CME

Gay patients

Context for care

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SUMMARY

Gays and lesbians are a part of our society and our practices: real people with real lives, not stereotypes. Understanding their inner world and their social milieu is the first step to providing care that is holistic and appropriate. The "coming out" process and other unique health issues are described. Guidance is provided on how to identify and relate to gay and lesbian patients.

RÉSUMÉ

Les gais et les lesbiennes font partie de notre société et de nos pratiques médicales: ce sont des gens avec des vies réelles et non des stéréotypes. La compréhension de leur monde intérieur et de leur milieu social constitue la première étape pour en arriver à dispenser des soins qui soient holistiques et appropriés. L'article décrit le processus de "visibilité" et les autres problématiques reliées à la santé. On y trouve certaines indications pour mieux identifier et communiquer avec les gais et les lesbiennes.

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THE GAY AND LESBIAN ELEMENT OF the Canadian cultural mix has become increasingly visible in recent years. This change in presence arises both from the onset of HIV disease in North America and from important human rights and Charter of Rights decisions across Canada. For example, in the 1992 Leshner case, an Ontario Human Rights Tribunal directed the provincial government to extend spousal benefits to same-sex partners of its employees. In the 1991 Garneau case, the British Columbia Supreme Court made a similar decision, saying that denial of benefits violated the Charter. In the Birch case, the Ontario Court of Appeal held that the Canadian Human Rights Code should be interpreted to include sexual orientation as a prohibited ground for discrimination. Captain Birch had been denied promotion within the Canadian Armed Forces because he was gay.

Family physicians will inevitably come into contact with openly gay or lesbian patients more frequently in their practices. Even within smaller communities across Canada, more and more gays and lesbians are feeling comfortable in being open and "out" within their community in both their personal and working lives. Family physicians must have a concurrent increase in their understanding of the realities of being gay in Canadian society: ie, what it means in terms of lifestyle and the medical, psychological, and social problems that can affect these patients.

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What do family physicians need to know?

We propose four goals for physicians in keeping with the four principles of family medicine[1]:

- to improve understanding of and comfort with the realities of being a gay man or woman;
- to have the sensitivity and skills to recognize such patients in their community and practices;
- to project at least a nonjudgmental and preferably a supportive attitude

toward these patients within the doctor-patient relationship; and
- to have adequate knowledge and skills to manage patients' unique health problems, whether personal, social, developmental, or medical.

What does it mean to be gay or lesbian?

Being gay must be seen as a single contextual facet of a person's life. It is not an illness label, nor does it simply denote sexual contact with a same-sex partner. Feelings of warmth, empathy, and emotional connectedness in relationships and identification with the overall social milieu are as important as the sexual act in defining "gayness."

Gay men and lesbians can and do live happy, productive lives. They live and love; work and play; have friends and family, and often children; and usually prefer long, committed relationships. They could be factory workers or artists; be your mailman or your physician; be young or old; be high flying swingers or single unemployed mothers. They can also be lonely and grief-stricken if they lose their partners; can have relationship or sexual problems; and can get sick.

They happen to be attracted to the same sex, but they do not want to *be* the opposite sex. In general, gay men like handsome men and want to look "masculine" (they go to the gym a lot these days); and lesbians do not all look like truck drivers. They feel normal and are normal, even though society often does not treat them that way. They and we are all people; being gay is just one aspect of who we are.

Same but different

The mix of emotional and physical illnesses and dysfunction these patients can have is in some ways like that of "straight" members of the practice but in other ways is dramatically different. For example, a couple experiencing relationship difficulties is often forced to deal with these issues without the supports normally available to "straight" couples. Because society continues largely to condemn homosexuality and gay coupling, a struggling gay couple cannot look to family, co-workers, or friends for support as readily as "straight" couples. As a result, gay and lesbian individuals and couples must put in place a network of close friends, a family of choice, to provide the supports required.

Consider the realities of living in an environment in which openly sharing one's day-to-day pleasures and pains with co-workers is possible only if reference to the sex of one's partner is carefully censored. Homophobia and heterosexism (the assumption that everyone is heterosexual) continue, unfortunately, to be the predominant attitudes in North American society.

Living gay

Year by year, more gay and lesbian individuals and couples demonstrate that it is quite possible to live openly, even in smaller communities, without being ostracized and, in fact, to have a respected and visible role in the community. Historically, fear has kept people from "coming out." In the 1970s and 1980s, older "established" gays increasingly began to live openly and honestly in their communities.

These visible role models make it easier and safer for young gay men and women to come out in the 1990s, a trend that is on the increase. Role models are also essential for development of self-esteem. Gay and lesbian support groups at virtually all universities and colleges across Canada now provide social contact with peers and enable self-disclosure in a safe and supportive environment.

Coming out

Being gay is not an illness, but gays do have unique health problems. The first psychosocial problem for gay men and women can often be the coming out process, which occurs most commonly during the late teens or early 20s, but (particularly when family or societal disincentives have been strong) it can

be long delayed, sometimes even after years of marriage. It could take weeks, or years, or be a lifelong process. However, once it has happened, people occasionally will say, "I've always known that I was gay."

Coming out should be understood as redefining one's own self-identity and accepting one's self-worth as a gay man or lesbian. It involves learning how to relate to same-sex individuals at all levels of human interaction and to family, friends, and society. It is far more complex than the simple announcement to family and friends that one is gay.

The coming out process is first of all an internal one. It is frequently aided by contact with other gay men and women, reading material, or supportive counselors who focus on accepting one's self and building self-esteem rather than on changing the sexual orientation once that orientation is clearly homosexual. The next step is to begin "testing the waters" by self-revelation to trusted friends or family and then gradually to extend that circle to whatever distance and complexity feels comfortable (eg, extended family, extended friends, work). The time of coming out can often be one of great social and sexual activity; a second "adolescence" for someone chronologically much older.

Patients who are struggling with coming out often present to family physicians with substance abuse (a common problem among gays and lesbians) or overt depression, with or without serious suicidal potential (especially worrisome and common among gay teenagers). Adolescents face particular difficulties from added self-esteem problems, peer pressure, confusion, lack of role models, and real risk of verbal or physical abuse if labeled gay.

Other health problems

Gays and lesbians are also subject to many psychosocial problems and illnesses in common with heterosexuals (eg, relationship problems, family stresses, financial and work difficulties, sexual dysfunction). All or any of these might be presented in the context of a gay lifestyle to an open and caring physician, and so knowing that context is essential to providing good care.

As well, some health issues and disease potential for gay men and women clearly are unique. Human immunodeficiency virus disease is the obvious example for men and certainly the most serious sexually transmitted disease, but also preventive medicine and screening programs require special consideration. Lesbians with no male sexual partners are at low risk for HIV and other STDs and usually do not have birth control pill renewals to bring them to the office regularly.[2] The challenge, then, is often to stimulate regular health maintenance visits. Breast examinations, blood pressure monitoring, and lifestyle or risk assessments still are needed.[5]

In addition to the usual components of health maintenance for men, including safer sex information, hepatitis B immunization should now be routine for any gay man with more than one sexual partner either at present or anticipated. Colitis among gay men is more commonly parasitic in origin and can be asymptomatic, so that screening for parasitic disease in even asymptomatic gay men should be done regularly. Asymptomatic pharyngeal and rectal gonorrhea must be considered among gay men who are not monogamous.[6]

How do you see "them"?

The obvious need is to identify these patients within your practice and clearly signal that you are interested in, and able to receive, that information in a supportive, professional manner. To do this could require a critical review of your practice to determine the degree to which it reflects the assumption that everyone is, or ought to be, heterosexual. To signal gay and lesbian patients that you are prepared to hear about and deal with issues related to their sexual orientation, try such simple changes as displaying

gay-positive literature (eg, same-sex safer sex pamphlets or posters, gay support group brochures) in addition to heterosexually oriented literature and using "sex-neutral" questions in interviews and questionnaires.

The easiest direct way to get accurate responses is to incorporate nonjudgmental questions about sexual activity or relationships into every social history, whether as routine "new patient" information or when social context is important for managing a particular problem. An option, when faced with an emotionally distressed patient, is to enquire about problems in or support from relationships with men or women. When a sexually transmitted disease is diagnosed, rather than assuming a heterosexual contact as the source, *ask*.

It is extremely important how these questions are asked and what words are used. For example, asking a patient whether he is homosexual is much less likely to get a truthful response than asking whether the individual "has sex with men, women, or both"; or whether he or she is living with a man or a woman. The word "homosexual" is seen as a judgmental and medicalized term by many in the gay and lesbian community. The terms "gay man or woman" or "gay or lesbian" are the preferred and more comfortable terms that members of the gay community would normally use to describe themselves.

It is important as well to realize that many men who are sexually active with other men, whether or not they are married, may well *not* identify themselves as homosexual, gay, or bisexual. This is particularly true in smaller or conservative communities. Similarly, some women in intimate relationships do not apply the label "lesbian" to themselves.

The other key to projecting a nonjudgmental attitude is clearly identifying and dealing with one's own biases and prejudices and trying to discard any moral or religious judgments and poorly informed stereotypes. Increasing medical evidence shows that gay men and women in no sense choose their sexual orientation any more than heterosexuals choose to be "straight."[7,8] The only choice gay men and women have is whether to live outwardly as they know themselves to be inwardly. To educate yourself, do not be afraid to ask your identified gay and lesbian patients more about their lives and lifestyles. Most will be delighted that you asked.

Academic medicine, both undergraduate and graduate, is finally developing educational programs to increase awareness of, sensitivity to, and understanding of gay men and women. Particularly within family medicine, specific educational objectives are being developed in some programs to improve the skill and knowledge of family practice trainees. The Section of Teachers of Family Medicine plans to include sample educational objectives on gay and lesbian issues in its new curriculum guide. Seminars or lecture programs have been developed at the University of Western Ontario, University of Saskatchewan, McGill University, and Memorial University of Newfoundland, for example. Unfortunately, most Canadian faculties of medicine did not have formal objectives or courses as of October 1993. As well, the College of Family Physicians of Canada and its provincial chapters have begun to have speakers on gay and lesbian health issues. The presentation of this paper at the Annual Scientific Assembly is one.

Conclusion

Times are changing, and physicians must change with the times to meet the needs of all their patients, including the 5% to 10% who are gay and lesbian.[9] They are normal people who want to live normal lives, and expect increasingly to be treated normally by society and their physicians. Family physicians

in particular should see "gayness" as just part of who *we* are as people: a context, not a disease.[9] ■

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References

1. The College of Family Physicians of Canada. *General information and regulations on program accreditation and examinations. Family medicine. Emergency medicine. Care of the elderly.* Mississauga, Ont: College of Family Physicians of Canada, 1993:9.
2. Hepburn C, Gutierrez B. *Alive and well: a lesbian health guide.* Freedom, Calif: Crossing Press, 1988:8
3. White J, Levinson W. Primary care of lesbian patients. *J Gen Intern Med* 1993;8:41-7
4. Simkin RJ. Unique health care concerns of lesbians. *Can J Obstet Gynecol Wom Health Care* 1993;5:516-22.
5. Simkin RJ. Lesbians face unique health care problems. *Can Med Assoc J* 1991; 145(Dec 15):1620-3.
6. Willoughby BC. Health concerns (excluding AIDS) for male homosexual patients. *Can Fam Physician* 1988;34: 1765-9.
7. Hamer DH, Hu S, Magnuson VL, Hu N, Pattatucci AM. A linkage between DNA markers on the X chromosome and male sexual orientation. *Science* 1993;261:321-7.
8. Bailey JM, Pillard RC. A genetic study of male sexual orientation. *Arch Gen Psychiatry* 1991;48:1089-96.
9. Gonsiorek JC, Weinrich JD. The definition and scope of sexual orientation. In: *Homosexuality. Research implications for public policy.* Newbury Park, Calif: Sage Publications, 1991:11.

For further reading

Blumenfeld WJ, editor. Homophobia: how we all pay the price. Boston: Beacon Press, 1992.

Clark D. *Living gay.* Millbrae, Calif: Celestial Arts, 1979.

Clark D. *Loving someone gay.* Berkley, Calif: Celestial Arts, 1987.

Gonsiorek JC, editor. *A guide to psychotherapy with gay and lesbian clients.* New York: Harrington Park Press, 1985.

Homosexuality and the family. *Journal of homosexuality.* Binghampton, NY: Haworth Press, 1989;18(1/2).

Isensee R. *Growing up gay in a disfunctional family.* New York: Prentice Hall, 1991.

Issues in biological essentialism versus social constructivism in gay and lesbian identities. *Journal of homosexuality.* Binghampton, NY: Haworth Press, 1993; 24 (3/4).

Kirk M, Marsden H. *After the ball: how America will conquer its fear & hatred of gays in the 90's.* New York: Plume Books, 1990.

Loulan J. *Lesbian passion: loving ourselves and each other.* San francisco: Spinsters/Aunt Lute Book Co, 1987.

Muchmore W, Hanson W. *Coming out right: a handbook for the gay male.* Boston: Alyson Publications, 1991.

Muller A. *Parents matter.* New York: Naiad Press, 1987.

Schneider M. *Often invisible.* Toronto: Central Toronto Youth Services, 1988

Silverstein C. *A family matter: a parent's guide to homosexuality.* New York: McGraw-Hill, 1977.

Silverstein C, Picano F. *The new joy of gay sex.* New York: HarperCollins, 1992.

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