Serving *All* the Community? The Views and Preferences of Lesbian and Gay Consumers of Health Care

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Introduction

Organisations wishing to ensure that they provide appropriate and high quality services need to understand their entire 'customer' base (Kotler, 1997). One strategy for doing this is to segment their customer/consumer base, on the assumption that consumers are not homogeneous (Beane and Ennis, 1987) and that it is useful to identify groups of consumers on the basis of certain shared distinguishing characteristics which may influence their views of services and their patterns of service consumption (Morgan and Pritchard, 1998). Segmentation can be based on various characteristics and can yield valuable data for service provision and service development.

This paper contributes to the process of ascertaining the views and preferences of one segment of the consumer base of physical health care services, i.e., lesbians and gay men. 'Lesbian' and 'gay' are terms used to describe people 'whose sexual and emotional feelings and behaviours are exclusively or predominantly directed towards others of the same sex' (Coyle, 1998 p.164). However, this segment of the population has been variously defined, for example, in terms of lifestyle (Hughes, 1997) and the visibility of their relationships (Jacobson and Samdahl, 1998). Additionally, marketing research has already identified that this group has certain characteristics relevant to marketing such as a relatively high disposable income (Wood, 1999) (although this is greater among gay men than lesbians), a high level of education (Oleck, 1995) and a high level of brand loyalty (Pitts, 1999). This information has been used to segment lesbians and gay men in the context of other domains of service consumption such as in tourism (Hughes, 1997; Pitts, 1999).

The research presented in this chapter is based on the assumption that the sexuality of consumers will influence their views and preferences in relation to health care services. This assumption arises from the recognition that the use of health care services can call for the explicit or implicit disclosure or management of potentially sensitive information which may influence the nature of subsequent interactions between the patient and health care professionals. This includes information about patients' sexuality. For lesbian and gay patients, this may create particular dilemmas because lesbian and gay sexualities are often subject to

social disapproval, prejudice and discrimination (Snape *et al.*, 1995; Herek, 1998). This situation may mean that lesbian and gay patients have particular views and preferences regarding the provision of health care services and the ways in which their sexuality is dealt with in health care contexts. However, it is acknowledged that many other factors, such as gender, will also shape their views and preferences so that these views and preferences will sometimes represent the outcome of an interaction between sexuality and other factors.

Lesbian and gay sexualities have already been considered and studied in the context of health care, largely in terms of health care staff's (perceived) attitudes towards and interactions with lesbian and gay patients and patients' openness about their sexuality in interactions with staff (for example, Dardick and Grady, 1980; Douglas *et al.*, 1985; Paroski, 1987; Webb, 1987, 1988; Rudolph, 1988; Hellman and Stanton, 1989; Faugier and Wright, 1990; Eliason and Randall, 1991; Irwin, 1992; Annesley and Coyle, 1995). Much work has also been conducted in the specific context of staff attitudes to gay men with HIV/AIDS (for example, Scherer *et al.*, 1991; Siminoff *et al.*, 1991; Wadsworth and McCann, 1992; Vermette and Godin, 1996). In addition, studies have been conducted which have reported lesbian women's and gay men's experiences and evaluations of mental health services (Proctor, 1994; Golding, 1997; Annesley and Coyle, 1998; McFarlane, 1998; Milton and Coyle, 1999). All of this work points to some positive but many negative experiences of care. Although recommendations have been produced by professional bodies regarding the care of lesbian and gay patients (for example, Royal College of Nursing, 1994, 1998a, 1998b), the extent to which these are currently reflected in health care practice is debatable.

It was hoped that, in ascertaining the views and preferences of a group of lesbian and gay (potential) consumers of health care services, the present study would contribute to this body of work and would produce findings that could be used by providers of health care services to improve service provision to lesbians and gay men. By attending to the research findings, providers could thus be helped to work towards ensuring that health care services respond to the needs of the whole community.

Method

Participants

Forty self-identified lesbians and gay men (16 lesbians and 24 gay men) took part in interviews in the UK (in the Guildford area in Surrey) and in Israel (in Tel Aviv and Jerusalem). Six lesbians and seven gay men participated in interviews in the UK; 10 lesbians and 17 gay men took part in interviews in Israel. Data were gathered from two countries in an attempt to reduce the risk of producing findings that were specific to a particular health care system. The countries in question were chosen on the grounds of convenience to the researchers.

Participants were recruited through lesbian and gay groups and organizations, through personal contacts of the researchers and by approaching individuals in lesbian and gay pubs and meeting places. This sample was extended by 'snowballing', i.e., asking interviewees to recruit additional participants from their social networks who might provide a different perspective on the research topic. Being a qualitative study, the aim of this sampling strategy was to obtain diverse rather than representative perspectives on the research topic.

Procedure

Interviews took place in lesbian and gay pubs and meeting places using a semi-structured interview format (Smith 1995). These locations were chosen partly for practical reasons and partly because it was felt that they would enable interviewees to feel at ease. Although the interviews focused upon participants' views and preferences (as lesbians or gay men) in relation to physical health care services, ample scope was provided for participants to discuss issues

which were relevant to this topic but which were not included on the interview schedule. To illustrate their views, participants were encouraged to draw upon their personal experiences of health care and their friends' experiences.

While 15 interviews were conducted on a one-to-one basis (eight in the UK, seven in Israel), participants often subsequently involved friends and others in the ensuing discussions in a quasi-focus group format. These additional participants (n=25) contributed their own viewpoints and experiences. The interviews in the UK were conducted in English; the interviews in Israel were conducted in Hebrew.

Ordinarily in qualitative research, interviews are tape recorded in order to afford the researcher a detailed record of the data. However, in this case, tape-recording proved impossible due to the high level of background noise in the interview locations. The interviewer (YP) therefore made detailed notes during the interviews, summarizing the content of participants' responses and recording their actual words when they made points which seemed especially pertinent to the research questions. These notes were then elaborated immediately after the interviews.

Analysis

These notes were subjected to thematic content analysis to illuminate underlying themes in participants' talk (Smith 1995). The analysis was not guided by specific prior hypotheses but instead allowed key themes to 'emerge' from the data, the aim being to gain an account of participants' own views and preferences. However, the adoption of a semi-structured interview approach to data collection means that data are at least partly shaped by the core questions asked of all participants. The analytic process involved the careful re-reading of the interview notes by one researcher (YP) to discern common themes and differences in the accounts provided by the participants. A preliminary set of themes was developed and illustrative quotations were noted. This was subsequently checked by the other researchers to ensure that themes were consonant with and grounded in the data (see Elliott *et al.*, 1999, on the importance of these procedures for ensuring the legitimacy of qualitative research). In addition, the translation of those quotations which were originally in Hebrew has been checked by a native Hebrew speaker who is also fluent in English and who was not part of the research team. In the quotations that follow, empty square brackets indicate where material has been omitted and material within square brackets has been added for clarification.

Results

Background Information on Participants

Some basic background information was gathered from the 15 lesbians and gay men who participated in one-to-one interviews. Participants' mean age was 25.4 years (range 16-40); the mean age of the UK group was 25.2 years (range 19-40) and the mean age of the Israeli group was 25.6 years (range 16-34). Eight participants (three in the UK; five in Israel) were currently involved in at least one sexual and emotional relationship; seven (four in the UK; three in Israel) did not currently have a partner. In terms of the extent to which others in their social world knew about their sexuality, 13 participants (all eight UK participants and five Israeli participants) said that some people knew: 10 said that only those 'who should know' knew about their sexuality; more specifically, three said that only those who were close to them knew (for example, family and close friends). Two participants (both Israeli) said that everyone in their social worlds knew. Due to the informal nature of the interviews with the other 25 participants, it was not possible to gather background information from them.

The analysis of the interview data centred around three major themes, relating to a perceived need for health care staff to develop an awareness that patients might be lesbian or

gay, preferences regarding the gender of health care staff who are providing treatment and the non-desirability of having health care services specifically for lesbians and gay men. No systematic differences were observed between the data from UK participants and the data from Israeli participants, even though the data were analysed in two groups based on participants' nationality.

The Need for Staff Awareness

The situation that was most commonly identified as problematic for lesbian and gay patients in health care contexts concerned the failure of health care staff to consider that patients might be lesbian or gay (see also Dardick and Grady, 1980) and that a person of the same gender accompanying a patient might be their partner. In specific terms, many participants spoke of situations where a patient was taken for a medical examination and - without consulting the patient - health care staff asked their partner to leave the room. This was said to have arisen from staff's failure to consider that two people of the same gender could be a couple. For example:

There is one thing in particular that I find uncomfortable and this is the fact that the doctor did not ask my partner if she wants me to stay in the room. Immediately they make the assumption that we are friends and not a couple and I think that they should be aware of that. (lesbian woman: Israel)

What makes me angry is the fact that he (the doctor) did not ask me. He did not even think that maybe we are a couple – he thought that we are just friends. At least he could ask. (lesbian woman: Israel)

One participant expressed bewilderment at why this should occur:

Why are there no procedures that ask the doctor to ask the patient [] 'Do you want him or her to stay in the room?'. Is it so complicated? (gay man: UK)

As Kitzinger and Coyle (1995) have observed, lesbian and gay relationships are routinely unacknowledged and rendered invisible in many social contexts. When this occurs in what may be anxiety-provoking health care contexts, it is not surprising that it should lead to strong, negative emotional reactions. Even those participants who had not experienced in-patient or out-patient services after having developed a lesbian or gay identity identified this lack of acknowledgement as a situation that could cause them most concern. Regardless of the reasons for staff's failure to consider that two people of the same gender could be a couple, participants interpreted this in terms of discrimination against lesbians and gay men.

When asked to reflect upon how health care staff could improve services for lesbian and gay patients, all participants recommended that staff should develop their awareness of lesbian and gay sexualities, specifically in terms of considering that two people of the same gender might be a lesbian or gay couple. For example:

Just to be aware that if there are two men, it is not necessary that they are just good friends. They can be a couple. (gay man: Israel)

One participant pointed out that staff should not make assumptions about the nature of the relationship between patients and those accompanying them, regardless of their gender:

They should ask every couple – does not matter what their genders are – if they are

together. How do they know if a man and a woman coming together are a couple?
Maybe they are brother and sister. (gay man: UK)

Preferences Regarding the Gender of Health Care Staff

Although a range of views were expressed concerning preferences for male or female health care staff, many participants did express preferences concerning the gender of health care staff who might be involved in their care. These preferences were mostly related to situations where health care professionals would be required to conduct examinations of 'intimate' areas of the body (such as in breast, testicular, gynaecological and rectal examinations) or to engage in close, sustained contact with the patient's body (such as when providing massage in physiotherapy).

Some participants related their preferences to their sexuality. Some explained that they preferred to be examined by a health care professional of a different gender because they would not want to risk finding the staff member sexually attractive and becoming sexually aroused during the examination; it was feared that this could lead to embarrassment and social discomfort for both the patient and the member of staff. However, it was felt that this was unlikely to occur in gynaecological examinations because of the physical discomfort involved in these procedures.

Other participants invoked their sexual identity in different ways. Some participants expressed the view that heterosexual men are more favourably disposed towards lesbians than towards gay men and that heterosexual women are more favourably disposed towards gay men than towards lesbians ('Men are not friendly to gays and women are not friendly to lesbians' – lesbian woman: Israel) (see Kite, 1984, and Herek, 1994, on this). This led them to prefer receiving treatment from a health care professional of a different gender, which seemed to be based on an assumption of universal heterosexuality among health care staff.

Some lesbian women said that they would prefer to be examined by a woman because they did not trust men. This distrust was not specifically related to their sexual identity and arose from considerations that might be shared by some heterosexual women:

I just do not trust men. Maybe he (the doctor) just wants to touch my breast because I am another sex attraction for him. (lesbian woman: UK)

Other preferences for male or female health care staff that were not related to the patient's sexual identity were based on assumed connections between the gender of the staff member and the quality of the treatment they could provide. For some, these connections centred on the assumption that a professional would be better able to understand the body and feelings of a patient of the same gender. For example:

The only thing I can think about where I would prefer a woman to a man is when you need to shave your (pubic) hair because she has to do it for herself so she may take more care. She will know what the results can be if you do it the wrong way. (lesbian woman: Israel)

[In a breast examination] it will be easier for her [a female staff member] to understand what I am feeling and my way of thinking. A man, I think, could not understand what it is for a woman to lose a breast. (lesbian woman: Israel)

I would prefer a woman gynaecologist because she has something like this [gynaecological concerns] at home. (lesbian woman: Israel)

Other participants' preferences were based on (assumptions about) gender-specific physical

qualities that were felt to influence the quality of treatment. For example, male health care professionals were assumed to be physically stronger than females which, in some areas of health care such as orthopaedics, was seen as advantageous; one woman's preference for a female gynaecologist was based on the fact that women have smaller hands than men and so would be able to offer a more comfortable examination.

Some other participants did not express preferences regarding the gender of health care staff involved in their treatment. Although some thought that they would have positive or negative reactions to male or female staff, these participants felt that these reactions were immaterial and that the quality of treatment was more important than the gender of the staff who were providing the treatment. In discussing their views, these participants sometimes bracketed their sexual identity and gender in startling ways:

When I am going to a hospital, I am like a piece of meat that needs some treatment and I do not think that my identity – the fact that I am lesbian – should be taken into account.
(lesbian woman: Israel)

Health Care Services Specifically for Lesbians and Gay Men

It might be assumed that one way of ensuring that the health care needs and preferences of lesbians and gay men are properly addressed would be to develop health care services specifically for lesbians and gay men. However, none of the participants felt that this would be desirable. Their rejection of this idea was based on a desire to avoid becoming ghettoised and marginalised – a fear that lesbians and gay men would become 'separate [] from the community' and be seen as negatively different. Participants felt that the development of separate health care services would create the impression that 'being gay is a disease' or dangerous and that lesbians and gay men need to be separated from the rest of the population for fear of contagion. When discussions explored the desirability of developing specific services for lesbians and gay men in other contexts (such as hotel services), resistance was much less marked because it was felt that such a development would not carry the same connotations of disease, danger and contagion.

Discussion

In common with other research with lesbians and gay men and other qualitative research, this study has certain limitations. Firstly, it is impossible to determine the representativeness of samples of lesbians and gay men because the parameters of these populations are unknown. Instead, research with lesbians and gay men tends to aim for a diversity of participants with the intention of exploring the research phenomenon from multiple perspectives (for example, see Davies *et al.*, 1993). This study deliberately sought such diversity by recruiting participants from two countries and by ensuring that both lesbian and gay perspectives were adequately represented. However, the core sample could have been more diverse in terms of age, which might have provided access to more varied outlooks that reflected age- and development-related differences.

Secondly, although the sample is sizeable for a qualitative study, no conclusions can be drawn concerning the generalisability of the findings. When researching a relatively sensitive topic with a specific group, it is often necessary to build up an increasingly comprehensive picture through a series of small-scale, complementary studies, with each extending the insights gained from previous work. In relation to the exploration of the views and preferences of lesbian and gay consumers of health care services, the present study may be seen as contributing to the development of a comprehensive knowledge base. Other researchers may wish to extend this process by conducting studies with lesbians and gay men whose voices are missing from the present study (for example, older lesbians and gay men; lesbians and gay men who are less

involved with lesbian and gay communities; and lesbians and gay men from ethnic minority communities) and whose position might have led to a different set of views and preferences from those reported here. In addition, further research might usefully attempt to identify differences between the views and preferences of lesbian women and gay men. It might also be worth considering service providers' conceptualizations of the needs and preferences of lesbian and gay consumers of health services and their views concerning the feasibility of developing services in accordance with these needs and preferences.

It is noteworthy that the themes reported in this paper demonstrated both unity and diversity among the participants. Calls for greater awareness and knowledge among health care staff of lesbian and gay sexualities – specifically in terms of considering that two people of the same gender might be a lesbian or gay couple – and resistance to the creation of health care services specifically for lesbians and gay men were universal. On the other hand, all shades of viewpoint were represented on the question of participants' preferences regarding the gender of health care staff involved in their care.

Although further research is required before policy and practice can be developed or revised, provisional recommendations can be offered concerning the universally-acknowledged need for the development of staff awareness. This can be achieved in various ways, such as by ensuring that lesbian and gay sexualities and lifestyles are addressed in an informed and integrated way in the curricula of all education and training programmes in health care and by providing post-qualification training for health care staff. This could be usefully located within a broader framework of considering the needs and preferences of patients from diverse backgrounds, which would avoid singling out and problematising lesbians and gay men and would permit useful parallels to be drawn with other social groups (such as ethnic minority groups) which may suffer discrimination. Educational interventions could include both information-giving and opportunities (perhaps through structured exercises) for staff to reflect upon their attitudes towards lesbians and gay men and their feelings about providing health care services to lesbian and gay patients (see Irwin, 1992, and Taylor and Robertson, 1994, for further recommendations). However, due to the uncertain relationship between attitude change and behaviour change (Ajzen and Fishbein, 1980), attention would need to be paid to the question of how to increase the likelihood of increased awareness being translated into practice. This may involve role-playing scenarios with lesbian and gay patients that are akin to real-life practice contexts and/or providing opportunities for staff to reflect on their practice some time after receiving educational interventions.

By increasing staff awareness of lesbian and gay patients, the situations which participants described in which their partnerships were not recognized might be more easily avoided (see Royal College of Nursing, 1998a, for recommendations on how to address 'next-of-kin' issues with lesbian and gay patients). Health care professionals might then be able to involve partners in the care of patients as a resource for providing support (Dardick and Grady, 1980). An awareness of the possibility that two people of the same gender might be partners may also obviate the need for patients and partners to disclose their sexual identity explicitly to staff, which they may not wish to do. Instead, if staff are attuned to the possibility that two people might be partners, interactions between staff, patients and partners can be based on a tacit recognition of the relationship, which may subsequently enable patients and/or partners to feel sufficiently comfortable to disclose their sexuality and discuss their relationship in more explicit terms. More generally, it could be hypothesized that heightened staff awareness and sensitivity could promote the development of a positive relationship between staff and patients, which is a vital component in good psychological care (Nichols, 1993).

Provisional recommendations can also be offered on the issue of patients' preferences regarding the gender of health care staff who are involved in their care. Given the diversity of views expressed in this study, it may be beneficial for health care staff to recognize that some

patients may have particular preferences and to ascertain these preferences before treatment commences, with the aim of taking patient preferences into account during treatment, where possible. These recommendations are, of course, not specific to lesbian and gay patients. Indeed, if this procedure were routinely applied to all patients, it might lead patients to feel that they were being respected and might enhance their perceptions of the quality of their care.

It could be said that the provision of high quality care for lesbian and gay patients involves the same general principles that shape high quality care for any patient group, including knowledge of, sensitivity to and respect for patients and their needs and preferences. This research can therefore be seen as contributing to that body of work which reminds health care staff of the importance of these principles and identifies some specific ways in which they can be expressed to ensure that lesbian and gay patients receive high quality health care services.

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