

Perceptions of lesbian, gay and bisexual people of primary healthcare services

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Accepted for publication 17 December 2005

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doi: 10.1111/j.1365-2648.2006.03944.x

NEVILLE S. & HENRICKSON M. (2006) *Journal of Advanced Nursing* 55(4), 407–415

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Aim. This paper reports a study exploring people's perceptions of disclosure about lesbian, gay and bisexual identity to their primary healthcare providers.

Background. Disclosure of sexual identity to healthcare professionals is integral to attending to the health needs of lesbian, gay and bisexual populations, as non-disclosure has been shown to have a negative impact on the health of these people. For example, an increased incidence of suicide, depression and other mental health problems have been reported.

Method. From April to July 2004, a national survey of lesbian, gay and bisexual persons was carried out in New Zealand. Participants were recruited through mainstream and lesbian, gay and bisexual media and venues, and 2269 people completed the questionnaire, either electronically or via hard copy. The 133-item instrument included a range of closed-response questions in a variety of domains of interest.

Results. In this paper, we report results from the health and well-being domain. More women than men identified that the practitioner's attitude toward their non-heterosexual identity was important when choosing a primary healthcare provider. Statistically significantly more women than men reported that their healthcare provider usually or always presumed that they were heterosexual and in addition more women had disclosed their sexual identity to their healthcare provider.

Conclusion. Nurses need to reconsider their approach to all users of healthcare services by not assuming everyone is heterosexual, integrating questions about sexual identity into health interviews and ensuring that all other aspects of the assessment process are appropriate and safe for lesbian, gay and bisexual people.

Keywords: attitudes, bisexual, gay, homosexual, lesbian, nursing, primary health care, survey

Introduction

Much of the research relating to lesbian, gay and bisexual people (LGB) has been deficit focussed (for example, alcohol and drugs, suicidality, mental health, HIV/AIDS) and problematizes non-heterosexual identities and behaviours. We

have sought to describe LGB communities both by engaging the support of those communities in the planning, development and promotion of the study reported here. 'Lavender' is a term that has been synonymous with lesbian, gay and bisexual culture for several thousands of years (Grahn 1984). For example, Levine (1992) refers to 'lavender ghettos' as

places where large numbers of LGB people choose to congregate and this has led to the promulgation of political gay rights activities. We therefore use the word as a means of ensuring the visibility of LGB communities as having the same rights and entitlements as non-LGB populations, and of communicating to LGB communities that this is a non-problematizing study that engages with the community using its own language and symbols.

Servicing the healthcare needs of all populations in a culturally sensitive and appropriate way is a core philosophical underpinning of nursing practice in New Zealand (Ramsden 2002). The degree to which this is operationalized within LGB communities has an impact on the health and well-being of this population group. A safe healthcare environment that is affirmative and conducive to LGB people disclosing their sexual identities will positively influence health outcomes (Hart & Flowers 2001).

Background

The need for population-based healthcare provision and an increased emphasis on primary health care was affirmed in *The Ottawa Charter for Health Promotion* (Health and Welfare Canada 1986). The directives associated with the Ottawa Charter were reaffirmed in the 1997 Jakarta Declaration (World Health Organisation 1997). The New Zealand government, like others, has embraced the central tenets associated with population health initiatives through its emphasis on primary health care, as reflected in *The New Zealand Health Strategy* (Ministry of Health 2000) and *The Primary Health Care Strategy* (Ministry of Health 2001). The New Zealand government wants to see an increased emphasis on primary care, illness prevention and health promotion to minimize acute episodes of ill health and the potential for injury. Such an approach is not only more compassionate, but also more cost effective.

Primary healthcare workers require knowledge and a skill set that is significantly different from those skills required for the management of illness and injury. The key agenda in primary health care is to work with communities to achieve health and well-being (McMurray 1999). In New Zealand, some of the key goals of primary healthcare nursing are to promote and improve health across the lifespan, as well as across populations (Ministry of Health 2003).

Working in partnership with cultural groups increases the possibility of understanding and addressing the specific needs of those groups. In New Zealand, this is termed 'providing culturally safe care'. Cultural safety is a regulated requirement that all Registered Nurses in New Zealand must demonstrate both at registration and to maintain an annual

practicing certificate (Nursing Council of New Zealand 2002, Ramsden 2002). Culturally safe practice incorporates a broad range of cultural groups, including those who identify as LGB. Therefore, if nurses are serious about providing population-based healthcare across communities, they will need to know about the health and well-being issues that specifically influence LGB people. To achieve this goal, knowing a person's sexual identity is pivotal in being able to gain access, understand, accurately assess and provide a high quality health service to this frequently marginalized group.

People who identify as LGB are a population group that has largely been ignored in terms of their primary healthcare needs beyond the healthcare issues associated with HIV, AIDS and other sexually transmitted diseases. Lack of awareness among healthcare professionals about the primary healthcare needs of this population group has the potential to result in giving ill- or uninformed advice, and consequently missed opportunities for the health promotion and education. A provider's lack of understanding about household composition may result in poor adherence to recommended therapies and lead to other misunderstandings. Thus, disclosure of sexual identity in the healthcare setting is essential if clinicians are to meet the health needs of LGB communities appropriately.

'Lesbian', 'gay' and 'bisexual' are terms that describe sexual identity. A number of different constructs contribute to sexual identity, including sexual behaviour, sexual attraction, fantasy and emotional attraction (see Coleman 1988). Each of these operates not only at any present moment, but also over time, so that any person may have at least eight different aspects of 'sexual identity'. In addition, the other diverse elements of identity that exist in non-LGBs is mirrored in homosexual communities. These include, for example, different cultural backgrounds, racial identity, age, place of residence and education. As a result of this complexity and variability, it is difficult to agree on a definitive definition of sexual identity. For the purposes of this study we gave people the opportunity to identify themselves and to locate themselves on the different scales of an identity construct.

Despite an apparent acceptance of LGB people in recent times, there is a continuing and underlying stigma associated with living a non-heterosexual lifestyle (Dean *et al.* 2000). Consequently, a pervasive and often covert level of homophobia, heterosexism and violence continues to be promulgated which directly affects the health and well-being of these diverse communities. For example, the notion of diversity is well recognized in publications relating to the various stages of growth and development across the lifespan, with only cursory mention being made in relation to LGB populations

(Heaphy *et al.* 2004). Consequently, health and well-being issues are predominantly discussed within a heterosexual frame of reference.

Disclosing one's sexual orientation is a phenomenon that is unique to LGB people. Heterosexual populations need not worry about disclosure, for heterosexuality is almost inevitably assumed. Such 'heteronormativity', and even outright homophobia in healthcare environments, can present major barriers to LGB people's ability to access health care. For example, Dean *et al.* (2000) found that some healthcare workers are uncomfortable with providing services to this population. Mackereth (1995) identified that heterosexism and homophobia within nursing materialized into the provision of substandard care to LGB people, and urged the profession to address this form of discrimination, as well as to challenge other healthcare professionals to do the same.

Additional barriers that are erected by heteronormative attitudes can be found in the process of gathering assessment data. Assessment frameworks rarely include options for non-heterosexual responses. For example nurses, as well as other healthcare professionals, routinely ask such heterosexually biased questions as 'Are you married, single, widowed or divorced?' (Dean *et al.* 2000, p. 107), options rarely possible for LGBs. Assumptions that heterosexually partnered people are not also sexually active with same sex partners may prevent full and accurate assessment of health risks. Moreover, opportunities to disclose sexual orientation within healthcare settings have been found by several authors to be minimal (White & Dull 1997, 1998, Robertson 1998, Dean *et al.* 2000).

Fear of homophobic reactions through actual previous negative experiences, including mildly judgemental interactions, with healthcare professionals influences LGB people's decisions as to whether they will disclose their sexual orientation to healthcare providers. For LGB persons, disclosure is not a unique event: they must choose whether or not to self-disclose in every new situation and environment. Klitzman and Greenberg (2002) claim that most gay and lesbian people perceive self-disclosure as a risk, resulting in either hiding their sexual orientation to be sure to receive health care or not accessing primary healthcare services at all. These barriers can have an important impact on the health and well-being of this population.

Although LGB identity does not itself put an individual at increased health risk, some non-heterosexual populations are at greater risk of developing cancer (Palefsky *et al.* 1998), have higher rates of cigarette smoking, alcohol and recreational drug use (Stall *et al.* 1999), are more likely to have issues with body image (Dean *et al.* 2000), have an increased risk of contracting HIV (Hart & Flowers 2001) and are more

likely to experience mental health issues including suicide (Hughes & Evans 2003) than heterosexual populations. Reticence by LGB people to disclose their sexual orientation to healthcare professionals, combined with an increased risk of ill health, is of concern, especially when global healthcare systems are fiscally driven, and pressure to reduce spending within this sector is high.

The study reported here forms part of a larger research project titled *Lavender Islands: portrait of the whole family*. The Lavender Islands project is the first national strengths-based study of LGB people to be undertaken in New Zealand. We deliberately chose not to focus on traditional and problematic areas such as mental health, suicide, health, alcohol and other drugs, and, of course, HIV/AIDS, but rather concentrated on developing a more general understanding of this community. Thus, questions about access to health care and healthcare provider attitudes were included in the survey, while specific healthcare concerns were not.

The study

Aim

The aim of this study presented here was to explore the disclosure of sexual identity by LGB people to their primary healthcare providers.

Design

A national survey of LGB persons was carried out from April to July 2004. The survey tool was developed by an interdisciplinary research team in close consultation with a community advisory group made up of LGB community leaders and members. Funding and practical limitations meant that the tool was available only in English, which may have excluded people with low English literacy from participating.

The questionnaire was available both electronically and in hard copy and data were collected between April and July, 2004. Electronic sampling is becoming both more popular and more accepted in research with so-called 'hidden' populations (Elford *et al.* 2004, Riggle *et al.* 2005), although its challenges are now being explored. For example, Rhodes *et al.* (2002) found that their internet sample was older but, after controlling for age and education, there were no statistically significant differences from their conventional sample. Ross *et al.* (2000) found that their Internet sample was more likely to be younger than their conventional sample, whilst Whittier *et al.* (2004) found no statistically significant age differences in age or education between their Internet respondents and their conventional sample.

Recruitment

Since New Zealand has a combination of dense urban centres and sparsely populated rural and remote areas, the study was promoted through both mainstream and gay-targeted media, including websites and weblinks, print media, radio and television. Because of the nature of the project it attracted a great deal of mainstream media attention and received strong support from LGB-targeted media. In addition, promotion material about the study and a link to the URL of the website were sent out through the community advisory group contacts. This last method proved to be one of the most efficient and productive avenues of recruitment. We discovered that LGB communities in New Zealand appeared to be extremely dense and well-linked personally and electronically. This kind of 'viral sampling' may be an example of what Gladwell (2000) calls 'the law of the few', where social epidemics spread quickly once they reach a set of well-connected people.

The target group were men and women in New Zealand who experience sexual attraction or desire for people of the same sex or who engage in sexual activity with people of their same sex, regardless of what they call themselves and regardless of their primary or 'legal' relationship. In addition, an introductory ethics note about the study said that the study was limited to people 16 years of age and over.

Questionnaire

The final survey instrument contained 133 items, and took between 18 and 45 minutes to complete. Questions on health and well-being were the following:

- Overall [how would you rate your health]?
- In your experience, unless you specifically tell them otherwise, do health professionals presume you are heterosexual?
- When you chose a primary healthcare provider (like a doctor), how important is that person's attitude to your sexual identity?
- If you have seen a healthcare professional in the last 3 years, have you told that person about your sexual identity?
- If yes, [how did you feel your healthcare professional responded]?
- Do you believe that in general your healthcare provider's attitude to your sexual identity influenced the medical treatment you received?

Ethical considerations

The study was approved by a university human ethics committee. Anonymity was ensured by separating email

addresses from completed questionnaires on return and by ensuring that no personal identifiers were evident on either electronic or hard copies. Personal disclosures in the qualitative section of the instrument, and even occasional snapshots enclosed in returned paper questionnaires, suggested that anonymity was not a concern for many participants.

Data analysis

Data were imported from the website or hand-entered into an SPSS 12.0.1 (SPSS Inc. 1989–1999) spreadsheet for statistical analysis, including ANOVA and chi-square tests. The data were screened for duplications, data entry accuracy and missing values. A statistical significance level of 0.05 was chosen.

Results

A total of 2269 unduplicated responses were received, 83.6% from the website and 16.4% on paper (returned by Freepost). With respect to gender, 45.2% of the sample was female and 54.5% male; 0.2% identified themselves as transgendered or intersexed (a combined $n = 5$ for both these responses) and eight (0.4%) did not respond to the gender question. Only respondents who responded 'male' or 'female' are included in the gendered analysis that follows.

This was a highly educated sample, with 51.1% of respondents having an undergraduate or postgraduate degree, compared with 15% of New Zealanders in general (Ministry of Social Development 2004). Not surprisingly, therefore, it was also a relatively high-earning group: the modal income band was \$50,001–\$70,000 (compared with \$10,001–\$15,000 for women and \$30,001–\$40,000 for men in the 2001 New Zealand Census) (NZ\$1 = US\$0.68, £0.39 and €0.57). There was a variety of relationship configurations: 45.0% of respondents were in a relationship with a same-sex partner and lived with that partner; 13.5% were in a same-sex relationship but the partner lived elsewhere; 3.5% were in a primary opposite-sex relationship. Of 1846 respondents to the question about children, 22.6% ($n = 417$) said that they had some kind of parenting relationship.

Most respondents described their overall health as 'excellent' or 'very good' (71.5%, see Table 1). Reported health varied statistically significantly by gender, but this difference was non-significant if 'excellent' and 'very good' responses were combined. There was no statistically significant difference in health status by age group (under-40 years and over-40 years).

Table 1 Overall health of participants (*n* = 2256)*

	Frequency	Percent
Excellent	749	33.2
Very good	865	38.3
Good	457	20.3
Fair	129	5.7
Poor	42	1.9
Very poor	2	0.5
Terrible	12	0.1
Total	2256	100.0

*Thirteen participants did not respond to this item.

Respondents were asked to rate on a seven-point Likert scale how important to them a healthcare professional's attitude toward sexual identity was when they chose a primary healthcare provider; on this scale 1 was 'very unimportant' and 7 was 'very important'. Both men and women said that a healthcare professional's attitude towards sexual identity was important, although the mean for women ($\chi = 5.41$, $SD = 1.821$, $n = 1014$) was statistically significantly higher than that for men ($\chi = 5.12$, $SD = 1.989$, $n = 1225$; $P < 0.001$). Analysis by age also showed that healthcare professional's attitude towards sexual identity was important, although the mean for those aged under 40 ($\chi = 5.46$, $SD = 1.885$, $n = 1034$) was statistically significantly higher than that for those 40 years and older ($\chi = 5.07$, $SD = 1.929$, $n = 117$; $P < 0.001$).

With regard to provider assumptions about sexual identity, women (83.2%, $n = 842$) were statistically significantly more likely than men (65.8%, $n = 804$; $P < 0.001$) to report that their healthcare provider 'usually' or 'always' presumed them to be heterosexual (Table 2). In the analysis by age group, 76.2% of under-40 years ($n = 894$) and 70.9% of those 40 years and older ($n = 734$) said that their healthcare provider 'always' or 'usually' presumed that they were heterosexual (Table 3).

Statistically significantly more women (71.7%, $n = 728$) than men (64.7%, $n = 792$; $P = 0.002$) had told their

Table 2 Responses by gender to the question, 'Does your healthcare provider presume you are heterosexual?'

	Female (%)	Male (%)	Total (%)
Yes, always	425 (42.0)	329 (26.9)	754 (33.8)
Yes, usually	417 (41.2)	475 (38.9)	892 (39.9)
Not usually	66 (6.5)	122 (10.0)	188 (8.4)
Never	9 (0.9)	18 (1.5)	27 (1.2)
I don't know	95 (9.4)	278 (22.7)	373 (16.7)
Total	1012 (45.3)	1222 (54.7)	2234* (100.0)

*Thirty-five participants did not respond to this item or were excluded because they did not identify as male or female.

Table 3 Responses by age to the question, 'Does your healthcare provider presume you are heterosexual?'

	Under 40 years (%)	40 years and older (%)	Total (%)
Yes, always	446 (38.0)	299 (28.9)	745 (33.7)
Yes, usually	448 (38.2)	435 (42.0)	883 (40.0)
Not usually	80 (6.8)	106 (10.2)	186 (8.4)
Never	14 (1.2)	13 (1.3)	27 (1.2)
I don't know	186 (15.8)	182 (17.6)	368 (16.7)
Total	1174 (53.1)	1035 (46.8)	2209* (100.0)

*Thirty-five participants did not respond to this item or were excluded because they did not give their age.

healthcare provider about their sexual identity. Statistically significantly more of those 40 years and older (75.5% $n = 781$) than under 40 (61.2%, $n = 719$; $P < 0.001$) had done this.

Statistically significantly more women (11.4%, $n = 84$) than men (6.1%, $n = 50$; $P < 0.001$) reported that healthcare providers were uncomfortable with disclosure of sexual identity, although in both cases the number was quite small (Table 4). In the same way, statistically significantly more of those aged 40 years and older (85.1%, $n = 678$) than under 40 (77.8%, $n = 574$) said that their healthcare provider was completely comfortable with the disclosure ($P = 0.001$; Table 5).

Statistically significantly more men (42.6%, $n = 366$) than women (27.9%, $n = 214$; $P < 0.001$) said that their healthcare provider's attitude influenced their care in a positive way, although most respondents of both genders (67.1% of women, 55.0% of men, $n = 988$) said that it did not influence their health care at all (Table 6). Statistically significantly more of those aged under 40 (62.4 per cent, $n = 483$) than 40 years and older (59.5% $n = 498$) ($P = 0.014$) said that their healthcare provider's attitude did not influence their care in any way, although 32.8% of under-40s and 37.9% of those aged 40 years and older said that this attitude had influenced their care in a positive way (Table 7).

Table 4 Responses by gender to the question, 'How comfortable was your healthcare provider with disclosure?'

	Female (%)	Male (%)	Total (%)
Complete comfortable	570 (77.7)	700 (85.6)	1270 (81.8)
Somewhat uncomfortable	84 (11.4)	50 (6.1)	134 (8.6)
Ignored it	80 (10.9)	68 (8.3)	148 (9.5)
Total	734 (47.3)	818 (54.7)	1552* (100.0)

*Seven hundred and twelve participants did not respond to this question, possibly because they had not disclosed their sexual identity or were excluded because they did not identify as male or female.

Table 5 Responses by age group to the questions, 'How comfortable was your healthcare provider with disclosure?'

	Under 40 years (%)	Over 40 years and older (%)	Total (%)
Completely comfortable	574 (77.8)	678 (85.1)	1252 (81.6)
Somewhat uncomfortable	78 (10.6)	56 (7.0)	134 (8.7)
Ignored it	86 (11.7)	63 (7.9)	149 (9.7)
Total	738 (48.0)	818 (54.7)	1535* (100.0)

*Seven hundred and thirty-four participants did not respond to this question or were omitted from the analysis because they did not disclose their sexual identity or because they did not give their age.

Table 6 Responses by gender to the question, 'Did your healthcare provider's attitude influence your care?'

	Female (%)	Male (%)	Total (%)
Yes, in a positive way	214 (27.9)	366 (42.6)	580 (35.6)
Yes, in a negative way	38 (5.0)	21 (2.4)	59 (3.6)
Not in any way	515 (67.1)	473 (55.0)	988 (60.7)
Total	767 (41.1)	860 (52.9)	1627* (100.0)

*Six hundred and forty-two participants did not respond to this question, possibly because they had not disclosed their sexual identity or were excluded because they did not identify as male or female.

Table 7 Responses by age to the question, 'Did your healthcare provider's attitude influence your care?' [(n = 1611)* – check totals – why are the different? Done]

	Under 40 years (%)	Over 40 years and older (%)	Total (%)
Yes, in a positive way	254 (32.8)	317 (37.9)	571 (35.4)
Yes, in a negative way	37 (4.8)	22 (2.6)	59 (3.7)
Not in any way	483 (62.4)	498 (59.5)	981 (60.9)
Total	774 (48.0)	837 (51.9)	1611 (100.0)

*Six hundred and fifty-eight participants did not respond to this question or were omitted from the analysis, possibly because they had not disclosed their sexual identity or because they did not give their age.

Discussion

Study limitations

There are limitations to the generalizability of our findings. Firstly, whether the sample is statistically representative of the LGB population could be challenged. However, this issue was clearly identified from the outset of the study, and every effort made to reach out to the various sectors of LGB communities throughout the country. Nevertheless, the

people who participated in the research were self-selected and largely connected to a wider network of LGBs throughout the country. They were also people who were most likely to consent to respond to the questionnaire and in all likelihood had integrated their sexual identity fully into their lives. In other words, these were very 'out' respondents who wanted to be heard, seen and counted. However, currently the present study is the only one of its kind in New Zealand, and the profile of its participants is similar to that of studies targeting other aspects of the LGB community (for example, Saxton *et al.* 2004). Because of participant self-selection, of course, the ability to generalize the findings to all LGB people (however defined) in New Zealand is also limited. However, in all likelihood, because our sample probably represented the group most likely to have disclosed, we have probably understated the issues.

Both women and men across all age groups identified that a healthcare professional's attitude toward sexual identity was important to them when they chose a provider. It is of some concern, then, that approximately three-quarters of respondents reported that their healthcare provider 'always' or 'usually' presumed that they were heterosexual until told otherwise. This finding may confirm that LGB people do not 'come out' to their healthcare providers because they associate disclosure of their sexual orientation with negative reactions. For example, research has shown that substandard, inappropriate and rough care has been provided to LGB people who have disclosed their sexual identity (Schatz & O'Hanlan 1994, Hart & Flowers 2001).

LGB people find themselves in the position of specifically having to refute a basic assumption by healthcare professionals about their identity (that they are heterosexual), an assumption that may have major implications for their overall health care and management. All healthcare professionals need firstly to be aware of the existence of LGB identities and then accept that these identities are within the normal range of sexual identity and behaviour (Hughes & Evans 2003). Our finding in this respect is all the more salient for nurses, who are frequently the first point of contact for consumers of primary healthcare services. Nurses should not only ensure that they give opportunities for disclosure, but should also seek permission from the person to pass that information to other healthcare professionals who may be involved in their care. Doing so saves LGB people the additional stress of having constantly to 'come out' and explain their situation when in contact with other healthcare professionals.

We found that more women than men were likely to have disclosed their sexual identity to a healthcare provider. However, research by Klitzman and Greenberg (2002)

What is already known about this topic

- Many healthcare providers, including nurses, presume that lesbian, gay and bisexual people who seek healthcare services are heterosexual.
- Lesbian, gay and bisexual people have specific healthcare needs and may not understand these needs until they are educated by healthcare providers.

What this paper adds

- Healthcare professionals' attitudes toward their sexual identity are important to lesbian, gay and bisexual people and these attitudes greatly influence the quality of healthcare both offered and received.
- Providing lesbian, gay and bisexual people with opportunities to disclose their sexual identity is integral to the provision of a quality and appropriate health service.
- Despite additional training and the increasingly public profile of lesbian, gay and bisexual people, healthcare workers still largely assume that clients are heterosexual until proven otherwise.
- Nursing curricula need specifically to address heteronormativity and homophobia within healthcare environments, and provide appropriate theoretical and practical preparation to ensure that lesbian, gay and bisexual clients receive culturally safe nursing care.

suggested the opposite, that more men than women had disclosed, and these authors claimed that lesbian women might choose not to disclose their sexual identity because their healthcare provider was more likely to be male. However, our finding may have occurred because lesbian women already had an established relationship and were 'out' to their healthcare practitioners. Concomitantly, some of the men in our study may not have felt comfortable with disclosing their sexual identity to their healthcare practitioner. This finding was also reported by Fitzpatrick *et al.* (1994), who identified that a statistically significant number of gay men had thought it irrelevant to disclose their sexual identity to their healthcare professional, even though some of these men were HIV positive.

In the era of HIV and hepatitis B and C, appropriate sex and lifestyle health education must be a core part of any health assessment, regardless of age. In the Lavender Islands study, 61.0% and 60.3% of the under 40 and those aged 40 years and older groups of men respectively

reported more than one partner in the last 12 months, and 24.4% of men aged 40 years and older ($n = 134$) reported more than 10 partners in the last 12 months. Clearly, health education for risk reduction must remain a lifetime concern, even where the person perceives their health behaviours as 'irrelevant'.

A relatively small proportion of respondents reported that their healthcare professional seemed 'somewhat uncomfortable' about sexual identity or ignored the disclosure of information. While Hart and Flowers (2001) support this finding, Smith *et al.* (2004) explain that ignoring the disclosure of non-heterosexual identities is not necessarily deliberate, but relates to lack of knowledge and experience in working with LGB people. This has important implications for the provision of appropriate primary healthcare services to LGB people, including members of their families and/or significant others. It is also possible that issues relating to having a LGB partner and/or family member will not be appropriately and adequately dealt with by healthcare providers.

Conclusion

Our findings challenge nurses to reconsider their approach to people who identify as LGB because, if they are ignorant of a service user's sexual identity, it is unlikely that they will provide services that address their needs. The literature has clearly identified that, if primary healthcare providers do not assume that all people are heterosexual, are comfortable with working with LGB communities and provide consumers with opportunities to disclose their sexual identity and behaviours, then users of those services are more likely proactively to seek health care, are more likely to adhere to treatment regimes and will be more satisfied with the care received (Taylor 1999).

Nursing has a commitment to providing holistic care and therefore needs actively to challenge the heteronormative delivery of healthcare services, as well as the prevalence of homophobia amongst healthcare professionals (Richmond & McKenna 1998). In addition, specific education on how to interview LGB consumers of primary health services appropriately, as well as ways to provide health promotion and health education to these marginalized groups, should be incorporated into nursing curricula. This is supported by Dean *et al.* (2000), who identifies that the education of health professionals has failed to provide a quality healthcare service to LGB populations.

LGB healthcare consumers are well tuned to the nuances associated with information sought by professionals and will respond only to the extent that they feel that their

responses will be heard and respected. Integrating questions about sexual identity into health assessments can be constructed in a behavioural way: 'Do you have sex with men, women, with both or neither?', 'Have you and your partner been assessed for the possibility of transmitting infections to one another?', 'If you have more than one sexual partner, how do you plan to prevent sexual transmission of infections such as hepatitis B or C or HIV?' Interview questions can also be constructed about family relationships: 'Who lives in your household?', 'Are you in a relationship with someone who you do not live with?', 'Who is most likely to visit you whilst you are in hospital?', 'Do you plan to parent any children?'

The education of nursing, medical, social and other human service professionals must continue to include the array of possible human identities and relationships, and understand each as normative. Such inclusiveness must be taught from the first day of their educational experiences and range from teaching assessment tools to case studies and end-of-life decisions. It is important to note that not only are attitudes in direct, formal contacts with consumers important, but informal and casual conversations between staff that are likely to be overheard are also integral to LGB consumers' assessments of the 'safety' of the environment and the limits of their disclosure.

There are calls for nursing to include political action in its repertoire of skills (Hughes 2005). The formation of political alliances with LGB community groups is a way in which nursing could strengthen its relationships with consumers. Primary healthcare nurses could work closely with consumer groups to assist with the promotion of LGB concerns to healthcare service providers, local government and other government health officials. Being actively involved in LGB community organizations demonstrates to these groups that nursing is genuinely interested in listening to the key concerns that affect their lives, as well as offering opportunities to provide health promotion and health education that meets the specific needs of this cultural group.

Finally, the large sample size is a major strength of our study and provides a firm foundation for future studies focussing on the healthcare needs of this minority group. Future studies using qualitative methods are now needed to capture the richness of data evident in the narratives of LGB people as they interact with primary healthcare services. In addition, more targeted sampling of particular age groups, as well as studies that focus solely on gay men, lesbian women and bisexual people, need to be undertaken because cultural differences transcend not only age but also gender and sexual orientation.

Author contributions

SN and MH were responsible for the study conception and design and drafting of the manuscript. SN and MH performed the data collection and data analysis. MH obtained funding and provided statistical expertise. SN and MH provided administrative support and made critical revisions to the paper. SN and MH supervised the study.

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