

Exploring Medical Personnel's Discourses on the Sexual Health of Lesbian and Bisexual Women in Greater Lisbon, Portugal

Exploración del Discurso del Personal Médico Sobre la Salud Sexual de Mujeres Lesbianas y Bisexuales en Gran Lisboa, Portugal

Explorando os Discursos da Equipe Médica Sobre a Saúde Sexual de Mulheres Lésbicas e Bissexuais na Grande Lisboa, Portugal

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Abstract

This qualitative exploratory study analysed the discourses of medical personnel on lesbian and bisexual women's sexual health. We aimed at identifying the best practices to eradicate heteronormativity in this sector and enhance health care provision for this population. We interviewed 16 physicians in the metropolitan area of Lisbon using semi-structured interviews. The thematic analysis identified a lack of professional knowledge in dealing with non-heterosexual patients, despite the consensual discourse on the necessity of non-discriminatory practices.

Keywords: lesbian, bisexual women, medical personnel, sexual health, heteronormativity.

Resumen

Este estudio cualitativo exploratorio analizó los discursos del personal médico sobre la salud sexual de mujeres lesbianas y bisexuales, con el fin de identificar las mejores prácticas para erradicar la heteronormatividad en este sector y contribuir a la mejora de la prestación de servicios sanitarios para esta población. Entrevistamos a 16 médicos/as del área metropolitana de Lisboa a través de entrevistas semiestructuradas. El análisis temático mostró que a pesar de tener un discurso consensual sobre la necesidad de llevar a cabo prácticas no discriminatorias, los/las profesionales de la salud muestran una falta de conocimiento sobre sus pacientes no heterosexuales.

Palabras clave: lesbianas, mujeres bisexuales, personal médico, salud sexual heteronormatividad.

Resumo

Este estudo qualitativo e exploratório analisou os discursos de pessoal médico sobre a saúde sexual das mulheres lésbicas e bissexuais. Tem como objetivo identificar as melhores práticas para erradicar a heteronormatividade nesse setor e melhorar a prestação de cuidados de saúde para essa população. Foram entrevistados 16 médicos da área metropolitana de Lisboa, através de entrevistas semiestructuradas. As análises temáticas identificaram a falta de conhecimento profissional em lidar com pacientes não heterossexuais, apesar do discurso consensual sobre a necessidade de práticas não discriminatórias.

Palavras-chave: lésbicas, mulheres bissexuais, pessoal médico, saúde sexual, heteronormatividade.

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SCIENTIFIC RESEARCH ARTICLE
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Health Care Provisions for Lesbian, Gay, Bisexual, and Transgender (LGBT) Populations

The relationships between lesbian and bisexual women and their healthcare providers are vital to achieve equal, universal, and effective access to health services for these patients. In this article, we explore the discourses of Portuguese healthcare providers from the metropolitan area of Lisbon on sexual and reproductive health, and consider their knowledge and experiences regarding health care services for lesbian and bisexual women.

The implementation of the Human Rights Charter (United Nations, 1948) has influenced the way health systems develop their policies and regulate their services in most countries. Directly linked to healthcare is the right to the highest attainable standard of health and protection from medical abuse. Non-heterosexual populations have, however, suffered from the effects of heteronormativity in different cultures (Fish & Bewley, 2010) in addition to social inequalities influencing access to healthcare and services. Historically, health sciences—especially medicine—considered that anomalous sexual orientations and identities were pathologies caused by biological, hormonal or psychological deficiencies and, therefore, conditions that needed treatment (Fish, 2009). Ever since the depathologization of homosexuality by the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (1973) and the World Health Organization International Classification of Diseases (1992), medical attention to LGBT health-related issues has undergone improvement (Fish, 2009). The World Association for Sexual Health (2008) points out that sexual health cannot be achieved without condemning all forms of sexuality-related violence such as gender and sexual orientation related discrimination, within healthcare systems.

Nevertheless, discriminatory practices and services continue to be reported throughout

the medical care, nursing, and healthcare sectors (Burch, 2008; Campo-Arias & Herazo, 2008; Fish & Bewley, 2010; Marques, Oliveira, & Nogueira, 2013). Assessing the quality of healthcare services for the LGBT population contributes to the identification of laws, misconceptions and potential opportunities for improving the medical system to more efficiently include all patients.

In this article, we understand heteronormativity as a set of norms guaranteeing “the mundane production of heterosexuality as the normal, natural, taken-for-granted sexuality” (Kitzinger, 2005, p. 477), and heterosexism as a system of beliefs and values that denies and stigmatizes non-heterosexual behaviours, identities, relationships and communities (Herek, 1995).

Research has shown that lack of awareness and heteronormativity in health service contexts force LGBT women into hiding, which may benefit their privacy but might result in the loss of key information regarding their healthcare conditions, and affect care service standards (Staley, Hussey, Roe, Harcourt, & Roe, 2001). Evidence has been found that non-heterosexual people delay or avoid using health care services because of heterosexism or previous negative experiences with practitioners and, thus, tend to resort to community guides and listings of gay-friendly services and providers (Saulnier, 2002). Moreover, in many contexts they face a lower reported health compared to heterosexuals and use more often healthcare services (Bakker, Sandford, Vanwesenbeeck, Vanlindert, & Westert, 2006). Research findings also suggest a higher incidence of mood and anxiety disorders, as well as depression and suicidal behaviours in non-heterosexual people when compared to heterosexuals (Bostwick, Boyd, Hughes, & McCabe, 2010; King et al., 2008).

The experiences of LGBT women within heterosexist social contexts impose specific conditions entailing emotional and medical consequences. Health services need to fully implement

the declaration of human rights and, consequently, to document and guarantee access to healthcare for sexual minority groups such as LGBT women.

Lesbian Sexual Health and Access to Healthcare

Lesbian and bisexual women face particular forms of heterosexism in their societies, not only in terms of culture but also in terms of health. Regarding lesbian healthcare access in the United States (US), Heck, Randall, Sell, and Gorin (2006) found that women involved in same-sex relations had had significantly less contact with medical support in the previous 12 months. This situation differed from that of men in same-sex relationships, a finding interpreted by researchers as a result of the AIDS epidemic.

In Canada, while assessing the use of healthcare services in a general population sample for research project (Tjepkema, 2008), it was observed that compared to heterosexuals, lesbians and bisexual women had a greater probability of seeking out mental healthcare. On the other hand, lesbians were less willing to consult a general practitioner and to take a Papanicolaou (Pap) smear test, and bisexual people were more likely to feel their health needs went unmet when compared to heterosexuals. A recent study by Conron, Matthew, Mimiaga, and Landers (2010) on a population-based sample did not support such findings and observed no differences in relation to sexual orientations and 3-year Pap smears, lifetime mammography, diabetes and heart disease testing. Nevertheless, these authors stress the need for the prioritization of obesity and cardiovascular disease in lesbian and bisexual women because of the differences found in mental health, drug use, smoking, violence victimhood and access to healthcare.

In a sample of 96 American women self-identified as lesbian, bisexual or transgender, 30% did not have any information on human papillomavirus transmission in female sexual

contact and did not identify the cancer risk associated (Polek & Hardie, 2010). In this study, 52% of women reported having disclosed their lesbian orientation to healthcare providers, 6% stated they were asked about it, and 26% would have disclosed it if asked. The study reveals that healthcare providers do not have a systematic practice of taking into account sexual orientation issues, which may have detrimental effects in terms of sexual healthcare provision.

In a US sample, lesbian and bisexual women showed a higher prevalence of obesity, alcohol and tobacco use and lower rates of parity and birth control pill utilization. In addition, they were less likely to have a health insurance policy or undergo a pelvic examination or mammogram (Cochran et al., 2001). The authors note, however, that in the case of breast cancer they did not differ from general population estimates.

Lee (2000) performed a meta-analysis study on lesbian sexual health and pointed out the need for screening for cervical cancer in lesbian and bisexual women—as only 54% had had a Pap smear in the previous year and 7.5% had never had one—and for teaching sexual techniques to prevent the spread of the human papillomavirus. Concerning breast and endometrial cancer, lesbian and bisexual women present some risk factors such as lower use of oral contraceptives and higher numbers of nulliparity than those of heterosexual women. Regarding sexually transmitted infections, risks derive from vagina to vagina contact, cunnilingus, anilingus, digital or manual vaginal or anal contacts, insertion of sex toys into mouth, vagina, or anus, and other oral-genital contacts (Lee, 2000).

Therefore, the social context of heterosexism may impose different conditions for accessing healthcare leading to differences in health indicators having to do with check-up and testing frequency and information requirements regarding sexual risk factors. Next, we briefly consider healthcare provider perspectives.

Healthcare Providers and LGBT Health

The role of healthcare providers in guaranteeing prevention and access to treatment for LGBT women is essential and requires both research and public and political planning and actions. As is the case in social and cultural contexts, discrimination is still present in the health sector although efforts to attain equality in health are being made.

As of 2004, the Portuguese Constitution (see Oliveira, Costa, & Nogueira, 2013; Santos, 2012) explicitly mentions sexual orientation in the article concerning equality of all citizens under the law. Since 2007, this legislative movement towards integration has included provisions on hate crimes and against labour discrimination. In 2010, the Parliament approved same-sex marriages, stating, however, an explicit restriction concerning adoption by same sex couples and keeping medically assisted reproduction unavailable for them. Therefore, lesbians do not have equal access to sexual and reproductive healthcare.

In this context, the positions of healthcare providers are very important in terms of healthcare provision. In a study of Portuguese university students including future healthcare professionals, Gato and Fontaine (2012) identified prejudice towards lesbian and gay parenting and a lack of knowledge on current research. Moita (2001), in a qualitative study on Portuguese healthcare providers, reports discourses expressing negative interpretations of homosexuality as morally reprehensible and as a deficit or flaw.

Campo-Arias and Herazo (2008) note implications of heterosexism in the field of medicine that negatively affect the patient-provider relationship and diminish the attention paid to this group of patients. This poses an obstacle to controlling the AIDS epidemic because, since they do not disclose their sexual orientation, LGBT women receive less information on

prevention and safer sex behaviours in accordance with their specific sexual practices.

Regarding discrimination due to sexual orientation, a proactive consultation role for practitioners can be an important factor in healthcare provision for these populations. Healthcare professionals become at ease in dealing with non-heterosexual patients through direct contact and experience in clinical settings. There is a need for educating general practitioners on how to discuss sexual matters, recognizing their own barriers and communicating more effectively, for example in asking questions that do not assume heterosexuality, and facilitating the disclosure of sexuality (Hinchliff, Gott, & Galena, 2005).

As Burch (2008) demonstrates, whilst some medical doctors report low levels of knowledge, up to 40% expressed some confidence in their self-effectiveness in providing a sensitive service. This study identifies how heterosexual assumptions compete with supportive provider/client interactions and contribute to the denied or reduced healthcare provision for LGBT women.

There is an increase in medical education attention to developing interpersonal skills and the cultural competence of future healthcare providers. Kelley, Calvin, Chou, Dibble, and Robertson (2008) set out a short training programme with information and debates. After training, students showed greater knowledge of healthcare access and the LGBT population, were more willing to treat patients with gender identity issues, and had enhanced their awareness of the LGBT population and clinically relevant practices.

Studies analysing healthcare services and providers' views are scarce. Our paper seeks to contribute by exploring the discourses of healthcare providers on this particular subject. In addition, it reports the results of a research based on identification of the barriers and obstacles to effectively promote lesbian and bisexual women inclusion in health care provision. Our study aims at: (a) exploring Portuguese

healthcare providers' discourses on sexual health issues of lesbian women, their knowledge of and experiences with specific lesbian health issues and sexual practices, and their clinical skills for dealing with non-heterosexual women; (b) identifying the best practices within the framework of eradicating heterosexism in lesbian healthcare.

Method

Participants

We interviewed 16 healthcare providers, 14 women and two men, with an average age of 42.4 years ($SD=9.1$ years, and ranging from 27 to 51 years old). All interviewees worked within the Greater Lisbon Metropolitan Area.

Two participants were general practitioners from a general health centre (the two male practitioners) while the remaining 14 were specialized in gynaecology/obstetrics. Eleven of the latter were working in three Lisbon state maternity wards while three healthcare professionals worked in a private fertility clinic. A snowballing recruitment method was applied, through telephone invitations and institutional contacts. Public service clinical directors received emails explaining the scope of the study, and the interview duration before being invited to participate. The present sample is based on the medical personnel that volunteered to participate in the study.

Instruments

The interviews were semi-structured, with a questionnaire designed to fit the objective of the study. During interview preparation, the study objectives were explained once again. The interview included general questions on personal and professional contacts with lesbian and bisexual women (type of contact, duration, quality of contact), and on perceptions regarding social discrimination of lesbians and bisexual women (in general and in terms of healthcare). It also

included specific questions on experiences with lesbian women as healthcare providers: knowledge, situations with patients or colleagues, healthcare system inclusion of non-heterosexuals, the extent of past training on lesbian and LGBT issues and the wish to receive such in the future, and any recommendations for better lesbian and bisexual healthcare. The questionnaire was developed by the research team in accordance with the literature available and was discussed with key informants, namely lesbian women and medical personnel, at an early stage of the research project; it aimed at eliciting information on lesbian and bisexual women not only in terms of healthcare provision, but also in a broader context of discrimination in Portuguese society.

Procedure

Interviewers began by emphasising that respondent answers were entirely confidential, and requesting the signature of an informed consent to record the session, which warranted access to the data including elimination, voluntary participation, full information on the purposes of the study, anonymity and confidentiality. The interviews were carried out by the second author, in the offices of the respective healthcare providers, between July and October 2011. They had an average duration of 40 min and verbatim transcriptions of the taped interviews were made. Two participants refused permission for recording and hence answers were written down *in loco*, retaining the original discourse to greatest possible extent. Interview duration ranged from 10 to 60 min, depending on the practitioner's availability.

Analysis

Thematic interview analysis was used to analyse the interviews. This technique identifies patterns (themes) in textual data (Braun & Clarke, 2006) that are repeated along the discourses and are useful to explore a specific subject. Themes

are central for organizing concepts that are identified in a textual dataset (Clarke & Braun, 2013). These themes have different expressions related with repetition but also, to a certain extent, variability. Thematic analysis is proposed as a method that allows contextualization —attentive to the ways by which people signify their experience but also to the way such meanings reflect a wider social context. Therefore, following the identification of core themes, we then derived some sub-themes and specificities of the themes.

Results

In this case, two main themes were identified, each with several subthemes as follows:

1. Lesbian women discrimination: denial and inclusion. In this theme we identify two subthemes: (a) personal healthcare provider barriers, and (b) institutional barriers.
2. The need for knowledge and skills to provide care for non-heterosexuals. In this theme we identify two subthemes: (a) disclosure of sexual orientation and communication with healthcare providers, and (b) recommendations for healthcare practices and services.

Lesbian Women Discrimination: Denial and Inclusion

This first theme analyses how participants reflect on (a) personal provider barriers and (b) institutional barriers to healthcare. The inclusion of healthcare diversity implies openness to recognizing and accepting non-heterosexual orientations as well as knowledge of specific factors potentially present in these groups. LGBT populations vary in their behaviours, sexual practices, relationship types, cultural and social levels of acceptance, and perceptions of rights. Knowledge on how these levels intertwine with health prevention and treatment in lesbian populations varies between healthcare providers with frequent consultation experiences with lesbians and those with fewer experiences with them. The effective integration of LGBT's by

some healthcare providers has probably contributed to a greater incidence of lesbian disclosure (analysed subtheme b of theme two). Additionally, those practitioners motivated to research lesbian health related issues in the literature and in online resources returned more suggestions on promoting lesbian client healthcare access (recommendations).

Concerns about non-discriminatory practices and health services were unanimous among all our respondents. They stated that they did not discriminate between specific groups and had no intention of doing so. Nevertheless, their experience in diversity inclusion was more frequent and conscious in the case of ethnic minorities. The fact that they are more visible and the potential cloak of invisibility in the case of sexual orientation were not identified in discourses. Such silence may indicate a lack of appropriate information on the particular conditions prevailing in this minority.

We identified practitioners' personal barriers to lesbian equality in healthcare in opinions that revealed heterosexism on issues such as same-sex marriage and reproduction. For example, same-sex relationships and parenthood within them were perceived as neither "normal" nor socially desirable. The expression of personal values concerning lesbian women was not always balanced with awareness of how they might interfere with quality, and with confidence and openness in healthcare interactions between lesbians and practitioners. Opinions may represent barriers to healthcare because values and moral considerations on gay, bisexual and transgender women, specifically on lesbians, inevitably shape the quality of healthcare actions, communication, and information sharing. Even if not openly discussed, the patient might interpret healthcare providers' reactions and the information conveyed, including healthcare information, as inadequate or irrelevant to their personal situation to the extent of feeling discriminated against, and hence, avoid future clinical situations.

We interviewed both gynaecologists/obstetricians and general practitioners. Their values regarding motherhood and parenthood indirectly interfere in relationships with patients that might need prevention and reproduction related treatments and advice on sexual behaviours and relationships. Negative values towards lesbian reproductive rights do in fact influence effective healthcare in the lesbian population, through the inadequate conveying of health information and a lack of discussion on relevant information for fear of stigma and discrimination, and amounting to frequent delays, when not outright avoidance, in seeking out healthcare services (Staley et al., 2001; Saulnier, 2002).

In the following excerpt, a provider states her client changed her previous gynaecologist because of the practitioner's misinformation and prejudice, which clearly affected the quality of healthcare:

I remember one lesbian who came into my office—she was extremely beautiful, very very beautiful—telling me that with her previous gynaecologist—he was a man by coincidence—she had never told him she was lesbian because she did not feel any need. But on one occasion... she did say “Oh, but I am a lesbian”. The man, whilst continuing treatment, said out loud that he thought lesbians were all ugly and looked masculine, and so ugly that they did not have the ability to get a boyfriend or a man. (Woman, 45 years old)

The prejudice about lesbians being ugly women was stated during gynaecological observation and perceived by the client as an uncomfortable situation. The healthcare provider discriminatory opinions reveal a lack of awareness about the impact such comments hold for consultation quality.

As personal barriers, we also included the denial of discriminatory practices in health care settings. In the excerpt below a practitioner uses the terms “normal” and “abnormal” regarding non-heterosexuality as an abnormality and sees

inclusive clinical practices as unnecessary and depreciative:

We do not cope with it in any way. They are just like other women. They are treated like all women. Discrimination happens when someone wants a different treatment, that's what it is; it only happens if they do it themselves. I don't think different people should have different forms of treatment—that is discriminating. Just because they decided to behave differently from the norm, we do not have to give them more visibility. Should we discriminate against the ordinary then? The normal ones? What is normal varies, what it is today it is not tomorrow and I do not understand why they should have special treatment or visibility. (Woman, 51 years old)

While still providing healthcare services to lesbians, some practitioners showed prejudices and misinformation about non-heterosexual women, denial of healthcare discrimination and a lack of knowledge of specific lesbian issues. When approaching patients in sexual and reproductive healthcare, sexual relationships are as relevant as the sexual partner's sex and gender.

Institutional barriers may involve service regulations failures by omitting to include LGBT women and to specifically mention sexual, but also ethnic, religious, and disability or disease-based minorities, and by not providing information (posters, leaflets, other resources) oriented to non-heterosexuals, thus ignoring and denying patient diversity. There was less identification of such issues in the discourses, healthcare providers failing to reflect upon and analyse them, and few of the interviewed being aware of how services, institutions, and political norms interfere with lesbians' access to healthcare. Public maternity ward regulations for visits illustrate how institutional regulations may prove discriminatory and were reported by three providers in reference to three different parturient patients. According to visit regulations, each female patient can designate one person—usually her partner

and father of the newborn— who is allowed longer visiting times. Two healthcare providers recalled such situations:

The visit situation —it has not yet become a regulation policy. In the maternity ward, there is “the men visiting hour”, but actually called the “husband hour”, from 6 to 8. There are situations where eventually the mother or the granny goes, but if a person is in a different position... the fact of having to say that is not the husband, but the partner... (Woman, 40 years old)

In same-sex couples, designating such a person may imply disclosing one's sexual orientation to staff members, bringing about uncomfortable situations for several couples. Whilst the formal regulations in public services seem adaptable to particular patient situations, heterosexism nevertheless underlies the staff institutional practices and constitutes an institutional barrier. Discriminatory values, opinions and, indirectly, clinical practices, are perceptible in our sample despite the concerns and efforts not to perform likewise present in provider discourses.

The Need for Knowledge and Skills

A quality healthcare service needs to ensure providers receive training and build up experience in providing LGBT focused healthcare. Healthcare providers' specific skills and knowledge of sexual orientation and gender identity are fundamental for the effective inclusion of sexual diversity in the healthcare system.

Contact with diversity and issues on sexual minority healthcare increases the quality of healthcare provision as well as the level of satisfaction of different participants and should be part of both initial training and continuing professional development. All our healthcare providers (16) affirmed they had received no training on LGBT issues and could not recall it as training content in the curricula during medical courses and gynaecology or practice internships. Half of them had had no contact with any

campaigns on lesbian sexual health (via leaflets, the Internet, and scientific publications). Some providers with several lesbian patients affirmed they had looked for information in international journals and association websites and found it. This illustrates how lesbian public visibility in healthcare literature and information increases the interest to learn on behalf of the providers.

Nevertheless, there is a lack of knowledge on healthcare issues and clinical practices for non-heterosexuals, while at the same time these practitioners have personal reflections on best practices with lesbians and feel they have learned from their clinical experience with them:

I think it might be special how you cope with different issues. You should not refrain from preventing sexually transmitted diseases and while you should not impose contraception, you should convey that information, which can be well or badly understood. For some women, it is very often assumed, “I am a lesbian” and it is offensive to talk about contraception. I think it comes with the way you communicate the value you give to a choice, as sometimes it is really symbolic. (...) I notice that some lesbian women have had or have considered the possibility of having relationships with men. Information and prevention is still important — condoms, for example. What a person is not defined forever, and a lesbian will not necessarily remain consistently lesbian. She might still have heterosexual relationships. We need to inform in that sense too. (Woman, 40 years old)

(...) “Even with objects like dildos or anything, if I penetrate deeper, it hurts.” So, if it hurts, the partner cannot do it, they really used a device. So, she had dyspareunia... As a gynaecologist we need to know a little and sometimes this has to be explained to us, because we do not have any type of practice... sometimes we ignore how people do things and it is not really easy to help out. (Woman, 50 years old)

Health care providers seem to be aware of the need to communicate appropriately with

non-heterosexual women, trying to balance the differences and similarities in sexual health prevention for them. The lack of knowledge and the desire to learn and improve healthcare, even on the part of patients themselves, is expressed in the second excerpt on penetration in lesbian relations (consciously ignored by the practitioner). The cultural differences between lesbian women and other stigmatised groups (such as ethnic minorities) were not identified by practitioners who reported low levels of contact with lesbians, and only few among them showed interest in future training.

The next subtheme is sexual orientation disclosure in communicating with healthcare providers. Lesbian visibility in consultation settings expands the provider's search for information and knowledge, as the latter example above suggests. Furthermore, the more comprehensive and inclusive the provider proves to be, the greater the comfort offered to patients. Encouraging disclosure experiences may raise healthcare satisfaction levels.

Heterosexism can influence lesbian healthcare through denying, silencing or avoiding discussions on sexual and reproductive health (Fish & Bewley, 2010; Saulnier, 2002; Staley et al., 2001). Most participants had had experiences with women disclosing non-heterosexual orientations, but only some had the knowledge and skills to adapt their usual interview routines to this specific group. In the following items, surprise and a lack of learned skills in lesbian health are visible:

Our clinical protocol for clinic anamnesis is structured for a heterosexual context, because we have a line of questioning that starts with menstruation and its frequency, then sexuality and what age and so forth, and then at a certain point contraception and then pregnancy. So, the first time it happened to me, I thought the anamnesis was going to stop, there was nothing else to ask then, it was short. I think we need preparation and training. (Woman, 50 years old)

I was a bit ashamed because I thought all the time she was heterosexual until she said she was not. It was uncomfortable because I had assumed she was. I figured it out when she said "don't worry about contraception, I don't need it"—"But how come don't you need it if you said you were sexually active?" Ok, I get it now... (Woman, 46 years old)

The absence of training curricula contents on lesbian healthcare for medical students shapes diagnoses and treatment strategies that are not inclusive and cause confusion and surprise when encountering non-heterosexual sexual orientations.

In this excerpt, the relevance of sexual orientation to healthcare quality and to building up trust in the practitioner-patient relationship is questioned:

Obviously, that is not something we question, among other things, when looking for the consultation motive, right? We do not ask it. Medically speaking it is absolutely... it is another history data item, like anything else we ask. We are not looking for items just to satisfy our curiosity, only for what is clinically relevant. (Man, 29 years old)

If sexual orientation is not physiologically relevant to most healthcare situations, this provider is not aware that consultation quality and comfort might involve talking about relationships, partners and social situations.

The disclosure of sexual orientation in healthcare interactions was portrayed as a communication skill in discourses able to promote openness between the provider and the client:

I am not quite sure when it started. At some stage I must have changed my way of asking if the person had a relationship, if the person had sexual intercourse, always omitting "boyfriend" references and asking about "the person you like". I started using the expressions as a door that remains open. In fact, what happens is that then they say "I have

a girlfriend” or “I have a wife, I have sex with women, but I was married before and now I have a partner”. (Woman, 40 years old)

She was very relieved and I know she enjoys coming to my consultations, maybe because of my reaction. I don't know... it was a natural reaction. I don't think she regularly did gynaecological prevention before. She told me the contraception issue was always a problem because people would always think “why don't you do contraception at your age?” (Man, 31 years old)

Regarding relationships, the open-ended question technique is noted as a good practice facilitating both disclosure and regular prevention healthcare, as well as appropriate treatment patterns.

Discussion

Quality access to healthcare cannot be ensured without the inclusion of diversity in the planning and management of healthcare services. The need for healthcare providers' information and training is clearly noted by this study, as was earlier found in other studies (Bakker et al., 2006; Bjorkman & Malterud, 2007; Burch, 2008; Gato & Fontaine, 2012; Harris, Nightengale, & Owens, 1995; Marques, Nogueira, & Oliveira, in press).

Our research goal of identifying the barriers for effective inclusion of lesbian and bisexual women in healthcare provision was achieved in this study. The positioning against discrimination is central and unanimous in healthcare providers' discourses, but the lack of awareness shown as to how personal values interfere and impact on healthcare, and the specific knowledge and skills required for dealing professionally with such situations are important barriers that need to be tackled. Institutional and management services should run sexual diversity and anti-heterosexism health policies to guarantee access to health within the framework of human rights implementation. The resulting

increase in health knowledge/information will facilitate communication between providers and patients and influence visibility in consultations and in health settings. The health sector needs to reflect social and political changes, particularly in terms of sexual health, promoting equality for LGBT women through guaranteeing the right to health and the highest standard of healthcare services for all people.

We recognize healthcare providers need to be more aware of how their personal values may influence their practices even if not directly in terms of technical clinical practices (Burch, 2008; Campo-Arias & Herazo, 2008). Negative beliefs on same-sex marriages and LGBT parenthood can hinder the practitioner-patient relationship and affect access to quality healthcare for this population, even if unintentionally. On the one hand, personal barriers influence the level of healthcare access, and institutional barriers also create obstacles—for example, through the lack of information for lesbian women, or the discrepancies in health service visit regulations.

Research has shown how social stigma and heterosexism deter lesbians from visiting health services and interfere with their relationships with their healthcare providers, therefore, affecting lesbian women health prevention and treatment practices (Bjorkman & Malterud, 2007; Heck et al., 2006; Staley et al., 2001).

Most practitioners have acknowledged that they did not receive adequate, non-biased training on sexual minority health issues, and that there is a crucial need for training in order to achieve quality and equal health access and care for lesbian and bisexual women. If healthcare providers have the information and are able to develop their clinical skills with lesbian and bisexual women, then more women will feel comfortable about disclosing their sexual orientation and having their health problems prevented and treated appropriately (Fish, 2009; Kelley et al., 2008; Martinson, Fischer, & DeLapp, 1996; Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006).

In their discourses, all the practitioners in our sample express their intention not to discriminate and to offer equal standards of healthcare to their patients in accordance with the human rights declarations. However, heterosexual and homophobic discrimination practices are observed due, primarily, to a lack of knowledge of diversity and minority issues, misconceptions and prejudices, and lack of initial and continued training to deal with specific issues relating to populations such as LGBT women. The existent knowledge and skills were developed through contact with patients who disclosed their sexual orientation, thus motivating healthcare practitioners to research and learn more (Saulnier, 2002).

Taking into account the healthcare providers' discourses, we would like to recommend some instances of best practices able to contribute towards establishing clinical guidelines for LGBT healthcare:

1. Sexual minority healthcare should focus on factors other than identities so that assumptions are not made based on identity categories or moral opinions on diverse behaviours.
2. Sexual orientation disclosure represents an important factor for lesbian women access to healthcare, given that safe, open and genuine communication with healthcare providers increases the quality of care. Open questions should be correspondingly privileged.
3. Confidentiality issues should be clarified regarding sexual orientation and other relevant aspects.
4. Knowledge of sexual practices and orientation is important to the promotion of safer sex, the clarification of patient doubts, and the transmission of appropriate and relevant information.
5. Choices concerning safe-sex protection and contraception use should be made following the reception of appropriate information and the promotion of personal

choice. Contraceptives should not be imposed but negotiated considering all the pros and cons of utilization in each particular case.

6. Information should be provided on protective practices such as the use of condoms, gloves, and dental dams (Lee, 2000). Information should be provided on the heightened risks of engaging in cunilingus and anilingus during menstruation, the sharing of sex toys, violent vaginal or anal penetration (using fingers, sex toys, fisting) and any practices entailing contact with blood.
7. Healthcare providers should assess the heterosexuals experiences in their patients in order to understand their impact on well-being and quality of life.
8. Health services staffs should be trained in order to adequately cope with lesbian women healthcare, promoting safety, trust, and collaboration in healthcare.
9. The involvement of lesbian women in planning, implementing, and assessing health programs is fundamental to effectively ensure sexual minority access to healthcare.

In this exploratory study, we strove to analyse Portuguese healthcare providers' discourses on their experience, knowledge and clinical skills in relation to lesbian women sexual health.

There are limitations in our exploratory study given that the sample is not representative. This study was constrained by the difficulty in gaining access to other participants and the interviewees' lack of availability for more extended interviews.

Conclusion

Institutional sexual and reproductive healthcare guidelines should include information on minorities, including non-heterosexual women. Portuguese healthcare providers showed a lack of the specific knowledge and skills required for treating lesbian women with

the equality necessary to achieve a high quality standard of healthcare regarding sexual orientation. However, the concerns over the need of offering healthcare without discrimination were entirely consensual. We thus have every reason to believe that training programs on minority issues would benefit the current quality of the health services provided and, therefore, efforts should be undertaken to respond to this need.

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