

## Research paper

# Lesbian and gay experiences of primary care in one borough in North London, UK

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### ABSTRACT

This paper reports the findings of a research study which explored the experiences of lesbians and gay men in relation to primary care services in general practice in a multiracial borough in North London, UK. The research took a qualitative approach and used several methods including a literature review, interviews with stakeholders ( $n = 6$ ), focus group discussions ( $n = 27$ ) and completion ( $n = 42$ ) of a survey distributed to lesbians and gay men locally. The process facilitated the development of a grounded theory. The important themes to emerge were *finding a GP and coming out*, *sexual health issues*, *mental health issues* and *communication with the GP*. Given the high level of mobility among this population, there were problems in maintaining continuity of care, and a lack of protocols to facilitate the sharing of knowledge between patients and practitioners while reducing reliance on heterosexual assumptions. There were clear differences between the treatment of women and men in relation to sexual health, and neither approach

could be said to be patient centred or inclusive of diversity of need. The fact that many informants accessed alternative sources of healthcare indicated that they were concerned to promote and maintain their health and wellbeing in a holistic manner. The lack of transparent protocols within general practice inhibited some informants from being as open and honest about their sexuality with their GPs as they were with their families or their employers. The findings highlight (1) the need for organisational development within primary care to improve sensitivity to the needs of lesbians and gay men; (2) the value of research to engage with the social experiences of lesbians and gay men; (3) the importance of engaging with the differing experiences of lesbians and gay men in relation to sexual health concerns.

**Keywords:** gay men, general practice, heterosexual assumptions, lesbians, primary care, protocols

## Introduction

This study was part of a wider initiative to explore marginalised communities' access to primary care services in one London borough, conducted in the context of research which reveals considerable levels of mistrust among lesbians and gay men about their relations with healthcare practitioners. This particular study aimed to draw on the experiences of lesbian and gay informants to identify both barriers and examples of good practice, and to engage with the growing body of literature in this field (Silvestre, 2001; Heaphy *et al*, 2003; Hinchliff *et al*, 2005; Fish, 2006; Shankle, 2006)

as a basis for formulating a body of recommendations about how general practice might be reorganised to benefit the health and wellbeing of lesbians and gay men in its area of responsibility.

## Background

This North London borough has, according to the 2001 Census (Office of National Statistics, 2003), a population of 218 341. It is a diverse, multiracial,

multicultural population – factors that present challenges to the primary care services offered in general practice. The study reported here was one of several studies commissioned by a community organisation, with funding from the Neighbourhood Renewal Fund ([www.neighbourhood.gov.uk](http://www.neighbourhood.gov.uk)), into the experiences of minority groups in accessing primary care services.

Given that there is no monitoring of lesbian and gay people, it is difficult to estimate the size of the lesbian and gay populations. The Department of Trade and Industry (DTI) places the figures between 5% and 7% of the total adult population (DTI, 2003). Given the traditional patterns of movement to large cities by lesbian, gay and bisexual (LGB) populations, it can be argued that the LGB population of the borough in which this study took place is likely to be at least 7%. We thus deduced that the LGB population was likely to be in the region of 15 000 people.

The approach of general practitioners (GPs) towards the social and familial context of people who access their services has been widely debated. The Royal College of General Practitioners (RCGP, 2002) has endorsed a definition of general practice/family medicine which is respectful of diversity, and person centred in its focus. General practice, according to this definition, is ‘normally the point of first medical contact within the healthcare system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned’ (European Academy of Teachers in General Practice, 2002, p. 3). The specialty of general practice includes ‘care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of patients’ (European Academy of Teachers in General Practice, 2002, p. 3). Schilder *et al* (2001, p. 1646) have argued that ‘family’ can best be identified as ‘those persons closest in knowledge and affection, which should be the criteria in interpreting any individual’s social support’. This definition of ‘family’ is broader than that of more traditional models which tend, in the UK, to be based around heterosexual couples.

Heterosexual assumptions can prevent or inhibit practitioners from identifying particular patterns of non-heterosexual living; this, in turn, can result in non-communication and misdiagnosis. Heaphy *et al* (2003), in a study of lesbian, gay and bisexual people over 50 years, revealed these heterosexual assumptions on the part of health service providers as creating barriers to care. Phillips and Marks (2006) showed that the silencing of non-heterosexual identities in the field of residential aged care facilities hindered the provision of services that are culturally sensitive, safe and inclusive. Westerståhl and Björkelund (2003), in a study of GPs, identified GPs’ traditional concepts of

family and sexuality as a barrier to making lesbian patients visible. The lack of dialogue encourages some practitioners in the assumption that the lifestyles of those from non-heterosexual minorities are dysfunctional (Hinchliff *et al*, 2005).

The emergence of social movements since the 1960s and the subsequent increase in the number of meeting places openly catering for LGB people have helped people to *come out* as lesbian or gay. There is huge diversity within the LGB population. While many will be sexually active with people of the same sex, some will be aspiring to be so, and others will be occasionally sexually active with people of either sex. Additionally, there will be people living with the memory of having been sexually active with people of the same sex.

*Coming out* as lesbian or gay is, however, more than an acknowledgement of particular sexual activity. Plummer (1995, p. 82) has argued that it can be ‘the most momentous act in the life of any lesbian or gay person’, not so much an exchange of information as a redefinition of the relationship between the lesbian or gay person and the person listening to their *coming out* story (Plummer, 1995; Saddul, 1996; Taylor, 1999). Saddul (1996, p. 4) makes the point that ‘repeated negative experiences with providers ... may cause a person to delay or avoid seeking care’. Fish (2006) has developed a theory of heterosexism to conceptualise practices experienced in healthcare settings. Bakker *et al* (2006) show that use of health services is higher among lesbian, gay and bisexual people than heterosexual people. Schilder *et al* (2001, p. 1656) indicate the difficulty for health providers ‘when a minority group itself often has discomfort self-identifying ... when their social identity is also associated with stigma’. The problems of living with stigma result in many lesbian and gay people experiencing mental health, rather than sexual health, as their primary area of health concern (McFarlane, 1998; King and McKeown, 2003). In a study of gay men and primary care, Cant (2002) identified a reluctance on the part of GPs to make referrals to gay community organisations with the potential to prevent the onset or the accumulation of mental health problems.

## Conduct of the study

London South Bank University (LSBU) was commissioned by a lesbian and gay-led community organisation to conduct research to explore access to general practice services by lesbians and gay men in one London borough. This study was one part of a wider initiative to explore marginalised communities’ access to GP services in primary care. Ethical approval for the study was obtained from the appropriate local research ethics committee. The research team comprised

the two authors of this paper, and two other researchers (see acknowledgements) who facilitated two of the focus groups and contributed to parts of the analysis of focus group data, as described below.

Steering group meetings of staff and volunteer managers from the community organisation and staff from LSBU agreed that the research process would include a variety of methods with a strong emphasis on qualitative approaches (Cresswell, 2003; Britten and Fisher, 1993). An overall theoretical framework for the research was provided by intersectionality (Sloop, 2005). Intersectionality theory originated in the writings of African-American and Third World feminists, concerned to counter Western feminist theory's insufficient attention to women of colour by providing a more appropriately complex and nuanced analysis that incorporated attention to other social-demographic characteristics and the relations of inequality associated with them alongside gender relations (Collins, 1991; Mohanty, 1991). The main premise that is pertinent here is that any particular form of inequality or oppression is modified by its interactions with other forms of inequality or oppression, so that an exploration of lesbian and gay experiences of primary care requires a consideration of the intersections of sex, race, class and occupation, together with sexuality. Intersectionality provided the basis for a multimethod approach based on a literature review; interviews with stakeholders; focus group discussions; distribution of a survey in the wider LGBT population in the borough; analysis and writing up of the findings.

## The literature review

The review of appropriate literature at local, national and international level focused particularly on themes such as *coming out*, *definitions of family* and *access to primary care*.

## Interviews with stakeholders

Semi-structured interviews with six key stakeholders helped set the agenda and assisted in the formulation of the topic guide for the focus groups and the items included in the questionnaire used with the wider population group. These interviews were undertaken with two service users, two stakeholders in the local lesbian, gay, bisexual and transgender (LGBT) community and voluntary sector in the borough and two stakeholders in the statutory sector. One direct outcome of these interviews was the agreement that, because of the mobility of this population group and the impact that stigma can have on individuals' willingness to access local services, the opportunity to participate in the research would be open to people

who lived, worked, studied or socialised in the borough.

## Focus group discussions

Focus group discussions were held with four sub-groups from within the larger LGBT population. The target groups were lesbian and bisexual women; gay and bisexual men; lesbians, gay men and bisexual people from black and minority ethnic communities; and young lesbian, gay and bisexual people (see Table 1). While it was agreed that the prime focus of the research was lesbians and gay men, it was acknowledged that some people who attended the focus groups might also identify themselves as bisexual or in other diverse ways. There was debate about the organisation of sessions for groups such as people with disabilities or asylum seekers and refugees, but questions of resources and the perceived strength of particular social networks resulted in a decision to limit the groups to the above four. The topics covered were: sources of general advice and support that might impact upon health; finding a GP; relations with primary healthcare team in relation to *coming out*; mental health; sexual health.

Participants for the focus groups were recruited through lesbian and gay community channels, particularly the networks linked to the community organisation that commissioned the research. An information sheet was made available to all potential participants, emphasising issues of anonymity and confidentiality. Participants were advised at the beginning of each focus group that they could withdraw at any point without giving any reason. The focus groups were held in the premises of the commissioning organisation.

**Table 1** Focus group participants

Group	Number	Further details
Women	8	6 white, 2 black and minority ethnic; age range 30–50 years
Men	7	7 white; age range 20–70 years
Black and minority ethnic	3	3 women; aged under 40 years
Young people	5	5 white; 3 men, 2 women; aged under 26 years

The facilitators shared an attachment to the population group of each focus group insofar as the women's group was facilitated by a woman, the men's group by a man, the black and minority ethnic group by a member of a minority ethnic group and the young people's group by a young person.

## The survey

A questionnaire asking respondents about their views of general practice was distributed in hard copy format through lesbian and gay community channels such as community mailing lists and commercial venues. It covered topics such as preferred sources of advice in relation to general health problems, mental health, sexual health, gay-friendliness of current general practice, identification of types of people to whom respondents had *come out* about their sexuality. An information sheet was made available with each questionnaire distributed. While the forms were completed anonymously, respondents provided information on sexuality, gender, ethnicity, disability, age, refugee/asylum-seeker status, postcode and relationship with the borough in the study. Approximately 250 questionnaires were distributed and 42 were returned by post. The informants reflected the diversity of the borough inasmuch as, for example, they identified themselves as coming from eight ethnic backgrounds, 23.3% ( $n = 42$ ) considered themselves to have a disability, and their ages ranged from 16 to 65 years and over. Fuller demographic details are available in Cant and Taket (2004). There were no incentives for completion of the questionnaires. The response rate achieved is reasonable considering the mode of distribution of the questionnaire and the limited time frame of six weeks available for response.

## Data analysis

Staff from the research team at LSBU were responsible for the analytical process. The tapes of the focus group interviews were listened to repeatedly, and partially transcribed with a view to identifying further emergent themes towards the development of a grounded theory (Strauss and Corbin, 1990); likewise themes were identified from reading the data gathered from the questionnaires. This particular research study was influenced by the work of Charmaz (1990), who argued that grounded research is threefold insofar as it requires researchers to 'attend closely to the data (which amounts to "discoveries" for them) ... [to build] their theoretical analyses directly on their interpretations of processes within those data ... [and to] compare their analyses with the extant literature and theory' (Charmaz, 1990, p. 1165). This grounded theory approach enables the researchers to draw upon 'general

perspectives of their disciplines, their own philosophical, theoretical, substantive, and methodological proclivities, their particular research interests' (Charmaz, 1990, p. 1170). In this particular study, the researchers drew upon the theory of intersectionality as well as writings on primary care and on *coming out*. The data from each tape were analysed by the facilitator of that particular group and one other member of the team. The themes that structured the topic guide, produced as a result of the stakeholder interviews, also informed the analysis. This iterative process facilitated the development of a grounded theory insofar as scrutiny of and engagement with the data informed the formulation of the theory, through identification and use of emergent themes. The themes identified by these processes shaped the overall analysis and the writing up of the research.

Key themes arising from analysis of the focus group discussions and questionnaires were finding a GP and *coming out*, sexual health issues, mental health issues and communication with the GP and other members of the primary healthcare team. These are discussed in turn below.

## Findings

### Finding a GP and *coming out* in the general practice setting

All the focus group participants were registered with a GP. Some had been registered with the same practice all their lives and some had registered with the one geographically nearest to them. Those who had sought to find a practice that was LGBT friendly and thus sensitive to their personal and social circumstances had found that personal recommendations were particularly helpful. One woman informant had asked an official NHS body about gay-friendly practices in the area:

'to be told that "all GP practices are gay friendly" – I was then told by law they had to be. Then they said: "I suppose it's an HIV issue". I then went: "No, this is actually for me and I'm a lesbian" and they said: "Whoops, I shouldn't have said that".'

There was nothing to suggest that this staff member, whose responsibility was information provision, had ever received training to assist her to be culturally sensitive to the needs and expectations of lesbian and gay patients.

Twenty of the 42 questionnaire informants had *come out* as lesbian, gay or bisexual to their GPs; a further four had *come out* to other members of staff at the practice where they were registered; in total, 24 had *come out* to members of their primary healthcare team. This can be contrasted with the fact that 29 informants

had *come out* to their employers, even though they had powers of hiring and firing; these data were gathered before the introduction of legislation outlawing discrimination on grounds of sexual orientation in December 2003. Thirty informants had *come out* to their parents. It can be seen that this group of informants was predisposed to be honest about their sexuality in circumstances where there might be untoward consequences. Despite this, a lower number had *come out* to members of their primary healthcare team than had *come out* to their employers or their parents. Females were faced with a situation where many felt forced to *come out* as a result of the way initial registration with practices was structured in relation to sexual health. This issue is also relevant in the discussion of communication further below.

## Sexual health

There was a strong, marked contrast between the experiences of men and women focus group informants in relation to sexual health issues in general practice. None of the men reported ever having discussed sexual health with their GPs. Most of them were aware of the benefits of taking preventative measures to secure good sexual health and attended genito-urinary medical (GUM) clinics of their choice. One reported his experience of continuity of care at one such clinic.

‘I’ve actually had the same nurse at the GUM clinic for probably five years – I feel completely free to talk to him about anything – he’s a straight bloke and I have a better relationship with him than with any GP.’ (Male informant)

Women’s experiences were very different. Sexual health came onto the agenda as soon as they tried to register with a practice. Some practices required women to have a cervical smear test or proof of a test before they could register with the practice. Not only was an invasive procedure to be carried out on their initial contact with the practice, but they also found that the questions they were asked were insensitive to their experiences. For example:

‘During a smear, they were asking just really inappropriate questions – “are you having sex?” – yes – “are you worried about getting pregnant?” – no – “why not?” – my partner’s a woman – “oh” [with reported shock].’ (Female informant)

The apparent lack of any protocols to engage with lesbian and gay lifestyles suggests that, far from being a specific problem with the knowledge base of individual nurses, this was an institutional problem. General practice procedures made lesbians invisible in terms of sexual health, and required the patient not only to *come out* at a time not of her choosing, but also to assume an educational role about her healthcare

needs. Gay lifestyles were made invisible differently insofar as there was no structured opportunity for gay men to *come out* if they wished. The design of the information systems and the categories offered for recording information were not inclusive of non-heterosexual identities; this posed difficulties at the time of first registering with a new practice, as well as in later consultations.

## Mental health

Mental health issues were raised as a matter of concern by several focus group informants, many of whom also expressed concern about the reaction they would have received if they had raised them in the general practice setting. Both women and men had referred themselves to lesbian, gay and bisexual counselling projects, but there was no evidence to suggest that any GP had referred them to such projects. Nor was there any evidence that any referrals had been made to services that deal with the psychological consequences of being a victim of hate crime, although there was a well-established local agency that was particularly sensitive to lesbian and gay hate crime victims.

A participant in the black and minority ethnic focus group highlighted her view that lesbian and gay patients do not only present mental health issues relating to their experiences of sexuality:

‘I would discuss mental health with my doctor but I would be very careful because, as a black person, I think they’re just too quick to box you.’ (Female informant)

She was aware of the debate about the relatively high level of African-Caribbean people being diagnosed with illnesses such as schizophrenia (Mackenzie and Murray, 1999); she was concerned that inappropriate referrals to psychiatrists would not only fail to address her emotional problems but could also result in her being pathologised.

## Communication with the GP and other members of the primary healthcare team

Communication between GPs and patients was understood as being very significant, and while good communication was welcomed and appreciated, poor communication and the expectation of poor communications were identified as major barriers. For focus group informants, effective communication was particularly appreciated in relation to the process of *coming out* as lesbian or gay. For instance:

‘I was very depressed – and my GP raised the issue of my sexuality – I was married at the time and in a complete state of denial – and then the penny dropped and I could talk to him – not very comfortably at first – but he

supported me through the separation and divorce as well.’ (Male informant)

‘My GP gave me help without me even asking for it – she was helpful – said I was her first gay patient.’ (Female informant)

Both of these patients had already been with their practice for some time when the issue of sexuality was raised, and the fact that there was already a therapeutic relationship may have assisted the doctors to treat the problems connected with sexuality as part of the patient’s personal identity rather than its single defining feature. Several informants referred to the value of GPs asking questions of patients rather than making assumptions about them in the course of a hurried appointment. For instance:

‘I’m confident about my sexuality but not with my GP – if the GP makes the first step in trying to find out about your lifestyle I wouldn’t have a problem telling – if they make that initial move you know they’ve got an open mind.’ (Male informant)

The behaviour of the individual GP was not regarded as being the central barrier here, but the unequal power balance between doctor and patient was seen as problematic. If the doctor took the initiative and asked the first question, this was perceived by several informants as being encouraging and empowering. Such initiatives assisted lesbian and gay patients to articulate the whole of the narrative surrounding their health problem and assisted the GPs to make appropriate diagnoses and referrals.

Concerns were expressed about the difficulties of lesbians and gay men, who had migrated to London, talking about the health implications of their new lifestyle with GPs and other members of the primary healthcare team. The majority of the meeting places for young lesbians and gay men are commercially run venues where smoking and the consumption of alcohol and other drugs are pervasive. This poses problems for these new migrants. They are unsure about how to negotiate a personal solution for themselves between the extremes of social isolation or socialising in relatively unhealthy environments. One young man explained his thoughts on his experiences:

‘When you do move to London, if you haven’t got a support network already – you have to find some support and if you find that in a certain group that quite routinely drinks a lot and smokes a lot, then you do it. You go on the scene because, perhaps, you don’t talk to your family and your confidence is at an all-time low. I was really skinny – I was just like not eating – and they would say “Oh, you need to put on some weight” and I would say that I just wasn’t hungry – it was a whole mental health issue to do with *coming out* – but I wouldn’t tell the GP – they might not realise the pressure you’re under – it’s a physical thing linked to mental health.’ (Male informant)

There was no continuity of care context to this particular doctor–patient relationship and the doctor had not developed any way of interacting with this patient so as to enable him to tell the narrative of his current life in London. The patient’s fear of being stigmatised or rejected meant that he lacked the confidence to *come out* and share the narrative around the development of his sexuality; he found the advice from this particular GP less than useful.

Other informants told narratives of their experiences with GPs which illustrated the difficulties of establishing a trusting relationship with a new GP. One woman reported how ‘lesbian mother’ had been written across her child’s health records in relation to consultation on an unconnected issue. Several men were unsure about the impact that information about their sexuality would have on applications for mortgages and insurance. One informant reported that in a group practice, a doctor whom he had never met provided details about his sexuality to an insurance company, which made a false assumption about his HIV status and increased his premium. The differing interpretations of confidentiality and the value systems of some health practitioners had contributed to patients being fearful about trusting their GPs with information about their sexuality.

The findings from the focus group informants were reinforced by the questionnaire informants. They were asked to identify examples of their own negative experiences with the practice where they were registered. Eight informants (19%) specifically said that they were able to identify no examples of negative experiences. From the remaining informants, issues relating to communication were the most common among the negative experiences cited. Several GPs and other practice staff were criticised for making assumptions about heterosexuality and being insensitive to those informants who *came out* about their sexuality. Staff behaviour was described as having been ‘defensive’, ‘judgemental’, ‘patronising’, ‘rude’ or ‘uncomfortable’. Lack of respect had been shown to informants who *came out*, and this had manifested itself in inappropriate remarks about a male informant’s ‘effeminate’ behaviour, intrusive and irrelevant questions about sexual activity, regular usage of the prefix ‘Mrs’ to an openly declared lesbian and the lack of inclusion of an informant’s partner. Judgemental and physically rough treatment was mentioned by one informant in relation to her treatment by GPs whose religious beliefs were used to justify disapproval of her lesbian lifestyle. Health promotion advice was provided without any acknowledgement of the social context in which informants were living their lives. Four informants reported that diagnoses and treatment decisions were made without any explanations; one man had been sent to a hospital for an HIV test without discussion

or explanation. The repeated offers of contraception were resented by a number of women whose *coming out* seemed not to have been acknowledged by practice staff.

## Discussion

Many of the key themes presented here related to the mode of organisation of the practice. Of particular significance was the perceived lack of protocols to respond to the diversity of the local population, heterosexual assumptions, communication and accessing other sources of healthcare. The issue of protocols is not a request for special treatment for a minority, but reflects the need for innovative approaches to the recording and sharing of personal histories in practices where there are diverse patient backgrounds. Continuity of care is a pressing issue for such a highly mobile population (Kelley *et al*, 1997; Valentine, 1999). Lesbians and gay men are particularly likely to move accommodation frequently and so there is less opportunity for them to develop ongoing relationships with their healthcare practitioners and for the practitioners to build an in-depth knowledge of their patients' personal health histories. This highlights the role that protocols could have in facilitating the sharing of knowledge between patients and practitioners.

The approach of practices towards sexual health was identified by many informants as both problematic and reflective of heterosexual assumptions. There was a clear gender differentiation in that women were subjected to insensitive procedures before registration, whereas men were unlikely to encounter issues of sexual health at all. Neither with women nor with men could the behaviour of general practice be said to be patient centred or inclusive of diversity of need.

Communication was a key factor in determining individuals' level of satisfaction with service providers and this was seen as being more problematic with the GP services than with alternative healthcare providers. There was concern that sexuality was likely to be pathologised by GPs, and this frequently inhibited people from being as open with them as they were, for example, with their families. The process of pathologising sexuality can prevent practitioners from understanding the significance of particular attachments and affiliations within lesbian and gay population groups. Many GPs were perceived as relying on heterosexual assumptions. While it was acknowledged that some individual practitioners had been friendly and supportive to individual patients, there was no evidence to suggest that any of them had developed systems such as protocols for recording information about sexuality and lifestyles in ways which their patients

might deem to be appropriate and respectful (Miller and Weingarten, 2005).

The fact that many informants acknowledged that they accessed alternative sources of healthcare such as aromatherapy, counselling and internet support chat-rooms as well as lesbian-/gay-friendly sexual health clinics indicates that the informants were concerned to promote and maintain their health and wellbeing. None was, however, totally reliant on these other sources and it was our perception that they expected their primary care services to be as holistic in their approach as their other providers.

## Conclusions and recommendations

The widespread perception that lesbian and gay healthcare needs were invisible within the context of general practice indicates the need for action on several different levels. To clarify the extent of the problem it would be useful, initially, for practices to audit the frequency with which lesbian- and gay-related concerns are raised with practitioners; it would also be appropriate for primary care trusts to establish small grants schemes that could support both individual and collective attempts at advocacy. These steps could begin to generate debate and give pointers towards the prioritisation of particular research-related tasks and projects. As this process develops, opportunities should be taken to develop partnerships between the PCT and other community bodies, including lesbian and gay organisations, to monitor progress and identify future steps in the development of healthcare practice which is more inclusive of the needs and aspirations of the lesbian and gay populations.

These steps will also provide a framework within which it will be possible to conduct research on the healthcare implications of a number of dimensions of lesbian and gay experiences such as hate crime, sexual health and social isolation. By making the social experiences the starting point of this process, there will be opportunities to review and question the medical assumptions about lesbian and gay healthcare needs and to promote the development of more inclusive models of practice.

One specific healthcare issue which can be addressed within this context is the policy, or rather the lack of policy, of general practice towards the sexual health concerns of lesbians and gay men. This plays out differently for lesbians and gay men. Gender distinction within current practice leaves gay men to their own devices and forces women to engage in procedures at times and in ways that are not of their own choosing. Both approaches imply an attitude of neglect towards this significant area of health and neither of them encourages patients to integrate their

sexual health concerns into their overall healthcare agenda. That an intersectional framework was of value can be seen most clearly in two particular areas: how the heterosexist assumptions and systems in relation to sexual health operated with quite different effects for lesbians and gay men, and how concerns around mental health resulted in rather different presentations of self for black lesbians and gay men in comparison to those who were white.

This study engaged with the experiences of a diverse sample of lesbians and gay men and, in so doing, revealed the complexity of needs that this population group brings to general practice. As general practice seeks to engage and communicate more effectively with its service users/patients, this study urges disavowal of assumptions of heterosexuality and calls for further research into the links between the diversity of lesbian and gay population groups and their healthcare needs.

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#### CONFLICTS OF INTEREST

None.

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