

Papers

Interaction strategies of lesbian, gay, and bisexual healthcare practitioners in the clinical examination of patients: qualitative study

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Abstract

Objective To explore how lesbian, gay, and bisexual healthcare practitioners manage their identity in the clinical examination of patients.

Design Qualitative study using grounded theory.

Setting Hospital and primary health care.

Participants 16 healthcare professionals who identified themselves as lesbian, gay, or bisexual, and are involved in the clinical examination of patients.

Results Healthcare professionals engage in a complex interplay of identity management strategies to avoid homophobic abuse; as a signal of safety from homophobia and understanding for their lesbian, gay, and bisexual patients and as a desexualisation strategy principally for gay men and their women patients. Their training has not helped them deal with ethical and medicolegal anxieties.

Conclusion In the light of new legislation, published guidelines will help training and governing bodies understand and help ameliorate the added pressures on their lesbian, gay, and bisexual students and medical staff.

Introduction

Organisations such as the NHS are highly gendered and sexualised spaces.^{1,2} Sexual harassment and homophobic attitudes have also been shown to exist in such organisations.^{3,4}

In the examination of patients, sexuality is a taboo subject; professional and legal sanctions guard against violation of boundaries.^{5,6} General and gendered (such as using a chaperone) strategies to desexualise the clinical encounter reinforce certain gendered behaviours and privilege heterosexual desire.⁷

The medical literature in this area tends to focus on the use or non-use^{8,9} and function¹⁰ of chaperones, women patients' preferences for women practitioners,^{11,12} and informed consent.¹³ No studies specifically examine the experiences of lesbian, gay, and bisexual practitioners.

This study explores how lesbian, gay, and bisexual healthcare practitioners manage their sexual identity in the clinical examination of patients.

Methods

Grounded theory was the method of choice to inform data collection and analysis.¹⁴

Sampling

Subjects were recruited from the national Gay and Lesbian Association of Doctors and Dentists (GLADD), of which the

author is a member. Snowball techniques helped to refine and increase sample size. The association has 374 qualified doctors and medical students as members, and 85% have access to email (n = 318). Two separate emails, sent to the list of contacts via the GLADD committee, invited the recipients to participate in the study or pass the email on to interested parties. Forty six (15%) practitioners made contact by email; 16 (5%) agreed to be interviewed. All study participants gave written consent. The data were anonymised.

Measurements

The author used standard techniques to conduct semistructured interviews lasting one hour.¹⁵ Interviews took place at the participants' place of work or a mutually agreed neutral place, such as a coffee shop. One participant was interviewed by telephone.

Interview guide

The brief list of questions below is a subset of the full interview guide.

- Demographics including medical speciality, and sexual orientation.
- Does your sexuality affect your work? How? Are you "out" at work? Have there been verbal or physical threats?
- How does your gender and sexuality impact on the clinical examination? For example, do you use chaperones? Can you explain your rationale? Does that cause you any worries?
- Is your interaction different for different types of examination? Or different patient groups? Can you say why?

Analysis

I audiotaped and transcribed the interviews. Constant comparison analysis was used to interpret the data.^{14,16} Open coding entailed each transcribed line being scrutinised to establish categories and concepts. Comparison across scripts followed. This was an iterative process, in which categories were searched for in the data set and all instances were compared until no further categories could be identified. New data were used to assess the integrity of the conceptual framework. The 30 practitioners who made contact wrote lengthy responses on this subject, several raising their concern about being "outed" despite reassurance. These responses helped inform the data analysis. Respondent validation, reflexivity, and professional triangulation helped maximise validity and minimise bias: a separate group of 25 lesbian, gay, and bisexual practitioners attended a presentation of the data, and an anthropologist, ethnographer, and critical psychologist participated in a separate discussion of the data. The interviews generated a wealth of data through a process of constant comparison. The main issues emerging from this process are presented here.

Characteristics of participants in interview survey

Sex	Sexual orientation		
	Gay	Lesbian	Bisexual*
Male	13	—	1
Female	—	2	1
Transgender	0	1	0

*One man identified as both gay and bisexual, and one woman identified as both lesbian and bisexual.

Results

Four general practitioners, one oncologist, one paediatrician, one physician, one psychiatrist, two genitourinary specialists, three senior medical students, two nurse practitioners, and one physiotherapist participated in the study. Fourteen worked in large metropolitan cities and two in rural communities. The table shows details of the composition of sexes and sexual orientation.

Identity management

Passing can be defined as “the management of undisclosed discrediting information about self.”¹⁷ So, to “pass” could mean a person distancing himself or herself from the discredited group to avoid the effects of stigma in belonging to that group. Being “out” describes the level of disclosure of sexual identity either to oneself or to others¹⁸ and is not an all or none phenomenon. So a person may “out” themselves as gay to a family member, for example, stating their sexual identity, which has previously been assumed to be heterosexual. Other people may pick up on sexual identity, rightly or wrongly, by “reading” certain subtle subcultural codes, in behaviour or linguistic style, for example.

The identity management mechanisms, passing, and outing served three main functions.

Passing to avoid homophobia

Subject 14 (female): “I have grown my hair longer so as not to look so harsh and not so dykey ... It’s mostly from the young guys in the waiting area. They say ‘Oh, you fucking dyke.’ It’s so much more aggressive now, really, in practice, so I guess it’s a protective element more than anything...”

Outing as a signal to their lesbian and gay patients that they will be understood and safe from homophobia

Subject 2 (male): “A lot of gay men will join my list because I am gay ... there is a mutual sense of respect.”

Subject 5 (male): “There was an occasion when a teenager had taken an overdose, and as I was going through the history he broke down and said it was because he was gay that he taken the overdose. I did ‘out’ myself on that occasion ... [I] felt it was important to act as a kind of role model.”

Subject 8 (male): “A lot of gay men and lesbians have joined my practice, as I am gay, they pick up on me, you know, the longer eye contact; there is an acknowledgement. They would talk about things I would get [pause], in code I understand, for instance, they may describe something, and I understand them ... um ... they [pause] you know, they have similar stories.”

Outing as a desexualisation strategy principally for gay male practitioners examining women patients

Subject 8 (male): “Well, I offer women a chaperone as routine, really, if they want a chaperone or not, you know, we spoke about the gaydar thing [a colloquialism, describing the ability to discern sexual orientation], but some women are also in tune with that, you know they would touch my leg, not in a sexual way, and say, ‘Oh no, I can trust you!’ I think they can tell I’m gay ...”

Subject 9 (male): “The subtexts of the patients was [whispers], “You know they are gay; you don’t need to worry.”

However, if practitioners were “read” by some lesbian, gay, and bisexual and straight women patients, on occasion this led to the practitioner being sexually harassed. Practitioners used both general and gendered desexualisation strategies⁷ to manage this situation.

Ethical and legal considerations

Identity management strategies left practitioners struggling at times to resolve apparent conflicts between principles of autonomy (informed consent) and justice (freedom from discrimination),¹⁹ between personal (right to privacy) and public (professional) information giving.

Subject 10 (male): “I am ‘out’ to my colleagues and patients. Very rarely, say once every few years, someone will abuse me and say I am not going to be examined by that queer bastard or something like that. For some patients it may be an issue. Sometimes some men will come in and say I didn’t want to go to the GUM [genitourinary medicine] clinic cos they are all gay. Um, and I am left in a sort of dilemma as I am also gay.”

Interviewer: “How do you manage that?”

Subject 10: “Well it depends on how busy I am. If I am very busy I just get on with it. Then again, some of the straight guys who have been abused sexually by males, I feel obligated [sic] to tell them that I am gay, especially if I do something intimate to them, so they may prefer to see somebody else.”

In passing, some gendered desexualisation strategies (for example, in the use or non-use of a chaperone) left practitioners with concerns about claims of inappropriate conduct after the event if their sexuality were to be discovered. These were more evident with their heterosexual patients, although some male practitioners commented that their identity might be used as a defence if they faced a claim from a female patient.

Subject 3 (male): “We always have nurses for the women, but I see a lot of men with testicular cancer, and for them [the nurses] leave as it may embarrass them. I sometimes wonder if I am potentially exposing myself medicolegally. I mean, for me, I do my job and get on with it, but I guess if there was a claim they may say I was gay to sue me.”

Subject 12 (female medical student): “I was told to go and examine a woman [breast examination], and the boys were told to get a nurse as a chaperone, but I was told to just get on with it. It was fine; I asked permission, and she was with her sister and said ‘Oh yes, fine, we are all girls together’ and all that, but I thought, if only you knew, but I’m sure she wasn’t going to let me do it. It was fine; I felt I wasn’t crossing boundaries, but I guess that was my first insight into how I may be vulnerable.”

Discussion

In the examination room, desexualisation strategies help practitioners manage their own and their patients’ sexuality. Gendered strategies (such as use of a chaperone) assume a heterosexual orientation, conflicting with an lesbian, gay, and bisexual identity. Interaction strategies help lesbian, gay, and bisexual practitioners manage the individual and organisational manifestations of sexual prejudice, but in the examination room this leaves them exposed to particular anxieties that have not been dealt with in their training. Future research could measure the impact of these anxieties on the individual professional’s wellbeing, as research shows increased levels of stress in lesbian, gay, and bisexual people having to negotiate issues around passing and being out.²⁰ In the light of the recently implemented employment equality (sexual orientation) regulations,²¹ published guidelines^{22–24} may

go some way to help trusts, governing bodies, and educational establishments improve the working lives of their lesbian, gay, and bisexual students and staff.

It is generally considered acceptable for patients to choose a medical practitioner on the basis of sex but not on other grounds, such as race, although practitioners still struggle on how to deal with the ethical and legal dilemmas on racial discrimination²⁵ despite zero tolerance protocols. Future work examining the ethical and legal dilemmas relating to sexuality, ideally incorporating patients' views, could further help and protect practitioners and patients.

An essentialist account of gender and sexuality, equating sexual anatomy with sexual destiny, is more familiar to a medical audience.²⁶ This theoretical basis tends to propagate unhelpful myths about these concepts and skews research and clinical care.²⁶⁻²⁸ Social constructionism, postmodernism,²⁶ and queer theory²⁹ can enrich the medical profession's understanding of issues pertaining to gender and sexuality. These theories also help to explain why certain gendered and sexual ways of being are privileged. Future research in the medical arena embracing alternative discourses on gender and sexuality may address these skews, further our understanding of these concepts, and improve care for patients²⁶⁻²⁷ and hopefully the working lives of all practitioners.

Limitations of the study

This is a small study with 16 participants. Attempts have been made to minimise sampling bias and to improve validity and relevance. Not all lesbian, gay, and bisexual practitioners are members of GLADD, and it was not possible to observe clinical encounters directly.

I thank all participants and the GLADD committee and Ian Hodges, Susan Ormrod, Kingsley Norton, Vincent Quinn, Benjamin Soares, and Fiona Warren for their help, support, and encouragement throughout this project. Funding: This research was partially funded by the Foundation for the Scientific Study of Sexuality.

Competing interests: None declared.

Ethical approval: South East Multi-centre Research Ethics Committee.

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What is already known on this topic

Sexuality in the clinical examination of patients is a taboo subject

Desexualisation strategies help practitioners manage their own and their patients' sexuality

Some desexualisation strategies in the clinical examination of patients privilege heterosexual desire

What this study adds

Practitioners used interaction strategies to deal with homophobia

A lesbian, gay, and bisexual identity is used in certain ways to facilitate the clinical encounter with certain groups of patients

Potential ethical and medicolegal dilemmas need to be dealt with in training

A greater understanding of sexuality and gender issues in the clinical examination of patients is needed

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(Accepted 11 February 2004)

doi 10.1136/bmj.38071.774525.EB

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