

Hannah Brooks, Carrie D Llewellyn, Tom Nadarzynski, Fernando Castilho Pelloso, Felipe De Souza Guilherme, Alex Pollard and Christina J Jones

Sexual orientation disclosure in health care: a systematic review

Abstract

Background

Significant health disparities between sexual minority individuals (that is, lesbian, gay, bisexual, or transgender [LGBT]) and heterosexual individuals have been demonstrated internationally.^{1,2} In the UK, sexual orientation (SO) is a protected characteristic under the Equality Act (2010), which requires public services to promote and demonstrate equality for LGBT people. A large component of proving compliance with this mandate is monitoring SO, which is currently poorly done in the UK. National estimates of the adult LGBT population range from 1.7%³ to 9.9%,⁴ although the validity has been questioned.⁵ This has been recognised as a significant issue, and NHS England has worked with the LGBT Foundation and National LGB&T Partnership to implement an SO monitoring information standard from April 2017.⁶

Aim

To understand the barriers and facilitators to sexual orientation (SO) disclosure experienced by LGBT adults in healthcare settings.

Design and setting

Mixed methods systematic review, including qualitative, quantitative, and mixed methods papers following PRISMA guidelines.

Method

Study quality was assessed using the Mixed Methods Appraisal Tool (MMAT) and a qualitative synthesis was performed. Studies were included if their participants were aged ≥18 years who either identified as LGBT, had a same-sex sexual relationship, or were attracted to a member of the same sex.

Results

The review included 31 studies representing 2442 participants. Four overarching themes were identified as barriers or facilitators to SO disclosure: the moment of disclosure, the expected outcome of disclosure, the healthcare professional, and the environment or setting of disclosure. The most prominent themes were the perceived relevance of SO to care, the communication skills and language used by healthcare professionals, and the fear of poor treatment or reaction to disclosure.

Conclusion

The facilitators and barriers to SO disclosure by LGBT individuals are widespread but most were modifiable and could therefore be targeted to improve healthcare professionals' awareness of their patients' SO. Healthcare professionals should be aware of the broad range of factors that influence SO disclosure and the potential disadvantageous effects of non-disclosure on care. The environment in which patients are seen should be welcoming of different SOs as well as ensuring that healthcare professionals' communication skills, both verbal and non-verbal, are accepting and inclusive.

Keywords

disclosure; general practice; LGBT; review; sexual orientation.

INTRODUCTION

Significant health disparities between individuals identifying as part of a sexual minority (that is, lesbian, gay, bisexual, or transgender [LGBT]) and heterosexual individuals have been demonstrated internationally.^{1,2} In the UK, sexual orientation (SO) is a protected characteristic under the Equality Act (2010), which requires public services to promote and demonstrate equality for LGBT people. A large component of proving compliance with this mandate is monitoring SO, which is currently poorly done in the UK. National estimates of the adult LGBT population range from 1.7%³ to 9.9%,⁴ although the validity has been questioned.⁵ This has been recognised as a significant issue, and NHS England has worked with the LGBT Foundation and National LGB&T Partnership to implement an SO monitoring information standard from April 2017.⁶

Health disparities between heterosexual and LGBT people are still seen in mental health, with higher rates of anxiety and depression, self-harm, and suicide^{1,7-11} among the LGBT community, as well as in physical health. A recent UK-based review reported increased rates of some malignancies in the LGBT community, mixed diabetes rates, and higher rates of substance abuse, including binge drinking

and smoking.¹ Differences between sexual minority groups have also been reported, showing poorer mental and physical health in bisexual people of both sexes,^{8,9,11} as well as higher rates of high-risk health behaviours, such as smoking and excess alcohol intake.^{1,7,8,10} It has been noted that robust evidence comparing the different groups that make up the LGBT community is lacking,¹ particularly in reference to transgender, queer, and intersex persons.

The most prominent theory for differences in health by SO is minority stress.^{12,13} This hypothesises that a combination and accumulation of internal and external stressors (such as stigma and victimisation, and the distress felt in response to stigma and concealment of one's SO) interact to overcome an individual's ability to cope, resulting in psychological and physical disease.¹³ A further theory is fundamental causes, which posits that advantaged groups in society have the skills and resources necessary to minimise risk of disease, as well as to harness the appropriate health resources to lessen the consequences of disease, should it occur.¹⁴ A Swedish study has presented support for the fundamental cause theory applicable to the LGBT community, describing increased rates of high-preventable diseases — such as ischaemic heart disease, chronic obstructive pulmonary disease (COPD), and

H Brooks, BMBS, academic foundation trainee; **CD Llewellyn**, PhD, associate professor; **A Pollard**, MA, research fellow, Department of Primary Care and Public Health; **CJ Jones**, PhD, lecturer, Department of Clinical Medicine, Brighton and Sussex Medical School, University of Sussex, Brighton, UK. **T Nadarzynski**, PhD, lecturer, Department of Psychology, University of Southampton, Southampton, UK. **F Castilho Pelloso**, medical student; **F De Souza Guilherme**, medical student, Curso de Medicina da Universidade Federal do Paraná, Curitiba, Paraná, Brazil.
Address for correspondence
Carrie Llewellyn, Department of Primary Care and

Public Health, Brighton and Sussex Medical School, Mayfield House, Falmer, Brighton, East Sussex, BN1 9PH, UK.

E-mail: c.d.llewellyn@bsms.ac.uk

Submitted: 19 May 2017; **Editor's response:** 6 June 2017; **final acceptance:** 10 July 2017.

©British Journal of General Practice

This is the full-length article (published online 30 Jan 2018) of an abridged version published in print. Cite this version as: **Br J Gen Pract 2018;**
DOI: <https://doi.org/10.3399/bjgp18X694841>

How this fits in

Significant health disparities exist between sexual minority (that is, lesbian, gay, bisexual, or transgender [LGBT]) and heterosexual individuals. Disclosure of sexual orientation (SO) in health care links to both the minority stress and fundamental cause theories in the context of accessing appropriate services, and is therefore likely to be a contributing factor in these health differences. Incorporating more LGBT-specific knowledge and communication skills into undergraduate medical education is essential in aiding SO disclosure. Altering the healthcare environment, such as displaying signs or symbols that convey an accepting atmosphere — for example, a rainbow symbol or the Human Rights Campaign logo — may also help.

lung cancer — in LGBT people, compared with heterosexual people.¹⁵

Disclosure of SO in health care links to both the minority stress and fundamental cause theories in the context of accessing appropriate services, and is therefore likely

to be a contributing factor in the health differences. In line with this, a recent British review found that many LGBT people are reluctant to disclose their SO, and will sometimes delay care due to fear of disclosure, even in the face of inappropriate or less appropriate care.¹⁶ The purpose of this review was to investigate the barriers and facilitators to SO disclosure in health care by LGBT adults, with the aim of identifying factors that can be easily modified in healthcare education and practice to improve disclosure, and therefore ensure provision of appropriate care.

METHOD

Search strategy

A search of eight databases (AMED, CINAHL, Embase, MEDLINE, PsycINFO, RCNi, ScienceDirect, and Web of Science) was conducted in March 2017. Terms were chosen to include all standard gender categories and minority SOs, focusing on SO disclosure in healthcare settings or to a healthcare professional. The final search conducted was: ((disclos* OR reveal* OR openness) AND (lgb* OR gay OR bisexual OR lesbian OR msm OR wsw OR homosex*)) AND (health* OR care OR consult*). The authors excluded all editorials, commentaries, reviews, and conference abstracts. Only articles published after 2000 were considered to ensure recent barriers and facilitators were captured, and only those in English were included.

Inclusion and exclusion criteria

Participants were aged ≥18 years and samples contained at least some self-identified as LGBT. Furthermore, only studies that displayed data provided by the participants on the barriers and/or facilitators to disclosure (or non-disclosure) of SO to a healthcare professional were included. Studies that did not specify disclosure to a healthcare professional, or those outside a healthcare setting, were excluded. Although the authors recognise that transgender is a gender identity rather than an SO, they have included transgender as they were unable to disaggregate transgender from LGB data.

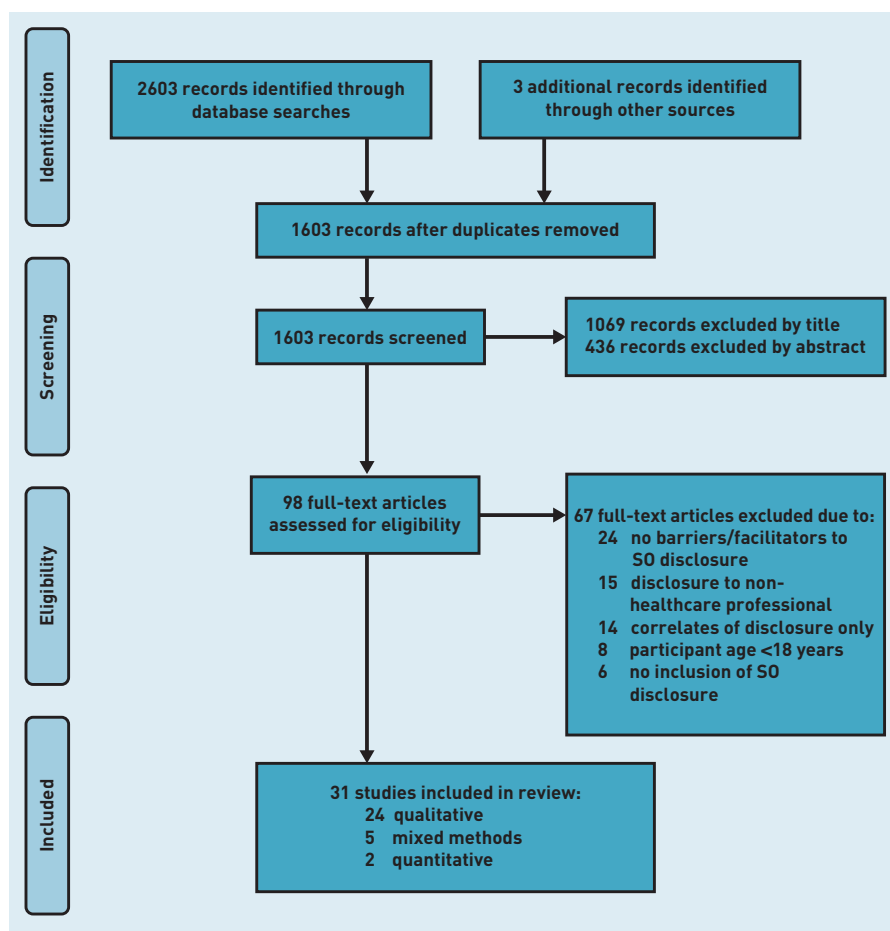
Study selection and data extraction

The process of systematic review is summarised using the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA)¹⁷ (Figure 1). Data were extracted using a proforma, followed by qualitative analysis.

Assessment of study quality

The Mixed Methods Appraisal Tool (MMAT)¹⁸

Figure 1. Preferred reporting items for systematic review and meta-analysis flow diagram for the inclusion of studies reporting barriers and facilitators to sexual orientation (SO) disclosure in healthcare.



was used to assess methodological quality. Two screening questions and four criteria for assessment were applied to each study, scoring sampling, measurement, analysis, and limitation consideration. This gave a score ranging from 0% (no criteria met) to 100% (all four criteria met) for each study, allowing one robust score to be used for multiple study types. Quality assessment was carried out by three assessors. Kappa scores were calculated to assess inter-rater variability.¹⁹

RESULTS

Studies identified

From 2603 records, 31 studies met the inclusion criteria (Figure 1; Table 1). Six studies presented data relevant to disclosure solely in a primary care setting, three in oncology, three in military medical settings, and one each in mental health and a home care setting. Eleven studies did not state or did not specify a precise healthcare setting but instead presented data from generic health settings, and six presented data from a variety of settings. In total, 2442 participants were included across the 31 studies identified for review.

Data synthesis

The barriers and facilitators identified are presented in four overarching themes (Box 1).

The moment of disclosure. Twenty studies commented on patients' beliefs of the relevance of SO to health care as both a barrier and facilitator to disclosure; people who thought it was relevant were more likely to disclose,^{20–30} whereas those who thought it was irrelevant were less likely to reveal their identity.^{21,23–25,27–29,31–39} One participant felt the need to disclose to enable their healthcare professional to provide 'more focused advice'²⁴ and another thought their 'gayness to be highly relevant to [their] health needs'.²¹ Others asked 'what's [my SO] got to do with, you know, my toe hurting?'²⁸ and felt '[SO] would only be important if a problem was discovered'.³⁶

Communication factors, such as using inclusive language^{30,34,36,39–41} and open, welcoming body language,^{23,34,36,41–43} were seen as facilitators to disclosure whereas the opposites — closed-off or unfriendly body language⁴¹ and heteronormative language,^{26,34} such as using a male pronoun to identify a female patient's partner, and vice versa — were viewed as barriers. There were mixed opinions on the merits of using direct questions to explore a patient's SO. The majority of participants appreciated

being asked and felt this was a good way to facilitate open communication between patient and provider,^{21,23,26–28,31,33,34,36,37,39,41,44,45} but a small number did not agree.^{25,27,30,41} There were similarly mixed views of the benefits of patient registration forms to document SO. Some described their delight at finding a registration form that included their SO as an option,³⁵ whereas many felt their SO was not accommodated by the options presented.^{26,36} Most described these types of written disclosure as a facilitator to disclosure,^{22,35,39,41,42,46} but only if they were adapted to be more inclusive and depict a broad spectrum of SOs.²²

The final barrier at the moment of disclosure was the patient's response to heteronormative assumptions. This was most commonly identified in the context of contraception and sexual health, with the giving of only heterosexually appropriate advice.^{27,30,31,45}

Perceived outcome of disclosure. Fear of discrimination, including receiving poor or unequal care,^{23,26–29,32,40,43,45,47,48} having a negative impact on their career^{25,43} or benefits,^{25,28} as well as criminalisation,^{43,49} were all cited as reasons not to disclose. In addition, many participants were hesitant to disclose for fear of a negative personal reaction from their healthcare professional,^{23,24,29,30,37–41,43,46,48,49} or feeling embarrassment or humiliation after disclosure.^{31,33,37,39,46} Many participants cited concerns of breaches in patient-provider confidentiality^{20,24,29,34,37,39,43,46,47,49} that would lead to non-clinical staff,⁴⁷ their family and friends,³⁴ or the wider community^{43,49} discovering their SO as reasons not to disclose. Similarly, documentation of SO in medical records was seen as a barrier to disclosure.^{24,25,28,29,46}

Healthcare professional factors. The majority of patients were more likely to disclose to a healthcare professional with whom they had a long relationship.^{23,39,47} Seven studies reported an increased likelihood of disclosure if the healthcare professional was themselves a member of the LGBT community.^{20,25,32,38,41,46,48} Although having a heterosexual healthcare professional was not seen as a particular barrier to disclosure, a healthcare professional being perceived as accepting of the LGBT community, or of their patient being LGBT, was a significant facilitator.^{32,34,39,40,43,46}

Environmental factors. Some participants preferred to disclose their SO in sexual health clinics rather than to their primary

Table 1. Characteristics of studies included in the review (presented in chronological order)

Author (publication year) country	Healthcare specialty	Study population	Selected sample characteristics (age, ethnicity, education level)	Sample size	Study design	Recruitment method	MMAT score, %
Barbara ⁴⁶ (2001) US	Not stated	Lesbian women	Age range 24–65 years; 69% white; 90% some college education	32	Qualitative, focus groups	Purposive, community-based	75
Beehler ²¹ (2001) US	Primary care	Gay men	Median age 38 years (range 25–52); 82% white; 91% some college education	11	Qualitative, interview	Snowball	50
Stein ²⁹ (2001) US	Range — 77% primary care	Men and women of any sexual orientation	Mean age 45 years (range 19–83); 76% white; 80% at least college education	575	Quantitative descriptive, survey	Convenience, snowball; community-based	25
Boehme ²⁸ (2004) US	Oncology	Lesbian and bisexual women	Mean age 49 years (range 26–67); 94% white; 97% at least college	39	Qualitative, interview	Purposive, community-based snowball	75
Clover ⁴⁸ (2006) UK	Not specified	Gay men	Age range 60–75 years; 100% white	10	Qualitative, interview	Purposive, community-based	50
McDonald ⁴⁹ (2006) Canada	Not specified	Lesbian women	Age range 26–56 years; 100% white; 73% at least college education	15	Qualitative, interview	Purposive, community-based	25
Bjorkman ⁴⁸ (2007) Norway	Primary care	Lesbian women	Mean age 41 years (range 28–59); all white; all well educated	6	Qualitative, focus groups	Convenience, online	75
Mulligan ³⁵ (2007) Australia	Not specified	Lesbian and bisexual women	Age range 20–71 years	47	Qualitative, interview	Purposive, online, and community-based	50
Adams ²⁰ (2008) New Zealand	Primary care	Gay men	Not specified	50	Qualitative, focus groups	Not specified	50
Bjorkman ³¹ (2009) Norway	Any, majority primary care	Lesbian women	Age range 18–≥60 years (68% aged 20–39); 87% Norwegian native; 67% some college education	121	Qualitative, online	Convenience, online questionnaire	75
Polit ³⁶ (2009) US	Not specified	Women of any sexual orientation	Mean age 55 years; 98% white; 73% at least college education	40	Qualitative, interview	Convenience, community-based	50
Daley ⁴¹ (2012) Canada	Mental health	Lesbian women	Age range 20–58 years; 83% white	18	Qualitative, interview	Purposive, healthcare, and community	75
Biddix ⁴⁴ (2013) US	Military	Gay and bisexual men	Age range 18–47 years (56% 18–27); 86% white; 91% some college education	30	Quantitative, descriptive survey	Convenience, online	0
Johnson ²² (2014) US	Not specified	Non-heterosexual women	Mean age 20 years (range 18–23); 77% white; all university students	9	Qualitative, interview	Purposive, online	75
Koh ²³ (2014) Australia	Primary care	Lesbian, gay, bisexual, or transgender men and women	Modal age 20–29 years (range 18–≥60)	99	Qualitative, online questionnaire	Purposive, online, and print	75
Sharek ³⁸ (2014) Ireland	Range	Lesbian, gay, bisexual, or transgender men and women	59% aged 55–59 years	144 survey + 36 interview	Mixed methods	Convenience, print/events/online	50
Sherman ²⁶ (2014) US	Military	Lesbian, gay, bisexual, or transgender men and women	>50% aged 40–59 years; 84% white	58	Mixed methods	Convenience, healthcare, online, and community	0

... continued

Table 1 continued. Characteristics of studies included in the review (presented in chronological order)

Author (publication year) country	Healthcare specialty	Study population	Selected sample characteristics (age, ethnicity, education level)	Sample size	Study design	Recruitment method	MMAT score, %
Wirtz ⁴⁵ (2014) Malawi	Range	Men who have sex with men	Not specified	8	Qualitative, interview	Responder-driven, purposive	75
Law ²⁴ (2015) Canada	Primary care	Lesbian, gay, bisexual, or transgender men and women	Mean age 32 years; 91% university education	12	Qualitative, interview	Purposive, snowball	75
Marques ²⁴ (2015) Portugal	Not specified	Lesbian women	Mean age 37 years (range 21–63)	30	Qualitative, interview	Snowball	75
Mattocks ²⁵ (2015) US	Military	Lesbian women	Age range 41–50 years; 35% white, 30% Hispanic, 15% African American	20	Mixed methods	Purposive, print, and healthcare	0
Quinn ⁴² (2015) US	Not specified	Men and women of any sexual orientation	Not specified	632	Mixed methods	Purposive, online	50
Underhill ³⁹ (2015) US	Range	Men who have sex with men	Median age 27 years (male sex workers); median age 39 years (MSM); 76% white; 40–50% college education	56	Qualitative, interview	Convenience, snowball	75
Fish ³³ (2016) UK	Oncology	Lesbian, gay, or bisexual men and women	Mean age 54 years (range 41–71)	15	Qualitative, interview	Purposive, community, and web-based	75
Furlotte ⁴⁷ (2016) Canada	'Home care'	Lesbian, gay, bisexual, or transgender men and women and their partners	Mean age 64 years (range 39–75); 96% white	24 (12 couples)	Qualitative, individual and paired interviews	Web-based, purposive, snowball	75
Legere ⁴⁵ (2016) Canada	Oncology	Lesbian and bisexual women	2 in 20s, 4 >40 years; 28% black	7 (6 patients, 1 HCP)	Qualitative, interview	Purposive, print, and online	100
Munson ²⁶ (2016) New Zealand	Primary care	Lesbian and bisexual women	Age range 23–47 years; 83% higher education	6	Qualitative, interview	Purposive, snowball	100
Roller ²⁷ (2016) US	Not specified	Lesbian and bisexual women	Mean age 41 years (range 21–59); all white; 67% college degrees	13	Qualitative, interview	Purposive, online	75
Venetis ³⁰ (2017) US	Not specified	Lesbian, gay, bisexual, or transgender men and women	Mean age 28 years (range 21–44); 66% white	24	Qualitative, interview	Purposive, community and online, snowball	100
Wanyenze ⁴³ (2016) Uganda	Not specified	Men who have sex with men	50% aged 21–25 years	85 + 61 key informants	Mixed methods	Purposive, snowball, responder-driven	0
Rose ³⁷ (2017) International	Oncology or primary care	Gay and bisexual men	Mean 64 years; 67% white	124 + 21 partners	Qualitative, interview	Purposive, online, and postal	50

HCP = healthcare professional. MMAT = Mixed Methods Appraisal Tool. MSM = men who have sex with men.

Box 1. Facilitators and barriers to sexual orientation disclosure in health care

Facilitators	References	Barriers	References
Moment of disclosure		Moment of disclosure	
Communication skills of healthcare professional		Communication skills of healthcare professional	
Response to a direct question	21,23,26–28,31,33, 34, 36,37,39,41,44,45	Response to a direct question	25,27,30,41
Inclusive language	30,34,36,40,41	Heteronormative language	26,34
Open body language	23,34,36,41–43	Closed body language	41
Relevant to care	20–30	No opportunity in conversation	33,37
Written disclosure	22,35,39,41,42,46	Irrelevant to care	21,23–25,27–29,31–39
Confronting heteronormative assumptions	21,27,29–31,33,40,47	Written disclosure	26,36
Perceived outcome of disclosure		Perceived outcome of disclosure	
Patient–provider confidentiality	22	Breach of confidentiality	20,24,29,34,37,39,43,46,47,49
Documented on medical record	24	Documented on medical record	24,25,28,29,46
Good/open healthcare professional response	32	Poor healthcare professional response	23,24,29,30,37–41,43,46,48,49
Healthcare professional factors		Healthcare professional factors	
Perceived accepting of LGBT	32,34,39,40,43,46	Perceived non-accepting of LGBT	32,37,38,48
Long relationship with patient	23,39,47	Long relationship with patient	34
Short relationship with patient	39	Short relationship with patient	46
Gender	36,38,39	Ill-informed of LGBT issues	20,31,36,46,48
LGBT	20,25,32,38,41,46,48	Environmental factors	
Environmental factors		Environmental factors	
Location/setting	35	Location/setting	32,35,38,39,44
Accepting visual cues	23,26,39,41,42,48,50	Religious icons	23
Supportive community	32,41	Unsupportive community	43,49

LGBT = lesbian, gay, bisexual, or transgender.

care provider.³³ On the other hand, military⁴⁴ and religious-affiliated³² settings were seen as impeding disclosure, as was care conducted in a group treatment setting.³⁹ Most notably, seven studies commented on visual clues in the healthcare setting that facilitated disclosure.^{23,26,39,41,42,48,50} These included seeing leaflets, stickers, and posters that were deemed LGBT friendly, such as the Human Rights Campaign logo or a rainbow sign.^{41,42,48} Religious symbols or icons displayed in the healthcare professional setting were barriers.²³

DISCUSSION

Summary

In the UK, it is estimated that only half of lesbian and gay people are out to their GP, with disclosure rates lower in bisexual people.¹⁶ The authors have found that the factors promoting or discouraging patient SO disclosure in health care are widespread and varied. The most commonly cited factors were associated with the patient–

provider interaction, which may provide useful targets to improve disclosure rates. Factors that were deemed to either enhance or reduce SO disclosure among females were having SO documented in their medical record and using written forms as a means of disclosing SO, as well as the type of language used during a consultation. Perhaps the use of prompts to aid disclosure, such as having a partner, a written form, or picking up on clues from the healthcare professional's speech, are more important to LGBT women than men as they may be more commonly assumed heterosexual, particularly in discussing their reproductive health,^{30,51} and are less frequently asked directly about their SO.²⁸

Although almost all studies were conducted in countries where homosexuality is legal, two were not. In both of these, barriers to disclosure were almost exclusively explored: commonly, the effect of an unsupportive community, fears of discrimination, and breaches

in confidentiality were described by participants. They were, unsurprisingly, the only two studies to mention criminalisation as a barrier. Although the factors explored were often extreme, ranging from not being treated by their healthcare professional at all, to the police being informed of the participant's SO, and fears of being ostracised from their community, they were echoed to a lesser extent in studies based in other countries.

Strengths and limitations

Although this is the first review to include participants that are both men and women, as well as participants from any sexual LGBT subgroup, there are some limitations. The MMAT has shortcomings. Although it allows the authors to assess different study types with one tool, they often found it difficult to assess the methodological qualities of each study without assessing the quality of reporting. Further, the authors found the MMAT criteria to be fairly crude measures of quality, particularly for qualitative studies. The quality assessment was not taken into account when extracting data from each study, with all the evidence being treated equally. Additionally, most of the mixed methods studies had particularly weak evidence from the quantitative branch of the study. The richest and most appropriate data were extracted from the qualitative arms.

The studies included for review also have limitations. Sampling the LGBT community is recognised as difficult due to the hidden nature of the population. The authors recognise participants need to have disclosed their SO before being recruited to studies, so may not have the same barriers and facilitators to disclosure as those who had not disclosed at all. Furthermore, the participants from each study were largely homogenous, comprising mostly well-educated, white, middle-aged people, who are the groups most likely to disclose their SO.⁵²⁻⁵⁵

Comparison with existing literature

Studies with only correlates of SO disclosure were excluded as they were outside the remit of this review. They do include, however, important information on the effects of patient sex, age, ethnicity, and SO on disclosure. For example, LGBT people who are from ethnic minorities,⁵²⁻⁵⁵ or identify as bisexual,^{52,53,55-57} or do not have a college education,^{53,54,58} or have a low income^{53,54} are less likely to disclose their SO to a healthcare professional. There is mixed evidence for the effect of patient

age^{53,54,58} and sex^{16,52,59} on disclosure. These are important factors to consider when implementing interventions in terms of targeting population groups.

Although useful to enhance the authors' understanding of demographics and disclosure, the quantitative data also support the predominantly qualitative findings. For example, a recent study from Canada found that higher levels of self-esteem, having a partner, and higher levels of social support from friends were significantly associated with healthcare professionals knowing a patient's SO, whereas participants with previous experiences of discrimination and higher levels of internalised homonegativity were less likely to discuss LGBT-related health issues with their healthcare professionals.⁶⁰

Implications for research and practice

Although some of the factors identified in this study are fixed, some could be targeted to minimise the barriers to disclosure. Five of the studies in this review commented on healthcare professionals' lack of LGBT-specific knowledge as a barrier to disclosure. This problem stems from the beginning of medical education, with one study noting a median of five LGBT-dedicated curriculum hours in US medical schools,⁶¹ and another study showing medical students in the UK lack confidence in the use of LGBT-specific health terms and their ability to locate LGBT-specific health information.⁶² Incorporating more LGBT-specific knowledge and communication skills into undergraduate medical education is essential to ensure that future healthcare professionals are armed with the tools they need to help their future patients disclose their SO, and then provide them with appropriate care and advice. The responsibility for medical education does not just sit within the undergraduate realm: there should be increased presence of LGBT-specific issues and appropriate communication tools in postgraduate curricula also.

At an institutional level, the design of healthcare settings should take into account the needs of LGBT patients. There are some changes that are easily implemented and inexpensive, including displaying signs or symbols that convey an accepting atmosphere, such as a rainbow symbol or the Human Rights Campaign logo, while others may take more time. It is important to ensure, however, that any healthcare setting changes are congruent with the beliefs of the healthcare professional working within them. A key intervention is the production of patient information

leaflets that are accepting of the LGBT community and that consider the differing needs of LGBT individuals compared with heterosexual individuals, providing LGBT-specific information when necessary.

Individual healthcare professionals should be aware of the differing physical and psychological needs of the LGBT community and remain open minded regarding their patients' SO. The authors encourage all healthcare professionals to reflect on their use of language, keeping an eye out for heteronormative phrases and assumptions, as well as those that may be inhibiting their patients' ability to disclose, and consider using alternative terms. The most common example of this is referring to a patient's partner as 'he' or 'she', rather than asking whether they are male or female or going further to ask whether the patient is, or ever has been, involved in a relationship with men, women, or both. Healthcare

professionals should also consider asking questions about each patient's SO in their daily practice, using open and accepting language. Further investigation into issues surrounding disclosure from a healthcare professional perspective would also provide a fuller understanding of the complexities surrounding SO disclosure in health care.

Ideally, robust population-level studies that include an accurate portrayal of the breadth encompassed within LGBT are needed. The current SO monitoring question in the UK has only five possible answers (heterosexual, gay/lesbian, bisexual, other, prefer not to say), which does not display the full spectrum of orientations and focuses only on sexual identity rather than attraction or behaviours. For example, an alternative means of monitoring those who describe themselves as 'other' would allow a much richer, and much needed, analysis of the population.

Funding

None given.

Ethical approval

Not applicable.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

Discuss this article

Contribute and read comments about this article: bjgp.org/letters

REFERENCES

- Hudson-Sharp N, Metcalf H. *Inequality among lesbian, gay, bisexual, and transgender groups in the UK: a review of evidence*. 2016. <https://www.gov.uk/government/publications/inequality-among-lgbt-groups-in-the-uk-a-review-of-evidence> [accessed 15 Jan 2018].
- Institute of Medicine. *The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding*. Washington, DC: IOM, 2011.
- Office for National Statistics. *Sexual identity, UK: 2015. Experimental official statistics on sexual identity in the UK in 2015 by region, sex, age, marital status, ethnicity, and NS-SEC*. ONS, 2016. <http://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/sexualidentityuk/2015> [accessed 15 Jan 2018].
- Public Health England. *Producing modelled estimates of the size of the lesbian, gay, and bisexual (LGB) population of England*. 2017. http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf [accessed 15 Jan 2018].
- LGBT Foundation, NHS England. *Sexual orientation monitoring: full specification*. 2017. <https://www.england.nhs.uk/wp-content/uploads/2017/10/sexual-orientation-monitoring-full-specification.pdf> [accessed 22 Jan 2017].
- Equality and Health Inequalities Unit. *NHS England response to the specific equality duties of the Equality Act 2010: NHS England's equality objectives in equality information*. 2017. <http://www.england.nhs.uk/wp-content/uploads/2017/03/nhse-sed-response.pdf> [accessed 15 Jan 2018].
- Lindley LL, Walsemann KM, Carter JW. The association of sexual orientation measures with young adults' health-related outcomes. *Am J Public Health* 2012; **102**(6): 1177–1185.
- Semlyen J, King M, Varney J, Hagger-Johnson G. Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry* 2016; **16**: 67.
- Conron KJ, Mimiaga MJ, Landers SJ. A population-based study of sexual orientation identity and gender differences in adult health. *Am J Public Health* 2010; **100**(10): 1953–1960.
- Sandfort TG, Bakker F, Schellevis FG, Vanwesenbeeck I. Sexual orientation and mental and physical health status: findings from a Dutch population survey. *Am J Public Health* 2006; **96**: 1119–1125.
- Elliott MN, Kanouse DE, Burkhart Q, et al. Sexual minorities in England have poorer health and worse health care experiences: a national survey. *J Gen Intern Med* 2015; **30**(1): 9–16.
- Lick DJ, Durso LE, Johnson KL. Minority stress and physical health among sexual minorities. *Perspect Psychol Sci* 2013; **8**(5): 521–548.
- Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull* 2003; **129**(5): 674–697.
- Link BG, Phelan J. Social conditions as fundamental causes of disease. *J Health Soc Behav* 1995; Spec No: 80–94.
- Bränström R, Hatzenbuehler ML, Pachankis JE, Link BG. Sexual orientation disparities in preventable disease: a fundamental cause perspective. *Am J Public Health* 2016; **106**(6): 1109–1115.
- Mitchell M, Howarth C, Kotecha M, Creagan C. *Sexual orientation research review*. 2008. http://www.equalityhumanrights.com/sites/default/files/research_report_34_sexual_orientation_research_review.pdf [accessed 15 Jan 2018].
- Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS Med* 2009; **6**(7): e1000097.
- Pluye P, Robert E, Cargo M, et al. *Proposal: a mixed methods appraisal tool for systematic mixed studies reviews*. Montreal, QC: Department of Family Medicine, McGill University, 2011.
- Landis JR, Koch GG. The measurement of observer agreement for categorical data. *Biometrics* 1977; **33**(1): 159–174.
- Adams J, McCreanor T, Braun V. Doctoring New Zealand's gay men. *N Z Med J* 2008; **121**(1287): 11–20.
- Beehler GP. Original research: confronting the culture of medicine: gay men's experiences with primary care physicians. *J Gay Lesbian Med Assoc* 2001; **5**(4): 135–141.
- Johnson MJ, Nemeth LS. Addressing health disparities of lesbian and bisexual women: a grounded theory study. *Womens Health Issues* 2014; **24**(6): 635–640.
- Koh CS, Kang M, Usherwood T. 'I demand to be treated as the person I am': experiences of accessing primary health care for Australian adults who identify as gay, lesbian, bisexual, transgender, or queer. *Sex Health* 2014; **11**(3): 258–264.
- Marques AM, Nogueira C, de Oliveira JM. Lesbians on medical encounters: tales of heteronormativity, deception, and expectations. *Health Care Women Int* 2015; **36**: 988–1006.
- Mattocks KM, Sullivan JC, Bertrand C, et al. Perceived stigma, discrimination, and disclosure of sexual orientation among a sample of lesbian veterans receiving care in the Department of Veterans Affairs. *LGBT Health* 2015; **2**(2): 147–153.
- Munson S, Cook C. Lesbian and bisexual women's sexual healthcare experiences. *J Clin Nurs* 2016; **25**(23–24): 3497–3510.
- Roller CG, Sedlak CA, Draucker Burke C, et al. Managing the conversation: how sexual minority women reveal sexual orientation. *J Nurse Pract* 2016; **12**(6): e259–e266.
- Sherman MD, Kauth MR, Shipherd JC, Street RL. Communication between VA providers and sexual and gender minority veterans: a pilot study. *Psychol Serv* 2014; **11**(12): 235–242.
- Stein GL, Bonuck KA. Physician–patient relationships among the lesbian and gay community. *J Gay Lesbian Med Assoc* 2001; **5**(3): 87–93.
- Venetis MK, Meyerson BE, Friley LB, et al. Characterizing sexual orientation disclosure to health care providers: lesbian, gay, and bisexual perspectives. *Health Commun* 2017; **32**(5): 578–586.
- Bjorkman M, Malterud K. Lesbian women's experiences with health care: a qualitative study. *Scand J Prim Health Care* 2009; **27**(4): 238–243.
- Boehmer U, Case P. Physicians don't ask, sometimes patients tell: disclosure of sexual orientation among women with breast carcinoma. *Cancer* 2004; **101**(8): 1882–1889.
- Fish J, Williamson I. Exploring lesbian, gay, and bisexual patients' accounts of their experiences of cancer care in the UK. *Eur J Cancer Care (Engl)* 2016; DOI: 10.1111/ecc.12501.
- Law M, Mathai A, Veinot P, et al. Exploring lesbian, gay, bisexual, and queer (LGBQ) people's experiences with disclosure of sexual identity to primary care physicians: a qualitative study. *BMC Fam Pract* 2015; **16**: 175.
- Mulligan E, Heath M. Seeking open minded doctors — how women who identify as bisexual, queer, or lesbian seek quality health care. *Aust Fam Physician* 2007; **36**(6): 469–471.
- Politi MC, Clark MA, Armstrong G, et al. Patient–provider communication about sexual health among unmarried middle-aged and older women. *J Gen Intern Med* 2009; **24**(4): 511–516.
- Rose D, Ussher JM, Perz J. Let's talk about gay sex: gay and bisexual men's sexual communication with healthcare professionals after prostate cancer. *Eur J Cancer Care (Engl)* 2017; **26**(1): DOI: 10.1111/ecc.12469.
- Sharek DB, McCann E, Sheerin F, et al. Older LGBT people's experiences and concerns with healthcare professionals and services in Ireland. *Int J Older People Nurs* 2015; **10**(3): 230–240. [Epub 2014].
- Underhill K, Morrow KM, Collieran C, et al. A qualitative study of medical mistrust, perceived discrimination, and risk behavior disclosure to clinicians by US male sex workers and other men who have sex with men: implications for biomedical HIV prevention. *J Urban Health* 2015; **92**(4): 667–686.
- Bjorkman M, Malterud K. Being lesbian — does the doctor need to know? *Scand J Prim Health Care* 2007; **25**(1): 58–62.
- Daley AE. Becoming seen, becoming known: lesbian women's self-disclosures of sexual orientation to mental health service providers. *J Gay Lesbian Ment Health* 2012; **16**(3): 215–234.
- Quinn GP, Sutton SK, Winfield B, et al. Lesbian, gay, bisexual, transgender, queer/questioning (LGBTQ) perceptions and health care experiences. *J Gay Lesbian Soc Serv* 2015; **27**(2): 246–261.
- Wanyenze RK, Musinguzi G, Matovu JK, et al. 'If you tell people that you had sex with a fellow man, it is hard to be helped and treated': barriers and opportunities for increasing access to HIV services among men who have sex with men in Uganda. *PLoS One* 2016; **11**(1): e0147714.
- Biddix JM, Fogel CI, Perry Black B. Comfort levels of active duty gay/bisexual male service members in the military healthcare system. *Mil Med* 2013; **178**(12): 1335–1440.
- Legere LE, MacDonnell JA. Meaningful support for lesbian and bisexual women navigating reproductive cancer care in Canada: an exploratory study. *J Res Nurs* 2016; **21**(3): 163–174.
- Barbara AM, Quandt SA, Anderson RT. Experiences of lesbians in the health care environment. *Women Health* 2001; **34**(1): 45–62.

47. Furlotte C, Gladstone JW, Cosby RF, Fitzgerald KA. 'Could we hold hands?' Older lesbian and gay couples' perceptions of long-term care homes and home care. *Can J Aging* 2016; **35(4)**: 432–446.
48. Clover D. Overcoming barriers for older gay men in the use of health services: a qualitative study of growing older, sexuality, and health. *Health Edu J* 2006; **65(1)**: 41–52.
49. Wirtz AL, Kamba D, Jumbe V, *et al*. A qualitative assessment of health seeking practices among and provision practices for men who have sex with men in Malawi. *BMC Int Health Hum Rights* 2014; **14**: 20.
50. McDonald C. Lesbian disclosure: disrupting the taken for granted. *Can J Nurs Res* 2006; **38(1)**: 42–57.
51. Neville S, Henrickson M. Perceptions of lesbian, gay, and bisexual people of primary healthcare services. *J Adv Nurs* 2006; **55(4)**: 407–415.
52. Durso LE, Meyer IH. Patterns and predictors of disclosure of sexual orientation to healthcare providers among lesbians, gay men, and bisexuals. *Sex Res Social Policy* 2013; **10(1)**: 35–42.
53. Bernstein KT, Liu KL, Begier EM, *et al*. Same-sex attraction disclosure to health care providers among New York City men who have sex with men: implications for HIV testing approaches. *Arch Intern Med* 2008; **168(13)**: 1458–1464.
54. Petroll AE, Mosack KE. Physician awareness of sexual orientation and preventive health recommendations to men who have sex with men. *Sex Transm Dis* 2011; **38(1)**: 63–67.
55. Johnson CV, Miriaga MJ, Reisner SL, *et al*. Health care access and sexually transmitted infection screening frequency among at-risk Massachusetts men who have sex with men. *Am J Public Health* 2009; **99(Suppl 1)**: S187–S192.
56. Kamen CS, Smith-Stoner M, Heckler CE, *et al*. Social support, self-rated health, and lesbian, gay, bisexual, and transgender identity disclosure to cancer care providers. *Oncol Nurs Forum* 2015; **42(1)**: 44–51.
57. Cochran SD, Mays VM. Disclosure of sexual preference to physicians by black lesbian and bisexual women. *West J Med* 1988; **149(5)**: 616–619.
58. Hirsch O, Löltgen K, Becker A. Lesbian womens' access to healthcare, experiences with and expectations towards GPs in German primary care. *BMC Fam Pract* 2016; **17**: 162.
59. Klitzman RL, Greenberg JD. Patterns of communication between gay and lesbian patients and their health care providers. *J Homosex* 2002; **42(4)**: 65–75.
60. Coleman TA, Bauer GR, Pugh D, *et al*. Sexual orientation disclosure in primary care settings by gay, bisexual, and other men who have sex with men in a Canadian city. *LGBT Health* 2017; **4(1)**: 42–54.
61. Obedin-Maliver J, Goldsmith ES, Stewart L, *et al*. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA* 2011; **306(9)**: 971–977.
62. Parameshwaran V, Cockbain BC, Hillyard M, Price JR. Is the lack of specific lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) health care education in medical school a cause for concern? Evidence from a survey of knowledge and practice among UK medical students. *J Homosex* 2017; **64(3)**: 367–381.