$ ), 65.8% ( $n = 231$ ) reported believing that their HCP was aware of their sexual orientation. Of these, 49% ( $n = 172$ ) reported that they had disclosed their sexual orientation without being asked, 8.0% ( $n = 28$ ) disclosed because the HCP asked, 7.4% ( $n = 26$ ) believed their HCP assumed their minority sexual orientation, and 1.4% ( $n = 5$ ) reported that someone else told their HCP. Table 1 provides additional descriptive statistics.

With respect to the first hypothesis, compared with HW, SMW were equally as likely to have received recent health care ( $p = .72$ ) and equally as likely to report feeling comfortable discussing their sexual health with their HCPs ( $p = .14$ ; refer to left-hand side of Table 2 for statistical results). SMW were somewhat less likely to report being satisfied with their HCPs than HW ( $p = .05$ ), however. SMW were equally as likely to have been given recommendations for and to have received cervical pap smears ( $p = .99$  for recommended pap smear;  $p = .37$  for having ever had a pap smear; and  $p = .36$  for having had a pap smear in last 2 years). After controlling for age, SMW were equally as likely as HW to have been given recommendations for and to have received a mammogram ( $p = .94$  and  $p = .62$ , respectively). Overall, then, hypothesis 1 received limited support. Although there were few differences between HW and SMW with respect to time since last primary health care visit diagnostic recommendations and receipt, or certain subjective evaluations of the quality of the health care experience, SWM were less likely than HW to report being satisfied with their HCPs.

With respect to the second hypothesis, findings indicated that non-lesbian SMW were equally as likely as lesbian SMW to have received recent health care ( $p = .84$ ), report being satisfied with their HCP ( $p = .12$ ), and report being comfortable discussing their sexual health with their HCP ( $p = .17$ ; refer to right-hand side of Table 2). Non-lesbian SMW were equally as likely as lesbian SMW to have received a recommendation for a cervical pap smear ( $p = .46$ ), to have ever received a cervical pap smear ( $p = .12$ ), and to have received a cervical pap smear in the past 2 years ( $p = .27$ ). After controlling for age, non-lesbian SMW and lesbian SMW were equally likely to have been given a recommendation for and to have received a mammogram ( $p = .17$  and  $p = .38$ , respectively). Hypothesis 2 was thus not supported. That is, non-lesbian SMW had similar health care experiences to lesbian SMW.

With respect to hypothesis 3, SMW who believed their HCPs knew their sexual orientation were more likely to report being satisfied with their HCPs ( $p = .01$ ) and more likely to report being comfortable discussing sexual health issues ( $p < .001$ ) compared with SMW who believed their HCPs did not know their sexual orientation (Table 3). Likewise, when we asked whether participants had disclosed their sexual orientation, we found a similar trend in the data. That is to say, those who reported disclosing their sexual orientation reported greater satisfaction ( $p = .01$ ) and comfort discussing sexual health issues ( $p < .001$ ). Among those whose HCPs purportedly knew their sexual orientation, the means by which they came to find out (e.g., explicit disclosure vs. “she just knew”), was not associated with satisfaction ( $p = .83$ ) or comfort discussing sexual health ( $p = .50$ ), however. Thus, hypothesis 3 was partially supported. That is, provider knowledge of patient sexual orientation was associated with better health care experiences. The means by which this knowledge was obtained, however, was not differentially associated with satisfaction or comfort discussing sexual health.

## Discussion

Although other researchers have examined differences in health care experiences among women of different sexual orientations, this study represents one of the largest community-based samples to investigate such differences (Diamant, Schuster, & Lever, 2000; Polek et al., 2008). Moreover, we have examined sexual orientation along two key dimensions, namely in terms of both private self-identification and with respect to providers’ knowledge of patients’ sexual orientation. We believe that both dimensions are important to understanding the needs of SMW in the health care context because perceived and actual bias (as evidenced by quality of preventive care) can occur whether sexual orientation disclosure has happened or not.

This large-scale survey study lends insight into health care satisfaction and receipt among SMW living in a midsized, Midwestern city. Contrary to hypothesis 1, we found no differences between HW and SMW with respect to recommended and received preventive health care interventions, and comfort discussing sexual health with primary HCP. Consistent with hypothesis 1, we found differences with respect to satisfaction with health care providers (HCP), however. The sample size of HW who reported being dissatisfied was very small and there seem to be substantial differences in satisfaction with HCPs between these two groups of women. Therefore, although the health care outcomes for the two groups may have been relatively similar, the divergence with respect to overall satisfaction with HCPs is important as it might have implications for SMW’s long-term engagement in medical care. Although there was a marginal difference with respect to satisfaction with HCPs, there were no other differences between SMW and HW and indeed, there were no meaningful differences between the health care experiences of lesbian and non-lesbian SMW.

With respect to hypothesis 3, our findings suggest that irrespective of specific sexual orientation, SMW whose HCPs knew of their orientation reported better health care experiences. However, the mode by which HCPs gained such knowledge was not associated with subjective indicators of health care quality. That is to say, there were no significant

differences among SMW whose HCPs knew based on whether they disclosed without being asked, whether their HCPs asked, or whether the HCPs came to know in other ways (e.g., someone else informed the HCPs). Therefore, hypothesis 3 was partially supported and underscores the importance of investigating how HCPs come to know about patients' sexual orientation rather than simply whether patient disclosure occurred (Diamant et al., 2000).

Although we are making a substantial contribution to the literature given that our data comes from a relatively large, community-based sample, we were comparing data among groups of uneven sizes and unfortunately, beyond age, we were unable to control for other factors owing to low cell counts. A larger scale, population-based survey should be conducted to find out whether these attitudes and experiences are representative of the broader population of U.S. women and to examine differences within larger, non-lesbian SMW populations. Furthermore, these data were cross-sectional, which poses inherent limitations. For example, we asked participants to retrospectively assess the nature of their relationship with a HCP they had visited within the previous 5 years and provide information about their HCPs' recommendations and provision of care. As a result, we expect some recall bias. Likewise, participants' current HCP satisfaction might be higher than overall satisfaction with HCPs if they have abandoned HCPs with whom they were less satisfied. It is notable, however, that SMW still reported less satisfaction than HW despite this potential bias.

We could not randomly assign HCPs to participants; therefore, it is likely that the providers SMW choose are those who are affirming of their sexual orientation. Indeed, SMW who participate in LGBT PRIDE celebrations are likely more open about their sexual orientation in public contexts than those who do not participate. This greater ease with having their sexual orientations be known may carry over to health care contexts and it might facilitate better access to information about HCPs who are affirming of LGBT populations. Moreover, just as SMW who attend LGBT PRIDE celebrations cannot be taken to represent all SMW, heterosexual women who attend public events celebrating the LGBT population may be very different from their counterparts who do not.

Of course, we must avoid making causal inferences with our data, particularly with respect to variables such as disclosure. That is to say, the very act of disclosure can influence patient satisfaction, but satisfaction likely facilitates sexual identity disclosure, as well. Likewise, we cannot determine whether patient satisfaction was more commonly contingent upon patients who are proactive in making their sexual orientation known or HCPs who make it a practice to initiate broad discussions with their patients about sexual health.

### **Implications for Clinical Practice and Research**

Despite these limitations, our study contributes to the extant literature related to SMW health care experiences. Our findings suggest that, although there are few differences between preventive health care recommendations and receipt when comparing lesbians with other SMW and when comparing all SMW with HW, SMW might be less satisfied with their care than HW women. We also found important differences with respect to the satisfaction and comfort SMW report when their HCPs know of their sexual orientation. Specifically, those whose providers knew and those who had disclosed reported greater satisfaction and comfort discussing sexual matters than those whose HCPs did not know or

those who had not told. That satisfaction with provider and comfort discussing sexual health did not vary depending on how HCPs knew—just that they did—has important implications for clinical practice and research.

In terms of practice, although there may be benefits to having an explicit conversation about sexual orientation, such a conversation may not be necessary, particularly if sexual orientation information is communicated in other ways (e.g., subtle cues). We cannot look at shifts toward greater acceptance of homosexuality among the general public, however, and presume that these shifts in thinking extend to people of other marginalized sexual identities or that such shifts are represented in health care clinic policy or practice. The American Medical Association has mandated physicians to become educated on health care disparities and to engage in nondiscriminatory practice, it has encouraged hospitals and clinics to broaden public nondiscriminatory statements to include “sexual orientation, sex, or gender identity,” and it has highlighted the deleterious consequences of “unrecognized homosexuality,” including the consequential failure to screen, diagnose, and treat relevant medical problems (American Medical Association, n.d.; Levin & Mayer, 2010). Likewise, we argue that primary HCPs should make discussions about sexual health routine with all patients (c.f., McNair, Hegarty, & Taft, 2003; Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006). By initiating the discussion and making non-gendered references to sexual partners, HCPs will achieve two of our goals: 1) They will be communicating a nonjudgmental attitude of inclusivity and respect, and 2) they will be opening a dialogue that might enable more frank discussions about sexual orientation.

In terms of research, we may be misinterpreting client satisfaction data if we restrict our definition of sexual orientation disclosure to incidents in which patients explicitly come out of the closet (e.g., Diamant et al., 2000). Studies examining the various processes by which sexual orientation is communicated to providers are necessary to enable a more nuanced approach to measuring disclosure. Furthermore, prospective research that would enable us to determine whether sexual orientation disclosure leads to greater HCP trust and a greater willingness to follow HCP recommendations (or whether such disclosure is independent of satisfaction) would be useful to determine how best to engage SMW and keep them engaged in regular health care and health maintenance routines.

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**Table 1**

## Participant Sociodemographics

	HW	Lesbian SMW*	Non-Lesbian SMW	Total
Number of participants	66	234	120	420
Age (y), mean (SD)*	29.71 (11.51)	34.62 (11.89)	27.28 (11.62)	31.75 (12.19)
Education, n (%)*				
Less than high school	0	9 (3.8)	6 (5.0)	15 (3.6)
High school or GED	36 (54.5)	77 (32.9)	57 (47.5)	170 (40.5)
College/technical school	22 (33.3)	112 (47.9)	45 (37.5)	179 (42.6)
Postgraduate	8 (12.1)	36 (15.4)	10 (8.3)	54 (12.9)
Ethnicity, n (%)				
American Indian	3 (4.5)	7 (3.0)	3 (2.5)	13 (3.1)
African American/Black	5 (7.6)	31 (13.2)	15 (12.5)	51 (12.1)
Asian American	0	0	1 (.8)	1 (.2)
Caucasian/White	44 (66.7)	168 (71.8)	81 (67.5)	293 (69.8)
Latino/a	8 (12.1)	18 (7.7)	6 (5.0)	32 (7.6)
Other or biracial <sup>§</sup>	6 (9.1)	10 (4.3)	14 (11.7)	30 (7.1)
Income, n (%)*				
\$0–15,000	29 (43.9)	53 (22.6)	55 (45.8)	137 (32.6)
\$15,001–30,000	13 (19.7)	75 (32.1)	32 (26.7)	120 (28.6)
\$30,001–45,000	12 (18.2)	57 (24.4)	17 (14.2)	86 (20.5)
>\$45,000	12 (18.2)	48 (20.5)	12 (10.0)	72 (17.1)
Residency, n (%)				
Urban/City	38 (57.6)	136 (58.1)	72 (60.0)	246 (58.6)
Suburban/Outskirts	21 (31.8)	76 (32.5)	30 (25.0)	127 (30.2)
Rural/Town	7 (10.6)	21 (9.0)	17 (14.2)	45 (10.7)
HIV status, n (%)				
HIV positive	0	2 (.9)	0	2 (.5)
HIV negative	60 (90.9)	221 (94.4)	105 (89.7)	388 (92.4)
Not sure	4 (6.1)	6 (2.6)	12 (10.3)	22 (5.2)
HCP awareness of participant sexual orientation <sup>†</sup>	84 (81.8)	178 (76.1)	53 (45.3)	288 (68.6)
Reasons HCP knows sexual orientation				
Disclosed without being asked	23 (34.8)	143 (61.1)	29 (24.8)	197 (46.9)
Disclosed because HCP asked	8 (12.1)	16 (6.8)	12 (10.3)	36 (8.6)
Someone else told HCP	2 (3.0)	4 (1.7)	1 (0.9)	7 (1.7)
HCP probably assumes it	21 (31.8)	15 (6.4)	11 (9.4)	48 (11.4)

*Abbreviations:* HW, heterosexually identified women; SMW, sexual minority women; SD, standard deviation; HCP, health care provider.

\* Lesbian-identified women were significantly older, more highly educated, and reported a higher income than heterosexual and other SMW.

<sup>†</sup> Lesbian-identified women's providers were significantly more likely to be aware of their sexual orientation than other SMW's providers.

**Table 2**  
Sexual Orientation Status and Health Care Receipt, Recommendations, and Subjective Evaluation of Health Care Experiences

Variable	HW, n (%)	SMW, n (%)	Chi Square	p	φ	Lesbian SMW, n (%)	Non-Lesbian SMW, n (%)	Chi Square	p	φ
Health care receipt, time since last primary health care visit (y)			.14	.72	.02			.04	.84	.01
<1	55 (83.3)	285 (80.5)				190 (81.2)	96 (80.0)			
1	11 (16.7)	65 (18.4)				43 (18.4)	23 (19.2)			
Health care experiences Satisfaction with HCP			3.99	.05	.10			2.39	.12	.08
Satisfied	65 (98.5)	321 (90.7)				218 (93.2)	106 (88.3)			
Unsatisfied	1 (1.5)	30 (8.5)				16 (6.8)	14 (11.7)			
Comfort discussing sexual health with HCP			2.19	.14	.07			1.91	.17	.07
Comfortable	59 (89.4)	286 (80.8)				196 (83.8)	93 (77.5)			
Uncomfortable	7 (10.6)	63 (17.8)				37 (15.8)	26 (21.7)			
HCP recommendations, ever Mammogram			.01*	.94	.005			1.90*	.17	.07
Yes	26 (39.4)	142 (40.1)				108 (46.2)	34 (28.3)			
No	40 (60.6)	209 (59.0)				126 (53.8)	86 (71.7)			
Cervical pap smear			.00	.99	0			.55	.46	.04
Yes	34 (51.5)	181 (51.1)				117 (50.0)	65 (54.2)			
No	32 (48.5)	170 (48.0)				117 (50.0)	55 (45.8)			
Preventive health care receipt Mammogram, ever			.25*	.62	.02			.77*	.38	.05
Yes	19 (28.8)	124 (35.0)				97 (41.5)	28 (23.3)			
No	47 (71.2)	227 (64.1)				137 (58.5)	92 (76.7)			
Cervical pap smear, ever			.82	.37	.04			2.38	.12	.08
Yes	49 (74.2)	241 (68.1)				167 (71.4)	76 (63.3)			
No	17 (25.8)	110 (31.1)				67 (28.6)	44 (36.7)			
Cervical pap smear, past 2 years			.84	.36	.04			1.22	.27	.06
Yes	33 (50.0)	197 (55.6)				126 (53.8)	72 (60.0)			
No	33 (50.0)	154 (43.5)				108 (46.2)	48 (40.0)			

Abbreviations: HW, heterosexual women; HCP, health care provider; SMW, sexual minority women.

† Analysis controls for age (i.e., <40 vs. 40).

\* Owing to small cell sizes, results from Fisher's exact test are reported.

Table 3

Sexual Minority Women's Satisfaction with Health Care Providers (HCPs) and Comfort Discussing Sexual Health With HCPs as a Function of HCP Knowledge of Patient Sexual Orientation

	Satisfaction				Comfort					
	Satisfied, n (%)	Unsatisfied, n (%)	Chi Square	p	$\phi$	Comfortable, n (%)	Uncomfortable, n (%)	Chi Square	p	$\phi$
Participant evaluations of HCP knowledge of her sexual orientation*			7.51	.01	.15			33.35	<.001	.31
HCP does not know	102 (29.1)	17 (4.9)				77 (22.1)	41 (11.8)			
HCP knows	218 (62.3)	13 (3.7)				208 (59.8)	22 (6.3)			
Participant disclosure of sexual orientation to HCP*			5.62	.01	.13			25.72	<.001	.27
Disclosure has not occurred	131 (37.4)	19 (5.4)				104 (29.9)	45 (12.9)			
Disclosure has occurred	189 (54.0)	11 (3.1)				181 (52.0)	18 (5.2)			
Means by which HCP gained sexual orientation knowledge <sup>†</sup>			.05	.83	.01			.46	.50	.04
Participant disclosed	189 (81.8)	11 (4.8)				181 (78.7)	18 (7.8)			
HCP learned by other means	29 (12.6)	2 (0.9)				27 (11.7)	4 (1.7)			

Abbreviations: HCP, health care provider; SMW, sexual minority women.

\* All SMW included in analyses.

<sup>†</sup> Only SMW who believed their HCPs knew of their sexual orientation were included in the analyses.