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How to approach the subject of the patient's sexual orientation in primary care?

INTRODUCTION

Sexual minorities represent a population with documented medico-psycho-social vulnerability[1]. They are currently grouped together under the acronyms LGBTQIAP (Lesbian, Gay, Bisexual, Transsexual, Queer, Intersex, Asexual, Pansexual) or LGBT+, terms taking into account all possible expressions of a given person's gender identity (GI) and sexual orientation (SO) (Sidebar 1).

In this population, increased suicidal risk has been observed[2,3]. Discrimination, stigmatization and homophobia can be sources of anxiety and depression, and they are liable to lead to increasing consumption of toxic substances or disordered eating habits or behaviors[2-4].

This population also encounters heightened risk of contracting sexually transmitted infections (STI)[2,5,6]. The first cases of acquired immune deficiency syndrome (AIDS) were discovered in the 1970s among men having had sexual relations with other men (MSM), leading to stigmatization that persists today7. Members of this population have been urged to undergo vaccination against meningococcus C, hepatitis and, since March 2017, the Human Papillomavirus (HPV).

As regards women having sexual relations with other women (WSW), there have been few studies on STI, and education on the subject is often sorely insufficient. This is in all likelihood due to the fact that the WSW population avails itself of health care services less regularly than heterosexual women, leading to delay (if not outright absence) of preventive measures and organized screening[8,9].

As for transidentitary persons, they are demanders of support adapted to their hormonal or surgical transition[2]. Up until now, there has been little published work dealing with this population. That said, a study carried out in 2011 highlights refusal of care by transgender persons in fear of

- Gender: A social construct designating the roles, behaviors and socially established activities that a given society considers as suitable for women or men.
- Gender identity: A given person's individual experience of gender that may or may not correspond to that person's biological sex..
- Sexual identity: A notion bringing together a given person's gender identity and sexual orientation.
- Sexual orientation: A given person's capacity to feel emotional, physical and/or sexual attraction toward individuals of the opposite sex and/or the same sex and to have intimate or sexual relationships with them.
- Trans identity / Transidentitary-transgender persons Transidentitary/transgender persons are those whose gender identity is not in agreement with the identity assigned at birth on the basis of their biological sex. Trans identities designate the fact of living, temporarily or permanently, in accordance with an appearance or social norms differing from those assigned at birth.

Sidebar 1- Glossary

prejudice and transphobia[10]. It would seem obvious that their relationship with the body before, during and after transition differs from that of the general population. A physical exam can be awkward, rendering a patient unusually apprehensive.

Over the course of his or her career, a general practitioner (GP) is called upon to accompany LGBT+ persons. It would seem to behoove him or her to be aware of the SO and GI of the persons he or she treats in order ensure patient-centered accompaniment.

Consultation is the meeting point of GP and patient. A physician-patient relationship is built around the different protagonists' representations. Representations have been defined as visions of reality determining the choices and acts in the life of an individual[11]. To avoid all prejudice toward the person he or she is tasked with supporting, it matters that a GP be aware of his or her personal representations of SO and GI. According to Goffman, a social interaction can be understood as a stage where the individual is an actor who fulfills un role[12]. During consultation, a GP conveys an image by means of social representation; non-verbal as well as verbal expressions are part and parcel of the communication strategies he or she put into place.

The main objective of this study was to understand how GPs approach their patients' SO. The secondary objectives were to identify the difficulties encountered by GPs and possible avenues for improvement leading to strategies designed to favor discussion of the issues surrounding health and sexual orientation.

MATERIAL AND METHOD

A qualitative study applying general inductive analysis was carried out amongst Hauts-de-France GPs.

Participants

The participants had to be male or female GPs holding degrees or engaged in specialized studies, practicing or having practiced general medicine in the Hauts-de-France region. GPs whose experience was limited to hospitals or who practiced medicine in another region were excluded from the study. Participant recruitment was carried out with maximum variation pertaining to age, sex, duration of activity, type and region of practice, experience in treatment of women and/or psychology during consultation. Application of these criteria facilitated recruitment of a palette of GPs with wide-ranging experience and practice.

Recruitment was carried out from November 2017 through May 2018 in accordance with the "snowball" principle using practitioner directories, alternative sites, social networks … and word of mouth.

- For you, what is the place in a general practice consultation for a subject such as patients' sexuality?
- Is it important to know patients' sexual orientation (SO)? Why?
- Are you acquainted with the specific characteristics of treatment of the LGBT population? Do you have any examples ?
- How about patients' sexual identity (SI)?
- Would you like to know more about health-related specificities?
- Do you ever put the question directly to your patients? Why? How?
- In what situation did it happen that you brought up with a patient the question of that person's SO? How did you feel?
- Have you ever encountered difficulties when accompanying a LGBTQ+ person? What types of difficulties?
- Do you think it is difficult for a GP to bring up this subject? If so, why?
- What, according to you, are the obstacles?
- How could we improve treatment in general practice of these types of patients?
- What strategies could we set up in view of better addressing SO?

Sidebar 2- Interview guide

Data collection

Individual semi-structured interviews were organized. The interview guide was preliminarily tested by the investigator (JT). The document evolved as the interviews proceeded, in view of aligning it to the greatest possible extent with the study objectives (Sidebar 2).

All of the interviews were conducted by JT, at her home, in medical practices, in the GPs' homes or at the Henri-Warembourg faculty of medicine, in accordance with participant preferences. They were recorded by Dictaphone and safeguarded in an encrypted document with VeraCrypt software, prior to being transcribed ad integrum using Word, anonymized and disidentified.

Data analysis

Analysis was a continuously evolving process that got underway following the first interview. It proceeded as the data were being gathered, allowing for readjustment of the guide and verification of data sufficiency. Thematic analysis was performed using axial coding. Double coding was effectuated independently by two researchers, contributing to data triangulation and reinforcing the internal validity of the study. NVivo 12® software rendered the thematic analysis reproducible and facilitated data collection and analysis.

The regulatory aspects

Analysis of interviews on doctors' professional practices did not necessitate the approval of the French Comité de protection des personnes (institutional review board).

The study received the approval of the French data protection authority (Cnil) on 27 October 2017.

RESULTS

Eleven GPs agreed to participate in the study: 3 women and 8 men, ranging in age from 27 to 70 years. Their salient characteristics are detailed in the Table. Data sufficiency was achieved after 10 interviews and confirmed by an 11th. On average, the interviews lasted for 24 minutes (from 11 to 47 min).

Prior knowledge

Acquaintance with the nomenclature utilized in discussion of the study population varied from one GP to the next; some were unaware of the LGBT acronym cited by JT. The notions of SO and GI were often conflated, necessitating clarification by JT: "Does sexual identity mean 'Is a person heterosexual, bisexual?' Or is it of wider scope, in relation to that person's gender?" (M7).

Some of the GPs admitted to a lack of medical knowledge concerning the LGBT+ population: "He asks me about something (sigh) about which I have little information and less knowledge" (M1); "Even for WSW, with regard to the risk of STI… were they to ask me a question, I would not wish to be overly reassuring" (M7).

One GP owned up to being informed by patients or associations: "We sit down at a table in the LGBT center, and that is where I learn things, with the Lesbian group, with the Trans group as well. That is when and where we begin to elaborate our responses" (anonymous).

Reasons for bringing up sexual orientation

One participating GP stated that she never spoke of sexuality: "In a way, I couldn't care less, it's not really my profession. And so I … if the subject is brought up I prefer to steer them toward a qualified sex therapist" (M10).

For the other GPs, it was important to talk about sexuality and thereby provide patient-centered support: "It's part and parcel of everyday life, any aspect of patients' everyday life may interfere with their mental or physical condition" (M5); "It's part and parcel of health in the broad sense of the term, it's part and parcel of balance in the broad sense of the term" (M11). More precisely, as regards sexual identity (SI), it seemed essential to bring up the subject in view of providing all-encompassing, person-centered support: "Gender identity belongs to the foundation of personality" (M6); "Anything related to identity has got to be important" (M11).

From the standpoint of physical health, the subject of sexuality may be brought up in different contexts: prevention, screening… As regards SO, M8 indicated: "Recently, the Haut Comité de santé (French health authorities) recommended Gardasil® for MSM, but without the necessary information, it cannot be prescribed". Discussing the patients' experiences, including their sexual practices, seemed important as a means of checking out on their health status: *"We need to proceed preventively … a dental dam can be used for oral sex on a woman" (M7); "For example with WSW, how are sex toys used, how are they disinfected? And if they are used with different partners ?"* (M11). As regards transidentitary patients, M4 pointed out: "*They undergo hormone-based treatments, are monitored by specialists, have planned or undergone surgery*".

As regards psychological support for the persons concerned, for most of the GPs it was important to talk about sexual orientation: *"There are forms of suffering related to sexuality that is not usual or habitual sexuality, and it means, you know, that the persons stand in need"* (M3).

How do GPs bring up the subject?

While most of the GPs agreed on the importance of bringing up SO and GI, more than half of them responded that they had not questioned their patients on the subject: *"I cannot remember that. No, not at all"* (M3); *"I have at no time put forward a question about sexual identity"* (M8). Some indicated that they let the patient be the one to broach the subject : *"They bring it up, things are simpler that way" (M5); "I let him introduce it"* (M6).

Some of the GPs explained that a specific context enabled them to address the matter at hand: *"In the context of illness, of screening, we tailor the patient's treatment"* (M4). For M6, the question "*needs to be justified by the issue of the day*".

Only one of the 11 participants said that he addressed the question to the patient,

Participants	Sex	Age	Duration of practice	Type of practice	Area of practice	Care for women	Practice of psychology
M1	M	56	7 years	MSP	Rural	No	Yes
M2	M	34	4.5 years	Group	Urban	No	Yes
M3	M	46	12 years	MSP	Rural	Yes	Yes
M4	M	31	4 years	Group	Urban	Yes	Yes
M5	F	34	5 years	Individual	Rural	Yes	Yes
M6	M	70	30 years	Individual	Urban	No	Yes
M7	M	30	10 months	Substitute	Urban	No	Yes
M8	M	27	5 months	MSP	Urban	Yes	Yes
M9	F	36	6 years	Substitute	Urban	Yes	Yes
M10	F	45	13 years	Individual	Urban	Yes	Yes
M11	M	64	30 years	MSP	Urban	Yes	Yes

Table 1 - Characteristics of participants

each time they were talking about sexuality: "*That is systematically my question*" (M11).

Most often the question was an open one with proposed responses allowing patients to specify their SO. One question type was cited repeatedly : "*Do you have one male, one female or several partners?*"

What obstacles do GPs encounter?

Numerous obstacles were mentioned by the GPs as reasons for which the question of minority sexual orientation was seldom if ever put forward. They cited a lack of consultation time, particularly when patients presented with several demands: "*Will we have the time to talk about it, without giving the impression of being even more brutal, if not rough around the edges?*" (M7). The GPs also evoked their apprehensions, for example a fear of interfering with their patients' personal lives and of being perceived as intrusive.

One of the GPs, after stating that he was homosexual, explained why he did not dare raise the question of sexual identity to his male patients: "*I do not want them to think that I'm chatting them up!*" (anonymous).

GPs' representations also had an impact on the accompaniment and support they provided. Several GPs expressed the idea that a non-heterosexual person would present him/herself in a way that would help the doctor to "*invest*" that individual with a specific sexual orientation, and admitted that at times, reliance on outward appearances would entail a judgment: "*Quite simply, some GPs may have the idea that it (SO) is either visible, or not visible*" (M7). In this respect, M8 perceived "some *stereotypes*", while M11 voiced concern over the judgment of a female colleague who seemed opinionated with regard to some patients' sexual preferences (SP): « No, but are you aware of what they're doing?"; "*Hey there, I beg your pardon, but they do as they like, what matters most is that they experience pleasure, and avoid putting themselves at risk*".

A wide-ranging array of societal, cultural and religious factors were cited as key obstacles to be taken into account during a consultation, so that they not have an impact on a GP's accompaniment and support. For M10, "*it's necessary to be clear about one's thoughts, as an individual*", before taking up the topic during consultation.

The experience, medical training and medical practice specific to each GP could entail a dearth of knowledge on LGBT+ persons. If a GP is unaware of the health issues specific to this population, he or she would tend to deem it unjustified to question his or her patients about their sexual orientation. Other participants feared that they would be unable to cope with a patient's demand: "*What I fear is that a teenager comes to see me and declares that born in the body of a girl, (s)he is nonetheless a boy, and is eager to undergo [sex change] surgery*" (M8); "*So what am I supposed to say to that?*" (M11).

Lastly, several GPs worried about needing to know where they could note relevant information in the medical records, and to be sure to put it in a place that would not be forgotten: "*To know in what section of the dossier you put it, so as to keep it in mind and maintain a trace of the screening method proposed*" (M4).

What strategies do GPs apply?

Given these multifarious difficulties, the GPs proposed different communication strategies designed to facilitate the broaching of the question (Figure).

First of all, there are strategies of verbal communication such as training by means of repetition of the question. The more regularly the subject is broached, the more the patient and the physician will feel at ease to bring it up: "*As I try to train myself to say it simply, on principle it works*" (M4). By systematically raising the question as early as an initial consultation, a GP should in each case obtain relevant information: "*I will postulate, until proven otherwise, that the sexuality of my vis-à-vis is unknown to me*" (M11).

Non-verbal communication strategies have likewise been proposed, based on establishment of a relationship based on listening, trust and non-judgmental attitudes: "*We must establish trust; once the patient feels at ease and once we convey positive signals, it will be easier for that person to speak, and the needed encounter is that much more likely to occur*" (M7); "*The calmer the atmosphere, the more we realize that [the patient] can calmly reply*" (M11). A dedicated consultation may be proposed to broach the subject of sexuality with a lessened time constraint.

The public health strategies envisioned include recommendation guidelines by the French Haute Autorité de santé and communication campaigns aimed at sensitizing physicians and patients to the specific characteristics of support and accompaniment for LGBT+ persons.

DISCUSSION

This qualitative study shed light on the difficulties experienced by GPs desirous to bring up the SO and GI of consulting patients. Numerous obstacles were cited, including limited consultation time, relevant knowledge varying from one GP to the next, and fears with regard to their representations of a specific patient population. In this context, GPs develop strategies of verbal and non-verbal communication with a patient possessing his/her own expectations and experience of life and previous care and treatment. These disparate elements highlight the heterogeneity of the support and accompaniment provided for the LGBT+ patient by the GP.

The GP's knowledge

For the majority of participants, it was difficult to bring up the subject of SO. Questions emerged concerning the GPs' state of knowledge with regard to the LGBT+ population, sexual preferences and the new sexualities.

As regards sexual preferences (SP), which are to be distinguished from sexual orientations (SO): According to a survey by Bajos and Bozon published in 2008, 4% of women and 4% of men in France have had or occasionally or regularly have same-sex relationships[13].

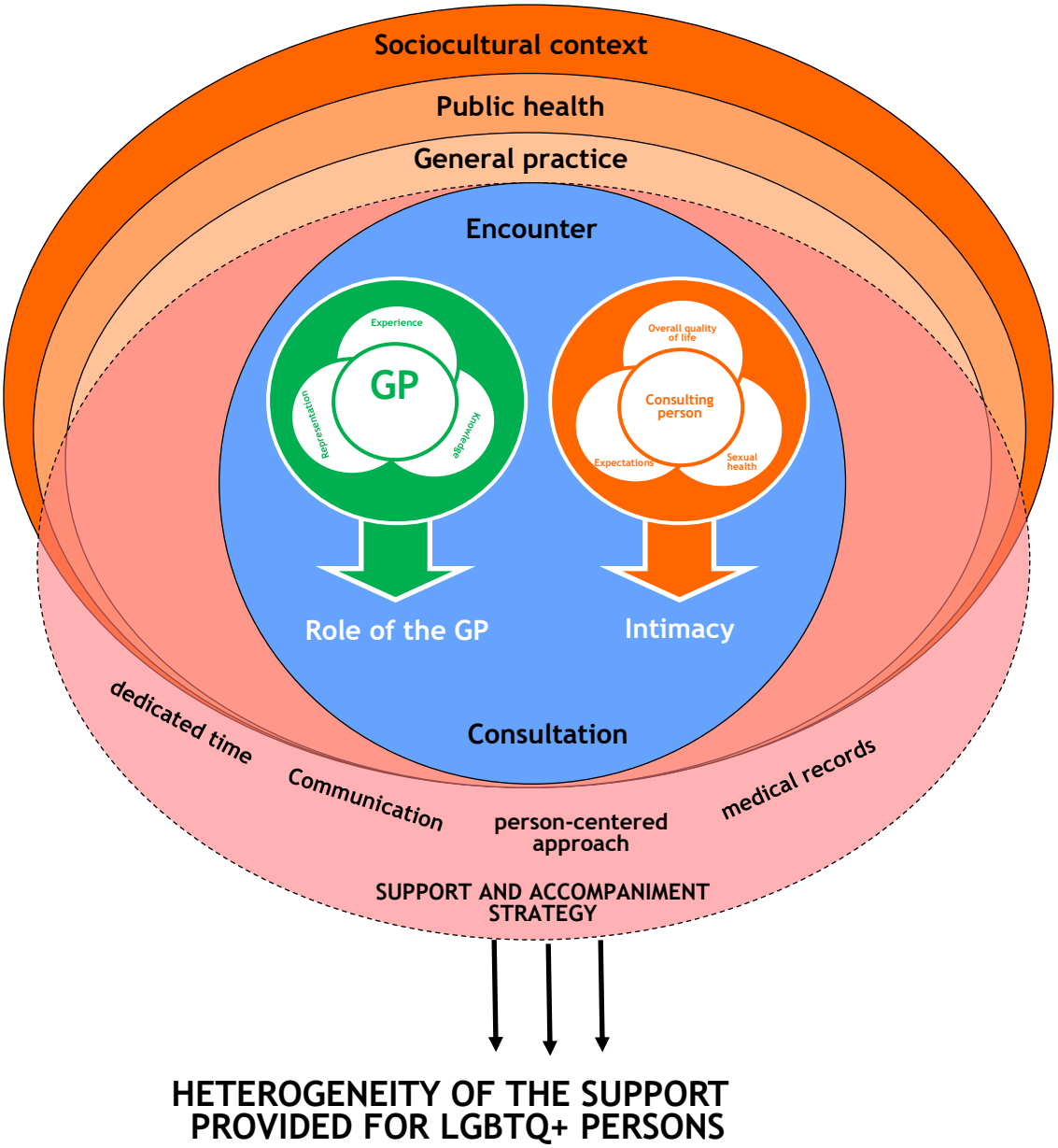

Figure - Determinants of approaches to the subject of sexual orientation
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In this report, SP evolution is documented; for example, oral sex has been on the upswing. Insofar as the survey demonstrates the existence of a gradient reported by the participants between the exclusively heterosexual and the exclusively homosexual SPs, it underscores the limitations of the binary (heterosexual cs. homosexual) model.

The consulting persons' expectations

Several GPs expressed misgivings over the legitimacy of bringing up patients' SO during consultation. Several studies have shown that patients indeed expect GPs to broach the subject of sexual identity (SI) over the course of a consultation. An American study compared the respective opinions of GPs and patients on how to approach SO and GI (gender identity)[14]. More than 7 out of 10 GPs thought that by raising the questions of GI or SO, they would be offending their patients, whereas only 9 to 11 out of 100 patients felt that they would definitely be shocked, were they to be asked this type of question. To conclude, there existed a highly pronounced contrast between GPs' representations of patients' expectations, and the actual expectations of the latter.

In a Swiss study involving men, 95% of the participants responded that they found it normal that a GP broach the subject of their sexuality for the purposes of counsel and accompaniment, while 90% of the participants wished that the physician initiate the discussion, and more than half of them thought that the subject of sexuality should be taken up over the course of the initial consultation in discussion of their personal and medical history[15].

Lastly, a Norwegian study dealt with the expectations of WSW; according to these women, it would be medically interesting for GPs to be cognizant of their SO in view of getting better acquainted with them as persons (rather than just as patients) and of facilitating communication[9]. These different studies highlighted patients' expectations concerning their attending physicians and legitimated introduction of SO.

Respecting the consulting person's intimacy

Several GPs participating in our study expressed misgivings about possible meddling in their patients' personal lives when taking on a subject as intimate as sexual identity. Indeed, SO and GI are intimate matters, making reference to a given individual's innermost being. For this reason, raising of the above-mentioned questions during consultation seems essential when a GP's is striving to achieve acquaintanceship with the person he or she is caring for, which necessitates his or her taking the patient's intimate experience into close account.

It bears mentioning that the notion of intimacy remains subjective, varying from one person to the next and hinging on the history of each individual. A patient's intimacy enters into the physician-patient relationship by means of his/her confiding and disclosing of body and soul. A patient's identity face to a caregiver comes into being according to the portion of his/her intimacy that the person is inclined to unveil16. The GP's intimacy norm and the patient's intimacy norm come face to face in the interaction known as consultation.

It consequently seems essential, if only so as to avoid appearing intrusive, that a GP become aware of the intimacy proper to each patient prior to bringing up the subject of SI during consultation.

Medical secrecy and management of medical records

As regards the concerns voiced by GPs on management of medical records, two articles of the French public health code should provide reassurance: article R4127-4 on the observance of professional secrecy, which is an obligation for all physicians; and article R4127 -45, on a patient's medical records and the confidentiality of the elements deemed necessary to diagnostic and therapeutic decision-making. Through compliance with medical confidentiality, respect of the patient's intimacy is guaranteed. More precisely, once the patient's consent has been secured, a GP can transmit to other health professionals the information he considers indispensable in the framework of coordinated care. When medical records are shared among physicians working together in a practice, the sharing is obviously brought about for medical purposes, and guarantees professional secrecy amongst the GPs who have examined the person during consultation. Given that medical records are subject to professional secrecy, it seems justified for these documents to contain information on the sexual identity of the consulting persons.

Limitations of the study

As the GPs recruited for the study were motivated to participate and were acquainted with the subject prior to the interviews, there may have been a selection bias. As for the investigator, she was a novice interviewer, a factor that may have been limited interactivity at the outset of the study. Her gradual gains in interview technique experience were illustrated by the increasing duration of the interviews she conducted.

CONCLUSION

The participating GPs found it difficult to bring up the subject of their patients' sexual orientations (SO). The main obstacles they mentioned were limited consultation time, variability of relevant GP knowledge and their fears and possibly prejudicial representations of "sexual minority" patients. A standardized question ("Do you have one male, one female or several partners?") could be addressed to each person, bringing into play a GP's abilities to listen and communicate, abilities essential to global, adapted, person-centered support and accompaniment.

Summary
Background. Regarding their medical, psychological, and social well-being, sexual minorities, Lesbian, Gay, Bisexual, and Transgender (LGBT+) are a particularly vulnerable population. The General Practitioner (GP) should be aware of his patients' Sexual Orientation (SO) in order to guarantee person-centered care.
Aim. To understand how GPs address the question of their patients' SO and the strategies they use to optimize person-centered primary care.
Methods. Qualitative study using semi-structured face-to-face interviews with GPs in the North of France. Interviews with GPs were conducted from November 2017 to May 2018, until enough data was collected. A theme-based analysis was performed using the software NVivo12®.
Results. Eleven GPs were interviewed. The GPs seemed to find it important to ask their patients about SO and gender identity (GI). Most often they took advantage of the consultation motive to address the topic, and preferred to use open questions or, when necessary, suggested answers so as to clarify what they had been told. GPs reported numerous obstacles: lack of time; their apprehensions and perceptions of their patients' expectations concerning treatment and their representation of SO and IG; and their training and professional experiences. They suggested different communication strategies to be used in the physician-patient relationship, in order, to make it easier to address SO and IG, nevertheless respecting the patient's intimacy.
Conclusion. Collecting data on patients' SO and GI is difficult for GPs. Standardized questions with suggested answers could be used to clarify SO and GI, calling upon communication skills such as active listening.
Keywords: primary care; communication; patient-centered approach; sexual orientation; sexual health.

References

1. Hammarberg T. Discrimination on grounds of sexual orientation and gender identity in Europe. 2nd ed. Strasbourg : Council of Europe Publishing, 2011.
2. McNamara MC, Ng H. Best practices in LGBT care: a guide for primary care physicians. Cleve Clin J Med 2016;83:531-41.
3. Beck F, Firdion JM, Legleye S, Schiltz MA. Les minorités sexuelles face au risque suicidaire. Acquis des sciences sociales et perspectives. Saint-Denis : INPES, 2014.
4. Calzo JP, Blashill AJ, Brown TA, Argenal RL. Eating disorders and disordered weight and shape control behaviors in sexual minority populations. Curr Psychiatry Rep 2017;19:49.
5. Mayer KH, Bekker LG, Stall R, Grulich AE, Colfax G, Lama JR. Comprehensive clinical care for men who have sex with men: an integrated approach. Lancet 2012;380:378-87.
6. Wilkin T. Primary Care for Men Who Have Sex with Men. N Engl J Med 2015;373:854-62.
7. Altman D, Aggleton P, Williams M, et al. Men who have sex with men: stigma and discrimination. Lancet 2012;380:439-45.
8. Mravcak SA. Primary care for lesbians and bisexual women. Am Fam Physician 2006;74:279-86.
9. Bjorkman M, Malterud K. Being lesbian – does the doctor need to know? Scand J Prim Health Care 2007;25:58-62.
10. Chrysalide. Enquête Santé Trans 2011. Lyon : Chrysalide, 2011.
11. Jodelet D. Les représentations sociales. Paris : Presses universitaires de France, 1989.
12. Goffman E. La mise en scène de la vie quotidienne. Paris : Éditions de Minuit,1956.
13. Bajos N, Bozon M. Enquête sur la sexualité en France. Paris : La Découverte, 2008.
14. Maragh-Bass AC, Torain M, Adler R, et al. Risks, benefits, and importance of collecting sexual orientation and gender identity data in healthcare settings: a multimethod analysis of patient and provider perspectives. LGBT Health 2017;4:141-52.
15. Meystre-Agustoni G, Jeannin A, de Heller K, Pécoud A, Bodenmann P, Dubois-Arber F. Talking about sexuality with the physician: are patients receiving what they wish? Swiss Med Wkly 2011;141:w13178.
16. Kiefer B. Le médecin et l'intimité. Rev Med Suisse 2011;7;1176.