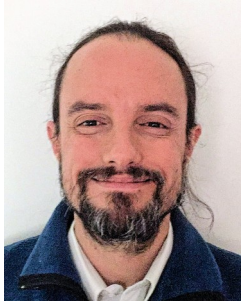

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90 – Healthcare for Sexual Minority Patients

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Sexual orientation (SO) can be classified according to three broad areas: desires, behaviours, and gender identity–, making it difficult to establish the prevalence of "homosexuality" or "bisexuality" in categorical terms. Consequently we preferred to refer to "people whose sexual orientation belongs to a sexual minority" (SMin).

Although homosexuality has not been considered a disease since 1973, even nowadays, the SMin population carry a greater burden of mental health problems (1) – which doubles the heterosexual population's likelihood of developing depression, anxiety, substance abuse and in committing suicide-, probably because of the stigma to which they see themselves subjected.

SMin people often have less access to health services and/or a lower quality of care, as a result of perceiving homophobia in the health system (real or not). They are less likely to recognize a professional who provides them with longitudinal care, feel greater dissatisfaction in solving their health problems and have lower rates of cervical cancer screening (2). There are three types of obstacles hindering a proper healthcare to SMin patients: the patient, the professional and the health system. See Table 1.

Accordingly, and further than providing information on inclusive care provided at each institution, we believe that the family doctor should be careful when questioning about risky sexual behaviour, and do so only in order to recommend the practice of safe sex, anti-hepatitis A and B vaccination, and case finding of sexually transmitted infections (STIs).

Its worth noting that there is evidence that the majority of SMin people wish to share their SO with the professional who provides care, as it increases their comfort during interviews and their perception of receiving an integral and comprehensive care. However, only a minority of practitioners performs open questions about the SO of their patients and only a minority of SMin patients feel able to talk openly about STIs, while 30% reported having received a negative reaction from professional after revealing their SO, which can probably hamper a good communication between the professional and the patient.

We recommend family physicians (FP) to not presume that our patients have a heterosexual SO, and formulate open questions without gender specificity, as free as possible from moral judgments, and remember that sexuality is fluid and can change over time (3).

Table 1: Knight's model adaptation to explain the obstacles that sexual minorities have to access health care.

PATIENT	PHYSICIAN	HEALTHCARE SYSTEM
Embarrassment, hiding and fear of the professional's reaction.	Personal discomfort, lack of training on how to ask, eventual heterosexism, homophobia or hostility.	Unfriendly environment
Unfamiliarity with some risks and some preventive services.	Unfamiliarity with the patient's behaviour, misinformation about preventive services. Time limitation; fear of opening the "Pandora box".	Lack of evidence-based guidelines for preventive health care. Some preventive health care services might not be covered by the insurance.
Fear of losing insurance coverage; that their employer will find out and terminate employment, etc.	Breaching doctor-patient confidentiality.	Possible discrimination against patients determined to be "high risk".

Source: Adapted from Knight D. Health Care Screening for Men Who Have Sex with Men Am Fam Physician 2004;69:2149-56.

Periodic health check

Besides the usual preventive practices according to each person's gender and age, several consensuses recommend performing: screening anxiety disorders, mood, diet and domestic violence (type C recommendations); development of a sexual history, screening risk behaviours, counselling for STI prevention and immunization against hepatitis A and B (also type C recommendations). The position of the authors of this chapter is that any of these preventive interventions should be derived from the risk assessment of each individual (behaviour) regardless of their sexual orientation (4).

Screening cervical cancer and anal cancer screening deserve a special mention. The lesbian population should be subject to the same preventive controls as those of the general population, given that the human papillomavirus (HPV) is also transmitted through sexual intercourse between women. (4)

Regarding anal cancer, its screening could be considered in those with HPV infection and/or human immunodeficiency virus (HIV), since any of both increases the incidence of this neoplasia.

To conclude, we leave as a message that the health professional who attends a SMin person may feel uncomfortable to attend to and/or may feel that they are not capable or in the capacity to answer any of their questions and/or to give any advice health. If facing this situation, it is important for the professional to admit his limitations, communicate them to their patient and eventually tell them they will investigate the issue or discuss it with other colleagues. One should not be alarmed by this situation if this was to happen, because the patient will most likely feel that we are taking care of them, probably making it one of their best experiences with the health system.

Take Home Message

- People with Smin access to worse health care than the rest of the population.
- Most people with Smin prefer to share their sexual orientation with health personnel. This helps them feel comprehensively addressed and that they are regarded as a person.
- Recommended for people with Smin preventive practices are the same for any person of the same age and sex.

Original Abstract

http://www,woncaeurope.org/content/abstract-no- 961-free-standing-paper-global-cultural-diversity-homosexuality

References

1. King M y col. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. BMC Psychiatry. doi:10.1186/1471-244X-8-70.
2. Tjepkema M. Health care use among gay, lesbian and bisexual Canadians. Component of Statistics Canada Catalogue no. 82-003-X Health Reports. March 19, 2008.
3. Klein F y col. Sexual orientation: A multi-variable dynamic process. J. Homosexuality. 1985; 11: 35-49.
4. Social and sexual committee members. Lesbian Health Guidelines. Journal Soc Obstet Gynaecol Can 2000;22(3):202-