# 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 who 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

In the examination of patients, sexuality is a taboo subject; professional and legal sanctions guard against violation of boundaries.[1 2] General and gendered (such as using a chaperone) strategies to desexualise the clinical encounter reinforce certain gendered behaviours and privilege heterosexual desire.[3]

The medical literature focuses on the use or non-use[4 5] and function[6] of chaperones, women patients' preferences for women practitioners,[7 8] and informed consent.[9] 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 used to inform data collection and analysis.

### Sampling

Subjects were recruited from the national Gay and Lesbian Association of Doctors and Dentists (GLADD). Eighty five per cent have access to email (n = 318). Two separate emails invited recipients to participate or pass the email on to interested parties. Forty six (15%) practitioners made contact by email; 16 (5%) agreed to be interviewed.

### Measurements

Semistructured interviews were used lasting one hour. Interviews were conducted at the participants' work or a neutral venue. One took place by telephone.

### Interview guide

The following 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. Open coding entailed each transcribed line being scrutinised, to establish categories and concepts. Comparison across scripts followed. This was an iterative process. The 30 practitioners who made contact wrote lengthy responses, 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.

## 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. See bmj.com for sexual orientation.

### Identity management

Passing can be defined as "the management of undisclosed discrediting information about self." 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 others and is not an all or none phenomenon.

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

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*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."

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

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 strategies[3] 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),[10] and 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 … 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."

In passing, some gendered desexualisation strategies 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 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."

Characteristics of participants in interview survey

| | Sexual orientation | | |
|---|---|---|---|
| Sex | 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.

**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 use 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

## 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. Interaction strategies help lesbian, gay, and bisexual practitioners manage sexual prejudice, but in the examination room there are also particular anxieties that have not been dealt with in training. Future research could measure these anxieties as research shows increased levels of stress in lesbian, gay, and bisexual people having to negotiate issues around passing and being out.[11] Recent employment (sexual orientation) regulations,[12] and published guidelines[13–15] may help improve the working lives of 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.[16] Future work examining the ethical and legal dilemmas relating to sexuality, ideally incorporating patients' views, could further help practitioners and patients.

An essentialist account of gender and sexuality, equating sexual anatomy with sexual destiny, is more familiar to a medical audience.[17] This theoretical basis tends to propagate unhelpful myths and skews research and clinical care.[17–19] Future research embracing the impact of alternative discourses on gender and sexuality may address these skews, improve care for patients[17 18] and 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.

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# Representation of authors and editors from countries with different human development indexes in the leading literature on tropical medicine: survey of current evidence

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## Abstract

**Objective** To assess the current international representation of members of editorial and advisory boards and authors in the leading peer reviewed literature on tropical medicine.
**Design** Systematic review.
**Main outcome measures** Country affiliations, as classified by the human development index, of editorial and advisory board members of all tropical medicine journals referenced by the Institute of Scientific Information (ISI) as of late 2003 and of all contributing authors of full articles published in the six leading journals on tropical medicine in 2000-2.
**Results** Sixteen (5.1%) of the 315 editorial and advisory board members from the 12 ISI referenced journals on tropical medicine are affiliated to countries with a low human development index and 223 (70.8%) to countries with a high index. Examination of the 2384 full articles published in 2000-2 in the six highest ranking tropical medicine journals showed that 48.1% of contributing authors are affiliated to countries with a high human development index, whereas the percentage of authors from countries with a low index was 13.7%. Articles written exclusively by authors from low ranked countries accounted for 5.0%. Our data indicate that research collaborations between a country with a high human development index and one that has either a medium or a low index are common and account for 26.5% and 16.1% of all full articles, respectively.
**Conclusion** Current collaborations should be transformed into research partnerships, with the goals of mutual learning and institutional capacity strengthening in the developing world.

## Introduction

Serious under-representation of editorial and advisory board members from countries with a low human development index in general medical and psychiatry journals has been documented recently.[1 2] In addition, very low proportions of published articles from authors from low income countries have been found in many research fields, including psychiatry,[3] cardiovascular disease,[4] and epidemiology and HIV/AIDS.[5]

The current global burden of infectious and parasitic diseases is heavily concentrated in the developing world.[6] Major national and international initiatives have been launched to improve research capacities in developing countries.[7] It is therefore interesting to investigate whether scientists affiliated to countries with low or medium human development indexes have more dominant roles in the research and control of tropical diseases than in other fields and hence share their experiences and disseminate their findings in the peer

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