

Treating Sexual Minority Patients



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When asked to write this article, my first reaction was that it would be rather short. Simply treat the sexual minority patient as you would any other patient. Nevertheless, I think I have some additional reasonable advice to add. Obviously this is not the first attempt in literature to discuss the medical issues in treating sexual minorities. Most of these articles discuss the special problems of the gay, lesbian and bisexual patient. Interestingly, the medical concerns of the transgendered (TG) and S/M patient are usually omitted. In an attempt to be different, I will approach this issue from the perspective of the treating physician.

It is important to distinguish between identity and behavior; which is not as simple as it seems. Individuals may choose to define their sexuality with a label, but their actual behavior may be very different. Medical risk is related to a patient's behavior, it does not matter whether a male patient identifies as gay, but it does matter if he has sex with men. Additionally, if he has anal sex with men (rather than a dildo-wielding woman) that opens him up to a different type of medical risk. The dildo exposes one to a different set of pathogens and problems than a penis.

Nevertheless, identity is also an issue. A woman who defines herself as a lesbian is often subjected to a variety of stresses that a heterosexual woman is not, without regard to her behavior. Will my partner be allowed to visit into the MICU? What will happen when my co-workers

meet my lover? Will my boss fire me?

The last issue is that orientation is fluid. There are people who defined themselves first as gay, then straight, then bisexual. It can be hard to imagine but there are people who are not quite sure what gender they are, and days when that gender is intolerable. Is a woman who is "happily" married, but secretly desires sexual contact with other women a lesbian or bisexual or even heterosexual? Does it change, if she begins an affair with another woman, or if she leaves her husband,

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or even if she becomes celibate? There are no simple answers. Just remember that because someone identifies with one sexual orientation, it does not necessarily define their actual behavior. To accept this fluidity, is the first step in not alienating your patient.

We tend to categorize people into the less societally accepted roles. A heterosexual man who has sex with a man is assumed to be gay, but a homosexual man who has sex with a woman is not assumed to be straight. Associating certain medical problems with specific sexual minorities acts to stigmatize that minority. We all know that unprotected anal coitus is a risk factor for HIV transmission, but it may surprise some that more heterosexuals take part in anal coitus than homosexuals. The point is—talk with all your patients about

safe sex for anal sex. The assumption that you can judge how to tailor your advice will unfortunately be proved wrong too often.

Your prospective patient's first contacts with your practice are your office staff and your forms. These patient information sheets routinely ask new patients seemingly simple questions but for some are quite difficult. Prospective transgendered patients must choose between male and female; S/M practitioners must choose between listing their spouse or S/M mistress as their emergency contact. How will the new doctor respond to a newly married gay couple? A new patient will judge your paperwork before ever finding out how accepting you are.

Your office staff can also be the cause of a misunderstanding. The odd look from your receptionist, the nurse that does not understand the need to have a chaperon when examining a female-to-male transsexual. The nurse that shudders when seeing nipple rings, the bookkeeper that refuses to explain a charge on the bill to the significant other.

The somewhat unfriendly form or staff can lead to a hostile or fearful patient. It is probably a good idea to read over your patient materials to make sure they are not inadvertently offensive. A frank discussion with your office staff, letting them know that you welcome sexual minority patients into your practice and will not tolerate any disrespect, can also

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be useful. Talking with colleagues can also help decide who has an interest in treating your sexual minority patients.

It seems only courteous to refer to patients as they request. Nevertheless, it can be difficult to remember to refer to your budding, but balding MTF transsexual patient as a she; write Frank on prescription, but refer to *her* as Francesca. It can be hard to remember to do a pap smear on Dick, your FTM transgendered patient. Hopefully, you already include the patient's significant other in major decisions despite legal status. Sometimes it is difficult to ferret out the relationships that are important to your patient. Your patient may have a wife and a master, or two significant others.

DISTRUST OF PHYSICIANS

It is a truism to say that many sexual minority patients mistrust traditional medicine. Some of this mistrust is understandable; many alternative sexual behaviors are also psychiatric diagnoses. Many patients have had unpleasant interactions with less than accepting physicians. Reliance on alternative medicine, folk remedies and the avoidance of traditional medicine is common. Sexual minority patients tend not to take care of health care maintenance or even simple problems. So when they finally seek medical care it is usually for a serious medical concern.

Along with the distrust of medicine is the distrust of mental health care professionals. So it is often difficult to suggest that your patient see a psychiatrist or psychotherapist. Nevertheless, depression, personality disorders, stress and other psychiatric problems are at least as likely among sexual minorities as the general population. Due to the stresses of living a non-traditional life, some psychiatric problems are more common. Then there are "drug fads" in the various sexual mi-

nority communities that may specifically lead to problems. Those who abuse drugs are more likely to seek medical attention, so physicians may inappropriately associate drug abuse with a specific sexual minority.

ANAL SEXUALITY

Anal sexuality is an area often forgotten in our medical school education. Possibly the best piece of advice you can give is: make sure anything inserted into the anus has a flange to prevent it from being sucked into the rectum. A second safety technique should include a string attached to the device to allow for retrieval. Discussions of how to prevent colonic perforations (smooth, soft toys, exceedingly short fingernails, quick referral for bleeding) should be given in addition to safer sex advice.

TREATING TRANS PATIENTS

There are no data on the best hormonal regimen for your transgendered or transsexual patients. It is important to realize that hypertension, hypertriglyceridemia, pancreatitis, exacerbation of migraines and deep vein thromboses are possible complications from hormonal treatment. The exact risks are not known, but male to female TG or TS patients should get regular breast exams and Pap smears.

SOME BETTER WAYS OF ASKING QUESTIONS INCLUDE:

Rather than ask "marital status?"

Ask, "Are you single, married, divorced, separated or partnered?" The next question is, "With whom do you live?"

Rather than "What form of birth control do you use?"

Ask "Do you use birth control?" If the patient says no, then ask "Do you need birth control?"

Rather than "Do you have any sexual problems?"

Ask, "Do you have any sexual concerns?" There is research showing that this question, however, will not uncover sexual

dysfunctions. You have to ask about each specific dysfunction.

For example, "Do you have difficulty having an orgasm, getting an erection, maintaining an erection, with pain during sex, lubricating enough or long enough, with the amount of desire you have for sex?"

Rather than "With how many partners did you have sex?"

Ask, "Are you sexually active?"


Rather than, "Who beat you up?"

Ask, "How did you get those marks/bruises/welts?"

Rather than, "What is your sexual orientation?"

Ask, "Do you have sex with men, women or both?"

This article presumes that you want to treat sexual minority patients. There are physicians who are unable to overcome their own issues and should refer these patients. Just because a physician is a member of a sexual minority community does not mean that the physician can nonjudgmentally treat any or all sexual minority patients.

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GROUP THERAPY

Two supportive groups for borderline and chronically ill (daytime, Medi-Cal accepted). Three insight-oriented groups for medium-to-high functioning adults (5:30-7:00 pm). One supportive/insight-oriented group for adults over 55 (daytime, Medicare accepted).

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