Caring for Lesbian Health

A resource for Canadian
Health Care Providers ❋ Policy Makers ❋ Planners

Revised Edition

Health Canada, Status of Women Canada
BC Ministry of Health and Ministry Responsible for Seniors
British Columbia Centre of Excellence for Women's Health

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www.lesbianhealth.ca

Caring for Lesbian Health: A Resource for Canadian Health Care Providers, Policy Makers and Planners, revised edition

Written by Maria Hudspith in conjunction with the Minister's Advisory Council on Women's Health, the BC Ministry of Health and the BC Ministry Responsible for Seniors, September 1999.

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Introduction

Recent research in epidemiology, clinical care and psycho-social fields has indicated the need to explore lesbian health needs and address barriers to wellness (Solarz, 1999). It is estimated that up to 10 percent of women are lesbian, although estimates vary depending on how the category of lesbian is defined (Laumann, in Solarz, 1999). Lesbians are mothers and daughters, young and old, members of Aboriginal, immigrant, visible minority and dominant cultural communities. Lesbians live with disabilities and are able-bodied, come from all class backgrounds and live in both rural and urban areas. Some lesbians are bisexual or transgender. To be responsive to all members of Canadian communities, health care providers, policy makers and planners need to address the specific needs and issues of diverse groups.

The World Health Organization states that health is a basic human right (WHO Constitution, 1946), recognizing that all people deserve equal access to health services and quality care. Everyone has the right to be treated with respect, and to receive care in a setting free from discrimination. However, lesbians may encounter difficulty accessing health care. Lesbians who come from other marginalized communities (visible minority, immigrant or Aboriginal communities, for example) face additional barriers.

The steps health care providers, policy makers and planners take to make health care accessible to lesbians create building blocks for making the system respectful of difference and attentive to the needs of other groups. These steps are not about special interests; they are the foundations of good practice and reflect Canadians' broadening concept of health and belief in health as a human right for all.

Don't make assumptions about me or anybody else. Take your chalkboard and wipe it clean every time you enter into conversation with a new patient. Go in with clear eyes and pure heart, understanding that we are all persons, even though the way we are in the world is different. When we are cut, we all bleed…You might say you don't have time. I say time is relative. There is always time to treat other people like human beings. (Stevens, 1998)

Glossary of Terms

Lesbian: A woman who forms affective and sexual relationships with other women. Some women who partner with women may not identify as lesbians. Some labels that were once derogatory have been reclaimed by lesbians and used with pride, such as dyke or queer. Some labels are culturally specific — for example, Two Spirited, referring to lesbians of Aboriginal heritage. It is also true that some women do not want to be labelled at all.

Bisexual woman: A woman who is as likely to form affective and sexual relationships with women as with men.

Closeted: Being "closeted" means disclosing one's identity to others rarely or not at all.

Coming Out: Refers to the process of first recognizing and acknowledging one's lesbian, gay or bisexual orientation to oneself and then disclosing it to others. This may occur in stages and is often a non-linear, lifelong process. An individual may be "out" in some situations or to some people and not to others. Some may never come out to anyone other than themselves and their intimate partners.

Gender Identity: One's psychological sense of oneself as male or female.

Heterosexism: The institutionalized assumption that everyone is heterosexual or should be; the belief that heterosexuality is innately right or superior to any other sexual orientation or identity.

Homophobia: The irrational fear or hatred of, aversion to, or discrimination against gays and lesbians.

Internalized Homophobia: When a lesbian or bisexual woman accepts society's stereotypes and negative labels and internalizes them.

Sexual Orientation: The capacity to develop intimate emotional and sexual relationships with people of the same gender (lesbian or gay), the opposite gender (heterosexual) or either gender (bisexual). Orientation is separate from sexual identity or behaviour.

Sexual Behaviour: What a person does sexually. A woman's sexual behaviour can be different from her sexual orientation. Some lesbians may have sex with men to conceive children, to conform to societal expectations of heterosexuality, for desire or to make money.

Sexual Identity: How a person defines herself. Sexual identity may not be congruent with sexual behaviour or orientation.

Transgender: A term used to describe the continuum of individuals whose gender identity and expression, to varying degrees, do not correspond to their genetic sex. This may refer to transsexuals (individuals who have changed their sex through surgery, hormones) or to people who, because of their non-conventional gender

presentation, may be seen as transgender (e.g., a woman with a masculine presentation who may be seen by others as male but sees herself as female).

Why is Lesbian Health Important?

Human rights legislation (both provincial and federal) exists to protect lesbians, gay men and bisexuals from discrimination on the basis of sexual orientation. While this protection has not been written into the Charter of Rights and Freedoms, the section pertaining to Equality Rights has been held to prohibit discrimination on the grounds of sexual orientation. However, sexual minorities still encounter both systemic barriers and interpersonal expressions of homophobia in society.

In the health care context, some hospitals and care providers are starting to bring policies and practices in line with human rights law. They are doing this by expanding definitions of family beyond biological kin, providing training on diversity and developing specific programs to meet the needs of lesbians, gays and bisexuals.

Why should we work to make the health care system accessible to lesbians? Fundamentally, the system needs to be responsive to, and inclusive of, everyone. There are health problems that may be more prevalent among lesbians or for which risk factors and interventions may be different. Many lesbian health issues could be remedied by improving access to care, by reducing discriminatory behaviours and attitudes in Canadian society and by working towards recognition and equality in the health system.

There are consequences to the invisibility of lesbians. A distrust of the medical system can lead people to seek alternative forms of health care — forms that they consider to be more inclusive. Invisibility can also lead to misdiagnosis or underdiagnosis. (Simkin, 1998)

The result of making care safe for lesbians means:

• Health care providers get accurate information about their patients and use that information to make informed diagnostic and treatment decisions.

• Patients are treated in a holistic manner, and their definitions of family/caregivers are respected.

• Patients' energy that may be spent on staying in the closet gets spent on healing.

• Social determinants of health, like systemic discrimination and the recognition of how multiple oppressions (like racism and homophobia) intersect, are acknowledged.

The Historical Legacy of Homophobia in Health Care

At the turn of the 20th century in North America and Europe, bio-medical models were used to define normalcy and deviance, particularly around issues of sexuality. Western medicine and science built on the history of the Church and tied concepts of bodily disease to those of aberrant morality (Stevens and Hall, 1991). Same-sex attraction and behaviour was defined as a disease and thought to be the result of genetic anomalies. Being gay or lesbian was considered dangerous and contagious, and many lesbians and gay men were confined in psychiatric or criminal asylums.

> A heterosexual woman doesn't go in afraid to say, "This is my partner." She will not have to think about whether or not this doctor in an emergency will hate her if she discloses that she is in this relationship, or if he will treat her differently. (Anderson et al., 2001)

Throughout the late 19th and 20th centuries, the medical establishment theorized about the exact nature and cause of homosexuality. Lesbians and gay men were studied and "treated" by doctors who aimed to identify and to cure. Many "scientific" studies were based on "data" from popular novels, tabloids and interviews with prison inmates and sex trade workers. Physicians developed lists of physical characteristics that could be used to detect lesbianism (e.g., wide shoulders, greater height and firmer muscles). Behaviours that could be considered unconventional or gender inappropriate (e.g., involvement in skilled labour, sports, or social movements, dedication to career) were also considered part of the

The Impact of This Legacy

This historical legacy has informed the policies and practices of health care and continues to influence lesbians' experiences with the medical system. Indeed, research on lesbians' experiences with health care providers demonstrates the unique struggles that lesbians face (Denenberg, 1995; Rosser, 1992; Stevens, 1995). Most fundamental is the question of being "out," or disclosing one's lesbian identity. While it is assumed that honesty, respect and confidentiality are the cornerstones of the patient-health care provider relationship, this is often not the case for lesbians, for whom the disclosure of a lesbian identity may have negative consequences.

A study of nurse educators in the United States found that 25 percent of participants saw lesbianism as "immoral" and "wrong" and 52 percent believed that lesbians should undergo treatment to become heterosexual (Rankow, 1995). These attitudes are not left at the doors of operating rooms or clinics, but affect the quality of care that lesbians receive. Discrimination impacts every aspect of health care interactions, from a woman's decision to access care through to the health care provider's diagnosis and treatment. A survey of the American Association of Physicians for Human Rights found that 67 percent reported knowing of instances where lesbian, bisexual or gay patients had been refused care or had received substandard care because of their sexual orientation (Rankow, 1995).

In Canada, a 1997 Ontario study reported that 51 percent of lesbian patients had not "come out" to their health care providers, even though 91 percent of the lesbian patients believed that this knowledge was important for their providers to have (Davis, 2000). Another recent study looked at the impact of the anti-lesbian/anti-gay social climate on lesbians living in northern British Columbia (Anderson et al., 2001). This study found that the anti-lesbian/anti-gay social climate in the north had permeated health care services and that significant changes were needed in services and in the community at large to increase and encourage lesbians' access to health care.

Health as a state of "physical, emotional and social well-being" may be difficult to achieve for lesbians who live in northern communities where homosexuality is reviled and personal safety may be at risk as a result. (Anderson et al., 2001)

Too often the presumption that all women partner with men guides the policies and practices of health care and renders lesbians invisible (Simkin, 1998; Luce et al., 2000). This invisibility directly affects the health of lesbians and the care they receive. To ensure that adequate care is provided, lesbians must often make a declaration of their sexual identity or sexual practices. This disclosure may be met with disgust, fear, hostility or misunderstanding, and the anticipation of such a reaction may discourage a woman from being out.

The fear of receiving homophobic treatment means that some lesbians pass as heterosexual in health care settings, providing incomplete or inaccurate information in an effort to camouflage their lesbian identity. This carefully constructed charade often results in mis-diagnosis and improper treatment, as well as discomfort and anxiety for the patient. The irony of disclosure is

great, as a Vancouver woman noted: "If I allow the presumption of heterosexuality to go unchallenged, I risk receiving inappropriate care due to misinformation. Yet if I am out, I fear antagonism, disgust or potential medical mistreatment." In an effort to avoid this negotiation of identity, many lesbians simply go without medical care, including routine check-ups, pap smears, mammograms and breast exams (Mautner,1998; Davis, 2000; Anderson et al., 2001).

Lesbian Health Issues

Lesbians share many health concerns with heterosexual women and also have unique health issues (Solarz, 1999). While there is some evidence of epidemiological trends among lesbians, the determinants of compromised health status or poor utilization of health services are often systemic barriers composed of homophobia in both society and care providers, and heterosexist bias in health policy or practice (O'Hanlan, 1997; Anderson et al., 2001). These barriers are compounded for lesbians who have disabilities, are economically disadvantaged or are members of visible minority or Aboriginal communities.

Many lesbians identify the following as issues that can have a significant impact on lesbian health and health care.

> Somehow, a chart notation of "decisions made re: management, friend present" does not carry the same weight as "decisions made re: management, wife (or husband) present." Our patients' support systems often go unnoticed and invalidated. (Simkin, 1998)

Aging

Older women who partner with women must cope with invisibility: older lesbians are often assumed to be widows of heterosexual marriages or "spinsters." Cultural silence about aging and sexuality means that older women will likely not be questioned about their sexual behaviour or orientation (Rankow, 1995; Deevey, 1990). Some lesbians who come out later in life risk rejection by their families, including adult children and grand-children. Older lesbians who lose their partners grieve without societal recognition of their significant loss (Isaac & Herringer, 1998).

My friend died because she was not able to self-diagnose her cancer early enough to save her life. She was an intelligent, capable, articulate woman. But as a lesbian, health care was not a place where she felt welcome. She never went. She never learned about doing breast exams. Her cancer got too advanced. (Stevens, 1995)

Breast cancer and other cancers

The incidence of breast cancer among lesbians is unknown, although some studies claim that it is up to three times higher than in heterosexual women (Rosser, 1992). Epidemiological evidence suggests that lesbians may be at greater risk for breast cancer due to having fewer pregnancies and having children later in life, heavier alcohol consumption, higher body mass index and less access to prevention/ treatment such as breast examinations by a physician (Solarz, 1999). Lesbians, like women of colour and members of other oppressed groups, may also be at risk for late diagnosis and therefore greater mortality from cancer (Davis, 2000; Mautner Project, 1998).

HIV/AIDS

Lesbians are at risk for contracting HIV through sharing needles for injection drug use, through alternative insemination with unscreened semen and through unprotected sex with male or female partners. There has been widespread debate about the possibility of woman-to-woman transmission of HIV through sex. Some studies have found higher rates of HIV among women who have sex with women than exclusively heterosexual women, although these statistics are affected by study participants who are behaviourally bisexual and who use injection drugs (Solarz, 1999). Although initial HIV prevention efforts were targeted at risk groups (according to the U.S. Center for Disease Control guidelines), lesbianism was not considered a

category of risk (Glassman,1995). This invisibility left lesbians out of the analysis and obscured the issues for women who have sex with women. While this silence has recently begun to shift, research studies have found that medical practitioners are often doubly ignorant around the issue of lesbians and HIV (Simkin, 1998; Glassman, 1995; Stevens, 1994b; Simkin, 1993b).

Legal status of lesbian partners

Families in the lesbian community are often differently constituted than those in traditional, heterosexual society, and may include same-sex partners as well as, instead of, or in addition to close friends and biological family. In many provinces, the people who lesbians consider family are not regarded as next-of-kin. Some lesbians make legal provision for someone (e.g., partner, friend) to make decisions or manage finances in a crisis. However, health care providers often do not know about such legal provisions and may not even be aware of the existence of a lesbian partner (Davis, 2000; Simkin, 1998; Deevey, 1990). The result is that many lesbian partners are shut out of decision-making in a health crisis (e.g., if a lesbian becomes mentally incompetent) and are not allowed the visiting privileges usually allotted to family.

I came out at a time when being gay was both illegal and a mental illness. I was sent to a psychiatrist when I was 13 because my mother didn't think I acted like a "proper" girl. I was eventually confined in a psychiatric hospital when I was 17. That's hard to shake, an experience like that. I mean, I'm in my sixties now and I still have anxiety when I interact with the health care system. (A Vancouver woman)

Mental Health

Although diagnosed mental illness is no more common among lesbians than heterosexual women, societal homophobia has implications for the mental health of women who partner with women (D'Augelli, 1989). Lesbians may suffer rejection from families, friends,

religious communities and co-workers. They may be the targets of hate crimes, including verbal and physical attacks, and may be denied housing, custody of children (their own or their partners'), employment, or health care. The impact of societal rejection if one is out, and the burden of maintaining a secret identity if one is not, can lead to isolation and depression (Denenberg, 1995; Bradford et al., 1994). The historical linking of homosexuality and mental illness by the psychiatric system still haunts many lesbians, particularly older women. In focus group discussions, some lesbians acknowledged not getting medical care for fear of disclosing their lesbian identity and being involuntarily treated for mental illness by homophobic care providers (Vancouver/ Richmond Health Board, 1997).

> [The doctor] was very attentive and real talkative before I told him that I was a lesbian and then the room became silent. His whole attitude changed, you could tell. And he stared at me. Like *stared* at me, you know. (Anderson et al., 2001)

Pregnancy and Parenting

Many Canadian lesbians are mothers with children from previous heterosexual relationships, children who are adopted, or children conceived through alternative insemination (Nelson, 1996; Arnup, 1995). While there is no demonstrated difference between children raised in lesbian families and those raised in heterosexual ones (Davis, 2000), lesbians and their children have the added stress of dealing with societal discrimination (Denenberg, 1995).

Self-education and self-care

Perhaps one result of lesbians' experiences in society and in the medical system is that many are very self-reliant when it comes to their health (Anderson et al., 2001;

Roberts & Sorensen, 1999). Many lesbians rely heavily on self-care and self-education, especially focusing on alternative and non-Western health care practices (e.g., herbal remedies, massage therapy, exercise, meditation). Taking a holistic, wellness-based approach to health rather than a disease-based approach may be especially important for health care providers working with lesbian patients (Mautner Project, 1998).

Almost every doctor that I have had has been heterosexual. They don't even know anything about lesbian health. "No, I don't need the pill, this is the fifth time you asked me." (Anderson et al., 2001)

Sexually Transmitted Diseases and Vaginal Health

Lesbians appear to be less likely to receive regular pelvic exams than heterosexual women (Solarz, 1999). A number of factors influence this, including heterosexist bias in screening procedures, fear/discomfort on the part of the patient and the misconception on the part of both patients and health care providers that STDs cannot be transmitted through woman-to-woman contact (Denenberg, 1995). Given that pelvic exams are the main screening device for sexually transmitted diseases, many lesbians do not get appropriate preventive care or medical treatment (Davis, 2000). Incidences of sexually transmitted diseases such as trichomonas, chlamydia, and gonorrhea are lower among lesbians than among heterosexual or bisexual women, but they still occur (Simkin, 1993b).

Substance use

Studies on substance use demonstrate a correlation between societal marginalization and substance misuse (Bushway, 1991). Some studies have shown higher use of alcohol, cigarettes and other drugs among a sub-popula-

tion of lesbians (Bradford, 1994; Hall, 1992). These studies found that lesbians tended to use psychoactive substances to cope with isolation and societal and internalized homophobia.

Violence in Relationships

Abuse is an issue of power and control, and it impacts lesbians. Although there is increasing awareness of this issue in lesbian communities, there is still a pervasive silence about lesbian battering and abuse. Lesbians who experience abuse are less likely than heterosexuals to seek help in the medical system and are less likely to turn to shelters (Saunders, 1999). Research has shown that when lesbians do reach out for help, the violence is often minimized and framed by care providers as "mutual aggression" (Scherzer, 1998). This silencing is particularly evident in cases of sexual assault (Orzek, 1988). Societal homophobia and sexism exacerbates the fear and shame that lesbian survivors of abuse and lesbian perpetrators experience.

Youth Issues

Developing a positive sexual identity can be particularly challenging for lesbian adolescents because of societal homophobia, heterosexual bias in educational curriculum and a lack of role models (Solarz, 1999). Lesbian and gay youth are two to three times more likely to commit suicide than their heterosexual peers, accounting for 33 percent of youth suicides (Simkin, 1993b). It is estimated that up to 40 percent of youth on the streets are gay or lesbian, turning to the streets after being forced out

of family homes because of their sexual orientation (Remafedi et al., 1991). This places gay and lesbian youth at a high risk for addiction, mental health issues and a host of other health problems.

I can't tell my parents … I'm just waiting until I graduate and then I can move out. Sometimes if we're watching TV, my parents will make comments when stuff comes on about lesbian or gay issues. It's pretty clear that if they ever found out, they'd kick me out of the house. I know another girl who couldn't deal with lying anymore. She told her dad, who threw all her stuff out her bedroom window and told her to leave. She's living on the street in Vancouver now. (A Victoria youth)

Tips for Health Planners and Policy Makers

• Getting input from the community you're trying to serve is vital. When addressing issues of diversity, form an advisory committee made up of staff, patients and members of the lesbian community as well as members of the general community. Promote grassroots involvement of lesbians in health planning and in developing appropriate strategies for outreach efforts.

• Review and revise all policies, forms and patient literature to eliminate heterosexual bias and non-inclusive language. Revisit the implementation and efficacy of confidentiality policies and procedures. Change forms from "single, married, divorced or widowed" to include "same sex partnership" or provide a blank line for the patient to fill in their relationship status.

• Allow space for the patient to define whom they want involved in their care (e.g., leave a blank line for patients to identify an emergency contact or to identify their partner if they wish). If the patient is unable to make her own health choices, regulations governing who can make those decisions vary from province to province. In British Columbia, for example, the *British Columbia Health Care (Consent) and Care Facility (Admission) Act* provides that in cases where the patient is unable to make her own health choices, a lesbian partner can be designated by the patient to fulfill this role. In this Act, "spouse"

means a person who (a) is married to another person and is not living separate and apart, within the meaning of the Divorce Act (Canada), from the other person, or (b) is living with another person in a marriage-like relationship and, for the purposes of this Act, the marriage or marriage-like relationship may be between members of the same sex.

• Sponsor a homophobia education workshop or a workshop about providing sensitive care to lesbians, gays and bisexuals. Advertise the workshop widely and encourage local/regional physicians and health care practitioners to attend. For ideas about groups to contact, such as PFLAG (Parents and Friends of Lesbians and Gays), please see the national websites listed in the Resource/Referral section at the end of this booklet.

• Order The Mautner Project's Tools for Caring about Lesbian Health Kit (1998), which includes an 18-minute training video and discussion guide for health care providers. Then organize a workshop for the health care providers in your institution, department or region. For ordering information, contact the Mautner Project for Lesbians with Cancer, 1707 L Street NW, Suite 500, Washington DC 20036. Phone: (202) 332-5536 or e-mail: mautner@aol.com.

• Be an ally. Challenge heterosexism and oppression of lesbians and gays wherever you see it. Homophobia in any form, and in any setting, will not end unless everyone takes responsibility for providing an alternative model of beliefs and behaviours. Simply saying, "Your language

offends me" or, "I wish you wouldn't use those kinds of words around me" can make others shift their perspectives. If challenging a colleague's or patient's homophobia directly feels too risky, there are other things you can do: arrange a staff training on diversity, establish an advisory committee to address issues of discrimination or even leave an article on homophobia in the staff lounge.

• Regularly evaluate how you're doing in terms of meeting the needs of the lesbian community.

(Tips section adapted in part from *Tools for Change, Mautner Project for Lesbians with Cancer*)

Tips for Physicians and Health Care Practitioners

• Be patient-centred. Avoid making assumptions about gender or sexual identity or about sexual/health behaviours. Let the patient tell you about herself and her issues.

• Take thorough histories, using inclusive language. Ask questions about sexual behaviour, not sexual identity. Instead of asking "Are you sexually active?" try "Are you currently sexually active? If so, are you active with men, women or both?" Instead of "What form of birth control do you use?" try "Do you need to use birth control?" This opens the door for all patients to talk about their sexual histories and behaviours without fear of a negative response. Be non-judgmental in response to the information that the patient gives you.

• Ask open-ended questions to solicit information about psycho-social stressors and supports. This demonstrates sensitivity and a holistic approach to health.

• Be aware that in many provinces, same-sex partners are not considered next-of-kin. Ask patients to define in writing whom they want involved in their care. For example, leave a blank line on your patient information form for patients to identify an emergency contact or to identify a partner if they wish. Encourage lesbian

patients with female partners to keep themselves informed about the latest federal and provincial regulations on same-sex partnerships. Also encourage lesbian patients with female partners to put their wishes in writing, especially on these two issues: (1) name the partner as the one who can make decisions if the patient becomes mentally incompetent; (2) specify that the partner has full visitation rights.

• Be aware that lesbians who have lost a partner or who are living with a partner with a debilitating disease experience pain and problems as would any heterosexual widow or spouse.

• Be aware that families in the lesbian community are often differently constituted than those in traditional, heterosexual society. For example, to many lesbians, friends are family. For lesbian patients, it may be especially important to keep visitor guidelines as flexible as possible.

• Respect the importance of lesbian music and books to some lesbians. Ask lesbians who are ill or dying what their friends can bring that will make their surroundings more familiar and help ease the process.

• Screen for, address and treat patient concerns linked to mental health and substance use. Recognize the impact that societal oppression has on these health issues. Screen for, address and treat concerns related to abuse and violence, whether domestic, sexual or bias-related.

• Make referrals with sensitivity. If your patient has trusted

you and come out as a lesbian, keep this in mind when referring to other practitioners. Try to refer to providers who are sensitive to issues of diversity.

• Show your patients that you care about diversity. Some health care providers have found that having information sheets and brochures on lesbian health issues in their waiting rooms or displaying a policy statement has helped lesbian patients to feel welcome. For example, some health care providers post a positive space sticker or sign like this: This Is a Positive Space. We do not discriminate on the basis of sexual orientation or gender identity.

• Find out whether a group in your area (e.g., lesbian/gay group, anti-discrimination course or union organization) offers homophobia education workshops or workshops about providing sensitive care to lesbians, gays and bisexuals, then attend it. If no such workshops exist, ask a lesbian/gay group to offer one to you and your colleagues. (See the Resource/Referral list at the back of this booklet.)

• If you do not have easy access to a group that can offer homophobia education workshops, order The Mautner Project's Tools for Caring about Lesbian Health Kit (1998), which includes an 18-minute training video and a discussion guide for health care providers, as well as other information. Then organize an education/discussion evening for yourself and your colleagues. For ordering information, contact the Mautner Project for Lesbians with Cancer, 1707 L Street NW, Suite 500, Washington

DC 20036. Phone: (202) 332-5536 or
e-mail: mautner@aol.com.

(Tips section adapted in part from *Tools for Change, The Mautner Project for Lesbians with Cancer*)

What Many Lesbians Look For in Health Care Providers

Office and forms:

• The office prominently displays a positive space policy (e.g., by posting a positive space sticker or sign saying that the office does not discriminate on the basis of sexual orientation or gender identity).

• The patient information forms use inclusive language (e.g., "partner" as well as "husband" or "wife").

The health care provider:

• has been recommended by a friend or other trusted health care provider

• advertises in lesbian- and gay-positive publications and venues

• recognizes and respects the lesbian patient's right to have someone (e.g., partner, trusted friend, advocate) stay with her during the appointment (including during a physical exam) if she wishes

• protects privacy and confidentiality, including on charts (it is important for many lesbians to know who can gain access to their medical records)

• uses inclusive, non-judgmental language

• does not assume that every patient is heterosexual

• already includes lesbians, gays and bisexuals in the practice

• gives ample time and opportunity to ask questions

• has received training on lesbian health issues (and has encouraged all staff to do so too)

• shows awareness of specific lesbian health issues (e.g., maintains a file of recently published articles on lesbian health, knows about websites pertaining to lesbian health or including information on lesbian health issues)

• expresses a willingness to seek more information and training on specific lesbian health issues

• respects and acknowledges lesbian patients' self-care and self-education about alternative health care practices, such as exercise, herbal remedies and massage therapy.

(Adapted in part from The Mautner Project for Lesbians with Cancer, *Tools for Caring about Lesbian Health Kit,* Washington DC, 1998, and from McInnis and Kong, *Your Everyday Health Guide: A Lesbian, Gay, Bisexual and Transgender Community Resource,* Vancouver BC, 1998.)

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Resource/Referral List: National Groups and Websites

This list includes examples of national groups and websites involved with lesbian health or including lesbian health issues. Please note that the list is not exhaustive and is subject to change.

British Columbia Centre of Excellence for Women's Health
(604) 875-2633
c/o BC Women's Hospital and Health Centre
4500 Oak Street
Vancouver BC V6H 3N1

Website (*click under "Lesbian and Bisexual Women's Health"*):
http://www.bccewh.bc.ca/resource.htm

Canadian Health Network/Reseau Canadien Santé
(613) 946-2066
1-877-891-4636
10th floor, Jeanne Mance Building
Postal Locator 1910A1
Ottawa ON K1A 1B4

Website (*use search word: "lesbian"*):
http://www.canadian-health-network.ca
http://www.reseau-canadien-sante.ca
E-mail: chninfo@innovaction.com

Canadian Women's Health Network
(204) 942-5500
Suite 203, 419 Graham Avenue
Winnipeg MB R3C 0M3

Website (*not many references to/for lesbians specifically, but includes* Network *health magazine on-line*):
http://www.cwhn.ca
E-mail: cwhn@cwhn.ca

Gay and Lesbian Medical Association
(*based in San Francisco, CA, but links to many articles for care providers and is national in scope)*
Website: http://www.glma.org

The Mautner Project for Lesbians with Cancer – Washington DC
(202) 332-5536
1707 L Street NW, Suite 500
Washington DC 20036

(*has produced a Tools for Caring about Lesbian Health Kit containing a training video and a discussion guide for health care providers, which can be ordered.*)
E-mail: mautner@aol.com

PFLAG (Parents and Friends of Lesbians and Gays) Canada
(*contains information and links on lesbian and gay issues, including health issues, and as of March 2001, has chapters in Alberta, British Columbia, Saskatchewan, Manitoba, Ontario, New Brunswick and Nova Scotia*)
Website: http://www.pflag.org

Réseau québécois d'action pour la santé des femmes

(514) 877-3189

4273, rue Drolet, bureau 406

Montreal QC H2W 2L7

Website: http://www.CAM.ORG/~rqasf

E-mail: rqasf@rqasf.qc.ca

Wellness Health Care Information Resources

Website (*accesses many links about gay, lesbian and bisexual health*):

http://www-hsl.mcmaster.ca/tomflem/gay.html