

LESBIAN PARENT PERCEPTIONS OF THE PATIENT-PHYSICIAN
RELATIONSHIP: AN EXPLORATORY STUDY
OF LESBIAN EXPERIENCES

By

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ABSTRACT

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Communication is the foundation of any strong patient-provider relationship. There is substantial evidence to suggest that openness on the part of the physician, along with a strong sense of trust on the part of the patient is critical to supporting a positive health care relationship. People who identify as lesbian, gay, bisexual or transgender (LGBT) have historically faced challenges finding physicians who are non-judgmental about patient sexual orientation and who are competent to navigate the unique issues facing the LGBT population. This study sought to provide an in-depth exploration of the interactions between lesbian parent families and their physicians to learn more about the characteristics that support strong relationships between patients and providers for this population.

This study expands upon foundational research on lesbian mothers conducted by Mercier in 1999. This study used the respondent pool established by Mercier to explore the perception of health care providers and factors that create a supportive patient-provider relationship among lesbian parents. Quantitative data were collected from respondents who completed the Lesbian Parent Health Care Survey. A subset of survey respondents volunteered for a subsequent phone interview that used a structured guide to gather in-depth qualitative data related to their health care experiences and the characteristics they seek in a health care provider for themselves and their families.

The results of the study reflect significant progress in the perceptions of the patient-provider relationship as compared to prior studies, and that open and supportive communication is the primary driver of satisfaction for lesbian-parent patients.

Furthermore, being able to come out to a provider and disclose sexual orientation was considered critical to providing a basis for patient satisfaction with their physician.

The majority of respondents in the study preferred female physicians, and physicians' sexual orientation was immaterial to patient satisfaction. Although some respondents did relate negative experiences in some instances, their overall perception of their health care relationships was positive, and this is attributed largely to careful screening of providers and consciously working to build rapport that supports open communication, trust, and an empathetic relationship.

Implications of the study for policy, practice, and research, as well as for educating health care providers, are discussed. Recommendations for practice and education for physicians and social workers are presented as an important factor in decreasing negative or biased attitudes towards lesbian families. Future research with lesbian parents based on the concepts of social identity theory and social minority groups is also suggested.

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DEDICATION

My interest in higher education could not have been possible without the expectations, support, and influences of my parents, George E. Dimond, M.D., and Irene W. Dimond. I am fortunate to have my mother still able to see me through my Ph.D.

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TABLE OF CONTENTS

LIST OF TABLES	viii
LIST OF FIGURES	x
CHAPTER 1	1
INTRODUCTION TO THE STUDY	1
Introduction.....	1
Background	3
Problem Statement	6
Basic Research Question.....	8
Design Overview	9
Significance of the Study	9
Definitions.....	12
Assumptions, Limitations, and Scope.....	13
Scope of the Study	14
Summary and Organization of the Study.....	15
CHAPTER 2	16
REVIEW OF THE LITERATURE	16
Introduction.....	16
The Evolution of Medical Social Work.....	16
Managing Discrimination in the Health Care Setting.....	19
Health Care Discrimination Based on Racial Minority Status	19
Discrimination in Health Care Based on Non-Racial Minority Status	22
Physician Communication and Patient Engagement	24
The Application of Group and Social Identity Theory to Discrimination in Health Care	28
Social Selection Theory and Discrimination in Health Care	32
The Application of Social Dominance Theory to Discrimination in Health Care.....	33
The Evolution of Health Care Delivery to the LGBT Population	35
Comparison of Heterosexism to Racism and Out-Group Status	37
Themes Within Research on Homophobia in Health Care.....	39
Combating Homophobia and Heterosexism Among Physicians During Medical Training.....	41
Gay and Lesbian Perceptions of Health Care	44
Issues for the U.S. Lesbian Population	45
Conclusion	46
Summary	49
CHAPTER 3	50
METHODOLOGY	50
Basic Research Question.....	52
Research Design.....	53
Methodological Approach	54

Appropriateness of Design.....	54
Population and Sample	55
Power Analysis	57
Survey	59
Lesbian Parent Survey Questions	61
Data Analysis	61
Study Validity	64
Internal Validity	64
External Validity	65
Ethical Assurances	65
Summary	66
CHAPTER 4	67
RESULTS	67
Introduction.....	67
Participant Demographics	67
LPHCS Open Ended Question Summary	72
Findings From Phase 2: The Qualitative Study	80
Interviews.....	81
Result of Phone Interviews	83
LPSQ Question 2, Perceived Quality of Care.....	86
LPSQ Question 3: Physician/Provider Empathy	89
Question 4: Screening Methods Used to Select Physician or Provider	90
Question 5: Important Characteristics/Traits of a Current or Past Physician/Provider	92
Summary	94
CHAPTER 5	97
CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS	97
Findings and Implications.....	99
Differences in Perception Based on.....	99
Preferences About Gender and Sexual Orientation of Providers.....	102
Physician Traits That Support Ongoing Patient Relationships.....	104
Perceptions About Quality of Care	106
Perceptions of Empathy	107
Restatement of Limitations	108
Recommendations for Further Study, Practice, and Research.....	111
Legal and Policy Implications Lesbian Parent Families.....	115
The Social Work Role With LGBT Patients.....	118
Achieving Equity in Health Care for LGBT Patients	120
Summary	122
APPENDICES	126
REFERENCES	156

LIST OF TABLES

Table 4.1. Demographics and Income Characteristics of the Lesbian Parent Sample	68
Table 4.2. Lesbian Parents' Children and Family Size.....	70
Table 4.3. Lesbian Parents' Self-Reported Health Status.....	70
Table 4.4. Physician Provider Characteristics as Reported by Lesbian Parents	71
Table 4.5. Lesbian Parents' Satisfaction With Their Family's Physician(s)	72
Table 4.6. Reliability of Coding of Qualitative Responses to Factors in Respondent's Coming Out to Physician [or Health Care Provider] (Question 9 on the LPHCS)	74
Table 4.7. Reliability of Coding for Qualitative Responses to Lesbian Parents Experience in Coming Out to Their Physician (Question 10 on the LPHCS)	76
Table 4.8. Reliability of Coding for Qualitative Responses to Whether Being Out Influenced Lesbian Parent' Use of Health Care (Question 11 on the LPHCS)	78
Table 4.9. Lesbian Parents' Opinion on Seeing a Provider With Same Sexual Orientation.....	84
Table 4.10. Lesbian Parents' Preferred Gender of Their Health Care Provider	85
Table 4.11. Chi Square Goodness of Fit Test for Sexual Orientation	85
Table 4.12. Chi Square Goodness of Fit Test for Preferred Gender.....	85
Table 4.13. Inter Rater Agreement on Quality of Care Received.....	87
Table 4.14. Were Lesbian Parents Satisfied With Care Received?	87
Table 4.15. Reasons Lesbian Parents Were Dissatisfied With Care Received.....	88
Table 4.16. Lesbian Parents' Ranking of Empathy/Understanding From Provider	89
Table 4.17. Lesbian Parents' Opinions on Whether Their Health Care Provider is Empathetic to LGBT Needs	90
Table 4.18. Cohens Kappa and Frequencies for Lesbian Parents' Criteria and/or Methods Used to Choose Their Present Physician.....	91

Table 4.19. Physician Characteristics/Traits Important to Lesbian Parents in Selecting Their Current or Previous Physician	93
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LIST OF FIGURES

Figure 4.1. Schematic diagram of social identity theory's basic principles	30
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CHAPTER 1. INTRODUCTION TO THE STUDY

Introduction

The health care delivery system in the United States represents a massive subsection of American society with estimates that it accounts for 6% of the national economy. A large part of the health care reform debate centers around improving access to medical care for all members of American society (Gruber, 2010). Physicians are the center of most ambulatory and inpatient processes. Patients often decide on care choices based on their physician's opinions and suggestions.

The development of a trusting and open relationship between patient and physician can be a lynch pin in patient satisfaction, perceptions of quality of care, involvement in decisions involving treatment, and lessening medical malpractice claims. Thus, the concept of familiarity with diverse social groups and family types is an important variable for physicians as they establish relationships with their patients. The more comfortable a physician is with the patient, their issues, and needs, the better the flow of interaction and communication.

Individuals who identify as lesbian, bisexual, gay, and transgender (LBGT) comprise one of the social groups who seek health care for themselves and their families. These individuals are often considered a social minority because of their sexual orientation. Based on this status, one can speculate whether physicians are understanding of diversity in sexual partner and non-traditional family constellation. Daley's (2003) research explored hospital policies and physician practices with regard to treating all females as heterosexual. One observation she made was "heterosexuality is so insistent that practices within the health care settings don't provide the opportunity for any

expression of diversity or difference. . . . A failure to acknowledge the assumption of heterosexuality fosters the invisibility of lesbians” (p. 105).

This writer spent a research internship reviewing both quantitative and qualitative data from a 2003 unpublished study by Drs. Lucy Mercier and Rena Harold. The study surveyed almost 200 lesbian mothers on a variety of health care related issues. One topic that revealed a need for further research was the relationship lesbians have with their primary physicians, specialists, and the implication of the relationship on medical decisions. The preliminary data revealed only 30% of all respondents were open with their own physician or children’s physician with regard to their sexual orientation and family structure. The data led to several questions with regard to lesbian mothers and families when they enter and negotiate the health care system, and new choice of physician.

This study explores the perceptions and preferences of lesbian parent families, as they choose and interact with physicians for self-care, and care for their partner and children. The importance of these perceptions also lies in how they interface with the physician’s belief system and interpersonal style. These variables can impact a patient’s perception of care and the overall interaction with their doctor. The focus of this study was to engage lesbian mothers around their perceptions and opinions of the patient/physician experience, based on sexual orientation. As the American medical care system edges slowly toward greater emphasis on wellness and primary care practice, the outcomes of the study will assist in adding data to the paucity of research which currently exists on how medical care professionals can most effectively interact with members of

the lesbian, gay, bisexual, and transgender (LGBT) community, and with lesbian parents in particular.

The central theme of the study's focus is primarily health service exploratory research, aimed to identify core competencies needed for culturally competent care of lesbian parents and their children. Data collection sought these women's perceptions, in an attempt to identify and define patient identified physician (or provider) characteristics that support the strongest possible therapeutic relationship. The outcomes of the study can help determine educational and clinical components of an effective curriculum for medicine, social work, and other related health professions.

Background

The concept of familiarity with diverse social groups, and in particular social minorities, is pertinent when considering the health care needs of lesbian, gay, bisexual, and transgender individuals. Regardless of the caregiver's belief system, the LGBT patient's perception of their physician and the physician's attitude toward them can affect the progress of any treatment plan. The dynamics of this relationship gain additional importance when you introduce children into the relationship. Lesbian parents who are making health care decisions both for themselves and their children must navigate the patient-provider relationship for themselves and their children. As an example, if lesbian mothers feel any concern about consequences for themselves or their children that might result from disclosing their sexual orientation, communication between the patient and care provider will be limited.

Although Harrison and Selengio (1996) proclaimed health care professionals should structure their continuing education such that they reassess their cultural

sensitivity as well as their attitudes toward the LGBT population, there is only limited education about cultural sensitivity for medical students pursuing their degree. Sanchez, Rabatin, Sanchez, Hubbard, and Kalet (2006) noted the benefits of such education early within a physician's medical training, stating "medical students with increased clinical exposure to LGBT patients tended to perform more comprehensive histories, hold more positive attitudes towards LGBT patients and possess greater knowledge of LGBT health care concerns than students with little or no clinical exposure" (p. 27). Despite this, there remain gaps in medical education that effect treatment orientation and attitudinal orientation toward LGBT individuals and their families.

Brotman, Ryan, Jalbert, and Rowe (2002) argued that although there have been many changes in the last 20 years toward acceptance of LGBT patients by health care providers, they still point to marginal acceptance.

Health care professionals, institutions, policy makers and researchers continue to marginalize LGBT people. At best, the health care and social service system has attempted to create a semblance of "neutrality" in health policy and practice and research based on the ideological belief that health care must be accessible to all, regardless of sexual orientation . . . However this inattention to sexual orientation can be equally harmful, especially in an environment that continues to be marked by homophobia and heterosexism. (p. 2-3)

The main source of diagnosis and treatment in health care has been the physician, historically, a White male. This pattern is changing, as more and more women enter medical schools and the profession. "Paternalism invested the physician with great control and independence in deciding about care" (Crenner, 2001, p. 229). A paternalistic health care delivery system assumes that the values, prejudices, and stereotypes held by individual physicians will be transferred to the patients they treat (Emanuel & Emanuel, 1991). Research has also been conducted to measure homophobic attitudes and opinions

in nursing professionals. Early studies demonstrated some physicians and nursing staff who resisted caring for patients because of their racial and social status (Gonser, 2000).

This research project includes a review of the historical and theoretical aspects of discrimination in health care based on minority status and social identity. Particular focus on discrimination against gay and lesbian patients is explored. A backdrop of the historical aspects of medical social work and the impact of physician attitudes and communication styles are presented as causal factors impacting patient satisfaction with care delivery. Implications for research, policy, and social work practice are discussed. The relevance to social work is particularly important, as more openly gay patients and families enter the health care delivery system. “Homophobia and heterosexism pervade the health care system and its sociocultural context. Social workers throughout the health care system have a responsibility to help eliminate the barriers to adequate and competent health care” (Peterson & Bricker-Jenkins, 1996, p. 43).

If LGBT patients are considered differently than heterosexual patients by health care providers, then one can understand a lesbian’s perceived lack of visibility within the American health care system. Mravcak (2006) identified lesbian and bisexual women as being confronted with three major barriers to health care:

1. Hesitancy of physicians to inquire about sexual orientation,
2. Hesitancy of lesbians and bisexual women to disclose their sexual behavior,
3. Lack of knowledge, comfort, and research regarding health issues specific to lesbians and bi-sexual women. (p. 2)

In Daley’s 2003 qualitative study on lesbian identity within health care settings, the research cites several medical practice implications based on the outcomes in the study. An important finding is that female heterosexuality continues to be assumed by health care providers leaving the onus with lesbians to “out” themselves. Additional

standards of visibility for lesbians vary by health care setting with lesbians having to do the research on which providers will be “safe” for them. Health issues directly related to lesbian sexual orientation have been not researched or generally addressed by physicians.

Trettin, Moses-Kolko, and Wisner (2006) authored a paper that highlights health care disparities between heterosexual and LGBT individuals. They also emphasize the lack of research conducted with lesbians, and their physical and mental health needs. “We acknowledge barriers that distance lesbian women from research and health care, and emphasize the importance of moving beyond these barriers to fill in gaps of knowledge about the specific health care needs of this minority population” (p. 67). Acknowledging this, the basic aim of this research study was to garner detailed qualitative information from lesbian parents to answer questions about physician choice and subsequent relationship and trait variables.

Problem Statement

Communication is the foundation of any strong patient-provider relationship. Physicians can only provide effective care and treatment when they are fully informed of all relevant health, psychological, and social background information, including a patient’s sexual orientation. Unfortunately, the uncertainty felt by many LGBT individuals in disclosing their sexual orientation may make them less likely to reveal it. The consequences of this failure to disclose can result in other limitations in communication. In turn, the patient-provider relationship suffers unnecessarily, potentially limiting treatment effectiveness, and contributing to misdiagnoses that can be problematic and expensive.

The fear of coming out to health care providers is not an unjustified one. The articles reviewed for this study indicate that discrimination engendered by homophobia and heterosexism is a barrier often confronted by gay men and lesbians when they consult a health care professional. "Homophobia and heterosexism, in fact, are the most common forms of discrimination in the health care system" (Brotman et al., 2002, p. 7). Until LGBT patients feel confident that the provider from which they seek care will treat them without prejudice or judgment, such lapses in communication will continue.

The problem this study seeks to address is the limited knowledge base about which patient-identified physician characteristics support the strongest possible therapeutic relationship between physicians and lesbian parents and their families. This information is important to both the mother and to her children, as she navigates the health system on both her own behalf and on behalf of her children. Understanding the qualities that a lesbian parent seeks in a physician can result in better relationship matching of patient and doctor, which in turn may support better health outcomes for mother and child.

Bonvicini and Perlin (2003) produced a compelling reason and rationale for clinicians to better understand the unique needs, characteristics and differences of lesbian families. In the conclusion of their article, they proposed the following:

The primary goal of raising awareness, providing knowledge, and facilitating communication skills in clinicians is to improve the health care and health outcomes of patients--in this case, gay and lesbian patients. Sensitizing clinicians to the unique health and psychosocial needs of gay and lesbian patients should increase their level of confidence in providing care to these populations. Patients who are satisfied with their healthcare experiences are more likely to participate in routine healthcare and adhere to medical recommendations. Patients who feel understood, respected, and confident in their clinicians' communication and technical skills, in partnership with their clinician, comprise a highly effective collaboration likely to produce positive patient health outcomes. (p. 120-121)

Basic Research Question

This study is driven by a single research question: What are the characteristics of relationships from the patient's perspective for lesbian parent families and their health care provider of choice which influence decision making about choosing a health provider and lead to a perception of high quality care? This question is supported by five related sub-questions, which are:

1. Is there a difference in lesbian parents' perception of health care relationship quality between those who are "out" and those who are not?
2. Do lesbian parents prefer physicians/providers of the same gender or sexual orientation as themselves and does the physician provider's gender influence the relationship from the perspective of the lesbian parent family?
3. What are the traits of a particular physician that lead lesbian parents to make the decision to seek care from him or her?
4. Do lesbian parents feel they receive quality health care for themselves and their families?
5. Do lesbian parents feel they receive sufficient empathy when receiving health care from physicians as opposed to other providers?

These questions were addressed through a mixed method design that began with a self-administered mailed opinion survey that assesses the perception of physician health care delivery among lesbian parents. Based on the survey results, volunteer respondents were contacted to participate in interviews to gather additional qualitative information about their perceptions and experiences with regard to health care delivery.

Design Overview

The purpose of the study was to survey opinions of lesbian parents on their perception of physician healthcare delivery for themselves and their children. A subset of information on whether they have come out to their health care provider(s) about their sexual orientation was also collected. The hypothesis was that the less familiar or comfortable lesbians are with the physician, the less likely they will be to reveal their sexual orientation or to discuss their family constellation. This, in turn, may make some women more reluctant to seek medical attention for themselves and/or their children. Upon completing a short questionnaire, the second phase of the study involved a sample of respondents who were willing to participate in interviews or focus groups conducted at a later time. Those who volunteered for this part of the study were contacted subsequently by the investigators. Details on sampling and study methodology are found in Chapter 3.

Significance of the Study

Presently, little is known about the factors that influence a lesbian mother's choice of health care provider. Even less is known about physician characteristics that are influential in the development of a long term relationship between a lesbian mother and a physician. A better understanding of which provider characteristics best support a strong collaborative patient-provider relationship for lesbian mothers can improve treatment outcomes for this population and perhaps be used to contribute to medical education in the area of cultural sensitivity and diversity training. Such information can also provide insight into the forms of advocacy and support most beneficial to lesbian parents and their families in fostering productive health care provider relationships.

Hinchliff, Gott, and Galena's (2005) study of general practitioners found respondents lacked knowledge on sexual practices of the LGBT population and that this lack of knowledge created barriers, making physicians feel ill equipped to deal with issues specific to gay and lesbian patients. The authors reported that physicians felt "lesbians and gay men were the outsiders" (p. 348) and provided additional respondent quotes as exemplifiers of the lack of comfort on the part of the physicians with gay and lesbian patients. Here are anecdotal examples:

They [lesbians] make me feel uncomfortable. I find them slightly aggressive. I'm not trained. I do find them a problem because I think they are pushing me to one side, I'm not a part of their world and I'm an outsider. (Female, 34241, age 55 years)

Homosexual relationships I find a bit more difficult, prescribing Viagra for homosexual men I think is a bit dubious . . . I think it is a slightly inappropriate use of resources really but it is probably my prejudices, I'm prepared to admit that . . . particularly if they are not in a stable relationship, I don't see appropriate. (Male, 14131, age 50 years)

The above quotes provide anecdotal examples of the concept that homosexuals, when viewed as an out-group, will be labeled with mistrust and prejudices. Peterson and Bricker-Jenkins (1996) summarized the issue, saying "It is impossible to be raised in the United States and not be heterosexist. Our images and language are bound to the assumptions of heterosexuality" (p. 44).

In an exhaustive review of lesbian health, Bernhard (2001) sadly began her summary section with the following quote: "The principal conclusion of this review is that very little is known about lesbian health" (p. 167). The author cited the following findings regarding lesbian healthcare:

- Little formalized education on LGBT health care issues existed in either medical or nursing school curricula.

- There is a paucity of research solely dedicated to the impact of lesbian ‘coming out’ and physician or other provider reaction (other than negative).
- The infrastructure that exists within health care is inherently driven towards heterosexual patients, and hence, it discriminates against sexual minorities. This phenomenon is prevalent in visiting policies, next of kin designations, forms, communication patterns, and attitudes from the health care team.
- Lesbians are less likely to seek care when a negative experience has occurred. (pp. 147-152)

Bernhard’s findings are corroborated by Peterson and Bricken-Jenkins (1996), who stated that research with respect to lesbians within the health care system is almost non-existent. They stated,

The limited research focused on lesbian health care has centered around the attitude of health care providers towards homosexuality. The differences are directly related to the homophobia and heterosexism that pervade the health care system and its socio cultural context. (p. 35-43)

The paucity of research and published literature around lesbians and health care results in a lack of information around lesbians, their families and health care experiences. Thus, this study seeks to better understand and clarify physician characteristics that may influence communication and relationships between physicians and lesbian families. This information has significance for future social work education, curriculum content, field placements, and practice methodology as it relates to lesbians and their clinical relationships with health and mental health providers. The study will also benefit medical education. Before engaging in a physician—patient relationship, practitioners may benefit from increasing their knowledge and understanding of the lesbian mother, her values, and priorities as it relates to herself, her partner, and her children.

Definitions

The definitions used in this study are in accordance with accepted terms within academic literature, as well as Merriam Webster's Collegiate Dictionary, 10th edition (1995).

Doctor: one who holds an advanced degree, and is licensed to practice (e.g., physician).

Gay: a homosexual male or female.

Heterosexism: discrimination or prejudice by heterosexuals against homosexuals.

Homophobia: an irrational fear of aversion to, or discrimination against homosexuality or homosexuals.

Lesbian: homo-sexual female.

Lesbian mother: a self-disclosed gay or bi-sexual female who is raising minor children in her household.

Lesbian parent: a lesbian who is parenting children with or without a partner in the household.

LGBT: for lesbian, gay, bi-sexual, or transsexual individual.

Medical social work: social workers who interact in a health delivery setting or host setting with physicians, nurses, and allied health staff.

Medical social worker: a Bachelor's or Master's level social worker employed in an acute, ambulatory, long term, or home care host environment.

Minority: a part of a population differing from others in some characteristics and is often subjected to differential treatment.

Partner: the identified second person in a dyad relationship. A person with whom one shares an intimate relationship.

Paternalism: a system under which an authority undertakes to supply needs or regulate conduct of those under its control in matters affecting them as individuals as well as in their relations to authority and to each other.

Physician: one educated, clinically experienced, and licensed to practice medicine.

Assumptions, Limitations, and Scope

As with any research, this study relied upon a number of assumptions. These include:

1. Many potential participants contained within this study also participated in a 1999 and 2003 survey about lesbian parenting. It is assumed that the respondents will also agree to complete another survey, and be willing to be interviewed if asked.
2. Women asked to participate in the survey were actively involved with a physician, and had opinions with regard to that relationship.
3. Lesbian parents had their children actively involved with a physician.
4. The written survey and subsequent telephone interviews would elicit appropriate data and information to test the research questions contained in this study.

Similarly, the study was also naturally constrained by a number of limitations that include:

1. Written surveys can have a very low return rate. Significance of data collected may be reduced if questionnaires are not completed and returned by potential respondents.
2. The survey is not bolstered by precedence within scholarly research or literature as lesbian families have not been widely studied.
3. The population being surveyed is largely homogeneous in race, income, and education. Thus, studying diversity within the research is very limited.
4. Exploratory research in and of itself presents inherent limitations, when considering quantitative results and extrapolations to a larger population.

Scope of Study

The scope of this study used a modified snowball sampling technique to re-recruit up to 80 respondents who completed a lesbian parent study in 1999, results from which were published in the dissertation of Lucy R. Mercier (1999), entitled *Lesbian Mother Families: A Qualitative Study of Perceptions of Institutional and Interpersonal Support*. The respondents of this study completed a survey to gather information on demographics, age, relationship status, family composition, and descriptive data on their health care experiences, and provider. The second focus of the study was comprised of data gathered in a structured telephone interview with a subset of respondents to elicit more specific information on their relationships with physicians and the physician characteristics they deemed important within their relationship with their physician.

The assumptions and limitations associated with this study must be acknowledged and considered, but do not exceed the standard constraints of any small-scale study like this. Thus, these factors are recognized within the context of the conclusions and how

they may influence the validity and reliability of conclusions drawn. Implications for research, policy, and social work practice will be discussed in accordance with the results and subsequent analysis.

Summary and Organization of the Study

This chapter has provided an overview of this study which seeks to provide insight into the characteristics that lesbian parents seek in identifying health care providers for their families. This study includes a review of the historical and theoretical aspects of discrimination in health care based on minority status and social identity. Particular focus on discrimination against gay and lesbian patients will be explored. A backdrop of the historical aspects of medical social work and the impact of physician attitudes and communication styles will be presented as related topics concerning patient satisfaction with health care delivery. Chapter 2 discusses the review of related literature in regard to health care delivery relationships, LGBT patients, and lesbian parenting. Chapter 3 describes the study participants, the instruments used, the research design, selecting and description of sample population, and the procedures and methodology used in the study. Chapter 4 discusses the results of the mixed method analysis, including an overview of the survey results and the coding of interviews. Chapter 5 discusses the findings of this study, the implications and limitations of this study, the recommendations for future research, and the relevant conclusions that can be drawn from this study.

CHAPTER 2. REVIEW OF THE LITERATURE

Introduction

This chapter reviews the historical and theoretical aspects of discrimination in health care based on minority status and social identity. Particular focus on discrimination against gay and lesbian patients will be explored. A backdrop of the historical aspects of medical social work and the impact of physician attitudes and communication styles will be presented as predictive factors impacting patient satisfaction with care delivery. This writer has experience as a medical social worker and feels it is important to inter-relate the social work role as an advocate with patients and their families.

Patient satisfaction and its influence on health care decision making for lesbian parents families are explored. Implications for research and social work practice are discussed. The relevance to social work is particularly important as more openly gay parents and their families enter the health care delivery system, often needing psychosocial support in a system that is ill equipped to meet their needs. Research on this topic can further educational and academic endeavors regarding such needs, and provide information on a scarcely studied subject.

The Evolution of Medical Social Work

Social work, as a profession, has been involved with micro, mezzo, and macro practice issues that impact individual, group, and community systems. Social workers in health care most often assume a role that involves interfacing with both the patient and the health care providers to link parties to necessary resources. This writer views the role of a medical social worker as it relates metaphorically to the role of an orchestra

conductor. Facilitation of diverse and often dissonant attitudes, actions and opinions can be a delicate art. Social workers can provide a vital link between patients and providers, and aid in establishing and maintaining a productive relationship between the two. Often, the social worker may be the most unbiased player in the triad because diagnosis, treatment, and judgments are typically dictated to patients and their families by the physician. The power differential that is often in play between patient and provider can be negotiated and bridged by a skilled social worker. This vital role is perhaps most important when working with patients who, due to lack of education, funds, or social standing, feel most vulnerable when they enter the health care system, or with those who are a part of groups who may be marginalized within the health care system. With respect to lesbian parents engaging with physicians and the health care system, Dr. Lucy Mercier's 1999 study indicates that over 70% of lesbian parents surveyed did not feel support from their physician. The perceived lack of support can correlate to many perceived real problems for lesbian parents and their families as they relate to physicians.

The underpinnings within the profession of social work in health care have been categorized with purposes like advocacy, assessment/intervention, and brokering services for oppressed groups and individuals (Cabot, 1907). The evolution of medical social work began with Ida Cannon in the early 1900s (Bartlett, 1975). Her efforts at Massachusetts General Hospital created the first recognized hospital based social work department. The caseloads of early hospital social workers included communicable diseases, (tuberculosis, venereal diseases), unwed teens, and the social minorities who ended up in the hospital. Cannon was a pioneer in introducing social work to hospital

care and in underpinning the importance of also treating the psychosocial aspects of illness. As stated by Cannon's colleague Dr. Cabot,

The social worker once thoroughly equipped and recognized as an expert in the understanding and management of the weaknesses and perversions of character. . . . The average social worker is, in my opinion far better equipped to treat neurasthenia than the average physician is. The mental and moral aspects of such cases altogether overshadow their physical aspects, and problems of occupation, of encouragement, of foresight, hindsight, and of responsible living are just what the social worker is constantly encountering. (Cabot, 1907, p. 1010)

Medical social workers are well documented in the literature for interventions with at-risk patient populations. Cannon's efforts provided a source of advocacy within a highly paternalistic health care system that was populated and governed primarily by White males. "Paternalism invested the physician with great control and independence in deciding about care" (Crenner, 2001, p. 229). Such a system assumed that the values, prejudices, and stereotypes held by individual physicians will be transferred to the patients they treat. Attitudes toward racial minorities are documented to be similar to Crenner's findings (Benkert & Peters, 2005). These findings reinforce the continuing need for advocates within the health care system who can negotiate the cultural differences and assumptions between patient and provider. They also highlighted the importance of advocacy with oppressed or minority groups, a pivotal role of social work into the 21st century.

In a 2004 study, Blanchard and Laurie found a high number of patients who had negative perceptions of the patient-physician relationship were subsequently less likely to seek needed care. They recommended research focused on what approaches can best improve perception of care with social minority groups. This study follows their advice in

that one of the central purposes is to seek clarification on lesbian parent perceptions of positive relationships with their physician.

Managing Discrimination in the Health Care Setting

The health care delivery system is a microcosm of society. Any sense of prejudice, stereotypes, and discrimination contained within the larger social spectrum has the potential to be mirrored within the medical profession. One of the primary aims of medical social work is to serve as an advocate for all patients, including minorities of all types who risk entering the health care system at a disadvantage. This chapter documents that health care has a long history of marginalizing populations based on race, socioeconomic status, gender and sexual orientation.

The following sections explore the history of health care systems/provider discrimination toward minority populations. The purpose of this exploration is to create parallels between the experiences of LGBT patients with those of other minority groups, and in so doing, to highlight the common experiences among minority populations and the need to better identify and understand the variables that may impact the real or perceived quality of their care.

Health Care Discrimination Based on Racial Minority Status

Racism in health care has a detailed history. “For as long as records have been kept, studies have reported racial differences in health care access and health status in the United States” (Otterson, 2005, p. 738). The most researched aspect of discrimination in health care is racism. Clark, Anderson, Clark, and Williams (1994) defined racism as “beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliations” (p. 867).

They further commented that discrimination is the behavior formed from racism and is expressed through actions that limit opportunities, or deny equitable treatment to individuals or groups. Research on discrimination based on race is an important review for this study. Documentation on a historically identified social minority can correlate to other social minorities within U.S. health care.

Disparities in health care delivery to the African American population began with slavery. Considered property rather than human beings, slaves were subjected to their master's desire or ability to avail them of health services. Poor living and environmental conditions contributed to poor health and to a high mortality rate for the slaves. "Descriptive accounts suggest that elevated mortality rates of slaves were associated with terrible living conditions of most slave quarters and diseases such as dysentery, cholera, pneumonia, and tuberculosis" (Scott & Heslin, 2003, p. 1348). Although slavery was abolished at the end of the Civil War, inferior treatment of former slaves continued, both socially and within the policies and resource distribution of the United States government.

Jim Crow segregation, begun in 1875, did not end until the civil rights legislation of the 1960s. During this period, public health ignored the needs of African Americans. Outterson (2005) observed that public health laws and practices were laced with social Darwinism against African Americans. The focus on health care for the African American population was not on the health of that particular group, but on protecting the health of the White population. Brunner (1915) asserted that during the latter part of the nineteenth century, health care for Blacks was primarily important only to stop a spread of communicable diseases to Whites, stating

There are 5,000 or more Negroes in this city who are parasites, and their removal would lower the death rate and reduce crime; therefore it is recommended that some remedy be applied by enacting building laws preventing the congestion of Negroes and the elimination of the depredating class. (p. 185)

Such attitudes persisted throughout the public health and medical communities.

From 1932 to 1972, the United States government conducted the infamous Tuskegee Syphilis study, during which nearly 400 African American men were unknowingly denied treatment for syphilis in order to conduct research on the longitudinal effects of the disease (Gamble, 1997).

Discrimination based on race and group identity was further exemplified in World War II. Although Black soldiers fought for the United States, they had segregated quarters, and battalions. The American Red Cross practiced racial segregation of blood plasma. In a 1942 cartoon, an injured White American soldier is told by a Red Cross staff “you might as well wait here--we ain’t got nothin’ but Negro blood” (Wailoo, 2006, p. 532).

Fifty years after the publication of that cartoon, the Institute of Medicine (I.O.M.) published a study of racial and ethnic health disparities (Smedley, Stith, & Nelson 2002). The study cited over 100 prior studies noting a wide range and high incidence of health care discrimination. The report states that people belonging to racial and ethnic minorities often receive a lower quality of care, even when income and insurance are equal to Whites. Wailoo (2006) highlighted the historic perspective of African Americans as a “tainted” group, with Blacks viewed as carriers of disease and illness. The stigma associated to a minority group persisted into the late 1970s, and revived when the AIDS and HIV epidemic entered United States health care. Wailoo stated:

Over time, stigmas associated with group identity have accentuated, and been accentuated by, disease associated stigma. Medical science, from bacteriology to genetics has fed into the process of stigmatizing individuals, by designating hidden invisible taints and thereby reinforcing broader prejudices and policies. (p. 533)

African Americans, as well as other identified minority groups, have suffered from undeserved biases, labeling, and stereotypes. These components synthesize into provider behaviors that actively or passively promote inequity in the care and clinical processes (Otterson, 2005).

Although African Americans are not the only racial minority to experience aspects of discrimination in the United States health care system, they have the longest history. Not only is documented discrimination evident in delivery of clinical care to minorities, but also in the decades of inferior research with respect to diseases associated with African Americans, such as sickle cell anemia. No other American minority has endured such a longstanding documented experience of discriminatory treatment based on minority or group status and identity (Otterson, 2005).

Discrimination in Health Care Based on Non-Racial Minority Status

Race is only one factor that invokes practitioner bias and discrimination. Being identified as a societal minority is shown to increase the likelihood of stereotyping and creates tendencies for prejudicial health care delivery (Ashforth & Mael, 1989). A recent study on health care services to the homeless population revealed that homelessness and low social class were commonly cited as the perceived basis for discriminatory treatment (Wen, Hudak, & Hwang, 2007). The same finding is evidenced in a study published by LaVeist, Rolley, and Diala (2003), who found “females were more likely than men to

report health/disability discrimination. Individuals with poor health were at increased risk of being victimized by age, health/disability, race, and income discrimination” (p. 339).

Low socio-economic status (SES) has been shown to be a contributor to discrimination in health care. In a 2004 published research study, Woo, Ghorayeb, Lee, Sangha, and Richter (2004) studied first and second year medical student perceptions of low socio-economic status (SES). The findings were significant. Most of the respondents had negative perceptions of the low SES patients in several areas. The authors pointed out that the physicians in training mirror their counterparts in practice. “Physicians are more likely to perceive low SES patients as being less intelligent, responsible, rational, physically active, and compliant” (p. 1918).

Identification as a patient with a chronic illness may also invoke perceived or real provider discrimination. Piette, Biddings-Domingo, and Shillinger (2004) surveyed over 800 diabetes patients to test for perceived discrimination in health care as it related to the interpersonal processes of care. Other variables studied were: race, education, income, age, and gender. Results indicated that patients with poorer than average ratings of their interpersonal relationship with their physician were more likely to perceive discrimination. Specifically, they cited lack of communication, and attitudinal issues from the physician as key variables of poor patient satisfaction. The recommendations that evolved from the study included:

- Both providers and patients shape their encounters and both parties can contribute to patients’ perceptions of discrimination within health care settings
- Provider bias may take the form of overt prejudice or stereotyping occurring below the level of conscious awareness
- Physicians must be aware that their practice style is interpreted by patients within the context of their societal experience and preconceived notions regarding medical care

- Mistrust of physicians may be high among traditionally disenfranchised populations. (p. 46-47)

LGBT status as a patient will be discussed in other sections of this paper. It is important to note, however, that in the limited literature available, the variables of prejudice and mistrust of health care as a system, are evident. Bernhard (2001) suggested that little has changed in health care for lesbians, and that there exists an urgent need for additional research. “Many lesbians feel unsafe in health care interactions” (p. 169). Bonvicini and Perlin (2003) recommended that physician communication with gay and lesbian patients must include strategies to provide a safe and welcoming practice environment. The communication includes consideration of partner and family relationships, as well as emphasis on confidentiality.

The aforementioned recommendations from the literature highlight the importance of effective communication between health care providers, patients, and for the purpose of this study, lesbian parents. Physician communication is often the greatest determinant of the perceived quality of the health care relationship, yet there are substantial barriers to effective communication between patient and provider. The following sections discuss the role of physician communication and the prevailing influences on the quality of the patient-provider relationship.

Physician Communication and Patient Engagement

The practice of medicine is both skill and science. Despite extensive scientific knowledge and skills, one of a physician’s most powerful assets is the quality of communication and dialogue he/she has with a patient. With increasing specialization in the medical field, a patient may only see a physician for a limited number of visits. Thus, the technical nature of the relationship takes precedence over patient centered care

(Smith, 2002). In a study of physician communication issues, patient and physician interface--or lack thereof--was found to be the single most common cause of lawsuits against physicians and hospitals (Wolraich & Reiter, 1979). The literature suggests that, despite the importance of effective communication in the patient-provider dynamic, physicians are traditionally poorly trained in this area. This lack of preparation is only made more evident when patients of diverse backgrounds further challenge the physician's ability to successfully interface with their patient and/or their patient's partner or family.

Brody et al. (1989), in their analysis of patient satisfaction with physician services sought versus those received, underscored the importance of what they called "communicative" interventions. The authors used a series of variance measures to evaluate the effects of pre visit desires, and post visit satisfaction. The following variables were associated with greater satisfaction of physician services provided: negotiation, education, non-drug treatment, and wanting and receiving stress counseling.

The Brody et al.'s (1989) findings were that patients were more satisfied when they were educated about their medical problems and were able to discuss their ideas and life stressors. Those who felt they had not received any or all of the "communicative" interventions were less satisfied with the physician. The findings contrasted the "technical" intervention correlation (i.e., ordered tests treatment, etc.) that is so often the centerpiece of physician communication. Patients' perceptions about examinations, tests, medications, and non-drug treatment were only minimally associated with levels of satisfaction with their physician. The study provides a rationale as to why a non-participatory communication model is not effective, and emphasizes the patient's desire

for a physician who engages them as an active part in their care, and listens to them as a non-judgmental professional.

Emanuel and Emanuel's (1992) study of physician-patient relationship types found that the traditional "guardian" role often taken on by physicians, whereby patient choice and control is minimal, leads to dissatisfaction among patient populations. Furthermore, the guardian model is also most pervasive with patients who do not display dominant characteristics of the societal in-group. Lastly, the paternalistic method of communication is used more often with racial minorities, patients with lower SES, and women.

A paternalistic style isolates patient needs and concerns. The traditional nature of medical education endured this type of physician communication style for decades. The dominance of the physician in the communication messaging limits any probability of patient participation. Cassell (1985) asserted that communication as a skill has never been allowed "in the halls of scientific study . . . the spoken language is the basic tool of doctor patient communication" (p. 67). Medical school and residency training has traditionally hardwired physician communication as a paternalistic dominant approach to obtaining patient information regardless of physician gender (Emanuel & Emanuel, 1992). As an adjunct to this reality, patients have historically accepted a one way paternalistic dialogue, with little attention paid to patient satisfaction. The paternalistic model is more prevalent among social minorities, or as Cabot (1907) equated years ago, "patients with bad habits" (p. 1006).

Babrow and Mattson (2003) emphasized that despite a large body of health communication theory, little has been accomplished with application. They cited the

continued tension between science and humanism. Adherents to the biomedical model exemplify tensions between traditional scientific imperatives, the significance of human mental realities, and human meanings of disease. The science of medicine must be matched with the art of understanding the human condition and communicating to patients with empathy.

The application of a model that emphasizes a more personalized, deliberative physician communication style alleviates the limitations of the biomedical model. It not only promotes patient involvement, but will increase patient satisfaction with care. Conversely, physician communication styles high in control and low in interaction with patients are more likely to produce lower satisfaction.

The importance of a strong, interactive communication between physician and patient is clearly found in research cited by J. B. Brown, Stewart, and Ryan (2003). Patients in their study who reported physician low attention to patient problems and gave inadequate explanations were 38% less satisfied than patients who had a chance to provide feedback and connect to the physician.

The rise in the last 20th century of patient as consumer has added a new element to the physician-patient relationship. Minority patient groups are now being educated to challenge medical stereotypes and constrained communication patterns. Patients are now also becoming better educated through mass media and the Internet regarding their role, rights, and responsibility in their own care. They have more questions, and want to explore treatment options. Within this health care “paradigm shift,” patients are evolving to expect “a patient focused approach for recognizing individual needs based on diverse elements-including culture, class, and sexual orientation” (Daley, 2003, p. 112).

The overwhelming body of literature points to the need for patients to view the physician as an interactive, empathic consultant/partner in making health care decisions. Physicians also need to be educated on specific needs of patients with different societal, racial, or cultural affiliations. Among patients in general and minorities in particular, one can speculate that lower levels of satisfaction will be correlated with more traditional paternalistic physician styles. Language, attitude used, non verbal stance, and messaging between patient and physician is a key area for future exploration and meaningful scholarly contributions to better understanding variables that contribute to a successful physician-patient relationship. This is one of the aims of this dissertation. As both patient and physician population change and become more diverse, opportunities for new areas of research and education in health care curriculum and training abound.

As both physicians and patients become better educated about their respective roles and the expectations each party has for the other, it is important to recognize the role and influence of social forces that are present within the relationship. The following sections discuss the influence of Group and Social Identity Theory, as well as Social Dominance Theory, on the patient-provider relationship.

The Application of Group and Social Identity Theory to Discrimination in Health Care

During the 1970s, social psychologist Henri Tajfel and his associates began work in developing social identity theory. This theory links individual and group identification and offers an explanation of prejudice, discrimination, and conflict based on group affiliation or membership (Tajfel & Turner, 1979). Tajfel and Turner's research is now known as *minimal group paradigm*. The research focused on conditions needed between

two groups to establish favoritism, domination, and discrimination based on one's identity as a group member.

According to social identity theory, identifying oneself as part of a group provides a sense of social validation and belongingness. One can enhance individual self-esteem with pride in one's group identification (i.e., the in-group). The individual can also enhance self-esteem by discriminating against the group to which one does not belong (i.e., the out-group). Social identity theory posits that membership in the in-group will lead to negative behaviors towards the out-group (Tajfel, 1974). Tajfel suggested that placing individuals into groups and categories (stereotyping) is based on normal cognitive processes. When following that line of reasoning, the differences between groups and the similarities within a group may become exaggerated (Tajfel & Turner, 1979). Social categorization is a potent explanation for prejudice in attitude and behavior. It promotes the "us versus them" mentality, which leads to bias and discrimination towards the out-group.

An important aspect of social identity theory that is most relevant is the focus on social categorization and its connection to intergroup discrimination. . . . The mere categorization of individuals and the creation of in-group and out-group is sufficient, according to social identity theory, for discrimination to occur. (Patti, 2009, p. 246)

Tajfel and Turner (1979) identified three processes within social identity theory that create the in/out-group cognition. These processes take place in stages. The first is *categorization*. In categorization, individuals assign people to social categories in order to understand them. Examples of such categories include race, religion, culture, profession, etc. Categories are used to define and expect values, norms, and behaviors. The second process is that of *social identification*. In this process individuals internalize the identity

of the group they choose to belong to and conform to group norms and expectations. *Social comparison* is the third process and final stage. Once the individual has internalized his/her group and social identity, they then compare themselves with other groups. According to the social psychologists, this concept hinges on the human tendency to create competition and hostility towards an out or minority group (Tajfel & Turner; see diagram in Figure 4.1 outlining the key elements of the theory).

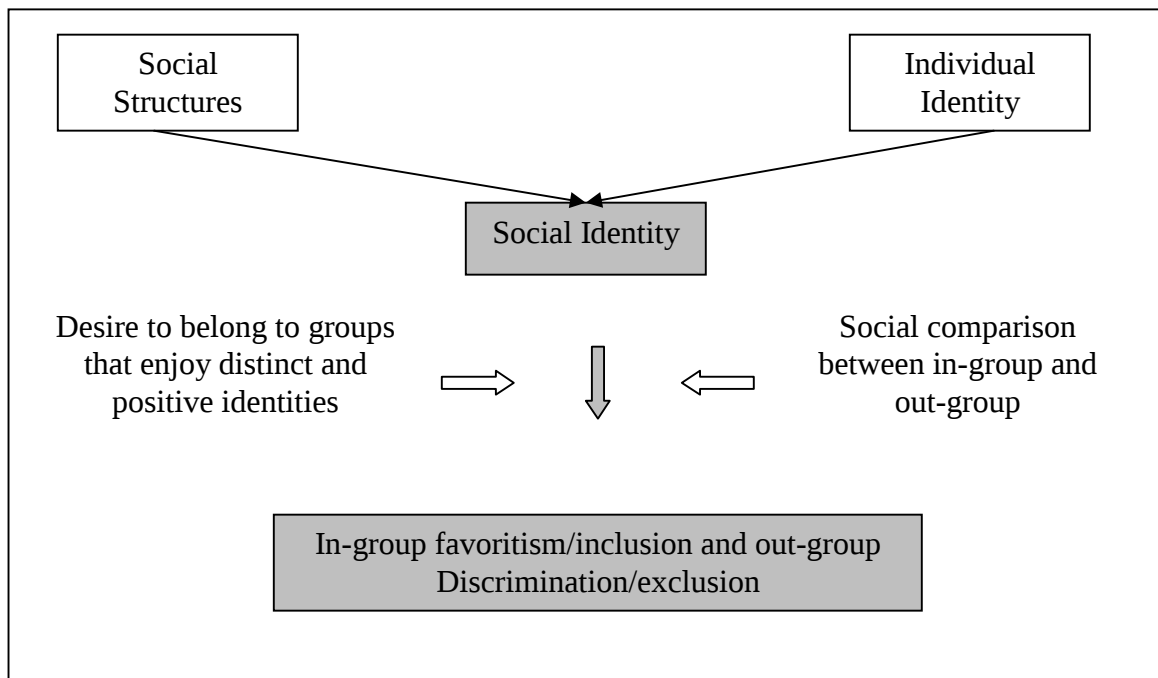


Figure 4.1. Schematic diagram of social identity theory's basic principles. (Patti, 2009, p. 247).

The three stages of social identity theory create fertile ground for application of the theory to the practice of discrimination in the health care system. Patients not in racial, religious, cultural, economic, gender, or sexual orientation in-groups are placed in an out-group status by physician and other health care providers. That status renders them

vulnerable to discrimination and inequities. In a summary of social identity theory, R. Brown (2000) observed that Tajfel was “passionately concerned” with societal problems such as minority rights and racism. He further noted that the theory’s main applications lie in the areas where “groups--be they national, ethnic or religious - are in dispute with each other” (p. 768).

Verkuyten and De Wolf (2007) argued that in-group favoritism and out-group prejudice are formed during childhood. Interesting to note is their assertion that:

In-group favoritism and prejudice do not necessarily decline with age related increases in cognitive maturity as socio-cognitive development theory would predict. One reason is that a dominant group can think and act in terms of the ways in which group distinctions are socially defined. (p. 910)

Tajfel, in his 1982 publication, observed that at a very early age, children from underprivileged groups tend to reflect the social consensus about the status and image of their group by adopting out-group identifications and preferences, while the majority children clearly showed ethnocentric attitudes. Many out-group members do not have a choice in terms of their assigned affiliation. Race, religion, culture, and socio economic status have obvious societal attributes. However, one out-group distinction that may be less obvious is sexual orientation, and this is based on the societal assumption of heterosexism. Unless information and/or appearances of outward behaviors allow other opinions to be created, heterosexism places individuals in the sexual orientation in-group of heterosexual.

Link and Phelan (1995) proposed that lifestyle, individual choices, and socially modeled behaviors within a group (e.g., smoking, alcohol use, exercise, diet, etc.) have a direct impact on illness and mortality. Major variables identified by the authors conform

to group membership as identified by Tajfel, including income, race, gender, social networks, occupation and religion as a construct for a socially identifiable group.

Social Selection Theory and Discrimination in Health Care

Assuming social identity theory as one explanation for out-group discrimination in health care, the sociological construct of *social selection* and causation can also be theorized as a possible cause. Accordingly, the scholar needs to pose questions related to which out-groups in society have less desirable social conditions, and whether that out-group status cause a higher incidence or risk of illness and disease? Related to these questions, other arise. Are societal minorities more likely to contract illness/disease due to the possibility of less fortunate living conditions, poorer access to care, or lack of education around healthy lifestyle choices? Would these circumstances apply equally to members of the LGBT community, in general, and to lesbian mothers in particular?

According to Young (2004), social causation of illness and disease requires a direct correlation to social conditions and interactions. One can look at the ongoing health care reform debate, and the correlation of disease, to no insurance/social minority status, to exemplify that minority affiliation leads in some way to the probability of societal and policy discrimination. The social causation concept assumes that biology and genetics are not the only predictors of disease, morbidity, and mortality. The concept connects social factors, such as SES, religion, and social identity to severity of illness, and risk of disease.

The question of gay and lesbian patients being negatively impacted due to their out-group status can be substantiated in recent literature. Bonvicini and Perlin (2003) argued that gays and lesbians have unique health risks that are important to the physician

when treating, diagnosing, and providing a plan for LGBT patients. However, “many of these health risks are not addressed because of lack of communication based on a number of [inaccurate] assumptions” (p. 115) by the physician.

Bernhard (2001) found that lesbians, regardless of access to care, are less likely to seek care than other women. She also asserted that lesbians delay routine care, as “they are afraid of being discriminated against because of their lesbianism. Their fear may be due to their own bad experience or to bad experiences they have heard described to them by friends” (p. 147).

The Application of Social Dominance Theory to Discrimination in Health Care

Social dominance theory builds on social identity theory. The focus of social dominance theory is on both individual and structural factors that may lead to group based oppression or discrimination (e.g., racism, sexism; Sidanius & Pratto, 2001). The central consideration of the theory is to assess why human society is grouped into hierarchies based on group identification. With this approach, social dominance theory asserts that historical discrimination toward certain groups is caused by systematic structural and institutional discrimination. The key principles of the theory advocate that every society has a system of social stratification. This grouping then causes conflict and oppression towards groups with a position of lower status in the hierarchy.

Patti (2009) observed that the inclusion-exclusion continuum is “linked to important psychological processes such as self-esteem, depression, anxiety, and a general sense that one’s life has meaning” (p. 251). Patti associated out-group status as relevant for members who may suffer psychological consequences of being excluded from the

dominant group. Patti's observation can be linked not only to psychological well-being, but also to physical health and well-being for social minorities.

Sidanius and Pratto (2001) stated that social dominance theory explains individual and systemic discrimination of out-groups. This discrimination is passed on from generation to generation, based on in-group attitudes and basic human predisposition. In using concepts from social systems theory, social dominance theory utilizes constructs in a macro sense, while social identity attributes more mezzo and micro causal factors (e.g., socialization within a family) towards views with respect to groups who have differences from one's own identified group. Further, a distinction between the two theories is that unlike social identity theory, social dominance theory emphasizes the distinction between social status and social power (Sidanius, Pratto, van Laar, & Levin, 2004). Social power relates to imposing one's will on others, while social status is associated with perceived prestige.

Both theories may explain pieces of the impact of institutional and individual discrimination to societal out-groups. Where social identity theory points to in-group/out-group behaviors, social dominance complements the concepts by assimilating more macro concepts such as societal structures, institutional behaviors, and social hierarchies to explain group oppression (Sidanius et al., 2004). The feeling of being discriminated against as an individual may drive one to actually identify with a group to feel more recognized and appreciated. As an example, a minority teen joins a gang to acquire a sense of belonging and power. In a study by Brewer (1991), one's feeling of shame in an individual out-group identity was actually bolstered by identifying with a more macro group identity. Brewer stated:

The basic tenet is that excessive individuation is undesirable--having any salient feature that distinguishes oneself from everyone else in a social context (even if otherwise evaluatively neutral or positive) is at least uncomfortable and at worst devastating to self-esteem . . . What is painful at the individual level becomes a source of pride at the group level--a badge of distinction rather than a mark of shame. Collective identities buffer the individual from many threats of self-worth. (p. 481)

When assessing the realities of discrimination in health care delivery, the epistemological overlay of theory is essential. This writer asserts that social identity theory and the theory of social dominance relate to the historical and current discriminatory practices within the U.S. health care delivery system. The discrimination is based on in-group perception of out-group based traits or group affiliation. Racial, ethnic, cultural, and religious minority group identification is frequently studied. By contrast, sexual orientation and gay or lesbian identification as an out-group status has been mainly invisible in U.S. health care. The next section of this paper explores the unique aspects of health care delivery and discrimination based on sexual orientation.

The Evolution of Health Care Delivery to the LGBT Population

As with the treatment of racial and ethnic minorities, the history of health care provision to LGBT individuals has historically been perceived as discriminatory, with negative attitudes from unsympathetic or prejudiced providers. Unlike racial, religious, or cultural minorities, LGBT individuals have traditionally learned to hide their identities to avoid discrimination. As noted by Trettin et al. (2006) in relationship to this study:

Knowledge about gender differences is growing, becoming incorporated into medical research, and improving health care. However, consideration of sexual orientation remains largely hidden under heterosexual norms and assumptions. Heterosexism pervades research and health care disparities between heterosexual and LGBT individuals. Heterosexism is especially oppressive to lesbian women because they hold the double minority status of being both female and homosexual. (p. 67)

Physicians and health care staff may impose heterosexist beliefs, as it is the norm in the larger U.S. society. The AIDS epidemic of the 1980s brought homosexuality and health care to a crisis point, and the disease and beliefs about HIV and AIDS sparked an overlay of moralistic, judgmental, and negative perceptions that were cast upon the gay community (Hinchliff et al., 2005).

Speight (1995) cited a 1993 survey of over 700 LGBT physicians, 67% knew of gay patients who had been refused care, and 88% had heard colleagues make disparaging remarks about gay and lesbian patients. Speight noted that medicine has had an ambivalent relationship with homosexuals “since it first appropriated the ‘problem’ from religious and legal domains in the late nineteenth century” (p. 142). He also reported that in the United States in the first half of the century, “tens of thousands of homosexuals received ‘evangelical sterilization’, as they were termed ‘genetic undesirables’ in the opinion of the American medical profession” (p. 143).

Indeed, when considering the historical context of physicians and homosexuals, it is important to note that the first two editions of the *Diagnostic and Statistical Manual of Mental Disorders*, published in 1952 and 1968, labeled homosexuality as sexual deviance. The manuals classified homosexuals as child molesters, voyeurs, exhibitionists, and people who commit antisocial or destructive acts (Hidalgo, Peterson, & Woodman, 1985). It was not until 1973 that homosexuality was removed as a disorder by the American Psychiatric Association. “Prior to the APA revision, social work had been guilty of defining homosexuality as an illness, subjecting gay clients to conversion (to heterosexuality) treatment” (Butler, 2004, p. 27).

Comparison of Heterosexism to Racism and Out-Group Status

With social identity theory as a theoretical framework, a comparison can be drawn between racism and the concepts of homophobia or heterosexism. As previously iterated, racism can be defined as beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups based on ethnic group affiliations (Clark et al., 1999). Within social identity theory, Blacks, ethnic, and social minorities serve as the out-group. The dominant in-group of the White male majority create perceived norms about the out-group that are negative, and create inequities toward the out-group within the societal context of haves and have-nots. Thus, there are similarities between the social structures to which racial minorities and homosexuals are assigned. Just as with racism, homosexuality provoked the historic social and cultural oppression imposed by the dominant in-group, that is heterosexual America. Compared to definitions of racism and subsequent discrimination and prejudice, the definitions of homophobia and heterosexism contain correlate constructs. Even within a minority group (e.g., Hispanic, African American), being homosexual can be a negative with the out-group members.

Weinberg (1972) defined homophobia as the fear and hatred of those who are or presumed to be gay or lesbian. Morrow (1996) defined heterosexism as the belief in the superiority of heterosexuality over other forms of sexual orientation. The correlation of social identity theory is that heterosexual group members view themselves as privileged and superior, while oppressing the LGBT population. “Homophobia and heterosexism are interlocking forms of oppression that are institutionalized in major social systems (e.g. laws, employment, benefits, marriage, health care, etc. . . .)” (Morrow, 2001, p. 152).

Butler (2004) stated that “while society may be more welcoming to LGBT individuals than it was 30 years ago, heterosexism remains pervasive and homophobia has not disappeared” (p. 29). Richmond and McKenna (1998) stated “the term homophobia defines the fear felt by heterosexuals when in proximity to homosexuals” (p. 363). Homophobia articulates the association of Tajfel’s theory on in-group dominance and out-group discrimination (Tajfel & Turner, 1979). The theme also resonates with the working definitions of racism as they relate to denial of equality and promotion of stigmatization (Clark et al., 1999).

Although the American Psychiatric Association changed its direction on the definition and view of homosexuality in 1973, public hostility remained an issue. Not until the much publicized story of police brutality following a 1969 raid of a gay establishment (The Stonewall Bar) in New York City did societal perception of homosexuality began to shift. Kimmel, Sang, D’Augelli, and Patterson (1995) commented on the public reaction to the Stonewall bar raid and subsequent riot, often referred to as “the Stonewall Incident.”

The event began to change the social construction of homosexuality from a personal pathology to minority group membership . . . what had once been a personal identity for gay men and lesbians became a collective identity and the stigma of homosexuality as a mental illness dissolved into the possibility of an open and proud minority status. (p. 190-191)

Within the theoretical context of both social identity and social dominance theory, homosexuality, as an out-group status within health care, can easily be compared with racial and ethnic discrimination. This comparison is exemplified in institutional, and provider discrimination and prejudice, based on the dominance of heterosexism in American society and historical paternalism within physician practices.

Themes Within Research on Homophobia in Health Care

Peterson and Bricker-Jenkins (1996) stated that inclusion of women, or female specific research in health care, was sparse until the early 1990s. They discussed that research with respect to lesbians within health care was almost non-existent. As noted previously in this chapter, Trettin et al. (2006) asserted that due to heterosexism, there has been a lack of research for the LGBT population. They noted, “sampling minority groups is challenging in general and especially when the group is stigmatized. Like all minority groups, lesbians are a heterogeneous population. Difficulty in obtaining adequate samples makes it harder to express the diversity of lesbian experiences” (p. 68).

A large piece of perceived stigmatization results from discomfort on the part of physicians. Taravella (1992) studied physicians at the University of California at San Francisco, and found that 35% of physicians felt “nervous” around homosexuals, and believed that “homosexuality is a threat to many of our institutions” (p. 34). Schwartz (1996) found that homophobia in practitioners is directly related to a tendency to provide “second class care” (p. 19). He stated “homophobia by health care providers is manifested in a wide range of reactions, from overt rejection, to benign neglect of gay male patients” (p. 20). The author tied the AIDS epidemic to the rise in homophobia, and noted that “current research shows that ignorance about HIV, and negative attitudes still exist among health care professionals” (p. 21).

Stein and Bonuck (2001) found that most gay men and lesbians disclose sexual orientation to their primary health care provider, but their findings on the outcome of disclosure were not entirely positive. A 2006 study by Appel found many of their 53 study respondents (median age 23 years) did not disclose their sexual orientation to

anyone. While 60% of these women disclosed their sexual orientation to their parents, only 31% told their health care provider. Among the latter group who shared their sexual orientation to their physician, 27% reported a negative effect from their disclosure. This statistic is supported in Mercier's 1999 dissertation, where only 29% of her study participants felt their medical provider was supportive.

Appel (2006) described an important legal case on discrimination based on sexual orientation. This 1999 California court case focused on physician refusal of care to a patient because of her sexual orientation. In this case, Guadalupe Benitez sued Drs. Christine Brody and Douglas Fenton for refusing to continue her infertility treatment with the medication Clomid when they found out she was a lesbian. Dr. Brody was quoted that she had "religious based objections to treating homosexuals to help them conceive children by artificial insemination" (p. 20).

In a survey of lesbian parents conducted by Mercier and Harold (2003), several questions about the patient/physician relationship were posed. Specifically, a key question was around the quality of the physician/patient relationships since coming out to the provider. Although most survey respondents confirmed coming out to their physicians, some respondents commented that the physician or physician staff had negative reactions. Some survey respondents, having had a negative reaction after coming out, stated reluctance to be honest again. One respondent commented

I have only come out to one of my health care providers. It was a physician's assistant (P.A.) and not my regular care provider. I believe the P.A. was uncomfortable with my disclosure although she didn't say so. I never saw the P.A. again. (Respondent ID #401; Mercier et al.).

Another respondent stated

I feel more comfortable coming out to females. I have a sense they are open minded--accepting of the difference--before I come out to them. (Respondent ID #6101; Mercier et al.).

With regard to not being legally recognized, another respondent stated

legislatively it would be great to have legal status for my partner as parent to our son. Stapling copies of powers of attorney to every health care file gets to be a drag. (Respondent ID # 9301; Mercier et al.)

Some of the themes and comments from the 2003 survey led to the formulation of questions and hypotheses in this study's research questions.

Combating Homophobia and Heterosexism Among Physicians During Medical Training

Literature indicates that themes of homophobia and ignorance on the part of physicians begin in the first phases of medical school. Unless previously exposed to the LGBT population, or entering into a directed course on the topic, homophobia may persist, or even be promoted by older physician trainers. In a 1985 study, Bauman and Hale found that medical students who participated in a workshop entitled Caring for the Homosexual Patient were more sensitive to LGBT issues than the control group of their peers who did not participate. The researchers concluded that sexual orientation must be understood in the context of patient care. The more a physician is trained in a holistic fashion, the better prepared they will be to provide comprehensive care.

Literature published in the last 2 decades displays evidence that homophobia can be measured in medical school. Klamen, Grossman, and Kopacz (1999) administered a questionnaire to second year medical students, the content of which measured students' attitudes towards homosexuality. The data demonstrated negative attitudes towards homosexual patients, with over 25% of the respondents believing homosexuality was

immoral and dangerous. Twenty nine percent of the respondents felt homosexuality endangers the institution of the family. As a result of the study, the authors recommended amendments in medical school curriculum to include exposure to the LGBT population, and this group's unique health concerns.

A recent article published by Sanchez et al. (2006) found that the majority of third and fourth year medical students surveyed had concerns about the challenges they face discussing sexual identity and behavior. These researchers recommend providing medical students with more education about and exposure to LGBT patients. They went on to report "Medical students with increased clinical exposure to LGBT patients tended to perform more comprehensive histories, hold more positive attitudes toward LGBT patients, and possess greater knowledge of LGBT health care concerns than students with little or no clinical exposure" (Sanchez et al., p. 27).

In a review of graduate medical education curricula, Townsend (1997) observed that there is little information about how "lesbian, gay, and bisexual issues are addressed in graduate medical education" (p. 114). He cited the negative biases held by training directors as a salient issue in medical student training. As medicine is generally taught as an apprentice model of skill base acquisition, if the trainer was not exposed to LGBT patients and attitudes, neither will be the trainee. Townsend also cited historical discrimination or invisibility of the sexual orientation of doctors in training. His survey of training directors indicated less than half of his sample believing that homosexuality was either normal or somewhat normal. He asserted, "care is not served when a segment of the population is treated with derision or neglect, or when LGB students and residents are encouraged to remain hidden" (Townsend, p. 116).

Robb (1996) found that “gay or lesbian patients have had negative experiences at the hands of the medical profession. Gay positive doctors say disenchanted patients often see them after encountering everything from ignorance to homophobia” (p. 21). Robb recommended that if a physician has a strong religious or personal belief that homosexuality is a sin or immoral, that the physician has the insight to “refer their gay or lesbian patients on, and not try to lecture them or pray over them” (p. 14).

McNair (2003) wrote that medical education generally ignores lesbian health at all levels. Moreover, the author stated that “negative attitudes amongst health care providers towards lesbians impact on the quality of health care for this group” (p. 644). Her research confirmed that lesbians display reduced health seeking behavior, including decreased routine checkups, and PAP smears than heterosexual counterparts. The discrimination and homophobia for lesbians is not limited to the patient base. McNair highlighted that over 50% of lesbian doctors and medical students in the United States experience some form of discrimination based on their sexuality. She cited a 1993 study involving 4,500 lesbian physicians that showed over 40% experienced harassment related to their sexual orientation, compared to 10% of heterosexual female physicians who reported harassment (Brogan, Frank, Eton, Sivanesan, & O’Hanlan, 1999). McNair expressed little optimism about solutions to lesbian discrimination, asserting that it will likely take decades to break down the structural homophobic barriers within the medical education curriculum and its trainers.

Efforts at education continue. Internal medicine residents at Rhode Island Hospital took part in a 3-hour seminar course designed to foster LGBT awareness (McGarry, Clarke, Cyr, & Landau, 2002). Their findings demonstrated a significant

improvement in the residents' self-reported comfort level and level of preparedness in dealing with LGBT patients. Similar to the McNair (2003) study, the authors concluded that even "a limited seminar can have an impact on residents' sense of preparedness and comfort to deal with the unique health care and psycho-social issues of lesbians and gay men" (p. 247).

Gay and Lesbian Perceptions of Health Care

The theoretical overlay of in- versus out-group dynamics for gay and lesbian patients is documented in the literature as cited above. Stevens and Hall (1988) found that lesbians often felt harassment or provider avoidance if they revealed their sexual orientation to physicians or nurses. Some qualitative comments from the study included first-hand accounts such as:

- As soon as I said I was a lesbian, the nurses started giving me disgusted looks. They were nasty to my partner.
- I was in the hospital and the nurses never came to my room . . . they specifically talked about not wanting to care for me because I was a lesbian.
- Seeking health care as a lesbian is like putting your life in someone's hands who really hates you. (p. 72)

Makadon (2006) cited overt discrimination of a LGBT patient and their partner as "disappointing, but not surprising" (p. 895). He used an example of his own health care to highlight that discrimination has no educational or social-economic limitations. "At the registration desk, I was asked rather publicly if I was married or single. When I replied that I had a partner, the clerk loudly exclaimed 'he's single'" (p. 895). This dismissal or judgment of sexual orientation is exemplified in Cavanaugh and Abbott's (2006) article, which depicted an initial evaluation in a physician's office:

A patient meets his doctor for the first time. Taking a history, the doctor asks, "you don't have sex with other men or nasty stuff like that do you"? The patient,

who is gay, leaves the office without revealing his sexual orientation, and never returns. (p. 195).

Following the true case example, the authors sympathize with gay men who may be reluctant to come out to their health care providers.

Issues for the U.S. Lesbian Population

If discrimination is progressive, then lesbians have a “double negative” in American society. In a male dominated culture, being female is often viewed as a barrier to be overcome. Add to the stigma of being female, the fact that a female dare venture into the perilous zone of a same sex relationship. One can also overlay women’s perceived lack of power within the American structure. The health care system is a representative subsystem within the larger American culture.

The research and literature on homophobia in health care cite special issues for the lesbian population. Quotes from the qualitative section of the Mercier and Harold (2003) survey exemplify the somber but sometimes positive view held by lesbians who are parents:

I come out when it comes up. I always fill out the name of my “spouse” which indicates she is a female. If a form says “husband”, I cross out and write in “life partner.” (Respondent ID #1301)

I came out to my prior family practice when the assistant asked the birth control question. The assistant seemed surprised and went on to the next question. She did not appear supportive . . . sort of put off I’d say. (Respondent ID#1701)

Past primary care physician suggested he be involved in a [sexual triangle] “mange a trois” when partner came out. (Respondent ID #2302)

The quotes exemplify the plight of lesbians in seeking fair and equitable treatment.

The aforementioned comments from the Mercier et al. survey correlate to another study on lesbian parents. The researcher was self-identified as “white, middle class,

heterosexually identified public health nurse and educator” (MacDonnell & Andrews, 2006, p. 355). The findings were sorted into qualitative themes. Isolation, heterosexism, availability for support, and provider education in diversity, emerged as significant themes in her study outcomes of lesbian parents. Another theme was the feeling by the lesbian parents of invisibility, especially around child bearing issues.

There appears to be a great need for LGBT education in the process of choosing gay friendly health care providers. Although, even if a LGBT positive provider is chosen, it does not decrease the likelihood of institutional discrimination if hospitalization is needed.

Conclusion

This chapter provides a review of the historical social work role in health care as it relates to groups who hold minority group status. It also contains a summarization of the role of physician communication and the impact of paternalistic attitudes on minorities in health care, and application of theoretical constructs as factors correlated with real or perceived discrimination. The identification of minority groups within the U.S. societal and health care structure are defined by race, gender, socio-economic status, disability or chronic disease, and religion. As the literature review demonstrates, LGBT status can be added to this list.

The chapter further compares the historical discriminatory policies and practices in the U.S. health care delivery system toward African Americans to the current interface with gay and lesbian patients. The variables of paternalism, heterosexism, and homophobia all contribute to a real or perceived feeling of discrimination by patients who disclose their sexual orientation to medical professionals.

The epistemological constructs utilized within the study conducted here are the theory of group or social identity (Tajfel & Turner, 1979), as well as the theory of social dominance (Sidanius & Pratto, 2001) as these constructs relate to defining oneself as part of a specific group, based on similar traits, beliefs, affiliation, et cetera. Intrinsic to both theories is the notion of in-group versus out-group, with the in-group being dominant. Inequity in societal status results in a greater propensity for prejudice, discrimination and hostility. Whether it is attitudinal or structural in nature, any out or minority group is at risk of becoming a target.

The minority group that provides the point of focus for this study is the LGBT population and its treatment from a dominant group, who are often untrained and inexperienced in dealing with health issues among gay and lesbian patients. Among this minority, of particular interest to this study are the experiences of lesbian parents.

As indicated throughout the literature review, medical research and subsequent publications are scarce based on health and the LGBT population. There is a particular paucity where lesbian and single sex parents are concerned. With a growing awareness of the LGBT population and an increase in states allowing same sex marriages, the importance of this study in improving treatment of lesbian and same sex parents by physicians and others in the health care system, validates the relevance of this study. Lesbians are entitled to a voice in experiences with health care providers. To insure such positive interactions, questions need to be asked about what types of lesbian patient-physician relationships work, and the variables involved in successful relationships.

Historical research has focused on racial and ethnic discrimination within the U.S. health care system. The focus of discrimination has been both institutional and personal

(on the part of physicians and other health care staff). Relatively speaking, there is a low volume of research geared toward decreasing homophobia among health care providers.

Research and provider education are the two positive actions to decrease homophobia in health care. Specific to the social work profession, the issue of advocacy is an immediate goal. Research, advocacy, and local, state, and national efforts by professional associations (i.e., National Association of Social Workers) can all assist in raising awareness among social workers on the LGBT health care crisis with institutional and professional homophobia. Brotman et al. (2002) suggested “health systems, institutions and providers must play an active role in combating prejudice and reducing barriers to LGBT people and communities” (p. 26). Short of the topic making its way to a prime time mass media presentation to gain awareness, multidisciplinary research and education seem the rational short-term course of action. Additionally, more comprehensive research should be encouraged in order to gather the qualitative and quantitative data needed to drive change, or minimally, increase awareness of issues impacting the quality of care lesbian and gay people receive.

Roberts (2006) noted that prior to the 1990s, research concerning lesbians and health care was primarily negative and discriminatory. She found hope in future research and feels the research and provider bias will be less of a concern and concluded, “Research is increasingly available to guide the development of improved care for and health promotion for lesbian women” (p. 588). However, it is important to recognize that even available research is often based upon limited sampling. “It has been argued that there is no such thing as a representative sample of homosexuals” (Donahue & McDonald, 2005, p. 364). This limited and flawed literature base provides rationale for

this inquiry and for others like it. Issues of equality and equity in health care access and treatment for gay and lesbian populations cannot be addressed until the nature of all issues are brought to light and solutions are properly vetted.

Summary

The literature review highlights the limited research and scholarly publications dedicated to lesbian parents, and their preferences for communication with physicians. The next chapter outlines the basic research question, which asks what the characteristics are between lesbian parent families and their physicians. The questions asked in the study are intended to garner information not previously found in the literature on lesbian parent interactions with physicians. Chapter 3 summarizes the methodological approach of this study. The study furthers the initial data found by Mercier et al.

CHAPTER 3. METHODOLOGY

The research conducted as an integral part of this study is thematic data collection and analysis routed in quantitative and qualitative (mixed method) design format. The human services field is increasingly recognizing the value and contribution of qualitative research. In the field of social work, a dedicated scholarly publication, entitled *Qualitative Social Work*, was begun in 2002. Bamberger, Rugh, and Mabry (2006) advocated that qualitative research findings can be developed inductively in a holistic and intuitive manner that enriches interpretation and understanding of data. They stated: “Qualitative data is substantive, involving identification of patterns in the data from which understandings must be developed and interpretations constructed” (Bamberger et al., p. 296). Thus, the data analysis employs a mixed model method.

The purpose of the study is to gain a better understanding of the opinions of lesbian parents on their perception of healthcare delivery for themselves and their children. A subset of information on whether the respondents have come out to their health care provider(s) was also collected. The hypothesis is that the less familiar or comfortable lesbians are with the physician, the less likely they will be to reveal their sexual orientation or discuss their family constellation. This, in turn, may make some lesbians more reluctant to seek medical attention for themselves and/or their children. Upon completing a short quantitative questionnaire, study participants were asked if they would be willing to participate in interviews or focus groups to be conducted by this writer at a later time. Those who volunteered for this part of the study were subsequently contacted.

With regard to survey participants, the 41 respondents were re-recruited from two previous studies. In 1999, Dr. Lucy Mercier completed her dissertation on lesbian families. Her research was based on surveys with 125 lesbian mothers and their partners. In 2003, Dr. Mercier and Dr. Rena Harold conducted another survey on lesbian families, with many of the same respondents. They presented their study results in 2007 at the Council on Social Work Education annual meeting (Mercier, Dimond, & Harold, 2007). The study reported here created a sample distribution list from these earlier studies. This writer acknowledges that repeated sampling may contribute to an element of response bias and may create reliability threat.

This writer attempted to re-create the participant cohort from the mailing and demographic information in the aforementioned studies by Drs. Mercier and Harold. Of the original list, 41 surveys were completed. Many had moved, and forwarding addresses and emails could not be located.

The problem this study seeks to address is the limited knowledge base about what physician characteristics support the strongest possible therapeutic relationship between physicians and lesbian parents and their families. This information is important to both the parent and to her children as she navigates the health system on both her own behalf and on behalf of her children. Understanding the qualities that a lesbian parent seeks in a physician can result in better relationship matching of patient-parent and doctor, which in turn, may support better health outcomes for parent and child. Lesbian parents were also queried on health care experience, their partners had.

Basic Research Question

This study is driven by a single research question, which asks: What are the characteristics of relationships between lesbian parent families and their health physician/health care provider of choice which influence decision making about choosing a health care provider and lead to a perception of greater quality care? This question expands to additional questions specific to variables under study:

1. Is there a difference in Lesbian parents' perception of health care quality between lesbians who are "out" with their physicians and those who are not?
 - a. Variable 1: Quality of Health Care (accessed via Lesbian Parent Health Care Survey [LPHCS] Q7; Appendix A)
 - b. Variable 2: Lesbian Parents' "Out" Status (accessed via LPHCS Q8)
2. Do lesbian parents prefer physicians of the same gender or sexual orientation as themselves?
 - a. Variable 1: Gender Preference of Health Care Provider/Physician accessed via Lesbian Phone Survey Questions Worksheet [LPSQW] Q1; Appendix B)
 - b. Variable 2: Sexual Orientation of Health Care Provider Preference (accessed via LPSQW Q1)
3. What are the traits of a particular physician that lead lesbian parents to make the decision to seek care from him/her? Lesbian Parent Survey Questions (accessed via LPSQW Q5)
4. Do lesbian parents feel they receive quality health care for themselves and their families (accessed via LPSQW Q2)?

5. Do lesbian parents feel they receive empathy when receiving health care from physicians? (accessed via LPSQW Q3)

These questions will be addressed through a mixed method design, beginning with a quantitative opinion survey that assessed perception of health care delivery among lesbian parents. Based on respondent agreement and availability, a sub-sample of survey respondents agreed to participate in interviews in order to gather additional qualitative information about health care delivery perceptions and experiences.

Research Design

The methodological approach for this proposed study is a mixed method exploratory study design. Creswell (2003) asserted that quantitative research is viewed as confirmatory and deductive in nature whereas qualitative is essentially exploratory and inductive by nature. The philosophical foundation behind quantitative and qualitative research is derived from a positivist perspective that was generated in the nineteenth century (Giddens, 1974). Positivism maintains that reality should be shaped by empirical information derived from the senses rather than interpreted from metaphysical constructs that cannot be measured (Creswell). Within the positivist paradigm, this study assumes that information gathered through our senses (feel, smell, hear, taste, and sight) is reality that can be identified and subsequently quantified or qualified.

Bloom, Fisher, and Orme (2003) asserted that qualitative research is a set of empirical methods used to describe and identify human experience based on words and behaviors. The quantitative researcher brings cumulative shared understandings and standardized procedures, and takes away numerical and statistical information that is interpreted in terms of abstract theories and value assumptions. The qualitative researcher

brings as few preconceptions as possible, and takes away a richer more subjective interpretation of what the human experience is all about, some of which may be summarized in numerical and statistical forms.

Methodological Approach

This study employs two phased, mixed method research design with a self-administered quantitative survey (phase 1) expanded upon with a qualitative respondent phone interview (phase 2). Analysis of data from both phases was used to answer the five research questions. Quantitative research is defined as “the numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect,” and qualitative research is described as “the non-numerical examination and interpretation of observations, for the purpose of discovering underlying meanings and patterns of relationships” (Babbie, 1992, p. 27). The basic design of a mixed method study is to identify patterns in groups and individuals as a function of the questions stated. Since the researcher does not have complete control over the information collected, the study is suggestive rather than rigorously causative. In addition, the context of surveying attitudes, experiences, and opinions assumes that participants’ attitudes are already formed. No attempt by the researcher will be made to influence these attitudes.

Appropriateness of Design

A mixed method research design was determined appropriate for the research project since it enables the collection of information from human participants fitting a specific demographic/attitudinal profile. Furthermore, within the quantitative approach, a broad number of participants (e.g., greater than 50) is necessary to ensure differences and

commonalities are appropriately represented within a sample, as reflected by the power analyses (Agresti & Finlay, 1997).

Rather than an exhaustive quantitative endeavor, the limitations of the number of participants will be optimal for consideration of this research to be considered exploratory in nature. Malhotra (2010) highlighted that the objective of exploratory research is to provide insights and understanding of a problem. The sample is typically small and non-representative. Analysis of the data is largely quantitative. The outcomes of such research are generally followed either by further exploratory studies, or conclusive research. The conclusive method allows for a formal and structured process for a large sample, and quantitative analysis. In this study, the mixed method procedure allows for greater exploration of the study questions using a smaller sample size.

Population and Sample

This study uses a population sample of lesbian parents. The sample population selected for the study consist of participants willing to respond to a survey. The sampling frame consists of lesbian parents who participated in a 1999 survey by Mercier and a second survey by Mercier and Harold in 2003. The purposeful non-probability sample for the current study consists of lesbian parents who agree to be re-surveyed. Most respondents are from the researcher's home state in the American mid-west. This purposive sample selection is appropriate for this mixed method design since "purposeful selection rather than random or randomized selection is better for qualitative work" (Bamberger et al., 2006, p. 271).

Merriam (1998) asserted that there are two basic types of sampling--probability and non-probability. Probability is described as conducting a random sample from the

sampling frame so that inferences can be reliably generalized to that population. Non-probability, on the other hand, is described as attempting to logically solve qualitative problems such as “discovering what occurs, the implications of what occurs, and the relationships linking occurrences” (Honigmann, 1992, p. 84). Bamberger et al. (2006) stated that random selection is not best when the number of respondents selected for data collection and analysis is small. “A small random sample is very likely to result in a skewed or distorted data set and in the findings based on it” (Bamberger et al., p. 325).

There are several different types of purposive sampling to include typical, unique, maximum variation, convenience, snowball, chain, and network. Convenience sampling is the type of sampling used in this study as it encompasses the person who is readily available to be researched (Merriam, 1998). As noted by Babbie (1973), purposive sampling is often used when “precise representation” is necessary to a study (p. 106). This sample qualification is applied here. He went on to say, “occasionally it may be appropriate for the researcher to select [the] sample on the basis of [his/her] own knowledge of the populations, its elements, and the nature of his aims” (p. 106), a statement also applicable to this study. Considering that the lesbian parents represent a minor percentage of the general American population, the ability of the research to identify and randomly sample among lesbians who are also parents is extremely difficult. Building upon a sample already identified through a previous study with this population allows for expansion of an existing data base with a valid sample. The convenience sample utilized here allowed for the gathering of data in this exploratory study while not taking on either the expense or the time needed when using a random probability sample (StatPac, 2007).

This sampling method enables the researcher to act within a certain period and under conditions that facilitate data collection. By its nature, exploratory research and use of convenience sampling sacrifice generalizability and therefore, may not provide sufficient representation of the target population. This means that those selected for the study may only partially represent the population being investigated. Replication may be necessary to fully validate study results (Keppel & Zedeck, 2001). Despite its deficiencies, convenience sampling is the best method of obtaining a sample population when time and conditions prohibit random sampling (Neuman, 2003). It is also this writer's opinion that while purposive convenience sampling runs the risk of introducing potential bias in responses, this risk is counterbalanced by the ability of this sampling method to assure that the respondents are indeed members of the population of interest, lesbian parents (Babbie, 1973; Vogy, 1999).

Power Analysis

A power analysis must be calculated whenever inferential statistics is being used. "Inference consists of ways of making predictions based on the data" (Agresti & Finlay, 1997, p. 3). Accordingly, in this study, Analysis of Variance (ANOVA) and Chi-square test of independence was attempted for use in order to analyze research questions 1 and 2 respectively. An inherent limitation is the small number of respondents in the written survey, thus limiting the ability to use strict quantitative methods for analysis (Mertler & Vannatta, 2005). When calculating the proposed sample size for the study there were several factors that must be taken into consideration. These factors included the intended power of the study, the effect size of the phenomena under study, and the level of significance to be used in rejecting the null hypotheses (alpha). The power of the study is

the probability of rejecting a false null hypothesis. As matter of convention, the power that would be adequate to reject a false null hypothesis is 0.80 (Kuehl, 2000). The next factor of importance is the size of the expected effect, which is an estimate measurement of the strength of the relationship between the independent and dependent variables in the study (Cohen, 1988). The effect size of the study can be characterized as small, medium, and large, details of which follow. The last thing of importance is the level of significance or critical alpha that is usually set at 0.05. “The alpha level is a number such that on rejects the null hypothesis if the p value is less than or equal to it. The alpha level is also called the significance level of the test. The most common alpha levels are 0.05 and 0.01” (Agresti & Finlay, p. 173).

To validate sample size, a formal power analysis was conducted to statistically determine the number of participants needed to conduct the study. To assess a sample size, power was set at 0.80 and the expected effect size was set at 0.25 for research question 1. Accordingly, for research question 1, the sample size necessary to likely determine a statistical difference is 128 participants where critical alpha = 0.05. This infers that there is an 80% probability that 128 participants will be sufficient to find a statistical difference between groups. For question 2, a minimum of five per cell is required to faithfully draw conclusions from results (Faul, Erdfelder, Lang, & Buchner, 2007). Given the sample size differences from the two analyses, the largest minimum sample size is taken; 128 participants are needed to participate in the study. However, since qualitative research is used to support quantitative findings, 30 participants may be sufficient to infer statistically significant findings. Sample sizes over 30 are often sufficient to obtain robust results (Tabachnick & Fidell, 2008). Therefore, a sample size

of 41 is used for the written portion of this study. According to Bamberger et al. (2006), in some cases it may be more important to know the impact on the most difficult to serve population than to know the general impact. It is important to note here that while 85 surveys were mailed, with 41 being returned, 21 surveys were returned with no forwarding address. This writer attempted to do reverse directory and other on line methods to update the demographics of the 21 “return to sender” surveys with no success. Thus, in reality, this writer was pleased to obtain 64% of the available and valid addresses of the sample that actually received the survey to self-administer and return.

Instrumentation

In accordance with the mixed method approach, two research instruments were used with all willing participants. Measure one was the Lesbian Parent Health Care Survey (LPHCS; Appendix A) that consists of 3 sections and 11 individual questions. This self-administered instrument gathered mainly quantitative data. Measure 2 is the Lesbian Parent Survey Questions Worksheet (LPSQW; Appendix B) consisting of five open and closed ended questions. This instrument was used to gather qualitative data in a phone survey format during phase 2 of the study.

Lesbian Parent Health Care Survey

The written questionnaire distributed via first class mail to participants is based on an earlier survey distributed to lesbian mothers (Mercier, 1999). The original survey consisted of both quantitative and qualitative questions. It gathered demographic data about the individual participant and her family, including the data on race, age, income, occupation, and education. The survey questions and variables were based on comparative studies found in heterosexual parenting literature, with limited studies on

lesbian families. All surveys were approved by the Michigan State University (M.S.U.) Institutional Review Board (IRB) committee. Both have been validated by literature focusing on a strengths perspective and evaluation.

The LPHCS survey distributed for this research study replicates the demographic, income, and family information of the original 1999 but differs by shifting focus from lesbian mothers' perceptions of relationships within and around their families to centering on lesbian parent perceptions of physician healthcare delivery for themselves and their families. A subset of questions was added on whether the lesbian parent has come out to their physicians or health care provider (e.g., physician assistant, nurse practitioner) was added. Dichotomous and open ended questions also focus on the participant's the experience of coming out to their physician or other provider and whether it influenced their use of health care.

A follow up interview process was an essential piece of the second phase of qualitative data collection, following the distribution and return of the written surveys. The original roster of Mercier's 1999 study consisted of 125 participants. Due to the time lapse between surveys, 85 original participants were at addresses that could be validated. Of the 85 surveys mailed, 41 were returned for an initial response rate of 48%. However, even with the initial validation of demographics, 21 surveys were returned. Thus, the actual sample of respondents available to complete the survey was decreased to 64. The return rate based on the available respondent population who received the mailed survey was increased to 64%. This return rate provided a number reflective of a normal distribution. Babbie (1973) noted "a demonstrated lack of response bias is far more important than a high response rate" (p. 165).

Lesbian Parent Survey Questions

A worksheet was developed to provide a structured interview outline during respondent phone interviews. Those respondents called were identified through their willingness to be contacted for the qualitative research interview on their written survey. Respondents were sent a letter asking for their participation in a phone survey prior to being called (see Appendix C). The survey worksheet contained five questions centered around respondent opinions on physician selection, quality of care, empathy, and traits leading to a successful interaction or relationship (see Appendix B). Worksheets were completed during the phone interviews, and acted as an aid for the content of the interviews. Interviews were conducted by this writer. All phone interviews were recorded and transcribed.

Data Analysis

Descriptive statistics were generated from demographic question responses to profile participating lesbian parents. The results are presented in the next chapter. In addition, research question 1 was tested using analysis of variance (ANOVA) to determine differences between groups. Statistics are displayed along with appropriate tables and graphs to support meaningful findings. All coded qualitative information are presented in Chapter 4, along with the inter-rater reliability validity, and Cohen's Kappa, as a measure of agreement.

The ANOVA equation is simply the sum of squared differences between groups divided by the sum of squared differences within groups. The basic calculation assesses the variation in scores found between groups and divides that by the variation in scores

found within groups. The resulting ratio (designated by F) is a measure of the strength of independence. F is always positive and always greater than 0 (Agresti & Finlay, 1997).

The two measures of validity, F and eta squared, were used to determine if mean scores differ between levels of the independent variable (Out and Not Out). Many texts and most software present a statistic denoted by F for testing that the population variances are equal (Agresti & Finlay, 1997). According to Mertler and Vannatla, (2005) eta-squared is also a measure of strength of association. It really measures “how much” association there is between the independent and dependent variables.

The analysis procedure was conducted using the Statistical Package for the Social Sciences (SPSS) software program, Student Version 17.0. The data analysis in Chapter 4 includes descriptive statistics, means, standard deviations, and frequencies where applicable. In addition, histograms were run as well as z-scores and Normal Q-Q plots to support assumptions of normality as necessary.

Research question 2 was analyzed using Chi-square test of independence to determine if groups differ by frequency counts. This statistic measures how close the “observed frequency are to the frequencies expected if the variable were independent” (Agresti & Finlay, 1997, p. 267). Responses were coded by observed preferences and tested to determine if they differ from expected counts. Chi-square test of independence uses Contingency tables to examine the relationship between subjects’ scores on two qualitative or categorical variables. “One of the most familiar statistics to most helping professional, is the chi-square. It is used to determine whether there is a significant difference between the expected and observed frequencies in different categories” (Bloom et al., 2003, p. 605). As will be detailed in the next chapter’s findings, the results

on preference for provider were so dominant, there was no variability to test for an association due to chance. Chi-square was used for validity, but the lack of variance observed in the responses rendered the results of Chi-square unremarkable. Thus, the statistic was empirically meaningless from the standpoint of group comparison. Research questions 3, 4, and 5 were examined by coding qualitative responses by theme (where appropriate) and then running descriptive statistics to determine frequency of categorical responses.

Inter-observer reliability testing is an essential component of the qualitative analysis. A Ph.D. researcher served as the second coder for this project. His coding analysis was compared to this writer's coding to assess level of agreement. "Percentage of agreement [by two observers] refers to the percentage of times both observers agree with each other in their observations. Interobserver reliability is quantified using a correlation coefficient, or some measure of agreement or Kappa" (Bloom et al., 2003, p. 68).

Cohen's Kappa is a widely used and accepted measure of reporting reliability of coded qualitative data. It is a "nonparametric statistical test of agreement among sets of rating" (Vogt, 1999, p. 150). The measure is user friendly in calculation and interpretation and well suited to the qualitative coding in phase 2 of the study. Perreault and Leigh (1989) stated that though Kappa also has limitations, it is the most widely used measure of inter-rater reliability across the behavioral science literature.

Assumptions were analyzed using z scores to determine degree of skewness and kurtosis; the degree of peakedness of a distribution equal to 0 when a distribution is normal (Mertler & Vannatta, 2005). Further homogeneity of variance was analyzed to

determine if distributions across groups were homogeneous. If parametric assumptions are not met, the researcher may choose to transform the continuous variable or reduce critical alpha to ensure a Type 1 error is not committed, rejecting the null when in fact it is true (Agresti & Finlay, 1997).

Study Validity

Internal Validity

Internal validity is defined as how confidently one can conclude that the change in the dependent variable was produced solely by the independent variable and not extraneous ones (Campbell & Stanley, 1963). Accordingly, there are eight empirically identified conditions that can threaten confidence in a study. These threats to internal validity include history, maturation, testing, instrumentation, and statistical regression, selection, experimental mortality, and selection interaction. Although all threats may be relevant, specific threats to this study may potentially involve just two. These two threats may involve selection and testing (Campbell & Stanley). A selection, also referred to as self-selection bias, threat suggests that participants may not be functionally equivalent at time of testing. A problem with self-selection bias “may arise in the comparison of groups when the groups are formed by individuals who choose to join them and thus are not formed by the researcher assigning them” (Vogt, 1999, p. 261). In the case of this study, efforts to mitigate this threat have been addressed by gathering a sample size that is sufficient to minimize bias for the study and is adequate for the statistical technique being used. A testing threat entails testing participants at different times or under different circumstances. The study design for the written section has participants completing the surveys under their own imposed conditions, as the survey is completed at

their discretion, venue, and level of confidentiality within their chosen environment. This certainly could be a threat to validity. The qualitative portion of the survey is more structured, with the time being pre-arranged, the interview being recorded, and this writer as a facilitator with all nineteen volunteer participants. Sampling strategies useful and appropriate for qualitative evaluation differ markedly from those appropriate from quantitative methods, concentrating on depth rather than breadth (Bamberger et al., 2006).

External Validity

The concept of external validity is defined as the extent to which the study can be generalized to the greater population (Agresti & Finlay, 1997). Generally, studies that employ randomization to select participants from the study population have more external validity than those that do not. For this study, drawing on a sample from a convenience sampling of lesbian parents, the majority of whom participated in a 1999 and 2003 survey, was used to sample the study population, which may weaken external validity. The rationale for the sample strategy used is provided earlier in this chapter.

Ethical Assurances

This study was conducted in accordance with Michigan State University research protocols in recognition that students acting as researchers are faced with ethical concerns. Researchers must obtain informed consent from all participants (Gall, Borg, & Gall, 2008). As previously noted, the study was presented to and approved by the M.S.U. IRB. Voluntary consent to participate was documented by the return of the phase 1 survey questionnaire and by verbal acknowledgement at the start of the phase 2 phone interviews. Elements of informed consent include: (a) notifying the participants of who

will conduct the study; (b) letting the participant know the time commitment required; (c) explaining the study in easily understandable language; (d) offering to answer any questions; (e) informing participants that their involvement is voluntary; (f) informing participants that they can withdraw at any time; (g) letting participants know the limits of confidentiality; and (h) ensuring that participants will emerge from the research unharmed (Rudestam & Newton, 2001). These elements were addressed in the cover letter explaining the LPHCS and in the phone interview introduction.

Summary

This chapter provides an overview of the methodology used in this research study. A mixed model method has been presented as the most effective for data evaluation, analysis, and measurement for the questions addressed here. The use of statistical tests and the threats to validity have been summarized.

Chapter 4 presented the actual findings and statistical analysis based on the methodology presented in this chapter. The statistics employed within this study are consistent with the expectations of social science researchers. As noted by Agresti and Finlay (1997), “Information gathering is at the heart of all sciences. The social sciences use a wide variety of information gathering techniques that provide observations used in statistical analysis” (p. 2).

CHAPTER 4. RESULTS

Introduction

As summarized in the literature review in this paper, a narrow body of social science literature focuses on the lesbian parent family experience with health care organizations and providers. This study aimed at expanding academic understanding of the lesbian parent health care experience by acknowledging lesbian parents' perceptions of the reasons for choosing and retaining physicians for themselves and their families. The research centered on a two phase, qualitative/quantitative, mixed method of survey techniques in order to garner information about lesbian parents' preference for gender, traits, and style of a physician that promotes an optimal experience. The second phase interviews were used to further detail the qualitative nature of lesbian parent opinions. The variables measuring physician relationship characteristics included: communication, style of practice, quality, gender, and sexual orientation.

Chapter 4 provides a demographic description of the lesbian respondent profile by race, age, income location of residence, and average age of children. It also presents descriptive qualitative data related to respondent satisfaction with physician, characteristics of physician, and level of perceived empathy.

Participant Demographics

The participant respondents involved in the research were comprised of 41 lesbian parents who completed and returned to self-administered phase 1 survey. The majority of these respondents also participated in earlier research by Mercier (1999) and Mercier and Harold (2003).

As shown in Table 4.1 the, majority of the respondents were middle aged ($M = 48.3$, $SD = 10.2$), with the average lesbian partner age being only slightly younger ($M = 47.4$, $SD = 10.1$). The majority of women surveyed were Caucasian ($n = 37$, or 90.2%), with the partner's race being slightly more diverse ($n = 33$), 80.5% were Caucasian. Most respondents were living in Michigan ($n = 32$, or 78%), with less than 10% residing out of state ($n = 5$, or 12%). The majority of respondents reported they were lesbian, with 1 respondent self-identifying as bi-sexual. For the purpose of the data analysis, this one respondent was grouped with those who identified as lesbian.

Table 4.1. *Demographics and Income Characteristics of the Lesbian Parent Sample (N = 41)*

Category	Average	SD
Average age of respondent ($n = 39$)	48.29	10.233
Average age of partner ($n = 39$)	47.36	10.093
	<i>n</i>	%
Respondent's race ($n = 41$)		
White	37	90.2
Black	1	2.4
Hispanic/Latina ^a	3	7.3
Partner's race ($n = 39$)		
White	33	80.5
Black	3	7.3
Hispanic	2	4.9
Native American	1	2.4
State of resident ($n = 41$)		
Michigan	32	78.0
Illinois	4	9.8
Washington, DC	1	2.4
Missing	4	9.8
Income ($n = 39$)		
\$35,001-50,000	2	5.1
\$50,001-75,000	10	25.6
\$75,001-100,000	9	23.1
Over \$100,000	18	46.2

^aOne respondent self-identified as Latina as her race

Table 4.1 also contains data on lesbian parents' average household income and insurance status. With regard to average household income, no respondents had an income of less than \$35,000. There were a small number ($n = 2$, or 4.9%) of respondents who had a household income of \$50,000 or less. The majority of respondents were above the national median income, with almost half of the respondents at an income of between \$50-\$100,000 ($n = 19$, or 46%), and the other half at \$100,000 and higher ($n = 18$, or 44%). All 41 respondents reported having health insurance for themselves, and the majority ($n = 10$, or 97.5%) had insurance for their children. Thirty nine (95%) respondents indicated their partner had health care insurance, with 2 respondents not completing that section of the survey.

With regard to health care, 96% of the respondents had a relationship with their physician for greater than 1 year. They reported no major health concerns. When asked to rate their own health status along with rating their partners' and children's, the overall self-assessment for all parties was positive. Table 4.2 presents findings related to study participant's number of children and average age of the children. Respondents and their partners had an average of two children with the mode being a single family household ($n = 19$, 46%). The average age of all children in the sample was 14 years old, with the three-child households having the highest average ($M = 17.2$ years).

Regarding their family's health status, the respondents reported no major health concerns for themselves or their family. Table 4.3 contains data on respondent's health status. When asked to rate their own health status along with rating their partner and children, the overall self-assessment for all parties was positive, with respondents mean health (1 = poor to 7 = excellent) being 5.75, their partner's mean health being 5.53, and

their children's rated at 6.46. This finding represents a potential bias in the respondent sample toward those who are not facing serious health issues for themselves or their family.

Table 4.2. *Lesbian Parents' Children and Family Size* (N = 41)

Category	Average	SD
Average number of children per household	1.71	0.6798
Average age of all children	14.35	10.2150

	n	%	Cum
Number of children per lesbian parent family			
1	17	41.46	41.46
2	19	46.34	87.80
3	5	12.20	100.00
Total	41	100.00	

Table 4.3. *Lesbian Parents' Self-Reported Health Status* (N = 41)

Family member	n	%	Mean health status*	SD
Self	40	98	5.75	1.03
Partner	38	93	5.53	1.29
Children (one child)	40	98	6.46	1.06

*7-point scale: 1 = very poor to 7 = excellent

Table 4.4 reports on respondents' physician provider characteristics; of interest, 37 (90%) of the respondents answered the question. Of the 90%, over 89% of the respondents had a female physician. This differs from Bernhard (2001), who reported that the general population of heterosexual women, 50% have female physicians. Regarding physician sexual orientation, over 80% of the physicians seen by respondents were heterosexual, and they reported that the majority of their partners saw heterosexual providers as well.

Table 4.4. *Physician Provider Characteristics as Reported by Lesbian Parents (N = 41)*

Sexual orientation of respondent's physician (n = 37)	<i>n</i>	%
Heterosexual	33	82.5
Gay or lesbian	2	5.0
Unsure	5	12.5
Sexual orientation of partner's physician (n = 36)	<i>n</i>	%
Heterosexual	29	80.56
Gay or lesbian	2	5.56
Unsure	5	13.59

Table 4.5 contains data on respondents' level of satisfaction with their physician providers. The satisfaction data were combined into a single physician category from the six types of physician categories of the original survey (question 7 LPHCS). The majority of providers most often seen by respondents were family practice, OB/GYN, and pediatricians. Survey participants also reported strong satisfaction with their providers with little variance in satisfaction with physician providers regardless of who was the patient: the respondent, her partner, or her child(ren). When asked to rate their provider on a 7-point scale with 1 being not at all satisfied, 4 being neutral, and 7 being extremely satisfied, the results were high levels of satisfaction in all three areas (self, partner, children). Of interest is that the lowest level of satisfaction is for their own personal physician care ($M = 6.10$) with respondents being more satisfied with care received by their partners and child/children ($M = 6.23, 6.59, 6.47, 6.75$).

There is an important difference between Mercier's earlier work and the data summarized in this survey. In the 1999 study, Mercier reported that 85% of total respondents were out to their provider; however, only 29.2%, or 31 respondents felt their medical provider was supportive (Mercier, 1999). An important variable in this survey, 96% of all 41 respondents were out to their identified primary care provider, and

satisfaction with their provider was 6.09 out of 7, which assumes a supportive relationship. This finding could well be an attribute of respondent bias in this study toward those with more positive feelings towards their physicians.

Table 4.5. *Lesbian Parents' Satisfaction With Their Family's Physician(s)* (N = 41)

Patient physician is caring for	<i>n</i>	%	Level of satisfaction with doctor*	<i>SD</i>
Self	37	90.0	6.10	1.23
Partner	34	82.0	6.23	.97
Child 1	34	82.0	6.59	.74
Child 2	18	59.0	6.47	.88
Child 3	4	9.7	6.75	.50

*7-point scale: 1 = low to 7 = high

In summary, the quantitative data from the first phase of the study found a respondent lesbian parent sample of middle aged, Caucasian women, with a middle class household income. Respondent households have an average of two children, averaging 15 years old. In terms of family health, respondents, partners, and children are all in good health and are satisfied with the care they receive from the physicians regardless of specialty. The vast majority of respondents were out to their physicians with the provider's sexual orientation being heterosexual. This quantitative data was expanded upon in the LPHCS with three open-ended questions at the end. Those findings are reported in the next section.

LPHCS Open Ended Question Summary

In addition to demographic, family, and physician information, the written survey contained three questions (9, 10, and 11 on the LPHCS) that were open ended for answers from the respondents. The questions from the survey are as follows:

9. What factors led to your decision about coming out/not coming out to your healthcare provider(s)?

10. Think about a healthcare provider who is aware that you are a member of a lesbian parent family (or that your children have lesbian parents). Describe your experience(s) coming out to them.

11. Do you think that being out or not being out influences your use of health care? Why or why not?

Responses to the questions were classified and coded by this writer. They were recoded as described in Chapter 3 by a doctoral level research investigator to assess inter-rater reliability.

Inter-coder rater-reliability was assessed using two measures, the percent agreement and Cohen's Kappa (Fleiss & Cohen, 1973). Cohen's Kappa is a generally strong measure of agreement.

Kappa is the proportion of agreement corrected for chance, and scaled to vary from -1 to +1 so that a negative value indicates poorer than chance agreement, zero indicates exactly chance agreement, and a positive value indicates better than chance agreement. A value of unity indicates perfect agreement. The use of kappa implicitly assumes that all disagreements are equally serious. (Fleiss & Cohen, 1973, p. 613).

For question 9 that asked about factors leading to coming out (or not) to a healthcare provider, the codes listed below were utilized to categorize respondent answers. These codes were developed based upon salient trends which evolved when listing the variables within the qualitative content in the respondent's answer.

1. Want trust, honesty, respect, acceptance
2. Education, advocacy, relevant for treatment
3. Fair and equitable treatment, like other families

4. Bad past experience, want positive relationship
5. Truthful relationship, integrity

Unfortunately, Cohen's Kappa could not be completely calculated, since one coder never used category 4 to code a response. A further assessment and discussion between coders, found some ambiguity in wording between categories one and five. Honesty and truthful relationship seemed redundant. An agreement was reached by the two coders on some of the discrepant cases. Table 4.6 displays frequencies and Cohen's Kappa for Question 9 on the LPHCS. It also contains the frequencies respondents expressed each category of response listed above and the percentage of respondents identifying that factor as leading to their decision to come out to their physician.

Table 4.6. *Reliability of Coding of Qualitative Responses to Factors in Respondent's Coming Out to Physician [or Health Care Provider] (Question 9 on the LPHCS) (N = 41)*

Responses	<i>n</i> responding this way	% total respondents	% agreement	Cohen's Kappa
Trust	10	24	0.73	0.34
Education	12	29	0.71	0.41
Fair	10	24	0.90	0.69
Bad past ^a	0	0	0.98	N/A
Truthful	13	31	0.70	0.12

^aBoth raters agree that no respondent commented on bad past experiences as factors related to coming out.

Respondents provided comments for question 9 on the LPHCS. Among these, 55% of the answers involved variables in categories one (trust, 24%) and five (truthfulness, 31%). These lesbian parents felt that in a physician relationship, trust, and honesty are critical to being out with their provider. If you combine those variables with code #3, equitable treatment for themselves and their families (24%), the impact of their provider's interpersonal traits and communication style takes on an element of priority.

This causal relationship was highlighted in Brody et al. (1989), and summarized in chapter 2 of this study. Patients' desire "communicative interventions" with their physicians. More refined results on the provider-patient variable were revealed in the follow up phone interviews.

Most respondent answers were very clear about their reasons for coming out to their physicians. Representative responses include:

In order to have our patient rights honored. (Respondent 3)

I felt it was easier to be open and honest. (Respondent 9)

Honesty. Simply, I want good health care and lying about my sexuality would [have] created a huge misunderstanding between us. (Respondent 16)

Honesty is critical in a physician/patient relationship. Sexual orientation, religion, race, etc., should not matter in the quality of care received. If it does, that's not a medical provider for me. (Respondent 17)

Determine acceptance from provider, and change if necessary. Want to be treated as a family. It is important in emergency contact [information]. Want to be advocate within the system. (Respondent 2)

It didn't occur to me not to come out--I didn't know how else my kids could get sensible care (Respondent 4)

We are totally out in our lives to everyone. We behave as if we are like any other family because we are. We consider ourselves educators when necessary (Respondent 5)

My pregnancy (Respondent 12)

I won't lie or hide my family status with anyone (Respondent 13)

It was important to us that our daughter's doctors know that we are both her moms so that both of us would be given the same respect when bringing her to appointments . . . we've had to explain who we are and why we're both there. (Respondent 21)

I wanted them to know my history and stop offering me services I did not need, i.e., birth control. (Respondent 22)

I believe in order to receive the best health care full disclosure is required
(Respondent 24)

We are open because we are the parents of two children. (Respondent 26)

The aforementioned responses to question 9 in the LPHCS highlight the themes of honesty, equity, and advocacy. The variables were consistent in the data collected during phone interviews presented later in this chapter. Question 10 in the LPHCS asked about the experience of coming out to the respondent's health care provider. Agreement between the raters was moderately high for inter-rater reliability. The categories of answers fell into three areas:

1. Staff issues, heterosexism, religious issues
2. Positive experience, no issues
3. Negative past experience, current positive

Table 4.7 summarizes frequency, percentage, percent agreement, and Cohen's Kappa, along with frequency data for the response categories.

Table 4.7. Reliability of Coding for Qualitative Responses to Lesbian Parents Experience in Coming Out to Their Physician (Question 10 on the LPHCS) (N = 41)

Responses	<i>n</i> responding this way	% total respondents	% agreement	Cohen's Kappa
Staff issues, heterosexism, religious issues	1	2	0.93	0.31
Positive experience, not an issue	32	78	0.90	0.68
Bad past experience, current positive	1	2	0.98	0.66

The data for question 10 clearly indicates that the majority of respondents felt positive about their experience of coming out to their physician or provider. Below are illustrative comments about the experience.

Insurance company customer service people are not well trained to understand domestic partner benefits. Also seem to change service quality when we explain the relationship. Front desk staff at hospitals the same. (Respondent 2)

My OB/GYN is very supportive. My Family Practice doesn't seem to like it, but we really don't talk about it. He is polite about it, but I couldn't really go into it with him. (Respondent 4)

We have never had an issue. In my 20s, I changed doctors when a male doctor I was seeing made remarks that led me to feel he was not open. Today, I'd confront it and probably still switch. (Respondent 5)

My trick is to refer to "my partner," "she" . . . I don't usually say "I'm a lesbian," although sometimes I do. (Respondent 6)

I was very nervous, but my doctor acted as if it wasn't a big deal at all. (Respondent 9).

It was fine, I don't feel guilty about being a lesbian (Respondent 10)

Both were relatively positive experiences and both providers were comfortable with our sexuality and our family configuration. The OB had worked with other lesbian couples and the family practitioner has a family member who is a lesbian (Respondent 11)

Very accepting – very wanting to help. Shared that they had lesbians in their own family (Respondent 13)

When she asked about birth control I said "I'm a lesbian" (Respondent 16)

We always make sure it is brought up in the very beginning. It is usually very casual and we try and downplay that we are any different than a heterosexual couple. (Respondent 24)

Over all well. Feel a bit put off by my partner being referred to as parent or bio mom, rather than parent of children in medical reports regarding the kids. (Respondent 29)

The nurse appeared flustered, but doctor was fine. (Respondent 35)

The comments reveal the desire to communicate honestly with the physician.

Some respondents have had a positive experience with their provider, but do have issues with insurance, and staff. This may also be indicative of a bias in respondents toward

positive experiences with their doctors. Such a positive response was observed in question 7 in the quantitative section of the written survey. The positive responses are very different than studies represented in the literature as summarized in Chapter 2 of this study. This finding is further explored in Chapter 5.

Question 11 on the LPHCS asked respondents if they think being out or not influences their use of health care. The survey has a yes or no answer, followed by an open ended question to elaborate why or why not. Eighteen respondents (43%) checked yes. Being “out” did influence their use of health care. Twenty two respondents (53%) did not complete the answer as a “yes” or “no”, but provided text on whether being out influenced their health care provider use, and 1 respondent (2%) answered no with no further text.

The coding categories utilized for question 11 are as follows.

1. Trust, truth, open communication
2. No influence, does not matter
3. Relevant information, influences relationship
4. Influences, general comments

Agreement between coders was strong. Frequencies, percentages, and inter-rater data is displayed in the Table 4.8.

Table 4.8. Reliability of Coding of Qualitative Responses to Whether Being Out Influenced Lesbian Parents’ Use of Health Care (Question 11 on the LPHCS) (N = 41)

Responses	<i>n</i> responding this way	% of total responding this way	% agreement/ Cohen’s Kappa
Trust	7	17	0.98 / 0.83
No information	9	22	0.85 / 0.66
Relevance	3	7	0.98 / 0.84
Influence	18	44	0.80 / 0.58

When combining classifications 4 and 5, as both categories are positive for influence, the data show 50% of the comments indicate that being out (or not) influenced these lesbian parents use of health care. Examples of comments with regard to a positive relationships are as follows:

At our age, we only want to trust our healthcare with those that focus on our health and not our lifestyle. Therefore, we can feel confident in getting help when we need it (Respondent 1)

I am always out because I don't want my kids to think it's ok to lie or avoid the truth. If I thought I'd get bad care, I'd change doctors. (Respondent 4)

I think they have to deal with all types of people. They see it all and have to be very open minded (Respondent 9)

I generally prescreen doctors. I only go to women if possible. (Respondent 10)
Being out allows me to feel comfortable discussing any/all health issues and concerns. (Respondent 11)

Because I am highly educated and hold a position of status. If I was low SES, [I] think it might negatively influence my healthcare. (Respondent 12)

Yes, allows me/us to be more open about our health concerns--more honest. Depending on the health concern it may or may not be necessary to share sexual orientation. (Respondent 13)

I think it is important to be honest with someone as important as your physicians. (Respondent 18)

I cannot imagine getting care or feeling comfortable getting care from someone who does not know I am a lesbian. (Respondent 32)

If you are closeted there are restrictions on attending hospital procedures of [your] partner. We have experienced this fact on more than one hospital situation. Also, our doctor's office doesn't allow us in the room together while husband/wife members can (Respondent 35)

Among those who felt being out did not influence their use of health care, comments are as follows:

No, we just haven't had any bad experiences. (Respondent 14)

All of our health care providers are accepting to provide excellent medical care sexual orientation is a non-issue. (Respondent 17)

It doesn't make a difference to me or my doctors. (Respondent 20)

We have had nothing but positive experiences (Respondent 24)

I don't feel any of my issues have been discounted and I feel I am given as much attention in my medical issues as anyone else. (Respondent 37)

The data collected and summarized in the written survey provides a fairly clear picture of the respondents' overall feeling of the importance of being out to their physician, their high satisfaction with their provider, overall preference for female providers, and the importance of the physician-patient interpersonal aspect of the relationship. Specifically, as patients, the respondents primarily have had a positive experience with their physicians in coming out, feel qualitative variables like trust and honesty are key components with regard to factors that influenced their decision to divulge their sexual orientation. These findings may also indicate that these respondents, being out to their providers, may also have been more apt to participate in this study.

Findings From Phase 2: The Qualitative Study

As stated in earlier chapters, this research study was structured into two distinct data gathering methodologies. The written survey was populated with descriptive and quantitative data, with the last three questions intending to be qualitative with respect to gathering more individualized opinions on the respondent's experience with her health care provider, and variables related to coming out and their perception of the degree of influence sexual orientation has on their health care.

The second phase of the study entailed a structured interview with questions presented by this writer to a sub group of respondents from the original written LPHCS

questionnaire. These respondents were identified by indicating their interest in participating in an interview at the end of the LPHCS instrument which they returned, when the survey had been completed. The questions addressed to these subjects were intended to obtain a richer and more in-depth understanding of characteristics of the patient/health care provider relationship that contribute to a quality relationship. The main intent was to gather qualitative data from participants in order to answer the primary research question of this study: What are the characteristics of relationships between lesbian parent families and their health physician/ health care provider of choice which influence decision making about choosing a health care provider and lead to a perception of greater quality care? Additionally, information was sought to determine whether respondents felt they are treated in a fair and equitable manner as compared to their heterosexual counterparts. Additional questions related to the main research question were: Does the sexual orientation or gender of the provider matter, and what are the traits of a physician/provider that lead lesbian parents to seek and maintain care from that provider? A question was also asked in the interviews that does not directly tie to the central research question but may be interesting for future research consideration and exploration: What techniques do lesbian parents use to pre-screen physicians for themselves and their families?

Interviews

At the end of the LPHCS form was a page designated for respondents who may be interested in volunteering for a follow up phone interview. Of the 41 completed surveys mailed back to this writer, 22 of the 41 respondents (54%) volunteered to be called for an interview. A letter was sent to them in March, 2009, indicating that this

writer would be calling to set up interview times (Appendix C). The content of the letter also updated them on the progress of the study.

During the spring and summer of 2009, 22 volunteers were called by this writer for interview times. Nineteen responded, and dates were scheduled. Each research interview was recorded and transcribed. Each volunteer was advised of confidentiality, the purpose of the interview, and that the data collected would be a part of this writer's dissertation for a Ph.D. in Social Work at Michigan State University.

In addition to the recording, this writer also utilized a lesbian parent survey questions worksheet (Appendix B). The worksheet contained: the date of the interviews, the name/code of the participant, the phone number, and time of the interview. Their verbal agreement served as informed consent for phase 2 of this study.

The document, entitled Lesbian Parent Survey Questions Worksheet (LPSQW), served as a template for each interview, and a documentation tool for comments. The questions formulated for the phone interview related directly to the study research questions stated in chapters 1 and 3 of this study. Specifically, the following variables were queried using yes or no responses, with open-ended explanations to elaborate on the reason for the response provided.

1. Gender and sexual orientation preference of health care provider (does provider sexual orientation/gender influence your selection?).
2. Traits of a particular physician that lesbian parents to make a decision to seek care from him/her.
3. Lesbian parents' perception of fair, equitable, and empathic treatment; does physician empathize with issues/needs of the LGBT world.

4. How do lesbian parents pre- screen for choice of physician?
5. Lesbian parents' perception of quality of care received by their provider both for themselves and their families, and whether this care was unbiased based on sexual orientation.

Result of Phone Interviews

Participants in phase 2 of the study interviews were asked five questions (see Appendix B). All of the answers had a qualitative response requiring content coding by to researchers checking for inter-rater reliability. The use of a second rater in addition to this writer and Cohen's Kappa analysis minimizes threats to response validity. "Kappa and other such measures of agreement are statistics that correct for agreement that would be expected by chance" (Bloom et al., 2003, p. 68). Because of internal validity concerns, an inter-coder assessment and analysis was performed on each of the five LPSQ questions, with results discussed in the following findings.

The first interview question asked respondents if seeing a provider of the same sexual orientation would be easier, harder, or immaterial. Quantitative responses are continued in Table 4.9. Further information was also asked if seeing a provider of the same gender was a factor in the physician-patient relationship, and if they preferred one gender over the other. The answers were coded into the following categories: male, female, does not matter, OB/GYN female, and depends on relationship. These responses are found in Table 4.10. Respondents were asked if seeing a provider of the same orientation would be easier, harder, or immaterial (see Table 4.11).

The inter rater reliability assessment for the qualitative component to the questions was carried out by merging the coding of each rater into a single SPSS file and

then estimating the percentage of agreement, and Cohen's Kappa. The first question had two parts: respondent preference of provider gender and preference for provider sexual orientation. A Chi-square test of proportions was used to calculate whether there was statistically significant association between the answers. Implicit in both parts of the question is the null hypothesis that lesbian parents do not have a particular preference.

With respect to Cohen's Kappa for the question, there were no coding disagreements for sexuality preference codes. Thus the Kappa statistic is 1.00. For the gender preference, there were two disagreements (percent agreement equals $16/18 = 89\%$). The Kappa statistic for question one is one of 0.725. Generally, a Kappa of 0.8 is considered very high reliability. However, given the small sample size, two disagreements drop the statistic below the threshold of very high reliability to high reliability for this sample. Tables 4.9 and 4.10 contain the Cohen's Kappa summary. A Chi Square test and goodness of fit test were also performed to test OPSQ question 1 for an association among the respondents' provider preference (easier, immaterial, harder) based on the characteristics of provider sexual orientation (Table 4.11) and provider gender preference (Table 4.12).

Table 4.9. *Lesbian Parents' Opinion on Seeing a Provider With Same Sexual Orientation (N = 19)*

Category	<i>n</i>	%
Easier	5	26.31
Immaterial	13	68.42
Harder	1	5.26

Table 4.10. *Lesbian Parents' Preferred Gender of Their Health Care Provider (N = 19)*

Gender	<i>n</i>	%
Male	0	0.00
Female	14	73.68
OB/GYN female	1	5.26
Does not matter	3	15.79

Table 4.11. *Chi Square Goodness of Fit Test for Sexual Orientation*

Category	Observed <i>n</i>	Expected <i>n</i>	Residual
Easier	5	6.3	-1.3
Immaterial	13	6.3	6.7
Harder	1	6.3	-5.3

Table 4.12. *Chi Square Goodness of Fit Test for Preferred Gender*

Category	Observed <i>n</i>	Expected <i>n</i>	Residual
Male	0	0.0	0.0
Female	14	6.0	8.0
OB/GYN female	1	6.0	-5.0
Does not matter	3	6.0	-3.0

The data demonstrate that lesbian parents do not find the sexual orientation of the provider to be important. Sixty eight percent ($n = 13$) stated the provider's orientation was immaterial. Twenty six percent ($n = 5$) said it would be easier to see a lesbian physician, and 1, or 5%, said it would be harder to see a lesbian physician. The Chi Square statistic of 11.789 ($df = 2$) is highly significant ($p = 0.003$) leading to a rejection of the null hypothesis of no preference. However, the power of this statistic is compromised due to the cell sized for two of the three categories.

The gender category frequencies clearly show that lesbian parents prefer female providers. The responses mirror the larger written sample results and therefore appear representative of the entire sample. Fourteen respondents, or almost 78%, said they prefer

a female physician. One respondent only goes to an OB/GYN and prefers a female. No one prefers a male physician, but 3, or almost 16%, said gender was immaterial. The Chi Square statistic of 16.333 ($df = 2$) is highly significant ($p < 0.001$). The null hypothesis can be rejected. Given the lack of variance in the preference and cell frequencies, a Chi-square analysis is confirming, but somewhat immaterial. The following comments exemplify each response category in the sexual orientation preference part of LPSQ question 1:

Immaterial: I am out to my current provider and I have gotten a good response from him and feel supported by him. (Respondent 2)

Easier: Well, the problem is . . . and we face this every time we have to find a new provider, is that, particularly in the social milieu of today that you don't know when you are seeing someone if they are . . . because of religious reasons or whatever...are discriminatory toward people who are gay. (Respondent 3)

Harder: I would feel more uncomfortable being . . . having a physician as a woman who was a lesbian. I think it would make me feel more uncomfortable, versus either a gay man or a straight woman. (Respondent 5)

Female preference: Definitely a female. (Respondent 8)

OB/GYN female preference: When I first sought out an OB/GYN, I sought out a gay friendly office. My personal physician is not a lesbian, but they are a very lesbian friendly office, and that was something I wanted. (Respondent 10)

LPSQ Question 2, Perceived Quality of Care

The second question in the qualitative interview asked respondents if they feel they received quality health care for themselves and their families. Subjects discussed that they felt they either did or did not receive quality treatment from their health care provider. Reflecting the high level of satisfaction reported in the LPHCS responses, 84% of the respondents in phase 2 ($n = 16$) were also satisfied with the quality of care they received from their provider (Table 4.13). Those who answered that they did not receive

quality health care ($n = 3$, 16%) were then asked to elaborate why, and the answers were coded into the following categories: communication, health care system, paternalistic, quality, and style.

Inter-coder reliabilities were performed in a manner similar to question one. Each category was coded as mentioned or did not mention. Cohen's Kappa was run on inter rater agreement. Table 4.13 contains the results of the Cohen's Kappa analysis. The only inter rater disagreement occurred on whether a respondent answered yes or no. There was complete agreement on each of the reasons given, once a respondent noted she had not received good care.

Table 4.13. *Inter Rater Agreement on Quality of Care Received (N = 10)*

Category	% agreement	Kappa
Yes/No	0.947	0.826
Communication	100.000	1.000
Paternalistic	100.000	1.000
Quality	100.000	1.000
Style	100.000	1.000

Table 4.14 is a cross tabulation table of responses on being satisfied with the quality of health care physicians/extenders have provided to respondent and family.

Table 4.14. *Were Lesbian Parents Satisfied With Care Received? (N = 19)*

Category	n	%
Yes	16	84.21
No	3	15.78

The vast majority of respondents were satisfied with the quality of care from their physicians, or extenders. Those who were dissatisfied with their care were asked to explain why. Using the aforementioned categories, there was variance regarding what the reason for dissatisfaction was with each of the coding reasons being mentioned at least

once but none of the reasons being mentioned by all three dissatisfied respondents. Table 4.15 contains the dissatisfaction coding frequencies.

Table 4.15. *Reasons Lesbian Parents Were Dissatisfied With Care Received (N = 3)*

Category	<i>n</i> time mentioned as a factor of dissatisfaction
Communication	1
Paternalistic	1
Quality	2
Style	1

Quality as a reason was mentioned by 2 respondents, the other categories were mentioned by each respondent separately. In this data summary, the exact comments provide a richer understanding for the reader on the quality concerns.

I had a lesbian doctor, whom I liked reasonably well. I was diagnosed with [something], and I stated I wanted additional testing [done]. And, I think I contacted off and on the first couple of times . . . the doctor. She said these tests are immaterial. I then [was sent] to the nurse line. So, I am talking to the nurse. So we had five different exchanges and I never got what I wanted. Felt like she was belittling of what I wanted and I never did end up getting [the tests]. Her style, and partly our health system in general, really elevates the doctor about patient interests. I have found often that unfortunately with female providers, they can be more paternalistic than the men. (Respondent 6)

We've moved around a lot, so I would say that when we were living in Wisconsin, in Racine, the health care was not very good. I think it is well known in the community not [to use] Racine health care . . . it is generally bad care. (Respondent 3)

The qualitative data indicate that the care that respondents felt dissatisfied with had more to do with variables other than their sexual orientation or family composition. The sample is quite limited but does point to variables such as location of care, communication between doctor and patient, and the interpersonal style of the physician, a variable explored later in this chapter.

LPSQ Question 3: Physician/Provider Empathy

In the content of question 3, respondents were asked if they feel they receive sufficient understanding/empathy when receiving health care from physicians. If respondents stated their doctors did not empathize, they were asked to elaborate. Their explanations were then coded into the following categories: insurance issues, has not come up, staff has issues, yes now, but had issues in the past.

An inter rater reliability was again performed on the empathy responses and elaboration. Table 4.16 contains the Cohen's Kappa analysis demonstrating powerful agreement.

Table 4.16. *Lesbian Parents' Ranking of Empathy/Understanding From Provider* (N = 19)

Category	% agreement	Kappa
Yes/No	0.944	N/A ^a
Insurance issues	100.000	1.000
Has not come up yet	100.000	1.000
Staff have issues	100.000	1.000
Yes, but issues in the past	0.944	0.769

^aIt was not possible to calculate Kappa in cases where only one coder utilized one category (one coder had all respondents in "yes" category), yet the percent agreement amount the other categories demonstrates high agreement between coders.

Eighteen of the 19 (95%) lesbian parents interviewed answered the third LPSQ question. All of these respondents felt that their physician empathized with issues and needs of the LBGT patient. However, some qualified their response in the manner noted in Table 4.17 with non-physician issues cited.

Table 4.17. *Lesbian Parents' Opinions on Whether Their Health Care Provider is Empathetic to LGBT Needs (N = 18)^a*

Category	n yes	%
Does doctor empathize	18	100.0
Insurance issues	2	11.0
Has not come up	2	11.0
Staff have issues	1	5.5
Issues in the past	3	16.6

^aOne respondent did not answer question

All respondents to this question stated their physician seemed to understand and/or with issues and needs of “the LGBT world.” A few respondents discussed other issues, such as insurance coverage, staff, and past bad experiences. An example of the respondents’ qualification is exemplified by comments below:

Just from the standpoint of going to an appointment together. My partner is not allowed in with me. They say HIPAA. I don’t know whether that’s the real reason. (Respondent 1)

[We have encountered discrimination], especially in terms of [my partner] providing insurance through her work and through her company, but there have been so many times the humiliation factor has been so evident because they make us go through all the ridiculous hoops every time. “Now, who are you and what is your relationship?” And, you feel this cold chill, you know. (Respondent 3)

Question 4: Screening Methods Used to Select Physician or Provider

The fourth interview question asked interview respondents what screening methods they employed to select their present physician/provider. All 19 respondents answered the question. Inter-coder assessment was once again implemented. Coding categories and Cohen’s Kappa and frequencies observed for the coded answers are contained in Table 4.18.

The results of question 4 indicate that quality and care is an important consideration when choosing a physician. This was mentioned by 5 lesbian parents (26%). However, “word of mouth” appears the strongest reason for choosing a physician.

Within the categories of word of mouth, lesbian, non-lesbian, and word of mouth non-specific (to source), almost half of those interviewed, or 47.36%, said they “screened” their physician through fellow lesbians, and lesbian parents before choosing their current physician. A reliability challenge to the coding categories was that “word of mouth” and “physician reputation” may well have been measuring the same thing, hence, this may be why reputation was not mentioned by many respondents.

Table 4.18. *Cohen’s Kappa and Frequencies for Lesbian Parents’ Criteria and/or Methods Used to Choose Their Present Physician (N = 41)*

Category	% agreement	Kappa	Frequency mentioned
Female	100.00	1.00	2
Had history	100.00	1.00	2
Interviewed	100.00	1.00	3
Hours/location	94.74	0.77	2
Multiple methods	100.00	1.00	2
Quality and care	89.47	0.69	5
Reputation	94.74	0.77	2
Word of mouth, lesbians	89.47	0.79	9
Word of mouth, non lesbians	84.21	0.65	6
Word of mouth, not specific	84.21	0.57	5

Note: All Kappa findings were significant for coder reliability.

Some illustrative comments from respondents regarding physician screening methods for physician selection are as follows:

Actually, its word of mouth, so other people that are in our community have told me about the physicians and that is why I go to people where I know I will be accepted. (Respondent 4)

We looked for a woman. We wanted somebody who did general family care knowing that we were going to have kids, and pretty much just wanted to see one physician so that they knew our family. We went by recommendations. Actually, we asked around other friends. “Who do you have? Who do you use? Who do you like?” [lesbian friends]. (Respondent 5)

Well I have to say I didn’t do much of a screening at all. So, that’s probably my fault. I just . . . well, word of mouth. I had heard good things about her. I liked her initially, but she sort of dismissed my concerns. It is disappointing when you are

just sort of dismissed out of hand. That is why I haven't gone back to her now. I finally said, that's enough. (Respondent 6)

I like someone who is easy to talk to. And again, is a female, and is highly regarded by her peers. (Respondent 8)

Question 5: Important Characteristics/Traits of a Current or Past Physician/Provider

This last interview question is integral to the basic research question of this study, which asks: What are the characteristics of relationships from the patient perspective between lesbian parent families and their provider of choice? This writer believes there is a correlation between the physician traits, interpersonal style, and the style of practice that creates a bond with their patient. All 19 respondents answered question 5.

Two sets of codes were merged into a single SPSS file allowing for an inter-coder reliability assessment. The question had 11 possible coding categories. For each respondent, the category was coded: 0 = "did not mention" or 1 = "mentioned." The inter-coder reliabilities then compared cross tabs of the two separate codings to determine the amount of agreement for each question.

The Kappa for the female category could not be computed because one coder categorized all respondents into 0 "did not mention" category. For all other physician characteristic categories, the inter-coder agreement was strong. The categories with the lowest agreement were "partner/child also able to see doctor as patient" and "took time for me, above and beyond routine." Further discussion between coders resolved any discrepancies as coding definitions were reviewed and re-clarified. Table 4.19 contains the reconciled frequencies and kappa statistics for coding of the important characteristic codes.

Table 4.19. *Physician Characteristics/Traits Important to Lesbian Parents in Selecting Their Current or Previous Physician (N = 19)*

Category	Mentioned <i>n</i>	%	Coder % agreement	Cohen's Kappa
Good communicator	5	26.3	0.895	0.729
Caring, kind, respectful, non-judgmental	5	26.3	100.000	1.000
Attention to detail	3	15.8	0.947	0.771
Engages patient in decisions with care	8	42.1	100.000	1.000
Empathetic/compassionate	3	15.8	0.947	0.771
Female	1	5.3	0.947	N/A
Holistic approach	1	5.3	100.000	1.000
Good listener	9	47.4	0.895	0.787
Partner/child able to see doctor as patient	3	15.8	0.895	0.604
Respect	2	10.5	0.947	0.771
Took time for me, above and beyond routine	7	36.8	0.842	0.627

As demonstrated in Table 4.19, the physician's listening skills ($n = 9$, 47%), engaging the patient in care decisions ($n = 8$, 42%), and taking time with the patient ($n = 7$, 37%) were the characteristics mentioned most often by the lesbian parents as important. In an effort to capture the detailed discussions within the interview questions, this writer applied 11 codes. However, from the standpoint of reliability, in retrospect, some codes could have been condensed, without skewing the results. An example of like categories are: good listener (47%) and good communicator (26%). If the two categories are combined, the results become 74% of respondents mentioned the trait as important. Another overlapping theme in categories is engaging patient in decisions with care (42%) and took time for me, above and beyond routine (37%). Combining the responses for the two categories together yields a 79% outcome. These are logical associations only since this raw data set is not large enough to meet the assumptions of random distribution of error necessary to run factor analysis to test for whether these physician characteristics

are conceptually and statistically related to one another (Cohen & Cohen, 1983). As this study is exploratory in nature, one of the recommendations for future research will be to test the characteristics on a larger sample population using factor analysis to test for character associations.

The results of question 5 validate findings in literature cited within the literature review section of this study (Brody et al., 1989; Emanuel & Emanuel, 1992). Patients want to be interactive with their physician, want a voice in decision making, and appreciate adequate time devoted to their health issues.

Some descriptive comments from respondents illustrative of the coded results are as follows:

I think the key issue is being a good communicator and treating you as a person who has a brain rather than just telling you what they are going to do. Engaging you in your own health care I think is very important. (Respondent 1)

She was interested in my opinions. I felt like she was extremely straight forward. She was respectful in listening to what I had to say, whether or not she agreed. (Respondent 6)

Open to our suggestions, an open dialogue between me and the doctor. Suggestions instead of “this is how we are going to do it.” It was “we could do this.” (Respondent 11)

She is a great listener. I don’t really know [if it matters] as far as being a lesbian mom, as far as being, I mean I had issues, a partner at different times, but also times I was single. A couple of those times I had real issues with my daughter, and the physician would just . . . well one time she took my daughter at 5:00 p.m., and sat and talked for an hour until 6:00 p.m. about something. It felt urgent to her [my daughter], and [the physician] was going above and beyond and it was great. I didn’t even expect that from a health care provider. (Respondent 19)

Summary

The response to the written survey associated with this study did not produce the hoped for number of participants. The limited number caused a shift in data analysis

available and reliable for use. However, even with 41 respondents, there was an adequate number to statistically represent a normal distribution. Respondents were, on average, middle aged, Caucasian females, in a partner relationship, with one or more children. Data from the quantitative section of the written survey revealed that most of the respondents had an adequate household income, had health insurance, and had a positive relationship with their current physician. Most ranked their health and the health of their families as good.

In contrast to Mercier's 1999 study, most respondents had a positive experience with their physicians. As cited earlier in this study, Mercier found that although 86% of the lesbian parents were out to their medical provider, only 29% responded that the provider was viewed as supportive.

The results in this study reflect that lesbian parents research physicians prior to making a decision to use them as their provider. The main method of screening is word of mouth. Once the selection is made, and care is initiated, the majority of the respondents in this study both reveal their sexual orientation, and express support and empathy from their physician. Additionally, where the physician's sexual orientation was immaterial to respondents, the vast majority of the lesbian parents preferred a female physician.

Coming out to their physician parallels Mercier's (1999) observation of lesbian parent behavior in other social structures, such as their child's school. She observed "Coming out to teachers, [school] administrators, and children's peers can be seen as a deliberate act in which lesbian mothers simultaneously increase their visibility in the

school environment in order to affiliate with other marginalized groups” (p. 149). The same correlation could be made with lesbian parents in the health care environment.

Chapter 4 presents summarized data from the written surveys, and the telephone interviews. Statistical methods were employed to validate qualitative trends. Chapter 5 will present and analysis of the data, conclusions, study limitation, and finally implication for future research, policy, practice, and education with regard to lesbian parents, and their interactions with physicians.

CHAPTER 5. CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The problem this study was designed to address is the limited knowledge base related to physician characteristics that may support a strong and trusting relationship between the physician, lesbian parents, and their families. The study was driven by a single research question: What are the characteristics of relationships between lesbian parent families and their health physician/ health care provider of choice which influence decision making about choosing a health care provider and lead to a perception of greater quality care?

The study was intended to garner further information and a greater depth of understanding of lesbian parent experiences with a health care provider. The survey and participant population were based on Mercier's 1999 dissertation research, and a subsequent 2003 study by Mercier and Harold. The two research questions posed in Mercier's 1999 study were: "What are the characteristics of relationships within lesbian mother families" and "What are the characteristics of relationships between lesbian mother families and institutions in the social environment" (p. 34). This study sought to extend the research as it relates to health care in the social environment, and specifically, physician relationships with lesbian parents and their families.

A review of relevant literature revealed that health care delivery in the United States has historically demonstrated some degree of discrimination toward patients based on minority status and social identity (Betancourt, 2006). Particular emphasis in the literature review was a summary of health care delivery to the LGBT population. Many publications and studies found lack of education and understanding of LGBT needs on the part of physicians (Bernhard, 2001). Other variables present in the literature on the

LGBT experience with health care were mistrust, stilted communication, and invisibility of sexual orientation as it relates to the patient/physician information sharing (Bonvicini & Perlin, 2003). There was a paucity of research related to specific patient identified physician characteristics that support a strong therapeutic relationship between physicians and lesbian parents. Rather, most of the literature portrayed the opposite trends of negative and stilted relationships between lesbians and physicians. Little in the literature was found specific to lesbian parents and their family physicians.

The development of a trusting and open relationship between patient and physician is critical to supporting patient satisfaction and positive treatment outcomes. Thus, interpersonal competence with diverse social groups is an important variable for physicians as they establish relationships with their patients. The more comfortable a physician is with the patient, their issues, and needs, the better the flow of interaction and communication. People who identify as LGBT are often considered a social minority because of their sexual orientation, and this diverse status may pose challenges for practitioners who are not educated in the health care needs and issues for this population.

As aforementioned, the purpose of this study was to explore the perceptions and preferences of lesbian parent families, as they choose and interact with physicians for self-care, and care for their partner and children. The focus of this study was to engage lesbian mothers in their perceptions and opinions of the patient/physician experience based on sexual orientation. As described in previous chapters, this study was framed by a single overarching research question, stated earlier in this chapter. This question was supported by five sub-questions, which included:

1. Is there a difference in lesbian parents' perception of health care relationship quality between those who are "out" and those who are not?
2. Do lesbian parents prefer physicians/providers of the same gender or sexual orientation as themselves and does the physician provider's gender influence the relationship from the perspective of the lesbian parent family?
3. What are the traits of a particular physician that lead lesbian parents to make the decision to seek care from him or her?
4. Do lesbian parents feel they receive quality health care for themselves and their families?
5. Do lesbian parents feel they receive sufficient empathy when receiving health care from physicians as opposed to other providers?

These questions were answered through a mixed method design that began with an opinion survey that assessed the perception of physician health care delivery among lesbian parents. Based on the survey results, volunteer respondents were contacted to participate in interviews and focus groups to gather additional qualitative information about their perceptions and experiences with regard to health care delivery.

Findings and Implications

This study sought to gain insight into the dynamics of the physician-patient relationship as experienced by lesbian parents who were making health care decisions for themselves, their partners and their children. The results of the initial survey and the follow up telephone interviews provided the basis for this analysis and the results, as they relate to the study's research questions are discussed.

Differences in Perception Based on "Out" Status

Respondents indicated that “out” status did influence their relationships with providers, and that their status was found to generally support openness and trust in their physician-patient relationship. Forty three percent of the written survey participants felt that being out to their physician influences their use of health care. Of the written survey respondents, the majority (96% of the sample) were in fact out to their physician. In addition to the perception of being out influencing care, 24% of the 41 respondents commented that coming out to the physician was relevant to care (7%), and that it impacted trust (17%). Thus there is supporting data in this study to link openness about sexual orientation as a key element in lesbian parent perception of care received from, and relationship with their physician.

The fact that respondents indicated high satisfaction with their physician, when they are forthcoming about their sexual orientation is important because it reflects the rapport that can be built when patients can be honest about their sexual orientation. This is of particular interest, as nearly half of the respondents believe being out influences care. This writer asserts that this can be an important finding. Brotman et al. (2002) stated that although coming out maybe the most problematic aspect in a health care encounter, “being out with one’s health care provider improves the chances of receiving appropriate and satisfactory health care” (p. 11). The respondents in this study appeared to agree with the authors’ statement.

Blanchard and Lurie (2004) researched patient perceptions of disrespect from providers. They found that measures of negative perceptions of the patient-physician relationship included: disrespect, perception of un-fair treatment based on race, social status, or language spoken. They concluded the negative patient-physician relationship

impeded care, and may contribute to health care disparities. Similarly, Trippet and Bain (1993) found that negative experiences for lesbians with physicians included poor communication and feeling disrespected.

Bagby (2006) cited a health educator's comments on lesbian and minority health, which correlates to physicians treating someone who may be a societal out-group member. "An obstacle for LGBT is not being comfortable going to providers who may not know they are treating a lesbian. It's similar to the Latino community--There's a language barrier, a different language being spoken between the patient and doctor" (p. 2). Bagby also cited a case study in which a lesbian visited her doctor while living a closeted life in rural Virginia, and the doctor berated her for 45 minutes for not using birth control. The patient accepted the correction, because it seemed a more desirable option than explaining why birth control wasn't necessary, stating "It was just not safe to identify as a lesbian, especially with your doctor, in this rural town" (p 1).

This study revealed findings that support Bagby's conclusions on the importance of open communication between lesbian patient and physician. The results found in Chapter 4 indicate that discussing sexual orientation can contribute to a sense of higher satisfaction with the physician relationship (Table 4.5) and a self-reported health status that is positive (Table 4.3). Thus, one can speculate that a patient-physician relationship, especially with social minorities, is more satisfying when there is honesty, a feeling of acceptance, comfort, and respect.

This study's findings are consistent with themes cited by Bernhard (2001). With respect to the few studies that indicate positive experiences with physicians, lesbians reported feeling that they were treated with respect, like human beings, and that they

were heard. They felt they could collaborate with the physician, and be believed.

Physicians who were sensitive and positive in their approach made lesbians feel accepted.

The most positive environment cited was when a physician treated lesbian patients with compassion, and as if they were like anyone else.

The study findings were echoed by one of the phone interview participants. She indicated that she and her family wanted to be:

Treated equally [by physicians] regardless of which one of us was the patient. Just be open and willing to hear our thoughts about things and our plan about how things should go. [I want her to be] knowledgeable, kind, caring, flexible, good listener, communicating equally with my partner and I so, if we are both in the room, there is shared conversation. (Respondent 11 phone survey)

The study respondents' indication of factors that influence coming out, and the experiences of coming out in this study are similar to a Canadian study by Geddes (1994), in which 94% of lesbian respondents felt it was important to reveal their sexual orientation to their physician. Their reasons for coming out were: the information was crucial for more accurate medical understanding and diagnosis, a desire for increased honesty and understanding with their physician, and a need for inclusion of their partner/children and clarification of their family structure to the physician. One must ask if Canadian attitudes, approval of same sex unions, and socialized health care may be variables in the outcome of the study. Notable are the similarities in responses between the Geddes study and the results presented in this study.

Preferences About Gender and Sexual Orientation of Providers

There was general agreement among the respondents for choosing female physicians, and 77% reported a preference for female practitioners. It is worth noting that none of the respondents stated a preference for male providers. Furthermore, the sexual

orientation of the provider was deemed immaterial for 68% of the respondents indicating that this was not a priority in their selection criteria. In fact, 89% of the respondents have a heterosexual physician, and 80% indicated their partner also had a heterosexual provider, with 14% unsure of their physician sexual orientation for their partner. From this, one can surmise that gender, and relational style takes precedence over sexual orientation, or seeking out lesbian physicians. Geddes (1994) found that lesbians most often have negative experiences because of their gender, as most cited bad experiences with male physicians.

Fourteen phone interview respondents (74%) preferred female physicians. One respondent in the phone interview preferred a heterosexual female physician over a lesbian provider.

I would feel more uncomfortable having a physician as a woman who was a lesbian. I think it would make me feel more uncomfortable versus either a gay man or a straight woman. . . . The physician I have now is a straight woman as a physician and they have always been straight. So, I guess that is where I feel the most comfortable. (Respondent 5 phone survey)

This phenomenon of familiarity of gender can be associated with Malat and Hamilton's (2006) research that examined the preferred race of health care provider among Blacks in the United States. They found that Black respondents felt discrimination may be likely from Black or Caucasian physicians, and seeking care from "black providers may not offer protection from unfair treatment" (p. 184). However, those respondents most concerned with receiving unfair treatment had a higher probability of preferring same race health care providers, thus choosing a Black physician. Lesbian parents may feel female providers are "safer" than male providers, given the high satisfaction scores with their physician (Tables 4.5, 4.14, 4.15), and of those asked about

whether their physician is empathic to LGBT needs, 100% responded yes. Perhaps gender is the key predictor for lesbian parent physician preference.

Bernhard (2001) stated that lesbians consistently report a preference for female providers, and cited multiple studies to validate her assertion. She concluded that research is needed to better understand the “lesbian client/health care provider interaction” (p. 169). Future research should explore the dynamics of same gender health care interactions. Malat and Hamilton’s research (2006) found higher satisfaction in patients who were paired with same race physicians. The same could be true with same gender patient-physician pairing.

Physician Traits That Support Ongoing Patient Relationships

The physician qualities highlighted as significant priorities for the respondents included good listening skills (47%), engaging patients in health care decision making (42%), and taking time with the patient (37%). All of these are likely characteristics that most patients seek in a clinician, but the potential barriers imposed by practitioners who are not versed in the cares and concerns of lesbian families may limit them in their capacity to adequately assess and treat lesbians and their families. “Unfamiliarity with matters which have particular impact for the health of gay and lesbian people can lead to a decreased quality of health care . . . a reluctance to discuss matters of sexual orientation may preclude the discussion of health issues” (Speight, 1995, p. 144-145).

The traits identified as priorities relate to prior research on physician characteristics. In their study of lesbians, White and Dull (1997) reported that respondents rated the communication style of the clinician as the most important variable in determining ease of discussion over difficult issues. Bernhard (2001) cited the works

of Paroski (1987), Robertson (1992), and Trippert and Bain (1993). All the aforementioned studies cited the fact that lesbians want providers who are comfortable with lesbian health issues and concerns. An examination of respondents' comments in this study highlighted Bernhard's findings. "I prefer to see a woman. I feel more comfortable with women. I think they are more caring and understanding" (Respondent 10).

Mravcak (2006) highlighted the creation of a therapeutic relationship with patients is based on building trust in order to overcome any barriers to quality care, and encourages physicians to create an environment conducive to "candid communication . . . using inclusive language may increase patient comfort" (p. 2).

Thus, consistent with the review of literature in Chapter 2, and the findings presented in this study, the key traits that can be most supportive to foster positive ongoing relationships for lesbian parents and their physicians primarily revolve around communication style on the part of the physician. Specifically, listening, providing empathy, engaging the patient in decision making and taking time with the patient are central themes, along with a trusting, open and honest relationship.

A respondent in this study stated she appreciated her physician's:

Attention to detail, her kindness and caring. I loved her as a doc and as a person. She became [my partner and child's] doctor. She was the most caring, thoughtful, and she never batted an eye about the gay issue. Your health care issues [make you] so vulnerable that you want some sense that the person is connected to you. It is an intimate part of your life. (Respondent 3 phone survey)

The quote highlights and summarizes the findings associated with rapport between physicians and patients. The results of this study affirm the critical nature of a

strong and open relationship between the two parties if patients can be comfortable enough to be forthcoming about their sexual orientation.

Perceptions About Quality of Care

Perceptions of care were quite positive, with 84% of respondents indicated satisfaction with the care they receive from their provider. In cases where dissatisfaction was expressed ($n = 3$), reasons cited included communication issues, paternalistic attitudes, issues of quality and differences in style. Thus, in the patient's mind, it can be inferred that perceptions of quality are intrinsically linked to satisfaction with the physician.

In Chapter 4, many of the qualitative responses related seeking out physicians were based on word of mouth. In fact, of the phone survey respondents, almost half said they used word of mouth to seek out their choice of physician. In their screening, the respondents matched their perceptions and expectations of physician quality with their questioning of friends, and others in their community. Thus, the quality of care rendered may be more weighted towards the physician's openness to treat lesbians, interpersonal style, and overall perception of "good care" given. Less weight may be given to a complex and technical methodology of physician quality (e.g., review of physician mortality rates with patients, medical training, etc.) than to interpersonal style. This observation may be a variable to be tested in future research.

The following quotes from phone interview respondents illustrate the screening process and perception of quality:

We got referrals, board certified referrals, on doctors who would be gay friendly.
(Respondent 3)

Word of mouth [is our screening method] so other people that are in our community have told me about the physicians and that is why I go to them. I know I will be accepted. I go on the recommendations of my [lesbian] friends. (Respondent 10)

We usually ask around for recommendations. I think that is part of the reason we have been lucky, is that we have gotten suggestions from friends and other people that have had good experiences with their doctors. So often we go to somebody with a good recommendation. (Respondent 15)

We looked for a woman. We wanted somebody who did general family care knowing that we were going to have kids, and pretty much just wanted to see one physician so that they knew our family. We went by recommendations, actually. We asked around other friends, “Who do you have? Who do you use? Who do you like?” (Respondent 5)

Perceptions of Empathy

All respondents in this study found their practitioners to be empathetic to LGBT needs. This may be the result of careful screening by the respondents, but might also reflect progress in diversity training and understanding by health care providers in recent years. To exemplify the power of empathy in this study, one respondent stated:

Well, she is very empathic, very much a listener, as opposed to an advisor. She really listens when you have a concern. As a matter of fact, she has a niece who is a lesbian. So she understands the difficulties we might face. She is just very warm, very kind, very understanding, and certainly non judgmental. (Respondent 4 phone survey)

The results of this study, with the majority of respondents, both out to and satisfied with their physician represents a significant positive change from literature a decade ago. Peterson and Bricker-Jenkins (1996) reported that limited research was found on lesbian health care with respect to attitudes of health care providers. They also referred to a multitude of studies that validate heterosexist views of physicians and reluctance of lesbians to come out to their physicians for fear of discrimination. Daley (2003) found in her study that “lesbians are not visible” (p. 114) in health care. Gonser

(2000) cited 1996 research which found gay and lesbian needs in health care generally are ignored, with the repercussion of the LGBT population avoiding routine care. The results of this study indicate that such circumstances and attitudes may be less common.

Despite the limited exploratory nature of this study, it is significant to note that lesbian parents are out to their physicians, feel that they receive empathy for LGBT issues and concerns, and that their perceptions of satisfaction and quality are high. This finding is very different from most published literature on lesbian health care. As compared with Mercier's (1999) data outcomes, most women in this study do feel support from their physicians, as exemplified by the total sample of phone interview participants responding positively to the question about physician empathy. Perceptions of empathy are contingent on the aforementioned qualities of attentive listening, collaborative decision-making, and trust. All of these require time and attention from the provider, as well as a willingness to understand and appreciate the patient's perspective on their health care issues.

Restatement of Limitations

A variety of limitations naturally constrain the conclusions drawn from this research. The potential limitations discussed in Chapter 1 were affirmed during the study. Many potential respondents of this study were originally asked to participate in Mercier's 1999 survey and Mercier and Harold's 2003 surveys. The number of actual respondents to this study was much lower than previously mentioned surveys. This outcome may be due to the gap between the 2003 survey and the current survey mailing. This writer did receive 21 envelopes returned due to no forwarding address. Added efforts to locate these previous participants of previous surveys were not successful (i.e., internet search).

This survey was constructed to be much more specific and detailed on lesbian experiences with physicians. The lower number of respondents may be correlated to those who had an interest in health care, and chose to participate. Perhaps those who were more assertive with their physician in terms of their sexual orientation, and were more satisfied with their care were more likely to want to complete the survey. Conversely, it is possible that women less comfortable being out regarding their sexual orientation may have been less likely to participate in this study. This phenomenon may have influenced response rate. The sampling type may also have contributed to the low return rate. Written surveys that are mailed can have a low return rate, especially as the demographics of the survey sample age (e.g., bad addresses).

This study was intended to be exploratory in nature and utilized convenience sampling as a technique. Convenience sampling does have an impact on study reliability and validity. Reliability relates to the extent to which an experiment, test, or any measuring procedure gives the same results on repeated trials. Study reliability may be marginalized because a pure random sample was not obtained. Results obtained from this study may not be categorically replicated later using a convenience or random sample from the same population.

Similarly, study validity may be lower as well. Validity is concerned with how successful the study is at measuring what needs to be measured. Although results from the study may be valid for the sample population selected, it may not necessarily be valid for the entire population. This study is attempting to measure how lesbian parents feel about health care provider characteristics and their impact on perceived quality of care. Thus, the study may indeed successfully measure what needs to be measured, but this

may not necessarily be generalized to the greater population of lesbian parents. Agresti and Finlay (1997) stated “no probability sampling methods are ones for which it is not possible to specify the probability of the possible samples” (p. 20).

Other limitations include the demographic characteristics of the population being sampled. The respondent sample is very homogeneous in many aspects. The majority of respondents are Caucasian (90%), with their partners being mainly Caucasian as well (80%; Table 4.1). The majority of respondents are all above the poverty level, as assumed by the United States government. In fact, 90% have a household income of \$50,000 or greater. The vast majority have insurance coverage for themselves, their children, and partners.

The social economic and demographic characteristics of this sample population exclude minorities, lesbian parents who may have economic challenges, and younger or older lesbian parents, as the age group in this study is in their late 40s. Further, the study only surveyed lesbian parents who were in relationships and raising children together. Although one couple indicated relationship issues, all respondents were living together with their children.

Lesbian parents in this study may be more assertive in their disclosure and preference for patient-physician relationship. The study limitations could have promoted a response from those who have a pro-active relationship with physicians. Never the less, physicians can benefit from the results of this study to better understand the unique needs of lesbian parents and their families.

Further, the literature cited in this study validates that the scholarly research on lesbian preferences for physicians based on characteristics or traits is very limited. The

paucity of literature, combined with the exploratory methodology of the study presents inherent limitations for extrapolation of data, and comparisons to larger population sizes. Despite its inherent limitations, the study provides a strong basis for future research in this area and also provides specific recommendations for practice.

Recommendations for Further Study, Practice, and Research

This study and the related literature review deal with potential, perceived, or real discrimination based on sexual orientation, and related social minority status. Particular emphasis is placed on this perception in health care delivery systems. Within the context of social work, a focused effort in policy reform, additional research, and curricular changes on this topic can be a recommendation. The information found in this study could enhance social work education, practice, and related areas as they relate to improved quality in services provided to members of the LGBT community, with particular interest in lesbian parents.

The social work profession's history in health care and role in advocating for social and racial minorities have also been summarized. Social workers should be the lynchpin of advocacy for social minorities, and the latter's interface with the U.S. health care delivery system. With gay marriage and same sex parent families becoming more overtly common and more visible within our society, the interface of LGBT patients with providers and hospitals deserves fresh consideration. The issue is especially important since same sex partners have been negated as next of kin or immediate family members in many hospitals, due to lack of legal status. Thus, organizational policies may inherently discriminate against lesbian parents and other LGBT relationships until federal

or state laws are changed. This is exemplified by one of this study's respondent comments:

The entire health care system is set up to respond to and benefit straight people. The responsibility is transferred to us, the patients, to self-identify, educate, advocate, etc. . . . Sometimes our power of attorney are not honored, for example. Always [get asked] the question "Who are you?" directed to the partner.
(Respondent # 6, written survey)

Berkman and Zinberg (1997) suggested that social workers need to learn more about LGBT families in order to be more effective with advocacy and practice. Moreover, they proposed that research was needed to further comprehend how negative attitudes towards LGBT clients relate to service outcomes, and client satisfaction. The recommendation can easily be extrapolated to physicians, and other health care professionals. Most importantly, physicians need education on the importance of their interpersonal rapport with lesbian patients.

Physician practice, research, and education could be benefited from the findings in this study. Physicians have a great opportunity to reverse previous LGBT perceptions with regard to health care and provider discrimination. As Mravcak (2006) asserted, concentrating on trust, non-judgmental language and office environment, and getting a tone of acceptance may be a welcoming start to a long term positive patient-physician relationship, not only with lesbian parents but all LGBT patients who present to the physician's practice.

Neville and Hendrickson (2006) studied perceptions of lesbian, gay, and bisexual patients in primary health care services. They reported that more women than men identified that the practitioner's attitude was important when choosing a provider: "statistically significant[ly] more women than men reported that their health care

provider usually or always presumed that they were heterosexual and in addition more women had disclosed their sexual identity to their health care provider” (p. 407). They suggest provider education, templates for assessment that include questions about sexual identity, and non-judgmental communication.

The recommendations recommended by Neville and Hendrickson are echoed by many other authors with regard to physician education and practice. Speight (1995) detailed the role of medical educators on the change in physician perception and subsequent relationship with gay and lesbian patients. His last statement in his article was as follows: “I recently asked one of my patients, if he had a choice, would he prefer his son to be gay or on drugs? Without hesitation he said “drugs any day” (p. 156). The statement reflects that discrimination and prejudice of any social minority will exist. Hopefully, with exposure, education, and enlightenment, stereotypes will diminish, allowing for a more fulfilling patient-physician relationship, as well as public acceptance and tolerance. As Speight’s article was written over a decade ago, this writer is hopeful that attitudes have shifted, as evidenced by lesbian patient perceptions captured and measured in this study.

Daley (2003) offered several recommendations for health practitioners as a result of her study on lesbian health. With respect to research, she asserted that additional qualitative research is needed to garner in depth attitude trends for lesbians as they perceive health care. Her conclusions and findings were as follows:

1. Healthcare organizational knowledge of lesbians is fragmented.
2. Lesbians are not a majority user of health care. Thus the ‘voice’ is incumbent on the patient to divulge information to the physician.

3. Sexual orientation is relative in importance to physicians depending on the diagnoses and subsequent treatment.

The implications for patient and physician are discounting of personal and family life unless the physician plays an active part in creating an environment for open and trusting communication.

Bonvicini and Perlin (2003) provided strategies for physicians to promote a supportive relationship for LGBT patients:

1. Accurate sexual orientation and relationship status of patients.
2. Communication of a safe and welcoming practice environment.
3. Communicate consideration of partner and family relationship.

Their suggestion for physicians is that sensitization of physicians to the unique health care needs of LGBT patients should increase patient confidence in care provision.

“Patients who feel understood, respected, and confident in their clinician’s communication and technical skills, in partnership with their clinician, comprise a highly effective collaboration likely to produce positive patient health outcomes” (p. 121).

Similar to Daley’s recommendations, the Bonvicini and Perlin concluded by encouraging further research to identify the unique health needs of the LGBT population. The authors also advocated for specific training for physicians in practice or residency on the “specific needs of gay and lesbian individuals and on sensitivity issues for enhancing communication in a gender neutral, non judgmental manner” (p. 121).

Very little has been written for physicians or other health professionals with regard to lesbian families and their interactions with and opinions of the U.S. health care system. Bernhard (2001) reported that many studies found that lesbians prefer female

providers. This study validates Bernhard's findings on gender preference for lesbians and lesbian parents. Further research is needed on the treatment choices lesbians may choose for their families. As society eases its outward distain toward same sex families, more research will be needed not only on LGBT parents, but also on their children's perception of equality versus discrimination in physician care rendered to themselves and their LGBT parents.

Additional research can be centered on multiple themes, given the size, structure, and limitations of this study. Most of the respondents in this study were from urban settings. Geography may be a variable in lesbian family comfort levels with physicians, as cited by Bagby (2006) earlier in the chapter. Perhaps rural communities are less tolerant. Another suggestion for future research is a survey of gay male couples who have children. Is their experience with physicians similar to lesbian families as they relate to physicians and health care organizations? Exploratory research can also be focused on the physician point of view with respect to treating social minorities and their families. Gender preference for female physicians was a strong trend in this study. Would that preference be duplicated in a larger, more diverse study? Certainly with more public discussion of gay marriage, and more media and cinema coverage that includes LGBT couples and families, it is imperative to continue research aimed towards a better understanding of the interface in all areas of LGBT life in American society.

Legal and Policy Implications Lesbian Parent Families

The operational definitions of homophobia impact people with alternative sexual orientations at all ages, but have a significant discriminatory effect on the societal definition and view of family constellation. As Mercier (1999) pointed out "lesbian

mother families reported that their families ‘become invisible’ in the community because organizations continue to ignore diversity of family type” (p. 155)

As previously mentioned in this chapter, one area that continues to hinder gay and lesbian patients is the legal barriers that prevent equality to the same services available to heterosexual couples and families. The inequities are magnified within the health care delivery system through visitation policies, exchange of information and other legal formalities that often accompany health issues. It is especially in these instances that social workers can be advocates and assist aging LGBT patients to be proactive. Social work interventions may include advocating for power of attorney wills, et cetera, assisting LGBT clients to negotiate internal hospital policies and procedures, and assuring linkages to needed community referrals. Planning is key for this population in preparation for lesbian parent families and other LGBT patients as they negotiate the health care system. Legal issues LGBT persons face can be a major barrier to a feeling of equity when interfacing with health care institutions. Orel (2004) reported results from a focus group of older gay and lesbians.

Legal issues were [an] identified source of concern for all focus group participants. [They] voiced their frustrations that same gender long-term relationships do not have the same rights as “married” couples. Specifically, all same gender couples have had to make special legal arrangements to obtain the legal rights afforded to heterosexual couples, but denied to same gender partnerships. (p. 66)

These legal limitations extend to LGBT families with children. As an example, only the legal or biological parent is generally recognized in a same sex family with children. The health services infrastructure available to the LGBT population is currently fragmented, and biased. Many hospital policies (e.g., visiting, next of kin notification), forms, and processes are created from a heterosexist orientation. The policies represent

the content in the social dominance theory, where in-group dominance is the norm. The out group position may negatively impact the lesbian family in the health care arena. As Mercier (1999) noted, “In addition to the social invisibility of lesbian parenting, respondents who were non biologic mothers described a sort of self-imposed invisibility as a way of dealing with the social and legal ambivalence of their places in the family” (p. 116). In this study, respondents echo the frustration with the health care system because of bias against their sexual orientation:

If the physician does not have discriminatory tendencies, then [likely it is seen in] the nurses or office staff. We have really, really encountered that, especially in terms of my partner carrying insurance for us [and family] through domestic partnership insurance arrangements at her work. (Respondent 3 phone survey)

Insurance company customer service people are not well trained to understand domestic partner benefits. They also seem to change service quality when we explain the relationship. [The same is true] with front desk staff at the hospitals. (Respondent 2 written survey)

I had coverage for my 1st son and myself for 15 years. When I changed jobs I had no insurance for myself or my son. My partner has had insurance for herself and our 2nd son through her 25 years of work. We have been together for 18 years and are not considered a family by insurance companies, and I can't receive health insurance through my partner's benefits. Not having health insurance influences my use of health care. (Respondent 33 written survey)

Legal and policy changes are needed to promote equity of service provision to lesbian parent families, and the broader LGBT population. Given the current state of same sex marriage bans in most states, policy change may be slow in coming to provide equal rights as heterosexual marriages. In lieu of formal and sweeping policy and law enactment, the health care profession must promote equality and availability of services, standardization of services regardless of sexual orientation, and education of hospital and agency personnel.

For medical social workers, LGBT advocacy opportunities are partially summarized in the following quote: “An important first step for the practitioner is the adoption of an advocate model of social work intervention” (Donahue & McDonald, 2005, p. 365). Such advocacy can be done through education of social work students, practice, or advocacy for policy change within the profession, or in a broader arena.

The Social Work Role With LGBT Patients

Social work professionals can play an advocacy and educational role with other health care team members around LGBT patient issues. “Social workers throughout the health care system have a responsibility to help eliminate the barriers to adequate and competent health care [for lesbians]” (Peterson & Bricker-Jenkins, 1996, p. 43).

However, the first task for a clinical social worker is to examine his/her own homophobia. Despite training in cultural diversity, an individual social worker may either have a negative bias towards LGBT patients or simply possess the professional ignorance, cited earlier in this paper, held by other health providers. Berkman and Zinberg (1997) stated:

Evidence suggests that social workers may be biased when dealing with gay and lesbian populations. The problem these populations experience when encountering heterosexual social workers are partially related to social workers’ often unconscious bias partially due to an information deficit concerning the gay and lesbian communities and the unique difficulties that homosexual men and women encounter living in a predominantly heterosexual society. (p. 319)

The authors suggested social work education, and increased exposure both in school and in practice, to the LGBT community. In a study by McFarland and Sanders (2003), social worker respondents to their study survey felt that their knowledge base about gay and lesbians needed improvement. “Respondents [social workers] felt they needed more detailed knowledge about gay lifestyles” (p. 74). These scholars suggested that social

work curriculum and continuing education courses contain LGBT specific content in order to provide social workers with better insight and knowledge for practice.

It is also important for social workers to recognize the basic philosophical differences between their profession and the medical profession. Medicine is a narrower and traditionally paternalistic and authoritative relationship pattern, based in the biological sciences, and medical technologies. By contrast, social work's interactive practice model focuses on social systems theory, person-in-environment, client engagement, and the individual's right to self-determination. This basic variance in professional practice models reinforces the importance for a social work advocacy role is assisting LGBT patients and family members negotiate the health care system, although physicians are not absolved from a responsibility to care for and treat this population with a bias neutral approach.

Makadon (2006) wrote that physicians may not be able, as individual clinicians, to change national health care policy or attitudes. Yet, he pointed out that provider likelihood of seeing LGBT patients or patients who engage in same sex activities, is on the rise. Social work practice in health care reflects Makadon's prediction. Medical social workers, while pivotal in promoting better understanding among all professions on patient diversity, are also faced with the reality that social worker attitudes toward LGBT clients must also be addressed. Hence, there is an imperative to promote curriculum recommendations, internships, and continuing education course content for the social work profession on the LGBT community, in order to decrease homophobia and heterosexism. As suggested with medical curriculum changes, Schools of Social Work would best prepare students with education of and exposure to diverse minority

populations including members of the LGBT community. Furthermore, perhaps curricular electives in LGBT family issues need to be considered at the graduate levels of social work in a standardized fashion, as guided by the Council on Social Work Education.

Achieving Equity in Health Care for LGBT Patients

Recent publications on LGBT limitations to fair and equitable health care offer suggestions for change. Specifically, increased research and funding for LGBT issues is needed. Roberts (2006) predicted that lesbians will have increased access for preventive care in the future, and will feel more at ease coming out to their physician or provider. Her main conclusion was “there continues to be widespread availability of culturally sensitive . . . services. Lesbians are no longer invisible and benefit from sensitive and informed care” (p. 588). Harrison and Silenzio (1996) asserted that health care professionals must structure their continuing education to become culturally sensitive, especially around ‘sexual minority’ patients. Their premise was that if physicians can distinguish sexual identity from sexual behavior, communicate clearly, and use gender neutral language, the quality of the physician and patient interaction for the LGBT population will increase. They do warn that attitude is the key variable. If a provider continues to display an insensitive attitude, then all other efforts are nullified. As an example of attitude impacting the relationship, one of the few study respondents who was dissatisfied with her physician care stated that it was largely due in part to the physician’s insensitive attitude towards her questions and requests for information. She felt as if the physician belittled her. “It was based on her style, and partly our health care system, which really elevates the doctor above patient interests” (Respondent 3, phone survey).

Gonser (2000) suggested some specific ways in which health care professionals can achieve culturally sensitive care for LGBT patients:

- Attend continuing education classes geared towards LGBT patient needs:
- Learn the basics on providing sensitive care:
- Examine personal values and beliefs:
- Create a safe, non judgmental office environment, and train office staff to be culturally aware and sensitive:
- Respect the relationships that are honored by LGBT patients, rather than rendering them invisible. (p. 74)

McNair (2003) stated that the “development of cultural competence is the main avenue for providers to evolve into a gay positive relationship with gay and lesbian patients” (p. 645). She recommended four main categories for provider learning: (a) knowledge and understanding; (b) communication skills; (c) attitude; and (d) practice environment. McNair’s recommendations are consistent with other literature on cultural sensitivity for LGBT health care priorities. Her warning to providers is that silence from LGBT patients will continue if trust is not established, and only widens the gap for provision of qualitative and comprehensive care. She stated: “The silence compromises the development of trust and the ability to reveal complex and relevant life issues to practitioners” (p. 643).

The issue of achieving equity in health care for lesbian parents and LGBT patients encompasses a complex combination of micro and macro implications. This study raised a number of issues related to the lesbian parent population’s preferences of physicians based on traits and relationship. Although it seems that the level of satisfaction and level of support is high between patient and physician, there continues to be frustration with organizational and structural policies that do not recognize lesbian families. This may

suggest both continued advocacy efforts for recognition of same sex families, and further research on the impact and reality of being treated as a societal minority in America.

Summary

The LGBT group of particular interest in the study reported here are lesbian parents. As noted previously in this study, lesbians are an out-group on two levels: first as women and second as women choosing a sexual partnership with other women, and raising a family. This differs, both historically and legally, from the dominant societal heterosexual couple and family in American society. This study has information on lesbian family preferences for medical care that can aid and inform health professionals. The findings can be developed and refined for curricular changes, (e.g., additional electives or classroom offerings, continuing education), and for future research on the topic (e.g., lesbian family perceptions of physician office staff in health care settings, gay male parent family perceptions and experiences with physicians and allied health professionals).

The purpose of this study was to further refine previous findings and outcomes in studies by Mercier (1999) and Mercier and Harold (2002), which focused on lesbian parent experiences. This writer intended to garner more in depth information with regard to the lesbian parent relationship with her physician. Specifically, the study asked about those characteristics of the physician which promoted a positive relationship with lesbian parents. While the study was exploratory in nature, with inherent limitations, the results of the study indicate several important findings. Competencies for health care professionals, and new knowledge about what characteristics are critical in the health care helping relationship, can be formulated from the current study findings. The

implications of a positive relationship between physician and the LGBT patient, in particular, can provide useful information for both direct practice in medicine and social work, and other health care professional training, as well as foster ideas and applications to further our knowledge base in scholarly literature and research on such a scarcely studied topic.

There appears to be a positive shift in lesbian parent perceptions of support with regard to their relationship and satisfaction with their physician as compared to data from Mercier's study (1999). This finding also differs from much of the literature reviewed. The hope is that the data in this study represent a change in the trend toward a more positive lesbian-physician relationship. However, the inference of change must be further tested in future research. This writer suggests some next steps to further validate and apply the theory and study findings presented in this paper. A similar survey can be developed and administered to a wider group of LGBT parents, in order to deepen the scope of responses and compare them to this study's findings. In addition to curricular changes for medical and social worker students, educational programs, sensitizing paraprofessionals in health care to lesbian and LGBT parent needs, can be developed with measurable pre and post testing for delineation of attitude and knowledge changes due to the education.

Specific physician characteristics were identified as strong determinants of a successful patient-physician relationship. The results also indicate that patient satisfaction with care is closely related to their perception of the physician characteristics. This writer suggests that the traits be studied on a broader population. Other social minorities can be used as a study population as well as a larger respondent base of LGBT parents. Research

can also be furthered on the perceptions of satisfied patients and their view of quality of care delivered. Perhaps quality is a more subjective term than originally thought by this writer, when formulating questions for the study, and can be further defined in looking at this construct from both the provider and patient perspective.

Another strong relational issue for lesbian parents was the gender of the physician. The majority prefer a female practitioner. This preference can be better analyzed in a larger study, but has some important recommendations for medical professionals who have lesbian parents or lesbians in their practices. Word of mouth appears to be a screening factor when lesbian parents choose a physician. The preference for females may be a guide for medical school students and educators. Male medical students may benefit from studying the traits of an interpersonal style that lead minority status patients to a perception of truthful, empathic, and unbiased care delivery, which they believe will be more available from women practitioners. All learners can benefit from data in the study that emphasize patient satisfaction with physicians who listen, communicate, take time with patients, and involve them in decision making with respect to care choices and treatment options.

Recommendations for practice and education for physicians and social workers have been presented. Education via curricular changes and continuing education for practitioners is an important factor in decreasing negative or biased attitudes towards lesbian families. The literature review, and subsequent author recommendations promote exposure to LGBT patients and issues early on in curricular and clinical training.

Policy and legal issues have been reviewed, and appear to continue to hinder lesbian parents feeling of equity, as exemplified by comments contained earlier in the this

chapter. Benefits discrimination and not being legally recognized as partners or a family is emblematic.

It is hoped that the results of this study can be utilized in a number of ways to further advocate for lesbian parents and the larger LGBT community to receive fair and equitable treatment as they engage with the health care system. The results contained in this study can be a basis for further qualitative and quantitative studies in order to better understand a marginalized community within U.S. healthcare who have received little attention in clinical and academic research.

APPENDICES

APPENDIX A. LESBIAN PARENT HEALTH CARE SURVEY COVER LETTER,
CONSENT FORM, SURVEY, AND CONTACT INFORMATION



March, 2008

Dear Research Participant,

You are receiving this letter because you may be eligible to fill out a questionnaire which asks Lesbian mothers about their family's health. This is a validation survey of a study done in 2002. The previous study was approved by Michigan State University.

The initial studies were conducted by Lucy Mercier, Ph.D. I am using Dr. Mercier's study as part of my doctoral dissertation. I will be re-validating the data to further our body of research on lesbian health. We will continue to do so, since we believe that accurate information about our lives is the most important tool that we have for training service providers and combating discrimination. Thank you for taking the time to be a part of the project.

At this point, we would like to add to the information that we have already collected by having you complete another questionnaire. This time, the survey will focus on your family's health and health care, because this is an area that many women told us was important to them. We hope that learning more about our health care experiences will make a difference in how medical professionals, insurance providers, employers and others respond to our families.

I hope that you will continue to support the study by taking about 15 minutes to fill out the questionnaire, and return it in the enclosed postage-paid envelope or email it back to margaret.dimond@xxxxxx.net. As always, we are interested in finding more biological and non-biological parents to participate, so if you know someone who may be interested, contact me, or include the information with your response.

Thank you,

Margaret Dimond, MSW, MPA
xxx-xxx-xxxx
margaret.dimond@xxxxxx.net

Enc.

LESBIAN PARENT HEALTH CARE SURVEY

Consent Form

You are being asked to participate in a study of lesbian parent families. We are interested in finding out more about your family, especially how you interact with your health care providers.

If you would like to participate in this research, please **read the following information** carefully before beginning the questionnaire.

- Participation in this study is voluntary. You may refuse to answer any item on the questionnaire, and may stop participating at any time with no penalty.
- The questionnaire will take about 10 minutes to complete.
- The questionnaire is intended to be anonymous. If there is any information that we think is compromising, we will use it only in ways that will protect your identity. Your privacy will be protected to the maximum extent allowable by law.
- We hope to follow this questionnaire with some face-to-face or phone interviews. If you are interested in being interviewed, use the information on the last sheet of the questionnaire to contact us. The interview would be about 1 hour, and we will review this consent form at the time of the interview. Interviews will be confidential; reports and publications will not reveal the identity of interviewees. Your answering the questions would constitute consent.

- If you have questions about your participation in this study, you may contact:

Rena Harold, PhD.
MSU School of Social Work
232 Baker Hall
E. Lansing, MI 48824
(517)432-3733
haroldr@msu.edu

Margaret Dimond, LMSW
MSU School of Social Work
232 Baker Hall
E. Lansing, MI 48824
(517)432-3733
mdimond1@hfhs.org

- If you have any questions or concerns regarding your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact – anonymously, if you wish – Peter Vasilenko, Ph.D., Director of the Human Subject Protection Programs at Michigan State University, by phone:(517)355-2180, fax:(517)432-4503, email: irb@msu.edu, or regular mail: 202 Olds Hall, East Lansing, MI 48824.
- I understand that participation is voluntary. I may refuse to answer any/all items on the questionnaire without penalty. This questionnaire is anonymous information taken and will not reveal my or my family identity. Any identifying information will not be shared with anyone else.

Signature (Optional)

Date

You indicate your voluntary agreement to participate in this study by completing and returning the attached questionnaire.

LESBIAN PARENT HEALTH CARE SURVEY

Thank you for taking the time to help us collect this information about the health care experiences of lesbians and their children. We have tried to be as inclusive as possible with these questions, but if you find that a section does not fit your family or experience, please let us know by writing on the questionnaire or a separate sheet of paper.

We hope to follow this questionnaire with some face-to-face or phone interviews. If you are interested in being interviewed, please fill in the section at the end of the questionnaire. Thanks again!

BACKGROUND INFORMATION

- 1. Please provide the following information for each member of your family. Include anyone you think of as family, even if s/he does not live with you. If you include someone in the “other” category, describe your relationship to them. If you have more than 4 children, write their information on a separate sheet of paper.**

	You	Partner	Child 1	Child 2	Child 3	Child 4	Other
Age							
Sex							
Race							
Has healthcare coverage? (y/n)							

- 2. Circle the number that best describes how you think of yourself.**

Lesbian				Bisexual				Heterosexual	
1	2	3	4	5	6	7	8	9	10

- 3. Place a ✓ on the line that best describes your annual family Income:**

___ under \$20,000	___ \$50,001 – 75,000
___ \$20,001 - 35,000	___ \$75,001 – 100,000
___ \$35,001 - 50,000	___ \$over \$100,000

4. For each child in your family, use one of these numbers to show how the child became a member of your family.

1 = your birth child through donor insemination – anonymous donor
2 = your birth child through donor insemination – known donor

- 3 = your birth child through heterosexual relationship
 4 = your partner's birth child through donor insemination – anonymous donor
 5 = your partner's birth child through donor insemination – known donor
 6 = your partner's birth child through heterosexual relationship
 7 = foster child
 8 = adopted child
 9 = guardianship - formal/legal
 10 = guardianship – informal
 11 = other (please describe)

___ Child 1
 ___ Child 2

___ Child 3
 ___ Child 4

5. What state do you live in? _____

FAMILY HEALTHCARE

6. Use the table below to describe the overall health of each member of your family. Use the rating scale provided to determine the number for current health status. For each family member, list up to 3 significant health concerns in the space provided.

Very poor Health Moderate Health Excellent Health
 1 2 3 4 5 6 7

	You	Partner	Child 1	Child 2	Child 3	Child 4	Other
Current health status (scale of 1-7)							
List up to 3 health concerns							

7. For each member of your family, place a ✓ in the column next to the health professional s/he sees most often.

Then, use the scale provided, to rate your satisfaction with the health professional.

Not at all Neither Satisfied
 Satisfied Extremely nor
 Dissatisfied Satisfied
 1 2 3 4 5 6 7

Type of health care provider	You	Partner	Child 1	Child 2	Child 3	Child 4	Other
Family practitioner							
Obstetrician/gynecologist							

Internist							
Pediatrician							
Physician assistant/nurse practitioner							
Other (describe)							
Satisfaction with health professional (scale of 1-7)							
Sex of provider (Male/Female)							
Sexual orientation of provider Heterosexual (H), Gay (G), Lesbian (L), Bi (B), Don't Know (D)							
Approximately how long has s/he been your provider?							

YOUR HEALTHCARE EXPERIENCES

8. We are interested in whether lesbian parents feel they can be open with their healthcare providers about their sexual orientation and/or family relationships.

Are you out to any of your family's healthcare providers? ____ Yes ____ No

If yes, place an ✓ in the table below for each provider who knows that you are a lesbian/bisexual or that your children have lesbian parents.

Type of health care provider	I am out to this provider
Family practitioner	
Obstetrician/gynecologist	
Internist	
Pediatrician	
Physician assistant/nurse practitioner	
Other (describe)	

9. What factors led to your decision about coming out/not coming out to your healthcare provider(s)?

10. Think about any healthcare providers who are aware that you are a member of a lesbian parent family (or that your children have lesbian parents). Describe your experience(s) coming out to them.

11. Do you think that being out or not being out influences your use of health care?
___ Yes ___ No Why or why not?

LESBIAN PARENT HEALTH CARE SURVEY
CONTACT INFORMATION

We would like to interview some women about their healthcare needs and experiences. Would you be willing to be contacted for a telephone or in-person interview? Your participation in the next phase is completely voluntary.

If you would like to be included in the next phase of this research, please write your name and contact information below. Even if you leave it blank, please detach this sheet from your survey, fold it, and return it to us separated from your completed survey. If you provide information so we can contact you further, that information will not be shared with anyone outside the research team. Your name and identifying information is in no way connected to your questionnaire or your participation in the written survey. Your name and demographics will be kept in a secure area, and will not be given to anyone aside from the investigators in the study.

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE _____

EMAIL _____

APPENDIX B. LESBIAN PHONE SURVEY QUESTIONS WORKSHEET

Lesbian Parent Survey Questions Worksheet

Date of interview:

Name of Participant:

Phone #:

Time of interview:

1. Would seeing a caregiver with the same sexual orientation as yourself be:
 - a. Easier than one who did not have the same sexual orientation?
 - b. Immaterial?If immaterial is your selection, could you provide an explanation or clarification as to your selection? Is gender a factor?
2. Have your physicians or extenders provided you with quality health care to you and your family?
 - a. if not, what were some of the issues or problems you experienced?
3. Does your current health provider seem to understand and/or empathize with the issues/needs of the LGBT world? (in what ways). If no, what problems have you experienced?
4. What screening methods did you use when selecting your present physician or provider?
5. Identify a current or past health provider you have had who gave you unbiased attention to your needs and problems. Please list some important characteristics and traits of that person...

NOTES:

APPENDIX C. LETTER TO POTENTIAL PHONE SURVEY RESPONDENTS



To: Lesbian Parent Health Survey Participant

From: Margaret Dimond, Ph.D. Candidate, Michigan State University

Date: June 1, 2009

Regarding: Follow up from 2008 written survey results

Thank you for completing the revised Michigan State Lesbian Health Survey, sent out in 2008. We are pleased that we could analyze forty one surveys for data compilation (unfortunately, we had a 25% return rate, which is statistically on the low side of validity). The positive news is that since the original 1999 survey was conducted by Lucy Mercier, lesbian moms feel healthcare is friendlier. The opportunity (as confirmed by my dissertation committee) is to further document the ways in which lesbian moms choose physicians. Once the choice is made, the research question arises...what traits about the physician keep you engaged?

In 2008 you indicated on the last page of the survey that you may be willing to be contacted for a telephone or in-person interview. The purpose of this letter is to request your agreement for a 10-15 minute phone interview. The scope of the questions will be thematic in the following areas:

- satisfaction with your physician
- how you and your family's' sexual orientation plays a part in your health care experience
- the traits and attributes you feel are important for a successful relationship with your physician.

Personally, I think this research can be ground breaking for medical education curriculum modification, and information for practicing clinicians. I realize your continued participation is a choice. To provide an incentive for you, I will send you a nominal gift card to confirm my appreciation for your participation. I so appreciate the opportunity to speak to you, and gain crucial research information. I will be contacting you in the month of June for a designated interview time.

Sincerely,

Margaret Dimond, MSW, MPA
xxx-xxx-xxxx
dimond@xxxxx.edu

Enc

APPENDIX D. UNIVERSITY COMMITTEE ON RESEARCH INVOLVING HUMAN
SUBJECT: APPLICATION, APPROVAL, AND RENEWAL

APPLICATION FOR INITIAL REVIEW
APPROVAL OF A PROJECT INVOLVING HUMAN SUBJECTS
Biomedical, Health Sciences Institutional Review Board (BIRB)
Social Science, Behavioral, Education Institutional Review Board (SIRB)
202 Olds Hall, Michigan State University
East Lansing, MI 48824-1047
Phone: (517) 355-2180
Fax: (517) 432-4503
E-mail: irb@msu.edu
Office Hours: M-F (8:00 A.M.-5:00 P.M.)

IRB#: 07-735
ID# i028008

1a.	Responsible Project Investigator: Name: Rena HAROLD ID#: XXX-XX-6554 Department: School of Social Work College: SOC SCI Academic Rank: Professor Mailing Address: 232 Baker Hall Phone: 2-3733 Fax: 3-3038 Email: haroldr@msu.edu
1b.	Secondary Investigator: Name: Margaret Dimond ID#: XXX-XX-1618 Department: SCHOOL OF SOCIAL WORK College: SOCIAL SCIENCE Academic Rank: NA Mailing Address: 232 Baker Hall Phone: 517-432-3733 Fax: Email: MDIMOND1@hfhs.org
1c.	Additional Investigators: Lucy MERCIER

2.	Study Coordinator: Name: Margaret Dimond ID#: XXX-XX-1618 Department: SCHOOL OF SOCIAL WORK College: SOCIAL SCIENCE Academic Rank: NA Mailing Address: 232 Baker Hall Phone: 517-432-3733 Fax: Email: MDIMOND1@hfhs.org	
3.	Title of Project: Lesbian Parent Health Care Survey	
4.	Have you ever received Preliminary Approval for this project?	NO
5.	Category of Review	2-7 EXPEDITED
6.	Is this project being conducted to fulfill the requirements of an education/training program?	Ph.D. Dissertation
7a.	Funding:	Project is not funded
7b.	The protection of human subjects often requires resources be dedicated for things such as the consent process (space, personnel), the performance of the research (trained personnel interacting with subjects, time, access to subjects, access to facilities) care of subject issues or injuries (counseling, medical care), confidentiality of data (space, equipment) and other monetary and non-monetary resources. Describe the resources that are available for this project for the protection of human subjects. The School of Social Work will provide copying for questionnaires, and appropriate locked storage for data to insure confidentiality. Investigators are trained researchers as well as trained clinicians who can provide resources and referral if needed.	
8a.	List all sites where this research will be conducted. Various locales in MI where LGBT family events are held, e.g., Lesbian Mom Network events, Rainbow Family Great Lakes Events. Some questionnaires may also be mailed to addresses voluntarily provided by lesbians who attend such functions and prefer to complete their surveys at home.	

8b.	Do any of these sites have their own IRB?	NO																																																							
8c.	Will MSU units outside the control or supervision of the investigator be involved in the conduct of the research?																																																								
9.	Do you have any related project that were approved by an MSU IRB? (a) IRB Numbers: 98776	YES																																																							
10.	Have you or will you submit this to any non-MSU IRBs?	NO																																																							
11.	Is another institution(s) relying on MSU's IRB as the IRB of record?	NO																																																							
12.	Are you using an FDA approved drug/device/diagnostic test?	NO																																																							
13.	Are you using an FDA approved drug/device/diagnostic test for a non-FDA approved indication?	NO																																																							
14.	Has this protocol been submitted to the FDA or are there plans to submit it to the FDA?	NO																																																							
15.	Does this project involve the use of Materials of Human Origin (e.g. human blood, tissue, or cell lines)?	NO																																																							
16.	Research Category <table border="0"> <tr> <td>Education Research</td> <td>☒ Yes</td> <td>Gene Transfer Research</td> <td>☐ Yes</td> <td>Clinical Trial Type</td> </tr> <tr> <td>Survey/Interview</td> <td>☒ Yes</td> <td>Fetal Research</td> <td>☐ Yes</td> <td>☐ Surgical</td> </tr> <tr> <td>Audio/Video Recording</td> <td>☒ Yes</td> <td>Medical Records</td> <td>☐ Yes</td> <td>☐ Therapeutic</td> </tr> <tr> <td>Oral History</td> <td>☐ Yes</td> <td>Stem Cell Research</td> <td>☐ Yes</td> <td>☐ Prevention</td> </tr> <tr> <td>Internet-based</td> <td>☐ Yes</td> <td>Medical Imaging</td> <td>☐ Yes</td> <td>☐ Other</td> </tr> <tr> <td>Analysis of Existing Data</td> <td>☐ Yes</td> <td>Oncology</td> <td>☐ Yes</td> <td>☐ Investigator Initiated</td> </tr> <tr> <td>International Research</td> <td>☐ Yes</td> <td>Clinical Research</td> <td>☐ Yes</td> <td>☐ Clinical Trial Phase</td> </tr> <tr> <td></td> <td></td> <td>Other</td> <td>☐ Yes</td> <td>☐ Phase I</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>☐ Phase II</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>☐ Phase III</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>☐ Phase IV</td> </tr> </table>		Education Research	☒ Yes	Gene Transfer Research	☐ Yes	Clinical Trial Type	Survey/Interview	☒ Yes	Fetal Research	☐ Yes	☐ Surgical	Audio/Video Recording	☒ Yes	Medical Records	☐ Yes	☐ Therapeutic	Oral History	☐ Yes	Stem Cell Research	☐ Yes	☐ Prevention	Internet-based	☐ Yes	Medical Imaging	☐ Yes	☐ Other	Analysis of Existing Data	☐ Yes	Oncology	☐ Yes	☐ Investigator Initiated	International Research	☐ Yes	Clinical Research	☐ Yes	☐ Clinical Trial Phase			Other	☐ Yes	☐ Phase I					☐ Phase II					☐ Phase III					☐ Phase IV
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17.	Project Description (Abstract) The purpose of the study is to survey opinions of lesbian parents on their perception of healthcare delivery for themselves and their children. A subset of information on whether they have come out to their health care provider(s) will also be collected. The hypothesis is that the less familiar or comfortable lesbians are with the physician, the less likely they will be to reveal their sexual orientation or discussing their family constellation. This, in turn, may make some women more reluctant to seek medical																																																								

	attention for themselves and/or their children. Upon completing a short questionnaire, the women will be asked if they would be willing to participate in interviews or focus groups to be conducted at a later time. Those who volunteer for this part of the study will be contacted subsequently by the investigators.	
18.	Procedures Surveys will be distributed, and collected after completion, or mailed to volunteer subjects who have provided their contact information. Participants may also choose to mail their questionnaires back to the investigators in stamped, pre-addressed envelopes. These data will be coded and entered in an SPSS data base for analysis purposes. Open-ended questions will be coded for themes. A subset of volunteer participants will be contacted for phone or in-person interviews, and/or participation in a focus group.	
19.	Does your investigation involve incomplete disclosure of the research purpose or deception of the subjects?	NO
20a.	Subject Population Adult women who self-identify as lesbian or bisexual and are parenting a minor child.	
20b.	Age range of subjects	21 to 65
20c1.	It is planned or expected that the following study population will be included in the research: ☒ Minors ☐ Pregnant Women ☐ Women of Childbearing Age ☐ Institutionalized Persons ☐ Students ☐ Low Income Persons ☐ Minorities ☐ Prisoners ☐ HIV/AIDS Individuals ☐ Psychiatric Patients ☐ Incompetent Persons ☐ Wards ☐ None of These	
20c2.	Will some or all of the subjects likely be vulnerable to coercion or undue influence?	
20d.	Total expected number of subjects (including controls) for the entire project period	50-100
20e.	Justify your sample size.	

	This sample size will be adequate to provide enough responses to get a real sense of the experiences of this group of women with the opportunity to either see if there is a trend or very diverse experiences among the women. In addition, this number will provide a large enough group from which to draw a subset for qualitative data collection and analysis.	
20f.	Describe the criteria for the inclusion of subjects. Any woman self identifying as lesbian or bisexual who is parenting a minor child and voluntarily completes a survey.	
20g.	Describe the criteria for the exclusion of subjects. Subjects who do not self-identify as lesbian or bisexual, who are not parenting a minor child, and/or who do not complete a survey.	
20h(1).	How will the subjects be identified, recruited and enrolled? Include who will make initial contact with the subjects, who will recruit the subjects, and who will enroll the subjects. Invited by investigators to participate by completing surveys at events for lesbian parents or families, or contacted by investigators via snail mail after having voluntarily provided their contact information at such events.	
20h(2).	Will an advertisement be used?	NO
20i.	Are you associated with the subjects?	NO
20j.	Will someone receive payment for recruiting the subjects?	NO
20k.	Will the research subjects be compensated?	NO
20l.	Will the subjects incur additional financial costs as a result of their participation in this study?	NO
20m.	Will this research be conducted with subjects in another country?	NO
20n.	Will this research be conducted with subjects in the U.S. from an ethnic group of sub-group or other non-mainstream minorities (including non-English speakers)?	NO
21a.	Risks and Benefits for subjects: Describe and assess any potential risks (physical, psychological, social, legal, economic) and assess the likelihood and seriousness of such risks. The risks are minimal, if any. Participants will be asked to give basic health status information including concerns about medical care. Because participation is totally voluntarily, participants may choose what to disclose and thus, there is no real risk to them. It is possible, however, that they may be upset if they have had negative experiences with the health care system.	
21b.	Describe procedures for protecting against or minimizing potential risks and provide an assessment of their likely effectiveness. Investigators are trained MSWs with many years of experience in the field. Although it is highly unlikely that participation in this study will provoke any serious issues, investigators are able to provide any needed information and referrals to help participants deal with any reactions that	

	they may have.	
21c.	Assess the potential benefits (if any) to be gained by the subjects in this study, as well as benefits which may accrue to society in general as a result of the planned work. Data resulting from this study can be used to improve services and health care provision for lesbians and their families. Participants will be able to feel a sense of giving back to their community, and that their responses may be able to inform policy and services.	
22a.	How will the subject's privacy be protected? Include a description of who will be interacting with the subjects or accessing and abstracting data from the subject's records (academic, medical, etc.) and where the study will take place. For example, will individuals not associated with the research study be present during the consent process and the conduct of the study? Only investigators will have access to the collected data. ID #s will be assigned and information will be coded to protect the identity of all subjects. Those subjects who complete the contact information for participating in a follow up interview or focus group will do so on a sheet that will be separated from their questionnaire and will not have their ID # on it, thus protecting their privacy. Consent forms will be given to the subjects at the time of the survey completion.	
22b.	Where will the data be stored and for how long? In a locked cabinet in the investigator's locked office, for a period of five years.	
22c.	Who will have access to the research data? Only the investigators.	
22d.	How will you ensure the confidentiality and/or anonymity of the research data? Include a description of the procedures and safeguards you will use, including if identifying information will be stored with the data. ID #s will be assigned and information will be coded to protect the identity of all subjects. Those subjects who complete the contact information for participating in a follow up interview or focus group will do so on a sheet that will be separated from their questionnaire and will not have their ID # on it, thus protecting their privacy.	
22e.	Is it appropriate for your research to have a monitoring plan to periodically assess the data to ensure the safety of subjects or to ensure negative outcomes do not occur (e.g., ongoing study of domestic abuse, clinical trial, full board projects)?	
23.	Does this project involve protected health information as defined by HIPAA?	NO
24.	(a) Select appropriate consent option.	Approval of a consent form

		and process
	(b) Consent Procedures: All subjects will be adults, and will have received a consent form (attached) that informs them of the purpose and totally voluntary nature of the study. The consent form is the first page of the questionnaire and consent to participate is given when subjects complete the survey. (b)(2) Will the subject or legally authorized representative sign a consent document(s)?	
25a.	Does any person responsible for the design, conduct, or reporting of findings of this protocol have a Significant Financial Interest (as defined for the MSU Faculty Conflict of Interest Policy) or other opportunity for tangible personal benefit related to the conduct of the research that might compromise, or reasonably appear to compromise, the independence of judgment with which their responsibilities would be completed under this research protocol? A reportable financial interest includes, but is not limited to, a financial interest in the sponsor, product, or service being tested, or in a competitor of the sponsor or product or service being tested.	NO
25b.	Has any financial arrangement, including compensation, ownership interest, stock options, or other ownership interest, (e.g., compensation that is: explicitly greater for a favorable result; in the form of an equity interest in the sponsor of a covered study; or in the form of compensation tied to sales of the product, such as a royalty interest) been established whereby the value of compensation or ownership interest to investigators conducting the study could be influenced by the outcome of the study?	NO
25c.	Is this a clinical study where the results may be used to support marketing applications for new human drugs and biological products and marketing applications and reclassification petitions for medical devices to the FDA, as required by law?	
25d.	Have you or will you submit an FDA form 3454 or 3455 (Conflict of Interest)?	NO
26a.	When would you prefer to begin this project?	9/1/2007
26b.	Estimated duration of project (including identifiable data analysis):	09/01/2008
ADDITIONAL DOCUMENTS/ATTACHMENTS		
01. 7/23/2007 Consent & Instrument (i028008_07-18-07_LESBIAN_HEALTH_consent_q.pdf)		

02. 7/23/2007 Survey/Instrument (i028008_07-18-07_qual_questions_for_study.pdf)
 03. 8/21/2007 Survey/Instrument (i028008_8-19-07_revised_LESBIAN_PARENT_HEALTH_CARE-SURVEY.pdf)
 04. 8/30/2007 Consent & Instrument revised (i028008_08-26-07_revised_LESBIAN_PARENT_HEALTH_CARE_SURVEY.pdf)
 05. 9/17/2007 Consent & Instrument (i028008_9-17-07_LESBIAN PARENT HEALTH CARE SURVEY.pdf)
 06. 10/8/2007 Consent & Instrument (i028008_10-8-07_LPHC_Survey.pdf)

COMMENTS	COMMENT AFTER REVIEW / EDIT BY IRB STAFF (Viewable by PI)	PI RESPONSE
Comment #1 Reviewer #61	9:58:28	8/2/2007 18:31:58
	Consent form Please make a separate bullet for the IRB contact information: The following phrase is recommended: If you have any questions or concerns regarding your rights as a study participant, or are dissatisfied at any time with any aspect of this study, you may contact - anonymously, if you wish - Peter Vasilenko, Ph.D., Director of the Human Subject Protection Programs at Michigan State University, by phone: (517) 355-2180, fax: (517) 432-4503, email: irb@msu.edu, or regular mail: 202 Olds Hall, East Lansing, MI 48824. Procedurally Is there an alternate/other means for the potential subjects to respond, other than responding back in the mail with the attached survey if they would like to be part of the focus group It would be preferable to use another means to collect identifying information on those who'd willing to be contacted for the next phase. Although you will separate this information when it is received, if no identifying information comes to you	Re: consent form, yes, we can easily make that change and will send it to you. Re: procedural comment - we can give the respondents already separated sheets on which to put their contact information so that the PIs can contact them if they are willing to participate. In this way, there information cannot be connected in any way to their survey data. Solely relying on participants to call the PIs if they are interested in participating will lower the response rate as people are busy and may not remember to initiate the contact. This method should make it possible for reviewers to feel that participants' survey data will be totally anonymous, and still allow PIs to contact subjects who voluntarily submit their names for contact. Re: PI educational requirement. Dr. Harold's human subject training was

	at all there is no risk to participants. It seems that you could simply ask them to call you if you are interested and at that time you could ask them for the identifying information you need. I think, especially if you do this, this could be exempted from further IRB review. In addition, all responsible PI need to have valid human subject training. Please see below: To Renew the Educational Requirement Training must be renewed prior to your training expiration date. To renew training, individuals are required to complete any six CITI, Course in the Protection of Human Research Subject, online modules. Please note that the CITI modules are used to renew the IRB educational requirement, and completion of these modules does not satisfy the IRB initial educational requirement. The initial IRB educational requirement is completion of the online MSU IRB tutorial (see "Initial Educational Requirement" above). Before beginning the CITI modules (required to renew training requirement), please read the instructions below. 1. Go to https://www.citiprogram.org to access CITI, an online Course in the Protection of Human Research Subjects 2. Click on the "Register Here" link 3. Click on "The Protection of Human Research Subjects" link 4. Under the "Participating Institutions" drop-down menu, select "Michigan State University (MSU)" and click "Submit"	valid when this proposal was submitted, through 7/27/07. She is currently out-of-town, and will complete the re-training after 8/14/07.
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	5. Create a username and password and click "Submit" 6. Enter the requested information (i.e., first name, last name, etc.) and click "Submit" 7. Enter the requested information (i.e., contact information, etc.) and click "Submit" 8. Select "Group 1 – MSU Investigators who are required to renew their Human Subjects Protection Training. You are required to complete the introduction, the MSU Module and any 6 additional modules appropriate to your work and interests." and click "Continue" 9. Select "No" 10. To access the modules, click on the "Grade book link" 11. Complete the Introduction and the MSU Module 12. Select and complete any 6 CITI modules Thank you	
Comment #3 Reviewer #68	12:05:20	8/26/2007
	I await the new version of the consent form and instrument. In addition to separating the Vasilenko information, please include contact info for the secondary investigator. Also include a statement to the effect that "Your privacy will be protected to the maximum extent allowable by law." (Even tho' the survey has no identifying info, you probably will know who you are asking to respond in at last some cases.) I suggest changing the last paragraph on the address page to something like this: "If you would like to be included in the next phase of this research, please write your name and contact information here."	Attached please find corrections based on reviewer #68 comments of 8/21. I am the only investigator, as this is my doctoral survey. I do not know how you would like to address secondary investigator. Thank you, Margaret Dimond A35191618

	Even if you leave it blank, please detach this sheet from your survey, fold it, and return it to us separated from your completed survey. If you provide information so we can contact you further, that information will not be shared with anyone outside the research team." You would then have a separate bag or envelope in which you collect the address forms and would have less chance of knowing who agreed and who did not. I hope these small but important modifications are not too onerous.	
Comment #5 Reviewer #68	13:08:55	8/30/2007 10:46:21
	investigator9s) Please submit your revised consent/survey. Thank you	Hello, I did send my revised consent and address page. Shall I resubmit? Margaret Dimond
Comment #7 Reviewer #68	12:33:39	10/7/2007
	I'm confused by this paragraph: "The questionnaire is anonymous. Information taken from your completed questionnaire will be reported in a way that does not reveal your identity. Identifying information will not be shared with anyone else. Your privacy will be protected to the maximum extent allowable by law." I suggest: "The questionnaire is intended to be anonymous. If there is any information that we think is compromising, we will use it only in ways that will protect your identity. Your privacy will be protected to the maximum extent allowable by law." The Primary Investigator was previously mistakenly referred to as the Secondary Investigator. Your	please review requested changes to the consent form. Thank you

	Advisor is the Primary Investigator and you are the Secondary, even though we all know it is your work (it's a formal thing). Her contact info does need to be there. I strongly suggest that you move the information about filling in the last page to the consent form and not include it in the test instrument itself. That way you can say something like: "We hope to follow this questionnaire with some face-to-face or phone interviews. If you are interested in being interviewed, please fill in the section at the end of the questionnaire. The interview would be about 1 hour, and we will review this consent form at the time of the interview. Interviews will be confidential; reports and publications will not reveal the identity of interviewees." Or better yet, follow the suggestion of another reviewers and make the last page contact info for you and ask them to contact you. Then the consent form would say something like "We hope to follow this questionnaire with some face-to-face or phone interviews. If you are interested in being interviewed, use the information on the last sheet of the questionnaire to contact us. The interview would be about 1 hour, and we will review this consent form at the time of the interview. Interviews will be confidential; reports and publications will not reveal the identity of interviewees. Your answering the questions would constitute consent." (Please correct the time if need be.) I suggest that this info be inserted before your contact info. I am not sure why there is a signature page. You have stated that filling out the questionnaire	
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	constitutes consent. In any case, it should not be delivered as part of the questionnaire but collected separately and before the questionnaire is filled out. Also, "I understand" language should not be used. I think you do not need it at all, however, unless other reviewers see a reason that I do not. I hope these are not too onerous.	
Comment #8 Reviewer #78	12:27:01	
	Investigator(s): I agree with previous comments by the other reviewers. I only have one additional question. Can you provide specific details on how subjects will be recruited for the project? Thank you,	

APPLICATION FOR RENEWAL or REVISION
APPROVAL OF A PROJECT INVOLVING HUMAN SUBJECTS
Biomedical, Health Sciences Institutional Review Board (BIRB)
Community Research Institutional Review Board (CRIRB)
Social Science, Behavioral, Education Institutional Review Board (SIRB)
207 Olds Hall, Michigan State University
East Lansing, MI 48824-1047
Phone: (517) 355-2180
Fax: (517) 432-4503
E-mail: irb@msu.edu
Office Hours: M-F (8:00 A.M.-5:00 P.M.)

IRB#: 07-735
ID# r030022

Title: Lesbian Parent Health Care Survey
Review Category: EXPEDITED 2-7
Expiration Date: 1/21/2011
Responsible Project Investigator: Name: Rena Harold ID#: XXX-XX-6554 Department: School of Social Work College: SOC SCI Academic Rank: Professor Mailing Address: 232 Baker Hall Phone: 2-3733 Fax: 3-3038 Email: haroldr@msu.edu

RENEWAL		
1.	Has there been a lapse in approval between your current project expiration date and the submission of this renewal application? (a) Explain why there has been a lapse in approval and what, if any, contact with human subjects has been made or data collected during the lapse in approval: Dr. Harold submitted the renewal in October 2009, but did so by emailing the form, rather than completing on line. Thus, it was administratively closed. We apologize for the error.	YES
2a.	Is the project being performed at Sparrow Hospital?	NO
2b.	Is the project being performed at Ingham Regional Medical Center?	NO
3a.	Project is funded	NO
3b.	Previous funding has ended	NA

3c.	Previous funding source same	NA
3d.	New funding source:	
4a.	How many subjects have been enrolled in the last approval period by your study team?	0
4b.	How many subjects have been enrolled to date (entire project period) by your study team?	41
4c.	How many more subjects will be recruited in the next approval period by your study team?	0
	If this is a collaborative, multi-site (e.g., national) project, complete d through f.	
4d.	How many total subjects have been enrolled in the last approval period?	
4e.	How many total subjects have been enrolled to date (entire project period)?	
4f.	How many more total subjects will be recruited in the next approval period?	
5.	Contact with subjects and data collection is complete and the research involves data analyses only.	YES
6.	Have any recruited subjects withdrawn from the research in the last approval period?	NO
7.	Have there been any unanticipated problems or adverse events in the last approval period?	NO
8.	Have there been any complaints by the subjects or their representatives related to their participation in this study in the last approval period?	NO
9.	Has there been any increased risk to subjects or others in the last approval period?	NO
10.	Please describe the benefits, if any, that subjects have received as a result of their participation in this study? The subjects have received no benefits	
11.	Brief summary of the study progress to date: The survey was completed by subjects in 2008, subsequent telephone interviews were conducted in 2009. The data is currently being analyzed. Any recommendations will result once the data is compiled and statistically analyzed.	
12.	Are there any relevant multi-center trial reports?	NO
13.	Is the approval period for this project two years (i.e. project was granted a two year approval as part of the demonstration project)?	

ADDITIONAL DOCUMENTS/ATTACHMENTS

COMMENTS	COMMENT AFTER REVIEW / EDIT BY IRB STAFF (Viewable by PI)	PI RESPONSE
Comment #1 Reviewer #	1/12/2010 13:45:17	
	STAFF COMMENT TO PI: Please have Margaret Dimond and Lucy Mercier update their human subject training as it has recently expired. In order to renew training please go to our website www.humanresearch.msu.edu and select the Education tab, from the drop down menu choose Required Training. Scroll down to 'To Renew the Educational Requirement' and click on the CITI link. If these individuals are no longer working on this project, please respond requesting that they be removed as additional investigators. Thank you, Katy Hunsche IRB Staff 432-6598	
Comment #2 Reviewer #24	1/13/2010 12:08:43	1/15/2010 15:00:35
	Thank you for your application. Please provide confirmation that no contact with subjects or their identifiable data has taken place since expiration or until approval.	No contact or identifiable data has taken place since expiration. Only data collection and analysis is in process. Margaret Dimond

REFERENCES

REFERENCES

- Agresti, A., & Finlay, B. (1997). *Statistical methods for the social sciences* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.
- Appel, J. M. (2006). May doctors refuse infertility treatments to gay patients? *Hastings Center Report*, 36(4), 20-21.
- Ashforth, B. E., & Mael, F. (1989). Social identity theory and the organization. *Academy of Management: The Academy of Management Review*, 14(1), 20-39.
- Babbie, E. R. (1973). *Survey research methods*. Belmont, CA: Wadsworth.
- Babbie, E. (1992). *The practice of social research* (6th ed.). Belmont, CA: Wadsworth Publishing.
- Babrow, A. S., & Mattson, M. (2003). Theorizing about health communication. In T. L. Thompson, A., M. Dorsey, K. I. Miller, & R. Parrot (Eds.), *Handbook of health communication* (pp. 35-60). Mahwah, NJ: Erlbaum.
- Bagby, D. (2006). Lesbians at risk. *Southern Voice*, 19(36), 1-31.
- Bamberger, M., Rugh, J., & Mabry, L. (2006). *Real world evaluation*. Thousand Oaks, CA: Sage Publications.
- Bartlett, H. (1975). Ida M. Cannon: Pioneer in medical social work. *Social Service Review*, 49(2), 208-229.
- Bauman, K. A., & Hale, F. A. (1985). Bringing the homosexual patient out: Teaching the doctor's role. *Medical Education*, 19, 459-462.
- Berkman, C. S., & Zinberg, G. (1997). Homophobia and heterosexism in social workers. *Social Work*, 42(4), 319-332.
- Benkert, R., & Peters, R. M. (2005). African American women's coping with health care prejudice. *Western Journal of Nursing Research*, 27(7), 863-889.
- Bernhard, L. A. (2001). Lesbian health and health care. *Annual Review of Nursing Research*, 19, 145-177.
- Betancourt, J. R. (2006). Eliminating racial and ethnic disparities in health care: What is the role of academic medicine? *Academic Medicine*, 81(9), 788-792.
- Blanchard, J., & Lurie, N. (2004). R-E-S-P-E-C-T: Patient reports of disrespect in the health care setting and its impact on care. *The Journal of Family Practice*, 53(9), 721-730.

- Bloom, M., Fischer, J., & Orme, J. (2003). *Evaluation practice: Guidelines for the accountable professional* (4th ed.). Boston, MA: Allyn & Bacon.
- Bonvicini, K. A., & Perlin, M. J. (2003). The same but different: Clinician-patient communication with gay and lesbian patients. *Patient Education and Counseling*, 51, 115-122.
- Brewer, M. B. (1991) The social self: On being the same and different at the same time. *Personality and Social Psychology Bulletin*, 17, 475-482.
- Brody, D. S., Miller, S. M., Lerman, C. E., Smith, D. G., Lazaro, C. G., & Blum, M. J. (1989). The relationship between patients' satisfaction with their physicians and perceptions about interventions they desired and received. *Medical Care*, 27, 1027-1035.
- Brogan, D. J., Frank, E., Eton, L., Sivanesan, S. P., & O'Hanlan, K. A. (1999). Harassment of lesbians as medical students and physicians. *Journal of the American Medical Association*, 282, 1290-1292.
- Brotman, S., Ryan, B., Jalbert, Y., & Rowe, B. (2002). The impact of coming out on health and health care access: The experiences of gay, lesbian, bisexual and two-spirit people. *Journal of Health & Social Policy*, 15(1), 1-29.
- Brown, J. B., Stewart, M., & Ryan, B. L. (2003). Outcomes of patient-provider interaction. In T. L. Thompson, A. M. Dorsey, K. I. Miller, & R. Parrot (Eds.), *Handbook of health communication* (pp. 141-159). Mahwah, NJ: Erlbaum.
- Brown, R. (2000). Social identity theory: Past achievements, current problems and future challenges. *European Journal of Social Psychology*, 30, 745-778.
- Brunner, W. F. (1915). The Negro health problem in southern cities. *American Journal of Public Health*, 183, 189.
- Butler, S. S. (2004). Gay, lesbian, bisexual, and transgender (GLBT) elders: The challenges and resilience of this marginalized group. *Journal of Human Behavior in the Social Environment*, 9, 25-44.
- Cabot, R. C. (1907, Nov. 2). Social work: The diagnosis and treatment of character in difficulties. *Charities and the Commons: A Weekly Journal of Philanthropy and Social Advance*, 19, 1001-1010.
- Campbell, D. T., & Stanley, J. C. (1963). Experimental and quasi-experimental designs for research. In N. L. Gage (Ed.), *Handbook of research on teaching* (pp. 1-4). Chicago, IL: Rand McNally.
- Cassell, E. J. (1985). *Talking with patients*. Cambridge, MA: MIT Press.

- Cavanaugh, T., & Abbott, D., (2006). A perspective on gay men's health. *Medicine and Health/Rhode Island*, 89(6), 195-197.
- Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans. *American Psychologist*, 54, 805-816.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.
- Cohen, J., & Cohen, P. (1983). *Applied multiple regression/correlation analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.
- Crenner, C. (2001). Organizational reform and professional dissent in the careers of Richard Cabot and Ernest Amory Codman, 1900-1920. *Journal of the History of Medicine*, 56, 211-237.
- Creswell, J. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. New York: Sage Publications.
- Daley, A. (2003). Lesbian health and the assumption of heterosexuality: An organizational perspective. *Canadian Journal of Community Mental Health*, 22(2), 105-121.
- Donahue, P., & McDonald L. (2005). Gay and lesbian aging: Current perspectives and future directions for social work practice and research. *Families in Society*, 86, 359-366.
- Emanuel, E., & Emanuel, L. (1992). Four models of the physician-patient relationship. *Journal of the American Medical Association*, 267, 2221-2226.
- Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G*Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior Research Methods*, 39, 175-191.
- Fleiss, J. A., & Cohen, J. (1973). The equivalence of weighted Kappa and the intraclass correlation coefficient as measures of reliability. *Education and Psychological Measurement*, 33, 613-619.
- Gall, M., Gall J., & Borg, W. (2008). *Educational research: An introduction* (8th ed.). Boston: Allyn & Bacon.
- Gamble, V. N. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health*, 87(11), 1773-1778.
- Geddes, V. A. (1994). Lesbian expectations and experiences with family doctors. *Canadian Family Physician*, 40, 908-920.

- Giddens, A. (1974). *Positivism and sociology*. London: Heinemann.
- Gonser, P. A. (2000). Culturally competent care for members of sexual minorities. *Journal of Cultural Diversity*, 7(3), 72-75.
- Gruber, J. (2010). The cost implications of health care reform. *New England Journal of Medicine*, 362(22), 1005-1017. doi:10.1056/NEJM/1005117
- Harrison, A. E., & Silenzio, V. M. (1996). Comprehensive care of lesbian and gay patients and families. *Primary Care*, 23(1), 31-46.
- Hidalgo, H., Peterson, T. L., & Woodman, N. J. (1985). Introduction. In H. Hidalgo, T. L. Peterson, & N. J. Woodman (Eds.), *Lesbian and gay issues: A resource manual for social workers* (pp. 1-6). Silver Spring, MD: NASW.
- Hinchliff, S., Gott, M., & Galena, E. (2004). "I daresay I might find it embarrassing": General practitioners' perspectives on discussing sexual health issues with lesbian and gay patients. *Health and Social Care in the Community*, 13(4), 345-353.
- Honigmann, B. (1992). *Handbook of social and cultural anthropology*. Chicago, IL: Rand McNally.
- Keppel, G., & Zedek, S. (2001). *Data analysis for research design: Analysis of variance and multiple regression correlation approaches*. New York: Prentice Hall.
- Kimmel, D. C., Sang, B. E., D'Augelli, A. R., & Patterson, C. J. (1995). Lesbians and gay men in midlife. In A. R. D'Augelli & C. J. Patterson (Eds.), *Lesbian, gay, & bisexual identities over the lifespan* (pp. 190-215). Oxford: University Press.
- Klamen, D. L., Grossman, L. S., & Kopacz, D. R. (1999). Medical student homophobia. *Journal of Homosexuality*, 37(1), 53-63.
- Kuehl, R. O. (2000). *Statistical principles of research design and analysis*. Belmont, CA: Duxbury Press.
- LaVeist, T. A., Rolley, N. C., & Diala, C. (2003). Prevalence and patterns of discrimination among U. S. health care consumers. *International Journal of Health Services*, 33(2), 331-344.
- Link, B. G., & Phelan, J. (1995). Social conditions as fundamental causes of disease. *Journal of Health and Social Behavior*, (Extra Issue), 80-94.
- MacDonnell, J. A., & Andrews, G. J. (2006). Placing sexuality in health policies: Feminist geographies and public health nursing. *GeoJournal*, 65(4), 349.

- Makadon, H. J. (2006). Improving health care for the lesbian and gay communities. *New England Journal of Medicine*, 354(9), 895-897.
- Malat, J., & Hamilton, M. A. (2006). Preference for same-race health care providers and perceptions of interpersonal discrimination in health care. *Journal of Health and Social Behavior*, 47, 173-187.
- Malhotra, N. K. (2010). *Marketing research: An applied orientation* (6th ed.). Upper Saddle River, NJ: Prentice Hall.
- McFarland, P. L., & Sanders, S. (2003). A pilot study about the needs of older gays and lesbians: What social workers need to know. *Journal of Gerontological Social Work*, 40(3), 67-80.
- McGarry, K. A., Clarke, J. G., Cyr, M. G., & Landau, C. (2002). Evaluating a lesbian and gay health care curriculum. *Teaching and Learning in Medicine*, 14(4), 244-248.
- McNair, R. (2003). Lesbian health inequalities: a cultural minority issue for health professionals. *Medical Journal of Australia*, 178, 643-645.
- Mercier, L. R. (1999). *Lesbian mother families: A qualitative study of perceptions of institutional and interpersonal support*. Unpublished doctoral dissertation, Michigan State University, East Lansing.
- Mercier, L. R., Dimond, M. A., & Harold, R. D. (2007, October). *Lesbian health care: Women's experiences and the role for social work*. Paper presented at the Annual Program Meeting of the Council on Social Work Education, San Francisco, CA.
- Mercier L., & Harold, R. (2003). [Lesbian Parent Health Study]. Unpublished raw data.
- Merriam, S. B. (1998). *Qualitative research and case study applications in education*. Thousand Oaks, CA: Sage.
- Merriam Webster's Collegiate Dictionary* (10th ed.). (1995). Springfield, MA: Merriam-Webster.
- Mertler, C. A., & Vannatla, R. A. (2005). *Advanced and multivariate statistical methods: Practical application and interpretation*. Glendale, CA: Pyrzak Publishing.
- Morrow, D. F. (1996). Heterosexism: Hidden discrimination in social work education. *Journal of Gay & Lesbian Social Services*, 5(4), 1-16.
- Morrow, D. F. (2001). Older gays and lesbians: Surviving a generation of hate and violence. *Journal of Gay & Lesbian Social Services*, 12(1/2), 151-169.

- Mravcak, S. A. (2006). Primary care for lesbians and bisexual women. *American Family Physician*, 74(2), 279-292.
- Neuman, W. L. (2003). *Social research methods* (5th ed.). Upper Saddle River, NJ: Prentice Hall.
- Neville, S., & Henrickson, M. (2006). Perceptions of lesbian, gay and bisexual people of primary healthcare services. *Journal of Advanced Nursing*, 55(4), 407-415.
- Orel, N. A. (2004). Gay, lesbian, and bisexual elders: Expressed needs and concerns across focus groups. *Journal of Gerontological Social Work*, 43, 57-76.
- Outterson, K. (2005). Tragedy and remedy: Reparations for disparities in Black health. *DePaul Journal of Health Care Law*, 9, 735-792.
- Paroski, P. A. (1987). Health care delivery and the concerns of gay and lesbian adolescents. *Journal of Adolescent Health Care*, 8, 188-192.
- Patti, R. J. (2009). *The handbook of human services management* (2nd ed.). Thousand Oaks, CA: Sage.
- Perreault, W. D., & Leigh, L.E. (1989). Reliability of nominal data based on qualitative judgment. *Journal of Marketing Research*, 26, 135-48.
- Peterson, K. J., & Bricker-Jenkins, M. (1996). Lesbians and the health care system. *The Haworth Press, Inc*, 5(1), 33-47.
- Piette, J. D., Bibbins-Domingo, K., & Schillinger, D. (2006). Health care discrimination, processes of care, and diabetes patients' health status. *Patient Education and Counseling*, 60, 41-48.
- Richmond, J. P., & McKenna, H. (1998). Homophobia: An evolutionary analysis of the concept as applied to nursing. *Journal of Advanced Nursing*, 28(2), 362-369.
- Robb, N. (1996). Medical schools seek to overcome "invisibility" of gay patients, gay issues in curriculum. *Canadian Medical Association Journal*, 155(6), 765-770.
- Roberts, S. J. (2006). Health care recommendations for lesbian women. *Journal of OBGYN and Neonatal Nurses*, 35(5), 583-591.
- Robertson, M. M. (1992). Lesbian as an invisible minority in the health services arena. *Health Care for Women International*, 13, 155-163.
- Rudestam, K. E., & Newton, R. R. (2001). *Surviving your dissertation: A comprehensive guide to content and process* (2nd ed.). Newbury Park, CA: Sage.

- Sanchez, N. F., Rabatin, J., Sanchez, J. P., Hubbard, S., & Kalet, A. (2006). Medical students' ability to care for lesbian, gay, bisexual, and transgendered patients. *Family Medicine*, 38(1), 21-27.
- Schwartz, M. (1996). Gay men and the health care system. *Journal of Gay & Lesbian Social Services*, 5(1), 19-32.
- Scott, R. P., & Heslin, K. C. (2003). Historical perspectives on the care of African Americans with cardiovascular disease. *Annals of Thoracic Surgery*, 76, S1248-55.
- Sidanius, J., & Pratto, F. (2001). *Social dominance: An intergroup theory of social hierarchy and oppression*. Cambridge, UK: Cambridge Press.
- Sidanius, J., Pratto, F., van Laar, C., & Levin, S. (2004). Social dominance theory: Its agenda and method. *Political Psychology*, 25(6), 845-880.
- Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care 2002*. Washington, DC: National Academies Press.
- Smith, R. C. (2002). *Patient centered interviewing*. Philadelphia: Lippincott Williams & Wilkins.
- Speight, K. (1995). Debating point: Homophobia is a health issue. *Health Care Analysis*, 3, 143-156.
- StatPac. (2007). *Sampling methods*. Retrieved August 29, 2007, from <http://www.statpac.com/surveys/sampling.htm>
- Stein, G. L., & Bonuck, K. A. (2001). Physician-patient relationships among the gay and lesbian community. *Journal of the Gay and Lesbian Medical Association*, 5, 87-93.
- Stevens, P., & Hall, J. (1988). Stigma, health beliefs, and experiences with health care in lesbian women. *Image*, 20, 69-73.
- Tabachnick, B. C., & Fidell, L. S. (2008). *Using multivariate statistics* (5th ed.). Boston, MA: Pearson.
- Tajfel, H. (1974). Social identity and intergroup behavior. *Social Science Information*, 13, 65-93.
- Tajfel, H. (1982). Social psychology of intergroup relations. *Annual Reviews*, 33, 1-39.

- Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *The social psychology of intergroup relations* (pp. 33-47). Monterey, CA: Brooks/Cole.
- Taravella, S. (1992). Healthcare recognizing gay and lesbian needs. *Modern Healthcare*, 22(45), 33-35.
- Townsend, M. H. (1997). Gay and lesbian issues in graduate medical education. *North Carolina Medical Journal*, 58(2), 114-116.
- Trettin, S., Moses-Kolko, E. L., & Wisner, K. L. (2006). Lesbian perinatal depression and the heterosexism that affects knowledge about this minority population. *Archives of Women's Mental Health*, 9, 67-73.
- Trippet, S. E., & Bain, J. (1993). Physical health problems and concerns of lesbians. *Health Care for Women International*, 20, 59-70.
- Verkuyten, M., & De Wolf, A. (2007). The development of in-group favoritism: Between social reality and group identity. *Developmental Psychology*, 43(4), 901-911.
- Vogt, W. P. (1999). *Dictionary of statistics and methodology: A non-technical guide for the social sciences* (2ND ed.). Thousand Oaks, CA: Sage.
- Wailoo, K. (2006). Stigma, race, and disease in 20th century America. *The Lancet*, 367, 531-533.
- Weinberg, G. (1972). *Society and the healthy homosexual*. New York: St. Martin's Press.
- Wen, C. K., Hudak, P. L. & Hwang, S. W. (2007). Homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters. *Journal of General Internal Medicine*, 22, 1011-1017.
- White, J. C., & Dull, V. T. (1997). Health risk factors and health seeking behavior in lesbians. *Journal of Women's Health*, 6, 103-112.
- Wolraich, M. L., & Reiter, S. (1979). Training physicians in communication skills. *Developmental Medicine and Child Neurology*, 21, 773-778.
- Woo, J. K. H., Ghorayeb, S. H., Lee, C.K., Sangha, H., & Richter, S. (2004). Effect of patient socioeconomic status on perceptions of first-and second-year medical students. *Canadian Medical Association Journal*, 170(13), 1915-1919.
- Young, J. (2004). Illness behaviour: A selective review and synthesis. *Sociology of Health and Illness*, 26(1), 31.