

# Disclosure for same-sex-attracted women enhancing the quality of the patient–doctor relationship in general practice

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## Background

Same-sex-attracted women describe lower satisfaction with their general practice care, compared with heterosexual women. Yet, they have greater health inequalities, which requires effective care. A lack of disclosure of sexual orientation to general practitioners (GPs) may be one factor influencing these issues.

## Methods

This study on the disclosure of sexual orientation by same-sex attracted women to their usual GP explored the impact of disclosure on the quality of the patient–doctor relationship. In-depth interviews with 33 same-sex-attracted women and 27 GPs in Australia were conducted during 2005–06. These interviews were analysed to understand the perspectives of the women and their GPs.

## Results

Disclosure in the context of provider sensitivity and normalisation enhanced the perceived quality of the patient–doctor relationship. Conversely, silencing of disclosure and pathologising of sexual orientation diminished the relationship.

## Discussion

Facilitating disclosure should be a shared responsibility between same-sex attracted women and their usual GP. This must be accompanied by improved GP knowledge and affirming attitudes regarding specific health needs of same-sex attracted women.

People who identify as lesbian, gay and bisexual (LGB) experience significant health inequalities, which are compounded by difficulties in accessing culturally sensitive healthcare.<sup>1</sup> A systematic review of patients who identified as LGB and their experiences of healthcare found it to be ‘generally poor’. Major concerns included:<sup>1</sup>

- heterosexism (assumptions of heterosexuality)
- communication barriers (eg provider discomfort)
- poor provider knowledge
- lack of LGB-specific resources and referral networks.

Same-sex-attracted women have lower satisfaction with general practice care than heterosexual women.<sup>2</sup> The extent to which disclosure of sexual orientation affects satisfaction of healthcare is not clear, although disclosure is generally regarded as being important for quality healthcare.<sup>3</sup> For example, non-disclosure of sexual orientation to healthcare providers has been associated with reduced mental healthcare, lower levels of screening and less preventive care when compared with those who had disclosed.<sup>4–6</sup> This is largely due to reduced continuity of care and aligns with arguments around the need for identifying other sensitive issues in the general practice setting. Such issues include the patients’ refugee status,<sup>7</sup> Aboriginal and Torres Strait Islander identity,<sup>8</sup> drug and alcohol use,<sup>9</sup> intimate partner abuse,<sup>10</sup> and child abuse.<sup>11</sup>

Satisfaction with care and the patient–doctor relationship for same-sex-attracted women is higher if expectations of cultural sensitivity are fulfilled by doctors.<sup>12</sup> Health providers’ sensitivity involves comfort with, and receptiveness to, diverse sexual orientation, specific knowledge of common concerns, particularly relating to experiences of discrimination, and care inclusive of intimate partners.<sup>13</sup> Few general practitioners (GPs) appreciate that disclosure and ongoing acknowledgement of

sexual orientation is integral to developing a quality patient–doctor relationship in primary care; many believe it is irrelevant.<sup>14</sup> Further, GPs and patients perceive significant risks associated with disclosure.<sup>15</sup> As a result, GPs rarely facilitate sexual orientation disclosure with their regular patients. Consequently, GPs may miss important opportunities to explore the full context of health issues related to sexual orientation and to provide tailored health promotion advice.<sup>1</sup> Examples of such advice include tailored safer sex messages, drug and alcohol reduction in the context of lesbian socialisation, or mental health promotion in dealing with homophobic environments. Alternatively, disclosure may occur, but is not a positive experience if GPs fail to refer to the patient’s sexual orientation again.<sup>16</sup>

Quality-of-care frameworks in general practice should encourage GPs to be inclusive of minority sexual orientation. One such framework defines quality of care for individual patients, while acknowledging this must be done in a quality system.<sup>17</sup> It includes two dimensions of quality care, access to care when it is needed and the effectiveness of interpersonal and clinical care. Using this framework, Kelaher et al have suggested that identification of a patient’s Aboriginal and Torres Strait Islander identity within general practice improves their quality of care.<sup>8</sup> They recommend that Aboriginal and Torres Strait Islander communities should be informed of the improvements in their healthcare that could arise if they are prepared to disclose their Indigenous identity.

Our research question for this paper was whether the identification of minority sexual orientation, within the patient–GP interaction, contributes to the perceived quality of the patient–doctor relationship from the patients’ and GPs’ perspectives. We answered the question by analysing our interviews with same-sex attracted women and their usual GP in our study.

## Methods

The study consisted of in-depth interviews with a convenience sample of same-sex-

attracted women and GPs. Approval for the study was provided by the University of Melbourne Human Research Ethics Committee in May 2004 (approval number 040155.1).

The same-sex-attracted women were recruited from another study, which involved 30 randomly selected Victorian general practices, from which 1531 women had completed a baseline survey and agreed to be contacted. Forty-eight of these women (3.1%) were same-sex-attracted and were approached, and 17 agreed to participate in this study. Five women were recruited through snowballing from the initial sample, and 11 were recruited from lesbian/bisexual community networks. A total of 33 same-sex-attracted women participated in the study. Two of the women interviewed were in a relationship together (although interviewed separately) and had the same GP. There were 27 GPs in the study, 22 of whom were the usual GP of the female participants (recruited with the women’s permission), and the other doctors were recruited through snowballing.

Detailed demographics of the sample are provided elsewhere;<sup>15</sup> however, the ages were 30–85 years for GPs and 21–72 years for same-sex-attracted women. GPs were informed that the study was about patient–doctor relationships and disclosure with regards to same-sex-attracted female patients. They were also told one of their own patients had been interviewed. The patient’s identity was not revealed, although some of the participants did tell their GP they were in the study. Interviews were conducted by one researcher (RM) in 2005–06.

The women were asked to describe their recollection of disclosure (if relevant) and GPs were asked to recall any disclosure by same-sex-attracted female patients. The groups were asked about their experiences of patient–doctor relationships over a period of time. Participants provided their own pseudonyms (used in this paper with their age), and were offered data checking of their interview transcripts. All authors

cross-coded initial transcripts. Critical hermeneutics were used to generate *a priori* themes and assisted in the inductive generation of new themes from the data through thematic analyses of the transcripts.<sup>15</sup> This theoretical framework allows for existing knowledge and theories to be tested and modified in the context of social stigma, discrimination and marginalisation.

## Results

Two-thirds of the women interviewed had disclosed their sexual orientation to their usual GP, while 12 (36%) had not. Central themes relating to the disclosure of sexual orientation were the reluctance of GPs to ask, resulting in perceptions of silencing, overt pathologising and normalising of sexual orientation. The first two themes diminished, whereas the third enhanced, the perceived quality of the patient–doctor relationship. While many GPs felt non-disclosure was congruent with creating an optimal patient–doctor relationship, very few same-sex-attracted women took this view.

### Silencing of minority sexual orientation

Silencing resulted from three possible misunderstandings by GPs: assumptions that women preferred to tell than be asked, assumptions of heterosexuality, or deliberate avoidance due to presumed irrelevance.

Although the majority of women preferred to be asked by their GP, almost all of the GPs preferred to be told. This, therefore, resulted in non-disclosure. An assumption that women would disclose their sexual orientation generally arose because of a lack of understanding of the many barriers women perceived. These barriers included difficulties in predicting their GP’s responses and few environmental cues for LGB sensitivity at the clinics. However, some of the GPs recognised women’s fear of negative reactions and their need to feel secure in the patient–doctor relationship before disclosing (Dr Katie, *Table 1*).

**Table 1. Findings: key themes regarding experiences of disclosure**

	Same-sex attracted women's experiences	General practitioners' experiences
<b>Inhibiting quality: silencing of disclosure</b>	<p>'My sexuality has never been questioned. There's been an assumption made that I'm heterosexual. I have this constant battle ... and you just let it go on I suppose.' – Miranda (lesbian, 61 years of age)</p> <p>'I saw a GP ... and she asked me if I had a steady boyfriend. And I said, "Well, not like my friends, because they are straight. Guy and girl". She goes, "okay well I'll put you down as single".' – Bee (bisexual, 25 years of age)</p> <p>'I did try to work with him [GP], and I think he tried too, I think he tried to understand where I stood. I mean I don't ever feel that I've been discriminated ... or I've been treated badly because of my sexual preference, but simply because ... some people don't believe that sexuality is very important ... and it is for me. [It is] one of the factors that has been ignored.' – Jenny (same-sex attracted, 72 years of age)</p>	<p>'I don't ask [about sexual orientation] because women who aren't lesbians may get either offended or surprised if we do ask them. So rather than upset them I am going with the greater majority.' – Dr Cahill (male, 54 years of age)</p> <p>'I think sometimes we try to show that we are tolerant by pretending somebody hasn't said anything [about being lesbian] ... just saying "Oh yeah" and then they might not feel that they were really acknowledged. Or they might think "Did she do that because she's not really comfortable".' Dr Audrey (female, 30 years of age)</p> <p>'I'm very careful to use the word partner, and many, many consultations end up with undefined gender, it just ends up and you never know. So I just leave it, that's fine.' – Dr Perry (male, 55 years of age)</p> <p>'I assume everyone's heterosexual unless they tell me.' – Dr Katie (female, 47 years of age)</p> <p>'I do find it hard to admit I don't have [knowledge], and in that area which is particularly sensitive.' – Dr Tyl (female, 61 years of age)</p>
<b>Inhibiting quality: pathologising</b>	<p>'He [the GP] said it's just something that you're going through at the moment [being lesbian], you can't go this way anyway, it's wrong. It was like he was God, I started to really doubt myself. Kind of intimidating as well. I was feeling really positive, but [after that] I started getting out of control.' – Angelina (lesbian, 37 years of age)</p> <p>'The GP freaked out [when she told him that she was lesbian at age 17] and he wasn't prepared to listen ... I'd never actually felt uncomfortable about my sexuality, but he made me feel that I was unwell ... And at that stage I didn't really need that.' – Eileen (lesbian, 45 years)</p>	<p>'I'm against it [homosexuality] as a person but that doesn't mean that it will influence my practice towards a person ... I just treat them like a normal person, treating them physically. That's their own beliefs, own moral issues, I don't have to deal with that.' Dr Michael (male, aged 55)</p> <p>"I mean it's obviously not the norm. We are not meant to be like that biologically." – Dr Normal (male, aged over 70 years)</p>
<b>Enhancing quality: Normalising</b>	<p>'If I went to a doctor and they said "Are you heterosexual?" I'd feel like saying "No I'm homosexual" would be a bit of an embarrassment, but if they say "Are you homosexual or heterosexual?" or the other way round, it's just like obviously they are open to both answers.' – Mina (bisexual, 23 years of age)</p> <p>'He [the GP] acknowledged it's pretty tough splitting up, whereas other people just go "Oh yeah it's just a relationship, it's not even really a relationship because it's gay". He was really in tune.' – Jamie-Lee (gay, 47 years of age)</p> <p>'She [GP] takes the visit to a personal level sometimes, she actually asks the question.' – Betty (lesbian, 41 years of age)</p> <p>'I think it's a nice thing to see a GP over time and develop a relationship where you can be quite open about different parts and also feeling like you can throw anything in that they may not have known about before and that would be accepted as being part of you and not just a new bit of information that is there to shock.' – Kiama (lesbian, 23 years of age)</p>	<p>'I just drop into the conversation every now and then that I'm aware that they're same-sex attracted and that it's not a problem.' – Dr Elisabeth (female, 39 years of age)</p> <p>'You should be able to say to someone "Are you gay or are you heterosexual?" and they should be able to say "I'm gay" without taking any offence. So we should be able to ask everyone, because really ... there's no way a doctor can know about someone's sexuality based on appearance.' – Dr Olive (female, 43 years of age)</p> <p>'I think they would see their sexuality as an important part of them. And that then could be part of the broader encounter that they want the doctor to have knowledge of lots of their issues. I think sexuality then would be part of that social history.' – Dr Harry (male, 53 years of age)</p> <p>'I guess that's the difficulty about trying to make sure that it's not just an intrusive question but it is actually handled sensitively, but also just fits into that overall sense of "Yeah this is good to know about you because this fits in with this and it's not just an obsessive interest".' – Dr Holly (female, identifies as lesbian, 39 years of age)</p> <p>'I think I would probably see quite a large proportion of lesbian patients. Most of the time they're very open about their sexuality. I suppose they feel safe in our clinic so it's not an issue.' – Dr Lith (male, identifies as gay, 44 years of age)</p>

Only three GPs routinely asked about sexual orientation as part of contextual history taking.

Silencing of sexual orientation was often an unintended consequence of heterosexual assumptions (heterosexism). Heterosexism was described by almost half of the women and more than half of the GPs. A few women preferred these assumptions and deliberately presented as 'straight-acting' to avoid disclosure. However, it was difficult for many participants, such as Nede and Miranda (*Table 1*). Nede was generally very open about being lesbian. However, her experiences with GPs had made her feel that she was 'back in the closet'. Many GPs described the language they used, indicating heterosexual assumptions were inherent in their day-to-day practice. For example, Dr Judy (48 years of age) felt 'a bit guilty because I actually say are you married?', rather than 'Do you have a partner?'. Deliberate silencing was also common.

GPs were aware of women's sexual orientation, but deliberately avoided acknowledging it. Several women said their GPs did not raise sexual orientation again after their initial disclosure, or avoided clarifying cues from women, which were sometimes quite explicit. This created the impression that the GP was uninterested or lacked compassion.

Several GPs concurred they deliberately ignored sexual orientation because they valued 'treating everyone the same', or because they believed sexual orientation was 'none of their business'. Dr Harry was one of several GPs with this approach who realised this view opposed his usually holistic social history approach (*Table 1*).

Intentional silencing resulted in serious consequences for some women's health. For example, Angelina (37 years of age) was met with silence when she disclosed to her previous female GP her male partner's abuse and her same-sex attraction. She did not discuss either issue again with a GP for many years.

Some GPs' lack of specific knowledge about biopsychosocial aspects of health

for these women contributed to their silencing discussion of sexual orientation to conceal their lack of knowledge (Dr Tyl in *Table 1*). Eileen, Dr Tyl's patient for a number of years, believed her GP did not remember her sexual orientation from visit to visit.

### Pathologising responses

The majority of women had not experienced negative GP attitudes. However, they were clear they would not return to that GP if faced with such attitudes. Only two GPs stated lesbian or bisexual orientations are pathological and require treatment (*Table 1*).

Dr Michael (55 years of age) said he thought 'homosexuals' have an 'inferiority complex' because 'they feel like it's a disease', and are 'psychologically disturbed'. Three women had experienced overtly negative reactions representing these attitudes (*Table 1*).

Women were adept at picking up cues that indicated negative attitudes or a lack of genuineness, even when these were subtle or deliberately concealed. For example, Dr Michael said he deliberately applied a 'flat facial expression' to 'be normal' so as not to reveal his negative attitude. However, his patient Madison (24 years of age) did not disclose to him as she feared he might be 'disgusted' and even 'reject' her. Non-disclosure for fear of negative attitudes led several women to conceal other important clinical issues such as depression, sexual abuse, abnormal vaginal bleeding and intimate partner abuse.

### Normalising of minority sexual orientation

Many women had positive experiences with disclosure that were respectful and affirming. This was clearly identified as optimal care. A few GPs described their efforts to display acceptance. Dr Imogen wanted to show 'it's no big deal to me' and also that 'it's a normal part of life', while Dr April (38 years of age), hoped she did not look 'surprised or disapproving' when she was told. Dr April's patient

Angelina said her GP had 'no reaction whatsoever' and said it was 'fantastic ... she treated me as a human being'. Dr April recalled Angelina's disclosure and felt Angelina had wanted her to react 'without being too effusive'. Sharon and Jill felt their disclosure had been a 'non-issue'. Jill said her GP seemed to regard it as 'just another fact' about her. Some women appreciated their GPs continuing to acknowledge their sexual orientation within consultations, such as referring to, or inquiring about, their same-sex partner. A common outcome of successful disclosure was a willingness to disclose other sensitive and potentially connected issues such as drug use, parenting desire or experiences of discrimination.

### Discussion

Our study found that disclosure of minority sexual orientation to GPs who had supportive and normalising approaches was clearly related to positive perceptions of quality in the patient–doctor relationships. Conversely, although pathologising and discrimination in healthcare is well described elsewhere as resulting in poor care,<sup>18</sup> it was silencing that was more common in damaging the care relationship between participants. Generally, women would not return to GPs who pathologised their sexual orientation.

Another Australian study highlighted that same-sex-attracted women often change GP in search of greater open-mindedness.<sup>19</sup> In our study, however, many women continued seeing their usual GP and tolerated the silencing. This was either because disclosure was not important to them or because they were waiting to be asked. Some did not want to put the patient–doctor relationship at risk by disclosing, for fear of a negative response. This silence resulted in a suboptimal patient–doctor relationship. The women could not be fully authentic, then did not disclose other related issues such as difficulties in their relationship, or experiences of homophobia.

Common experiences of silencing provide some explanation for the

dissatisfaction with GP care identified in the literature.<sup>2</sup> These issues are similar to those found in the systematic review,<sup>1</sup> although the authors of the review assume poor communication was to blame.

Among our participants, GPs' communication skills were generally seen as effective, whereas the barriers were more deeply rooted in attitudinal or intellectual misassumptions. Sexual orientation is inherently important for many same-sex-attracted women and requires attention.

We propose minority sexual orientation should be more actively included in primary care consultations. GPs, in particular, should take more responsibility for facilitating disclosure. This is certainly not in all consultations, or with all patients, but in circumstances where overt cues are apparent and sexual orientation is relevant. GPs tend to hand the responsibility of disclosure to women, whereas we suggest the responsibility should be shared.

Similarly, there has been a tendency in the literature to focus on predictors of disclosure that relate to patient rather than provider characteristics. For example, a US study of 396 people who identified as LGB showed non-disclosure was more likely among bisexual men and women than gay men or lesbians.<sup>4</sup> It also found non-disclosure among women with lower education or physical illnesses. However, respondents were not asked about their healthcare setting or provider behaviour such as discrimination. Similarly, few GPs in our study discussed their role in ensuring an inclusive environment. Many realised for the first time during their interview that their silencing approach was incongruent with their otherwise holistic philosophy of care.

A quality patient–doctor relationship is difficult to achieve in the absence of a culturally sensitive practice environment. Disclosure is less likely to occur if a patient has no initial cues to affirming attitudes. Campbell et al highlight that an openly accepting environment in primary care is particularly important for 'hard

to reach groups'.<sup>17</sup> Methods to create a sensitive environment are contained within guidelines for LGB care that have been endorsed by the Royal Australian College of General Practitioners. It includes displaying LGB symbols and specific materials, having inclusive intake documentation and non-discrimination policies (visit [www.glhv.org.au/fact-sheet/guide-sensitive-care-lgb-people-attending-general-practice](http://www.glhv.org.au/fact-sheet/guide-sensitive-care-lgb-people-attending-general-practice)). This guide also includes tips for how to facilitate disclosure, which are provided in *Table 2*. A rainbow tick accreditation is now available for clinics that have sensitised their environment through audit and training (visit [www.glhv.org.au/glbt-inclusive-practice](http://www.glhv.org.au/glbt-inclusive-practice)). This provides easy identification of acceptable services for people who identify as LGB.

The effectiveness of the patient–doctor relationship was central to satisfaction for the women in our study. As we have

described previously, this relationship is pivotal to overcoming barriers to disclosure for women, through enhancing trust and reducing the sense of risk.<sup>15</sup>

A Canadian study found that perception that the physician was 'gay-positive' was associated with disclosure, which in turn predicted continuity of care.<sup>20</sup> However, facilitating disclosure is just the first step. Providing competent care for women in the context of their lesbian, bisexual identity or same-sex attraction must follow. A Norwegian study of lesbian experiences of general practice identified that quality care must involve avoiding heterosexism, positive attitudes to lesbian sexual orientation and specific knowledge.<sup>21</sup>

Many GPs in our study felt they lacked specific knowledge of same-sex-attracted women's clinical issues such as pregnancy and parenting needs, sexual health and substance use determinants due to a lack

**Table 2. Tips for discussing sexual orientation\***

**Signposts to introducing sexual orientation:**

- I ask all my new patients about their social situation.
- I need to know something about your sexual history as it may be relevant to your symptoms.
- I need to ask about how you define your sexual orientation to ensure the best referral.

**Demographic questions**

- Do you have a partner? (rather than are you married)
- What is your partner's name?
- Is your partner male or female? (if their sex is not clear from the previous question)
- Do you live with anyone?
- Who do you regard as your close family?
- Are you co-parenting your children with anyone?
- Who is the biological parent? (rather than who is the real parent)

**Clarify documentation in the medical record:**

- I usually record significant relationships in the medical record. Are you comfortable with me recording your relationship?
- Who is your preferred contact for emergencies?
- Do you have a medical power of attorney/a living will/any form of documentation regarding your same-sex relationship?

**Other direct questions about sexual orientation**

- How do you describe your sexual orientation?
- Have you had any negative experiences relating to your sexual orientation?
- Would you prefer a gay/lesbian/bisexual-specific or a general support group?

*\*taken from the Guide to Sensitive Care for Lesbian, Gay and Bisexual People Attending General Practice, McNair, 2012. Available at [www.glhv.org.au/fact-sheet/guide-sensitive-care-lgb-people-attending-general-practice](http://www.glhv.org.au/fact-sheet/guide-sensitive-care-lgb-people-attending-general-practice) [Accessed: 14 May 2015].*

of training and experience. The literature confirms that medical education continues to contain very little, if any, minority sexual orientation topics.<sup>22</sup> In addition, care must be taken so minority sexual orientation does not become the central focus of the consultation.<sup>16</sup> For example, it should not be credited as causing a mental health issue that is actually unrelated. Health inequalities and social determinants related to being a same-sex-attracted women must be understood in the social context of a heterosexist and persistently homophobic society and not caused by their sexual orientation itself.<sup>23</sup>

Limitations of this study included that the sample deliberately comprised same-sex-attracted women and their usual GP. No implications can be drawn regarding the quality of relationships or nature of disclosure for women seeing casual GPs. Further, most interviewed GPs did not know which of their patients had been interviewed for the study. We therefore did not have the opportunity to provide their perspective on the particular relationship the women had discussed.

## Implications for general practice

An important quality indicator in making general practice accessible and effective for same-sex-attracted women is to create optimal conditions for disclosure of sexual orientation. The issues of quality care for same-sex-attracted women are equally applicable for gay, bisexual and same-sex attracted men. However, there are some different patterns of disclosure among men when compared with women. Gay men are more likely, and bisexual men less likely, to disclose their sexual orientation than same-sex-attracted women.<sup>4</sup> There are also important differences regarding specific clinical issues for men, such as higher levels of illicit drug use and the relationship of such drug use with depression that require further training.<sup>24</sup> Optimising the quality of the patient–doctor relationship for LGB patients will require raising awareness among GPs and LGB communities.

All levels of medical training should encourage the development of competencies regarding minority sexual orientation in order to minimise heterosexism and enhance relevance through improved knowledge. People who identify as LGB should have access to information about sensitive providers and be encouraged to understand why disclosure to such providers can enhance their general practice experience and ultimately their health.

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