

Research paper

Improving lesbian, gay and bisexual healthcare: a systematic review of qualitative literature from the UK

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What is known on this subject

- Many lesbian, gay and bisexual (LGB) people report that they have not revealed their sexual orientation to their GPs or other healthcare professionals.
- Some LGB patients report negative experiences of healthcare services.

What this paper adds

- This is the first systematic review of LGB patients' experiences of healthcare in the UK. It highlights overarching themes from individual qualitative research studies.
- The review identifies approaches that may benefit relationships between LGB patients and healthcare professionals.
- The review also identifies institutional-level changes that may improve LGB patients' experiences of healthcare.

ABSTRACT

There is evidence that lesbian, gay and bisexual (LGB) individuals have poorer experiences of healthcare compared with the general population, but the causes are not entirely clear.

A systematic review of the qualitative literature was conducted to examine LGB patients' experiences of healthcare provision in the UK. Medline, Medline In-Process, EMBASE, CENTRAL, PsycINFO, Web of Science and Cochrane Library databases were searched for qualitative studies published between January 2000 and May 2008 that contained experiences of general healthcare from the point of view of LGB patients or their practitioners.

From a total of 1889 citations, ten qualitative studies were included in the final systematic review. The studies highlighted important issues for

improving patient–practitioner relationships. Institutional-level changes, particularly improvement of protocols, confidentiality, LGB-friendly resources and GP training were also identified as important for improving health service provision.

Despite being limited by the size of the available literature, this review is likely to highlight many important issues in LGB healthcare in the UK, and to suggest direction for change. The findings are likely to be applicable to healthcare settings in other countries, where similar relational and institutional barriers may prevail.

Keywords: health services, qualitative research, review, sexuality

Background

People's experiences of healthcare may affect whether they decide to seek medical advice, their relationships with healthcare professionals and, ultimately, may have an important impact on their treatment and health status. These healthcare experiences are likely to vary within the population according to gender, age, ethnicity and, as investigated in the current review, sexual orientation.

Although approximately 6% of people in the UK are thought to be lesbian, gay or bisexual (LGB; Department of Trade and Industry, 2004), little research has investigated the health status of this group. The majority of published research relates to HIV, AIDS and sexually transmitted diseases, and very few studies have examined general LGB health.

A systematic review has indicated that there are increased rates of mental disorders, suicide and self-harm in LGB people (King *et al*, 2008), and a recent report on UK-specific LGB healthcare (Meads *et al*, 2009) showed increased rates of smoking, illicit drug use and mental health problems such as depression, eating disorders, self-harming and attempted suicide. Approximately 50% of LGB patients had revealed their sexual orientation to their GP. LGB patients' experiences of health services were generally poor. Most GP surgeries were not overtly LGB-friendly, mental health counselling was rated as unsatisfactory, and some GPs showed negative attitudes towards LGB patients. However, the reasons for poor experiences of healthcare among LGB patients were not entirely clear, and there is a need for further investigation. This paper examines experiences of healthcare provision for LGB patients in the UK from the perspective of both patient and practitioner by undertaking a systematic review of the qualitative literature. This review may also be applicable to healthcare settings in other countries, where there may be instances of similar relational and institutional barriers.

Methods

Sources

Medline, Medline In-Process, EMBASE, CENTRAL, PsycINFO, Web of Science (SCI and SSCI) and Cochrane Library databases were searched for reviews and primary studies of healthcare provision to LGB patients published between January 2000 and May 2008. A broad search strategy was used, including terms related to homosexual, lesbian, gay and bisexual people, restricted only by publication date and English language. This search identified both quantitative and

qualitative research, and specific qualitative material related to LGB healthcare was identified subsequently during title/abstract screening. An Internet search was conducted using Google, together with additional targeted searches of selected relevant websites. Citations from systematic and narrative reviews were checked for relevant studies.

Study selection

The criteria for study selection were that the research participants were LGB patients or their practitioners in the UK, that the studies had been conducted since January 2000, and that they described experiences related to an aspect of healthcare. Studies could investigate any intervention with any comparator group (or no comparison), but only those with qualitative material were included. Primary studies that were related to sexually transmitted diseases, safe sex and sexual behaviour were excluded.

All identified citations were initially screened by two reviewers (CM and MP) for inclusion according to the inclusion criteria. Any disagreements were resolved through discussion. Full texts were retrieved for potentially relevant articles, and were processed by one reviewer. These were checked by a second reviewer and any disagreements were resolved through discussion.

Data extraction and thematic synthesis

Qualitative information on experiences of LGB healthcare from the point of view of patients and professionals was extracted. Synthesis was undertaken using an approach similar to meta-ethnography (Britten *et al*, 2002), but involving both first-order concepts (expressions of participants) and second-order concepts (interpretations or explanations by researchers) in thematic analysis. Concepts were identified by reading and re-reading the included papers, and these were grouped into themes for narrative discussion. Synthesis was undertaken by a researcher who had no particular theoretical approach to qualitative research or LGB healthcare. Data extraction and thematic synthesis were undertaken by one reviewer. Another reviewer read papers and checked the findings for consistency.

Quality assessment

A quality checklist (Wallace *et al*, 2004) was recommended by an expert in qualitative research. This tool highlighted areas of potential bias related to the theoretical perspective of the study investigators, study design, methods of participant sampling, data collection,

suitability of data analysis, the extent to which reported data reflected those collected, and the extent to which the study could be generalised to all LGB individuals. Quality assessment of the included studies was undertaken by one reviewer.

Results

Identified studies

From the searches, a total of 2603 citations were identified, of which 714 were duplicates. Of the remaining 1889 citations, 233 papers and reports were retrieved for assessment (see Figure 1). Ten peer-reviewed, published, qualitative studies were included in the final systematic review (see Table 1).

Study characteristics

The ten qualitative studies related to the experiences of both LGB patients and healthcare professionals. They addressed issues of patient–healthcare worker communication and areas of health service provision. All of the studies were conducted in the UK (four in London, one in Sheffield, one in Southampton, and in four studies the exact location was not specified).

Eight studies recounted the experiences of LGB participants. Of these, four described the experiences of LGB patients in general practice; three of these studies concerned adults (Cant, 2002, 2005; Cant and Taket, 2006) and the fourth concerned older adults (Clover, 2006). A further two studies described the experiences of therapeutic counselling for LGB participants (Mair, 2003; Pixton, 2003), another study described experiences with regard to the maternity care of lesbian women (Wilton and Kaufmann, 2001), and the final study described the experiences of gay

men and lesbians who had undergone treatments for homosexuality (Smith *et al*, 2004).

Two studies related accounts of practitioners. Of these, one described GPs' perspectives on consultations with LGB patients (Hinchliff *et al*, 2005), and the other described GPs' views about administering treatments for homosexuality (King *et al*, 2004).

All ten studies used qualitative techniques to collect and analyse data. Eight studies used one-to-one interviews, described in five of these studies as structured or semi-structured interviews (Mair, 2003; Pixton, 2003; Cant, 2005; Hinchliff *et al*, 2005; Clover, 2006) and in two of the studies as in-depth, unstructured interviews (King *et al*, 2004; Smith *et al*, 2004). The other interviews were not described (Cant, 2002). Three studies used self-completion questionnaires (Wilton and Kaufmann, 2001; Pixton, 2003; Cant and Taket, 2006), while two involved focus groups (Cant, 2002; Cant and Taket, 2006). The quality of each study was assessed as moderate or good, but the external validity (generalisability) was often low (see Table 2).

Identified healthcare themes

Two themes were identified, namely potential improvements in the relationship between healthcare professionals and LGB patients, and potential improvements in LGB healthcare at an institutional level. In the following text, italicised quotes are used to identify concepts from study participants, and non-italicised quotes identify concepts put forward by study authors.

Improving the healthcare professional–patient relationship

Barriers to communication between healthcare workers and LGB patients were identified as an issue in the majority of studies, and the following themes were

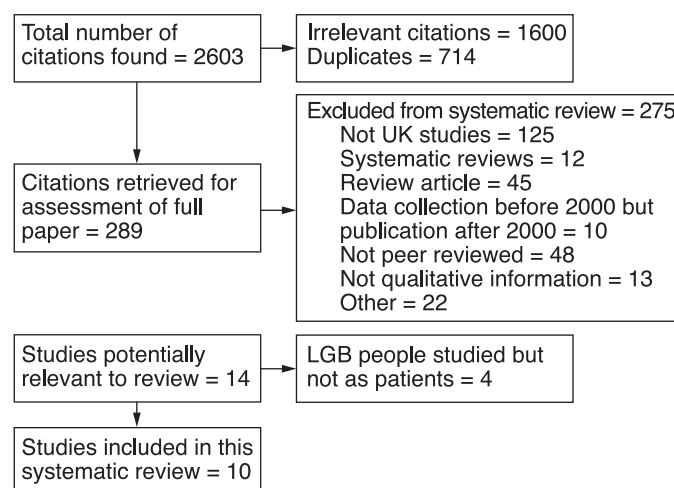


Figure 1 Quorum diagram.

Table 1 Characteristics of included studies

Author and date	Study objective	Population	Study methods
Cant and Tacket (2006)	Explores the experiences of lesbians and gay men in relation to primary care services in general practice	Lesbian women and gay men. 15 people in focus groups (20–70 years), 42 returned questionnaires (60–65 years). North London, UK	Focus groups and a self-completion questionnaire
Cant (2005)	Explores the experiences of coming out of gay men with their GPs and sexual health clinic staff	38 gay men (<i>c.</i> 20–65 years), 12 health service managers. London, UK	Semi-structured interviews
Cant (2002)	Explores the experiences of gay and bisexual men in primary care	17 gay and bisexual men (21–58 years). London, UK	Interviews (<i>n</i> = 17) and a focus group (<i>n</i> = 6 from whole sample)
Clover (2006)	Explores the experiences of older gay men in relation to health, gaps that exist in health and social care services and how primary care services could better meet the needs and concerns of older men	10 gay men (60–70 years). Greater London, UK	Semi-structured interviews ('conversation with a purpose')
Hinchliff <i>et al</i> (2005)	Explores GPs' perspectives on difficulties they face when discussing sexual health issues with lesbian and gay patients in primary care consultations	22 GPs (13 men and 9 women, 34–57 years). Sheffield, UK	In-depth interviews ('guided conversation')
King <i>et al</i> (2004)	Investigates the experiences of professionals who have administered and evaluated treatments for homosexuality in Britain since the 1950s	30 health professionals (12 psychiatrists, 16 psychologists, 1 nurse specialist and 1 electrician, 50–80 years). UK	In-depth interviews
Mair (2003)	Explores the experiences of gay men in therapy	14 gay men (22–51 years). UK	Structured interviews, face to face or by telephone
Pixton (2003)	Examines experiences of affirmation during counselling of lesbian, gay and bisexual people	17 (7 men and 10 women, 17–56 years), all had affirming experience of counselling. Southampton, UK	Paper questionnaire with open-ended questions, structured verbal interviews for some participants
Smith <i>et al</i> (2004)	Investigates the circumstances, referral pathway, process of therapy and aftermath of treatments for homosexuality since the 1950s from the point of view of the patient	29 people who had undergone treatments (28 men and 1 woman) and 2 relatives of former patients (27–83 years). UK	In-depth unstructured interviews
Wilton and Kaufmann (2001)	Explores the maternity care experiences of lesbians in the UK in order to evaluate service delivery to this group	50 lesbian women who had gone through pregnancy, all but one over 30 years. UK	Self-completion questionnaire

Table 2 Quality assessment of included studies

	Cant and Taket (2006)	Cant (2005)	Cant (2002)	Clover (2006)	Hinchliff et al (2005)	King et al (2004)	Mair (2003)	Pixton (2003)	Smith et al (2004)	Wilton and Kaufmann (2001)
Is the research question clear?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the perspective of the author clear?	N	Y	N	N	N	N	Y	Y	N	N
Has author perspective influenced the study design?	CT	CT	CT	CT	CT	CT	Y	CT	CT	CT
Is the study design appropriate to answer the question?	N	N	N	Y	Y	Y	N	Y	Y	N
Is the context or setting adequately described?	Y	Y	Y	Y	Y	N	Y	N	N	Y
Adequate to explore range of subjects/ settings?	Y	Y	N	Y	Y	Y	N	N	Y	Y
Drawn from an appropriate population?	N	Y	N	Y	Y	Y	Y	N	Y	Y
Adequately described?	Y	N	Y	Y	Y	N	Y	N	N	N
Rigorously conducted to ensure confidence in findings?	N	CT	Y	CT	CT	CT	Y	CT	CT	N
Appropriate analysis to ensure confidence in findings?	Y	Y	Y	CT	Y	Y	N	Y	Y	N
Findings substantiated by data/limitations considered?	CT	N	CT	CT	CT	CT	CT	CT	CT	CT
Claims to generalisibility follow from the data?	Y	Y	Y	N	N	N	N	N	N	N
Ethical issues addressed and confidentiality respected?	Y	Y	Y	CT	Y	Y	CT	CT	Y	CT

Y, Yes; N, No; CT, Can't tell

identified as important for improving the relationship between healthcare professionals and LGB patients.

AVOIDING HOMOPHOBIA AND HETEROSEXISM

Homophobia in the healthcare setting was cited by LGB respondents in three studies (Wilton and Kaufmann, 2001; Cant and Taket, 2006; Clover, 2006). Some medical staff were described as having been 'judgmental', 'patronising', 'intrusive' or 'rude', or as having shown a 'lack of respect' (Cant and Taket, 2006, p. 276). There was some evidence of rough treatment (Cant and Taket, 2006), poor emotional support for a suicidal patient (Clover, 2006), and frequent reports of unprofessional treatment on religious grounds (Wilton and Kaufmann, 2001; Cant, 2002; Clover, 2006). In studies of general practitioners, although most of them showed an open approach to LGB patients, there were some instances of unconcealed homophobia and a suggestion of substandard quality of treatment (King *et al.*, 2004; Hinchliff *et al.*, 2005).

Heterosexism, that is, the assumption that heterosexual orientation is the norm, was commonly experienced by LGB participants (Cant, 2002; Cant and Taket, 2006). One woman recounted being asked questions in the following conversation: 'Are you having sex? – Yes – Are you worried about getting pregnant? – No – Why not? – My partner's a woman – Oh [with reported shock]' (Cant and Taket, 2006, p. 275). However, despite a heterosexist attitude being more common, this was not always the case. For example, another medical professional strived to ask questions in a non-heterosexist way 'Do you have a partner?' or 'Who do you live with?... I try and ask those sort of neutral questions' (Hinchliff *et al.*, 2005, p. 350). Using open questions that do not assume heterosexuality may be an important step in overcoming barriers to communication.

IMPROVING HEALTHCARE WORKERS' KNOWLEDGE

Gay and lesbian respondents reported that various aspects of LGB knowledge were important in discussions with their GP, and there was concern that doctors did not understand gay sexual practices (Mair, 2003; Cant, 2005; Clover, 2006). This concern was also expressed by GPs, who were worried that their lack of knowledge about sexual practices might act as a barrier to discussion (Hinchliff *et al.*, 2005). However, two other studies suggested that LGB patients did not necessarily expect doctors to have detailed knowledge (Wilton and Kaufmann, 2001; Cant, 2002), but that they should 'approach their patients with an open mind, listen to them and engage with their experience.' As one gay man commented, 'they've just got to keep their wits about them and be able to talk intelligently' (Cant, 2002, p. 128). A lack of knowledge of terminology may not

always limit effective treatment or inhibit good patient–professional relationships if sensitivity and openness are used to engage with the patient intelligently.

IMPROVING PATIENT TRUST

Five studies showed that LGB patients anticipated poor treatment and/or homophobia from staff (Wilton and Kaufmann, 2001; Cant, 2002, 2005; Mair, 2003; Clover, 2006). In one study it was noted that 'anticipation or fear of differing treatment was more common than actual experiences of discrimination' (Clover, 2006, p. 46). An informant in a different study showed a general mistrust, and his comment may summarise the view of many LGB individuals: 'A doctor's a doctor, *ini!*' (Cant, 2005, p. 12). A preconceived notion that doctors will not understand or approve of homosexuality may act as a barrier, whereas improving trust may increase attendance and aid the development of good patient–professional relationships.

BEING PERCEPTIVE TO THE TERMINOLOGY USED

One study suggested that misunderstandings between patient and doctor may result from the use of differing terms to describe homosexuality. Some gay men chose to describe themselves as homosexual, while others rejected that term and preferred to describe themselves as 'gay' (Mair, 2003). One respondent described how this had acted as a barrier '... and I kept using the word "gay" and they kept using the word "homosexual", and I think it was that that distanced me' (Mair, 2003, p. 35). Differing preferences, held by different individuals, may make communication difficult. It may be important for doctors to be aware of the words that each patient uses and to refer to terms that the patient has chosen to describe their sexuality.

UNDERSTANDING EMBARRASSMENT

Apparent embarrassment or discomfort on the part of healthcare professionals was identified as a potential barrier to the relationship between patient and doctor. In one study, the fact that GPs and/or medical staff were 'uncomfortable' was listed by researchers along with other clearly homophobic reactions, such as being judgmental or rude (Cant and Taket, 2006, p. 276). A gay man in another study reported that 'I have a feeling that she is somewhat homophobic really. She might encourage me to talk [about gay issues] but her face is saying "Oh my God!"' (Mair, 2003, p. 38). Discomfort may result from homophobia, but it was suggested that it might also result from general embarrassment. In a study of GPs, 'doctors reported feelings of shyness, being uncomfortable and not wanting to be intrusive' (Hinchliff *et al.*, 2005, p. 348), and this embarrassment, when perceived as homophobia, may have played a role in the breakdown of communication. LGB patients

may need to be perceptive and tolerant of practitioners' discomfort until relationships of trust and mutual understanding have developed.

REDUCING OVER-CAUTIOUSNESS

Two studies suggested that communication barriers may result when healthcare workers and LGB patients are over-cautious when relating to each other (Wilton and Kaufmann, 2001; Hinchliff *et al*, 2005). A female GP commented that '*maybe I tread too carefully*' (Hinchliff *et al*, 2005, p. 349), and a lesbian woman in another study expressed her frustration with the healthcare professional's timidity: '*Using the word LESBIAN! (It's not catching)*' (Wilton and Kaufmann, 2001, p. 209). Humour was identified as promoting a relaxed atmosphere. For example, one woman's health visitor commented '*Oh, it's just like that programme on the telly!*' (Wilton and Kaufmann, 2001, p. 207), and an LGB participant identified the importance of a bold approach by both doctors and patients: '*They ask you straight out which I think is good ... but you've got to be truthful because to get anything back you have to give them the information*' (Cant, 2005, p. 14). An extremely direct approach may not be appropriate in all cases, and the ideal approach is likely to depend on many factors, including the patient's personality, health needs, personal situation and past experiences. Healthcare workers must be aware of the particular needs of each patient in order to communicate with them in the most appropriate and effective way.

IMPORTANCE OF AFFIRMATION

Four studies suggested that affirmation of LGB patients was important for the development of a trusting relationship (Wilton and Kaufmann, 2001; Mair, 2003; Pixton, 2003; Clover, 2006). One gay man commented that '*He seemed to realise much more how I felt and he was very concerned and he obviously seemed to think I was a nice person*' (Clover, 2006, p. 46). There was also an indication that ongoing dialogue was important in order to affirm that the healthcare worker had a positive attitude: '*The initial statement "Gay is fine" was there, but there was no ongoing affirmation*' (Mair, 2003, p. 37). In the healthcare setting, although medical staff may not see their role as primarily one of patient affirmation, this may be an important contribution to the emotional well-being of patients, and may help to build patient trust and improve communication.

Removal of institutional barriers

Other barriers to healthcare were associated with institutional-level issues, and common themes identified changes necessary to improve LGB health service provision.

IMPROVING PROTOCOLS

Two studies highlighted the fact that there was a lack of appropriate protocols that were generic to both homosexual and heterosexual patients (Wilton and Kaufmann, 2001; Cant and Taket, 2006). The authors of one study commented that 'The design of the information systems and the categories offered for recording information were not inclusive of non-heterosexual identities' (Cant and Taket, 2006, p. 275). This was highlighted as a particular problem by women in a study of lesbian mothers: '*My midwife asked me questions ... that I didn't really want to answer*' and '*I felt pressurised to give his [the father's] name*', and the lack of appropriate booking-in protocols was highlighted by staff '*apologising for the inadequacies of the form*' (Wilton and Kaufmann, 2001, pp. 206, 208). A systematic, transparent approach using a set protocol that is applicable to people of all sexualities is desirable in order to avoid inappropriate questions and patient discomfort.

IMPROVING APPROPRIATE REFERRALS

Three studies suggested a lack of appropriate referrals to social support groups and sexual health clinics for LGB people (Cant, 2005; Cant and Taket, 2006; Clover, 2006). Participants identified the importance of social support groups (Wilton and Kaufmann, 2001; Cant, 2005), one participant commenting that '*The group has achieved lots for me personally – cos I thought that I was in a situation that no one else can understand, but there's so many other people in that situation in life*' (Cant, 2005, p. 13). However, although self-referral was common, there was no evidence of GP referral to these types of groups (Cant, 2005; Cant and Taket, 2006). The importance of support groups was evident from the attitudes expressed. Lack of knowledge, reflection or a desire to help may be the cause of the poor rate of appropriate GP referrals. This may be an important area for improvement where large benefits for patients may be achieved.

IMPROVING PATIENT CONFIDENTIALITY

There were suggestions that confidentiality was not always maintained with regard to issues of sexual orientation (Wilton and Kaufmann, 2001; Cant, 2002, 2005; Cant and Taket, 2006). Particular fears relating to confidentiality were that information might be leaked and affect individuals' applications to mortgage and insurance companies (Cant, 2002, 2005; Cant and Taket, 2006). There was also anxiety that information might be shared and discussed with other members of staff (Wilton and Kaufmann, 2001) and subsequently reach the general community, with damaging effects (Cant, 2002). The implementation of appropriate

rules for confidentiality may reduce the risk of inappropriate use of patient details and improve confidentiality.

IMPROVING CONTINUITY OF CARE

In one study (Wilton and Kaufmann, 2001), an area that was identified as particularly important was the extent to which patients felt that there was continuity of care. This study examined the maternity experiences of lesbian mothers, and many relevant comments were made, for example, *'I really wish I could have had continuity of care, the same midwife throughout. ... This would have spared me so much anxiety'* (Wilton and Kaufmann, 2001, p. 209). Continuity of care may be desirable for all those experiencing healthcare, but it may be particularly important for LGB individuals, and especially for lesbian women during pregnancy and childbirth. Continuity of care limits the number of times a person is required to reveal their sexual orientation, and promotes the formation of a trusting relationship between patient and healthcare worker.

PROVISION OF LGB-FRIENDLY RESOURCES

A lack of overtly LGB-friendly resources in waiting rooms was identified as a problem by participants in a number of studies (Wilton and Kaufmann, 2001; Cant, 2002, 2005; Clover, 2006). LGB-friendly literature was seen to reassure LGB patients: *'It would have been helpful if literature and other spoken information gave examples from lesbian or gay families ... so that it was clear from the outset that there was not prejudice against us'* (Wilton and Kaufmann, 2001, p. 209), *'Why not have some stuff that's obviously gay ... if you see something like that it does give you a lot of confidence'* (Cant, 2002, p. 128). A major function of this type of literature may be to act as an assurance that practices will be gay-friendly. As suggested by a GP participant

in the study by Hinchliff *et al* (2005, p. 350), this might also be achieved by presenting a clear non-discriminatory policy so that *'people have it in black and white that they shouldn't be discriminated against.'*

IMPROVING TRAINING FOR HEALTHCARE PROFESSIONALS

In one study that examined the views and experiences of general practitioners (Hinchliff *et al*, 2005), many spoke of the need for better training, particularly in relation to understanding sexual practices among lesbian and gay people. However, there was a suggestion that the important skills may need to be developed over time. For example, *'Two participants described how, through direct experience of lesbians and gay men consulting about their sexual health, they had progressively overcome the difficulties which they faced'*, and one GP commented that *'You almost have to practise feeling comfortable and familiar'* (Hinchliff *et al*, 2005, p. 349). The investigators in this study highlighted the importance of experiential learning, identified by doctors as a positive way to become used to discussing sexual health issues with gay and lesbian patients (Hinchliff *et al*, 2005). Real interaction with LGB patients, rather than theoretical teaching, may be important for developing skills for good professional-patient communication.

Discussion

This systematic review covered issues that may be important for improving health services to LGB individuals. One factor that was frequently evident, namely internalised homophobia (Mair, 2003; Smith *et al*, 2004; Cant, 2005), was not discussed because it was beyond the scope of the review, but it may be an important factor for future consideration. Internalised

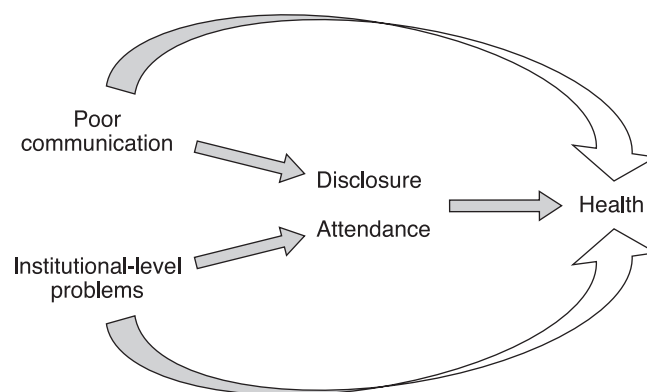


Figure 2 Possible relationship between LGB patients' experiences of healthcare and their subsequent health status.

homophobia has been defined as the internalisation of experienced prejudice and social stigmatisation, resulting in poor self-regard and internal conflict (Williamson, 2000). It may manifest itself in denial of sexual orientation, attempts to change, low self-esteem and contempt for other LGB individuals (Rainbow Project, 2009). It may be particularly important during the teenage years (Scourfield *et al*, 2008), and one investigator described how '*its existence had a profound impact on my awareness of just how deeply gay men's development can be affected by the negative messages which have been internalised during maturation*' (Mair, 2003, p. 35). Even with positive changes in health service provision, internalised homophobia may persist. Suggestions made in the current review should therefore be applied in the context of possible internalised homophobia, and awareness among medical professionals may promote better understanding of their patients' needs and responses.

Validation

It is useful to compare the findings of the present review with those reported by other investigators. There is little published literature from the UK to support or dispute the current findings, but there are a number of studies from the USA and elsewhere which, despite some limitations of applicability, are useful for validating the current work, and these are discussed below.

Consistent with the findings of this review, a review of lesbian experiences of childbirth in the USA highlighted the existence of homophobia in health services, with examples given of poor treatment and unprofessional conduct (McManus *et al*, 2006). Experiences of heterosexism in health services in Australia have also been described (Hughes, 2007) and, as in the present review, showed heterosexism at both personal and institutional levels. In studies included in the current review, participants commented on the importance of not making heterosexist assumptions, a factor that was also highlighted by lesbian women in another study conducted in Norway (Bjorkman and Malterud, 2007).

The present review highlighted the fact that many LGB patients have a preconception that doctors will show prejudice. A review of lesbian women's experiences (McManus *et al*, 2006) showed that the degree of disclosure of sexual orientation varied widely between studies (41–90%), but that more than a third of women believed that disclosure would negatively affect their healthcare. Privacy was identified in another US study as one of the most important factors that promoted feeling safe in a healthcare setting (Ginsburg *et al*, 2002), and issues relating to confidentiality, frequently cited in studies included in the present

review, may also be a concern for LGB individuals in other countries.

Finally, the importance of training for healthcare professionals, from the point of view of both patients and professionals, was also highlighted by researchers elsewhere. A large review of lesbian and gay healthcare in Norway identified it as a major barrier to effective communication (Bonvicini and Perlin, 2003), and this may be a common inadequacy in many health services. These international studies indicate that the current work may therefore be applicable to healthcare settings in other westernised countries. However, its applicability to less developed countries, for which there may be no published literature, is unclear.

Limitations

The current review highlights issues that affect relationships between LGB patients and healthcare professionals, and barriers to healthcare at the institutional level. However, it does not provide evidence for a causal link between these issues and subsequent LGB health. One possible hypothesis is that these factors have a direct impact on health or that they may affect attendance at health services and disclosure of sexuality to GPs, which in turn has an impact on health status (see Figure 2).

The connection between these factors may seem logical, but the degree of influence is uncertain, and this may limit the usefulness of the current review. Further research may be required to bring to light the extent to which patient experiences of healthcare affect their subsequent health status. However, despite this limitation, the review describes experiences of healthcare that may in themselves be considered important end points. Like all patients, LGB patients may reasonably expect to encounter respect, professionalism and engagement in the health service, and issues relating to experiences of healthcare may therefore be seen as important in their own right.

The changing legal and social climate may also pose some limitations to the interpretation of this review. In the UK, there have recently been a number of legislative changes, such as the Equality Act (Sexual Orientation) Regulations 2007 (Office of Public Sector Information, 2007), which makes discrimination in the provision of goods and services on the basis of sexual orientation unlawful, and applies to public bodies such as the NHS. In addition, from September 2008, the Department of Health Lesbian, Gay, Bisexual and Transgender Advisory Group (Department of Health, 2008) was established to inform service development and improvement.

These legal and political changes are welcome reforms that are likely to have a positive impact not only on the legal rights of LGB individuals, but also on

attitudes and practices in general society. The current review brings together all of the available research to date, but the studies included in the review were conducted before many of the recent legislative changes. This review may therefore be a better reflection of barriers to LGB healthcare that existed five years ago, and does not necessarily reflect present-day status. However, it may take time for the legal changes to result in social change, and it is likely that many of the issues highlighted in the review are still relevant. It may be of interest to compare the findings of this review with future research in order to assess the impact of the legal changes on barriers to LGB health.

The current review may be limited by the amount of published research available. The aim was to report only on material of relevance to the UK, so that the review might be directly applicable to the UK population. However, this restricted the amount of information available and excluded the larger body of literature from the USA. In addition, the majority of included studies were conducted in London (four studies) or other large cities (one study in Sheffield and one in Southampton). It appears likely that the data will have been derived mainly from LGB patients living in large urban centres, and may not be representative of those living in smaller towns or villages. Despite these limitations, the findings appear to be consistent with those from studies and reviews conducted in other countries and settings, which suggests that the current review provides a reliable representation of barriers to positive experiences of LGB healthcare.

Quality assessment of qualitative studies continues to be an area of controversy. Despite using a checklist that was considered to provide a reasonable assessment of study quality (Wallace *et al*, 2004), there were still likely to be areas of uncertainty. This is due not only to the ability of the checklist to identify areas of bias, but also to uncertainty in relation to the question 'What is a good piece of qualitative research?' The generalisability of the included studies was highlighted as an important issue in applying them to the whole LGB population, and in order to address this limitation the findings were presented in a transparent way, referring to the details of studies, such as population and setting, when reporting the results.

The appropriateness of conducting systematic reviews of qualitative research may be questioned. It is debatable whether information from studies with different population samples, different experimental aims and different methods of data collection can be considered and grouped within the same themes. Themes in this review can also only reflect research to date, and will inevitably fail to identify issues that have not yet been identified in primary studies.

Conclusions

This systematic review may be limited by the quantity and applicability of published research, and is unlikely to cover every important issue. However, despite these limitations, it continues to highlight many important issues in LGB healthcare, providing direction for equality-driven change. Recommendations from this review are that there is a need for the following:

- specific training for healthcare professionals in relation to LGB patients and their health
- information for healthcare professionals about relevant social groups and health establishments for referrals
- LGB- or non-sexuality-specific literature to be made available in healthcare establishments
- protocols that make no assumptions about sexual orientation
- strict measures to ensure confidentiality for LGB patients
- better continuity of care for LGB patients.

Future research may involve investigation of the relationship between LGB patients' experiences of healthcare and their subsequent health status. In addition, future research, if compared with the findings of the current review, may allow recent legal and political changes to be assessed in the light of their impact on LGB individuals' health.

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CONFLICTS OF INTEREST

None.

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