CHOOSING A HEALTHCARE PROVIDER: GAY MEN'S NARRATIVES

by

Robert Andrew Eilola

A Thesis
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of
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Choosing a Healthcare Provider: Gay Men's Narratives

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by

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Bachelor of Arts
Concordia College, 2012

Director: Gary L. Kreps, University Distinguished Professor
Department of Communication

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DEDICATION

"These waves are a reminder to many of us watching, a repetition of the message many of us, the luckier ones actually, have received elsewhere in our lives: you may be both gay and loved, but it is not the kind of love you want or need. There are always conditions. We may take the opportunity to yell back at bigots or to smile calmly as others do it for us, just as we sometimes accept scraps of acceptance because we are so starved. But that does not do nearly enough to heal the wounds of knowing that you are accepted and loved, once again, here again, here where you at least sometimes rule, conditionally."

-- Joshua Gamson, *Freaks Talk Back: Tabloid Talk Shows and Sexual Nonconformity* (1999).

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ABSTRACT

CHOOSING A HEALTHCARE PROVIDER: GAY MEN'S NARRATIVES

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A body of health research indicates the Lesbian, Gay, Bisexual, and Transgender (LGBT) community has a lower life expectancy due to health disparities and obstacles unique to the LGBT experience. Health communication research has shown that patients' relationships with their primary care physicians can have strong influences on their health outcomes. This study seeks to answer the research question, "How does a gay/bisexual man's relationship with his doctor influence his level of personal disclosure with his physician regarding health?" Through a survey of men who self-identify as gay or bisexual, links to the online survey were distributed by a snowball sampling through LGBT groups on Facebook and prominent LGBT organizations and activists on Twitter. Respondents completed a survey examining their demographic characteristics, their relationships with their primary care physician, and the health issues they have disclosed to their healthcare providers. A mixed method research design was used to address the research question, which asks whether or not a gay man's choice of primary care

physician plays an important role in the information he is willing to disclose about his health to that same person.

INTRODUCTION

"On this anniversary of Stonewall, I ask my gay sisters and brothers to make the commitment to fight. For themselves, for their freedom, for their country . . . We will not win our rights by staying quietly in our closets . . . We are coming out to fight the lies, the myths, the distortions. We are coming out to tell the truths about gays, for I am tired of the conspiracy of silence, so I'm going to talk about it. And I want you to talk about it. You must come out. Come out to your parents, your relatives (Shilts 1982)." Harvey Milk articulated those words at the 1978 gay pride parade in San Francisco to a crowd of thousands. Milk was the first openly gay man to be elected to public office in California when he won a seat on the San Francisco Board of Supervisors. Considered by many to be an influential force igniting the LGBT rights movement, Milk was responsible for passing a gay rights ordinance for the city of San Francisco and giving hope to many who were living in a closet of fear (Shilts 1982).

His words still echo in the lives of gay people everywhere over 30 years later and they are just as poignant as ever. Since his election into office, there have been many more LGBT officials elected as mayors and city supervisors across the country. In fact, the last several years have been historic for the LGBT community. The U.S. military repealed 'Don't Ask, Don't Tell,' a discriminatory policy preventing gay soldiers from serving our country openly; hospital visitation rights became a reality for same-sex

couples; hate crime legislation was passed around the country; the Supreme Court ruled part of the Defense of Marriage Act (DOMA) unconstitutional; and same-sex marriage was legalized in 35 states.

Despite numerous advancements toward equality, and a growth in societal acceptance, positive attitudes toward the LGBT community have not extended to healthcare settings (Eliason & Schope, 2001). In fact, each day people are denied healthcare because of their sexual orientation (Lambda Legal, 2009). Previous research has demonstrated the LGBT population encounters myriad types of discrimination from healthcare professionals, including discriminatory remarks while receiving care, refusing to be touched, or even being blamed for their health status due to their sexual identity or HIV status (Lambda Legal, 2009). In twenty-eight U.S. states, no laws exist to prohibit healthcare providers from refusing care to LGBT patients (Harvey & Housel, 2013). Societal stigmatization has been associated with severe health disparities for gay men, such as high rates of substance abuse, suicide, psychiatric disorders, obesity, and depression (McLaughlin, Hatzenbuehler, & Keyes, 2010; Ibanez, Purcell, & Stall, 2005; Herek & Garnets, 2007).

The healthcare system itself is not addressing these health disparities (Koester, 2013; Lambda Legal, 2009). Organizations designed to eliminate prejudice and discrimination (e.g., political advocacy groups, legal aid organizations) largely exist *outside* the healthcare system, forcing gay men to find their own ways to access the health care services they need (Koester, 2013). Little to no research exists analyzing how gay/bisexual men choose their primary care physician and how that choice impacts their

health, especially regarding non-sexual health issues (Koester, 2013). Most research to date on MSM and sexual health services has focused primarily on HIV testing (Lauby, & Milnamow, 2009; Mimiaga, Goldhammer, Belanoff, Tetu, & Mayer, 2007).

Many scholars have examined how the relationship between the patient and his/her provider influences an LGBT person's health (Klitzman & Greenberg, 2002; Beach, Keruly, & Moore, 2006; Mimiaga et al., 2007; Berstein et al., 2008). Researchers explain that effective patient-provider communication for gay patients is impossible without the patient being "out" or open about his/her sexual orientation (Berstein et al., 2008; Klitzman & Greenberg, 2002). Several studies have found effective communication between a doctor and patient regarding sexual identity improves health outcomes for gay patients, especially with regard to information about HIV (Beach et al., 2006; Mimiaga et al., 2007). While researchers have begun to address many facets of the LGBT community, few studies have examined the disclosure of outness in the patient and provider relationship.

Until recently, few studies existed pertaining to the healthcare experiences of LGBT people (Clift & Kirby, 2012). The Institute of Medicine (2011) issued a report recommending future research focus on access to and use of healthcare services among LGBT people. This current study contributes to this agenda by investigating how gay men choose primary care physicians and how that choice influences their level of disclosure regarding their sexuality. It is essential to explore this topic for several reasons.

First, LGBT people are coming out earlier than ever before. Influenced by increased societal acceptance that makes LGBT people less stigmatized and more visible (Pew Research Social & Demographic Trends, 2013), the average age for coming out has declined from the mid 20s in the 1980s, to 16 years old today (Lambda Legal, 2013). As the coming out process for gay people starts at an increasingly early age, education regarding LGBT health must start when LGBT people are still formulating their identities. Studies have shown gay and bisexual boys experience their first same-sex attraction around eight years old and for girls it is nine, with many starting years before that (Savin-Williams & Diamond, 2000). Waiting until patients have grown into adulthood may be too late to inform them of certain health risks facing their community.

Second, there is a lack of LGBT health communication research (Coulter, Kenst, & Bowen, 2014). While researchers are becoming more interested in this population, very little academic work and funding has been dedicated to understanding the unique healthcare problems faced by sexual minorities (Coulter et al., 2014). From 1989 to 2011, The National Institutes of Health funded 628 studies pertaining to LGBT health. While the relatively small number of studies has increased each year, almost 80 percent of studies thus far have focused on HIV/AIDS and other sexual health matters. Few studies examined mental illness, illicit drug use, alcohol use, and other health concerns facing the LGBT community (Coulter et al., 2014).

Third, for the first time ever, the World Health Organization (WHO) recommended in their 2014 July annual report, that all gay men should take antiretrovirals to prevent HIV (World Health Organization, 2014). Considering the health

of gay men has entered international spotlight yet again for sexual health, increasing understanding about where gay men choose to receive care and nature of their patient relationship with their primary care physicians has become critically important.

Finally, healthcare professionals receive very little training concerning LGBT health issues (Obedin-Maliver et al., 2011). The American Medical Association (AMA) promotes inclusion of LGBT health issues in their education policy for medical students but this training is not required (Harvey, & Housel, 2013). A recent survey found over the course of four years of medical school, on average, less than five hours of education is devoted to LGBT-related health content and roughly five percent of schools offered no LGBT education at all (Obedin-Maliver et al., 2011). Further research may indicate medical schools need more comprehensive LGBT-sensitive curriculum, thus changing education for both doctors and people who identify as LGBT.

In the following literature review, LGBT patient-provider communication, outness, and the impact of selecting a healthcare provider will be examined. Limiting the analysis to these three areas provides focus. The concept of outness relates most directly to the gay community. Understanding these bodies of research will help us learn how "outness" between doctors and patients affects the amount of disclosure between patients and doctors.

Terms and Concepts

Before surveying the literature, terms and concepts must be defined.

First, "coming out," or "coming out of the closet," refers to LGBT people publicly and privately claiming their non-heterosexual identity. This process is usually painful, as

it is often accompanied by social stigma (Dean, Mayer, Robinson, Sell, & Silenzio, 2000).

Second, homophobia refers to negative feelings toward LGBT people, which may range from an implicit negative attitude or viewpoint, to an action as explicit as a hate crime or violence (Hudson & Rickets, 1980).

Third, Herek (1992) defines heterosexism as "an ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship or community." Typically, we refer to negative attitudes toward gay people as homophobia. However, several scholars (Herek, 1992; Lorde, 1984; Neisen, 1990) believe heterosexism is a more appropriate term because it is a more all-encompassing definition that can include the different and often subtle forms of prejudice and discrimination LGBT people experience daily. Much like homophobia, heterosexism can be implicit or explicit (e.g., in a medical context, a doctor avoiding eye contact after their patient comes out to them could be a form of implicit heterosexism, and expressing concern or advising a gay patient to get counseling when they disclose their sexuality would be explicit). Both behaviors indicate that the homosexual identity is perceived as being inferior to the heterosexual identity; heterosexual privilege (i.e., inexperience with regard to stigma and discrimination) allows the behavior to often go unnoticed or unchallenged (Waldo, 1999).

Fourth, Kitzinger (2005) defines heteronormativity as "The myriad ways in which heterosexuality is produced as a natural, unproblematic, taken-for-granted phenomenon" (p. 478). These beliefs often presume that "there are only two sexes; that it is "normal" or

"natural" for members of the opposite sex to be attracted to one another; that social institutions such as marriage and family are designed around different-sex pairings; that same-sex pairings are (if not "deviant") a "variation on" or "an alternative to" the heterosexual couple" (Kitzinger, p. 478, 2005). Essentially, heteronormativity is the assumption that heterosexuality is normal or even a desired state of all people (e.g., in a medical context, rather than asking a patient how they identify, a heteronormative doctor would assume he or she is straight).

Fifth, primary care physician, or PCP, is the doctor that a patient has a sustained relationship with over a period of time to address a variety of health issues. This doctor is the patient's regular source of care (Safran, 2003).

Literature Review

Contemporary research demonstrates LGBT people and their straight counterparts are more alike than they are different. Yet, historically, LGBT people have been demonized because they have been conceptualized as different. Once homosexuality was recognized and named in the mid 19th century, people began to assign a stigma to the behavior, long before many started claiming it as an actual identity.

In one of his famous works, *Stigma: Notes on the Management of Spoiled Identity*, Erving Goffman (1963) studied the concept of stigma. He defined social stigma as "the process by which the reaction of others spoils normal identity," essentially a sign of discredit or disgrace which sets someone apart from others. The prejudicial treatment of LGBT people, whether through hateful acts or subtle homophobia, is one consequence of social stigma. Goffman describes different strategies that stigmatized individuals use

to manage their public identity to pass as someone who does not have that stigmatized characteristic (e.g., passing as heterosexual). These strategies might help individuals evade discrimination, but there may also be severe personal repercussions from these hiding efforts that can outweigh the positive effects (Goffman, 1963).

For decades, the medical profession aligned with religious institutions to perpetuate this stigma, forming a crusade against homosexuality—classifying homosexuality as a disease and suggesting that those "suffering" from it were in need of medical attention (Herek, 2012). Homosexuality was not revised in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until 1973 and not completely removed until 1986 (Herek, 2012). Even today, so-called "gay to straight" therapy, also known as sexual orientation conversion or reparative therapy, is still legal in many states. Often taking place in religious settings, counselors tell patients through psychotherapy and counseling they can be "cured" of their homosexuality (Just the Facts Coalition, 2008). Today, many hospitals and clinics are sponsored and supported by religious sects and organizations that do not support LGBT relationships (Harvey & Housel, 2013). The religious affiliations of these institutions create a culture where patients often stay in the closet to avoid stigma and discrimination. LGBT patients may not disclose their sexuality in these environments for fear of a negative reaction from their healthcare provider (Harvey & Housel, 2013).

Although progress has been made, this uneasy relationship between medical science and the LGBT community persists. In 2012, the American Psychiatric Association revised their longstanding policies and decided to no longer classify

transgender and gender non-conforming identities as mental disorders (APA, 2013). Over the years, the reality of stigma and discrimination in healthcare has forced many gay people to evade mistreatment by passing as heterosexual in order to fit in a heteronormative healthcare system, failing to disclose their sexual orientation (Lambda Legal, 2013).

Theoretical Grounding

While research regarding disclosure of sexual orientation is still limited, a large body of literature has examined self-disclosure more broadly. Sandra Petronio developed the Communication Privacy Management Theory, or CPM Theory, in 1991. She uses a boundary metaphor to explain how people choose whether or not to disclose private information. The theory suggests we draw a line between public and private information and depending on the costs and benefits associated with a specific act of disclosure, we choose whether or not to reveal that information. This theory is evidence-based and has been used across disciplines to better understand disclosure, including health communication issues, such as medical mistakes (Petronio, Helft, & Child, 2013), HIV/AIDS (Greene, Derlega, Yep, & Petronio, 2003; Ngula & Miller, 2010), e-health (Jin, 2012), and the digitization of healthcare (Anderson & Agarwal, 2011).

CPM theory is comprised of eight central assumptions: 1) "People believe they are the sole owners of their private information and they trust they have the right to protect their information or grant access." 2) "When these 'original owners' grant others access to private information, they become 'authorized co-owners' and are perceived by the 'original owner' to have fiduciary responsibilities for the information." 3) "Because

individuals believe they own rights to their private information, they also justifiably feel that they should be the ones controlling their privacy." 4) "The way people control the flow of private information is through the development and use of privacy rules. These rules are derived from decision criteria such as motivations, cultural values, and situational needs" (Petronio, 2013). 5) Successful and continued control post-access is achieved through coordinating privacy rules with 'authorized co-owners' regarding third-party access." 6) "Co-ownership leads to jointly held and operated collective privacy boundaries where contributions of private information may be given by all members." 7) "Collective privacy boundaries are regulated through decisions about who else may become privy, how much others inside and outside the collective boundary may know, and rights to disclose the information." 8) "Privacy regulation is often unpredictable and can range from disruptions in the privacy management system to complete breakdowns" (Petronio, 2013).

CPM theory provides a useful framework for examining the disclosure of sexual orientation. The CPM theory argues privacy management and disclosure are an integrated system containing coordination of privacy rules and expectations among multiple actors, such as patients, family members, health care provides, and hospital systems (Petronio, 2002, 2006). CPM has the potential to determine more effective ways of achieving successful disclosure in healthcare settings. For example, knowing how providers elicit information about sexuality, why patients choose to be open about their sexual identity, and how revealing that information impacts the doctor/patient relationship is crucial to quality healthcare (Petronio, 2002, 2006). CPM theory provides a powerful framework

for understanding the disclosure of outness and the role it plays in patient/provider relationships. CPM also illustrates the relational factors between the clinician and the patient that influence the process of disclosing sexual orientation during the delivery of health care services.

Healthcare Access

Although limited, emerging research suggests LGBT people face a variety of personal and structural barriers to obtaining high quality medical care (Clift & Kirby, 2012; Eliason & Schope, 2001; Institute of Medicine, 2011). On an individual level, LGBT people report experiencing disrespectful behavior from office staff and even refusal of treatment by medical providers, as well as other failures to provide quality care (Coulter, Kenst, & Bowen, 2014; Eliason & Schope, 2001; National Women's Law Center, 2013; Sears, 2009). Several other studies indicate LGBT individuals perceived the healthcare setting as threatening (Eliason & Schope, 2001) and that the stigma associated with being a sexual minority may cause some individuals to delay seeking medical care (Clift & Kirby, 2012; Institute of Medicine, 2011).

Health disparities affect the LGBT community in different ways. Several studies have concluded that, on average, lesbians show lower rates of preventive care for cancer than heterosexual women, including cancer-screening such as mammography or Papanicolaou tests (Buchmueller & Carpenter, 2010; Aaron, Markovic, Danielson, Honnold, Jonosky, & Schmidt, 2001; Cochran, Mays, Bowen, Gage, Bybee, Roberts, Goldstein, Robinson, Rankow, & White, 2001; Rankow & Tessaro, 1998). In 2001, Cochran et al. examined cancer in one of the largest studies of its kind of lesbian and

bisexual women. In seven independent surveys they compared self-reported breast cancer histories of almost 12,000 lesbian and bisexual women to national estimates for heterosexual women. They found that lesbians/bisexual women display higher rates of obesity, alcohol use, and tobacco use. The self-reported histories of breast cancer did not differ significantly from the U.S. female population estimates (Cochran et al., 2001). Cochran et al. (2001) ultimately concluded that diseases and conditions linked to obesity and smoking should be a concern for the LGBT community. The lesbian and gay population also exhibited lower rates of breast-cancer screening.

Buchmueller and Carpenter (2010) further supported this finding more recently with a nationally representative sample from the Behavioral Risk Factor Surveillance System annual national surveys when they used regression models comparing data of health insurance coverage, healthcare access, and women's cancer screenings of 5,265 individuals in same-sex relationships and 802,659 people in different-sex relationships. Once again, women in same-sex relationships were far less likely than women in straight relationships to have had a cancer screening performed recently and even less likely to have had a checkup with their primary doctor within the last year. The same women reported higher levels of unsatisfied medical needs.

Gay men are also less likely to seek medical services (Alvy, McKirnan, Du Bois, Jones, Ritchie, & Fingerhut, 2011; O'Neill & Shalit, 1992). In 2011, Alvy et al. conducted the first study that examined single men who have sex with men (MSM) in comparison to the general population. Using data from the National Health Interview

Survey in a study examining 871 MSM, they found MSM have less health care access than the general population.

Sexual minorities face structural barriers to receiving healthcare, such as not receiving healthcare benefits from one's life partner (Ash & Badgett, 2006) as well as psychological barriers, such as fear of stigmatization from employers who have access to their medical records (Dean, Meyer, Robinson, Sell, Sember, Silenzio, & Xavier, 2000). As previously mentioned, perceived stigma within healthcare, often when interacting with healthcare providers, may also make gay people less likely to seek medical services in general (Harrison, 1996; Dean et al., 2000).

Health Outcomes

Accessing healthcare is crucial for communities who experience health disparities. Many people falsely assume that LGBT health disparities arise solely from sexually transmitted diseases (Koester, 2013). While sexual health plays a central role in many of the difficulties facing the gay community, there are several health problems facing the LGBT community such as alcohol abuse, STIs and HIV, and mental health.

Alcohol Abuse

Past literature concludes LGBT populations have the highest rate of alcohol use (Bux, 1996; Hughes, 2005; Xavier, Honnold, & Bradford, 2007). In 2007, Xavier et al. conducted the first ever expansive, statewide survey of transgender people in the U.S. through the Virginia Transgender Health Initiative Study. A quantitative survey was performed from September 2005 to July 2006 with 387 respondents and a final sample of 350. The study found 93% of participants had consumed alcoholic beverages in their

lifetimes and a quarter of them felt it had been a problem at some point, significantly higher than the heterosexual population. In large part, researchers suggest this is a manifestation of the lack of safe space for the LGBT community. The safest places for sexual minorities for many years, and by many accounts even to this day, were gay clubs and bars, which enable the heavy consumption of alcohol (Bux, 1996).

Sexual Health

HIV and sexually transmitted infections (STIs) remain disproportionately high among men who have sex with men and transmission of these infections has been steadily increasing over the last two decades (Wolitsky & Fenton, 2011). Research studies have held longstanding conclusions that there are increased risks for gay men who participate in certain sexual behaviors, such as anal intercourse and oral sexual contact (Centers for Disease Control and Prevention, 2012; Herbst, Jacobs, & Finlayson, 2008; O'Neill & Shalit, 1992). MSM accounted for 61% of new HIV infections in the U.S. in 2009 and 79% of infections among all newly infected men, thus accounting for the largest portion of HIV infections for that year (CDC, 2012). The same year, men aged 13-29 accounted for 69% of all new HIV infections. At the end of 2009, an estimated 56% of people living with HIV were men who have sex with men. Additionally, 1 in 5 people currently living with HIV in the U.S. are unaware of their infection (CDC, 2012).

Wolitsky and Fenton (2011) explain it is not merely about having HIV or an STI that negatively affects sexual health for gay/bisexual men. Poor functioning in other areas of sexual health can increase the risk of STIs, as well as increase the level of infection in the early stages of HIV. For example, MSM who are uncomfortable with their sexuality

may choose not to disclose their same-sex behavior to their healthcare providers or delay HIV/STI diagnosis and treatment (Nelson et al., 2010; Wall, Khosropour, & Sullivan, 2010; Wolitsky & Fenton, 2011).

Compared to other men, MSM are more likely to have (or had in the past) various STIs including HIV, syphilis, gonorrhea, lymphogranuloma venereum (LGV), enteric STIs, human papillomavirus (HPV), human herpesvirus (HHV-8), hepatitis B, and possibly hepatitis A and C (Cohen, Russell, Golub, & Mayer, 2006; Douglas, Peterman, & Fenton, 2005; Nieuwenhuis et al., 2004; Rhodes & Yee, 2008; Valdiserri, 2008; Van der Bij et al., 2006; Xu, Sternberg, & Markowitz, 2010).

Men who have sex with men account for a majority of syphilis cases in the United States (Centers for Disease Control and Prevention, 2014). In the most recent data available from the Centers for Disease Control and Prevention (2014), cases of primary and secondary syphilis due to MSM rose from 77% in 2009 to 83.9% in 2012. In all racial, ethnic, and age groups, MSM displayed a larger percentage of cases of primary and secondary syphilis than did heterosexual men and women (Centers for Disease Control and Prevention, 2014).

Wolitsky and Fenton argue (2011) an extensive amount of research still needs to be conducted to understand how sexual behavior among MSM is shaped by developmental influences (e.g., the coming out process, early sexual experiences, acceptance/rejection by family and peers, school and work environments), self-concept and mental health aspects of sexuality (e.g., internalized homonegativity, body image,

social anxiety), and relationships with a partner and sexual interactions within and outside partnerships.

Mental Health

Due to the stigma and discrimination that LGBT people face everyday, they suffer from depression, psychosocial disorders, high-levels of stress, and in some cases these conditions lead to suicide. A body of research has focused on the mental health of LGBT youth (Coker, Austin, & Schuster, 2010; Garofalo, Wolf, & Wissow, 1999; Ramafedi, Farrow, & Deisher, 1991). In a survey of 137, 14 to 21 year old subjects, Ramafedi et al. (1991) found 41 respondents had attempted suicide with over half of the 41 reporting multiple attempts, thus concluding the suicide risk is two to three times higher for gay youth than their heterosexual peers. Those adolescents that also reported low levels of acceptance at home were nearly six times as likely to have depression and eight times as likely to have attempted suicide than heterosexual youth. For the transgender population the numbers are even more alarming. The aforementioned study conducted by Xavier et al. (2007) found 41% of transgender people surveyed reported attempting suicide at least once.

LGBT Patient-Provider Communication

To combat health disparities, researchers have begun examining the role of the primary-care physician in LGBT people's healthcare, specifically with regard to patient-provider communication (Beach, Keruly, & Moore, 2006; Lee, Melhado, Chacko, White, Huebschmann, & Crane, 2008; Mimiaga, Goldhammer, Belanoff, Tetu, & Mayer, 2007; Politi, Clark, Armstrong, McGarry, & Sciamanna, 2009). Previous research suggests that

effective patient-provider communication is imperative to reducing health disparities in the LGBT community (Beach, Keruly, & Moore, 2006; Lee et al., 2008; Mimiaga et al., 2007; Politi et al., 2009).

In a landmark study, Beach et al. (2006) examined the role of patient-centered approaches to healthcare—more specifically, caregivers approaching patients as unique and valuable individuals when treating them with antiretroviral therapy for HIV. Over 1,500 Patients were surveyed and the researchers found that when providers treated patients "as persons," patients were more likely to receive antiretroviral treatment, report a higher quality of life, including a positive attitude toward treatment and believed that their prescribed medications were improving their health. This study provides evidence that the quality of patient-provider relationships is closely related to quality of care and patient satisfaction with health care services.

Mimiaga et al. (2007) examined the perceptions of men who have sex with men about HIV, and their HIV/AIDS testing and treatment experiences. Those men who discussed their sexual behavior with their PCP felt positively or negatively about their health care depending on the communication style of the physician. Positive interactions included PCPs who introduced the subject casually, took time to adequately know and understand the patient, and did not exhibit signs of discomfort in their body language or manner of speech. Many respondents appreciated when doctors asked questions regarding sexual behavior as opposed to the patient having to raise the issue. In addition to communication style, some participants described their preferences for seeing the same provider over an extended period of time, having a clinician who sees a lot of other gay

patients, is associated with an LGBT organization, or identifies as LGBT him- or herself (Mimiaga et al., 2007). PCPs whose communication styles were perceived as negative included doctors who focused primarily on the risks involved with a patient's sexual behavior, doctors who were thought of as being judgmental based on their body language and speaking style, and doctors who were surprised and expressed shock after a patient "came out" to them. While many respondents acknowledged the feeling of embarrassment in their first interactions, they began to feel more comfortable with their PCPs as their relationships evolved (Mimiaga et al., 2007).

The Coming Out Process

Coming out, the process an individual goes through when identifying themselves as lesbian, gay, bisexual, or transgender, is a life-changing developmental step for many youths and adults alike. Until the late 1960s, coming out was viewed as a single occurrence: when one homosexual told another homosexual they had feelings of same-sex attraction (Hooker, 1965). Recognizing the shortcomings of this definition, Cohen and Salvin-Williams (1996) later suggested the coming out process encompasses two distinct actions: acknowledging one's sexual orientation to oneself and disclosing one's sexual identity to others, such as family, friends, and allies. To some degree, gay people are coming out their entire lives. Every time an LGBT person meets someone new they can decide to come out or to cover, pass, or deny (Griffith & Hebl, 2002).

The development of an LGBT identity is a long process that is often accompanied by depression, low self-esteem, and confusion. The task is considered complete when an individual has a positive self-image associated with the LGBT identity (Waldner &

Magrader, 1999). While development, expression, and disclosure often occur sequentially, many individuals might experience same-sex attraction but not identify as gay or bisexual. Additionally, some LGBT people might be comfortable with their sexual minority identity and choose not to disclose it to certain people, even to members within the LGBT community (Waldner & Magrader, 1999).

Coming out can be met with hostility and bigotry, yet there are clear psychological benefits to those who choose to come out (Berg-Cross, 1988; Cramer & Roach, 1988; Corrigan & Matthews, 2003). Individuals who choose to divulge their sexual identity to others often experience decreased stress, increased self-esteem, enhanced interpersonal relationships, and better performance in institutions like school and work (Corrigan & Matthews, 2003). Clearly, coming out is a complex process. It is key to understand this identity formation and the effects of its disclosure to deliver effective health care services to members of the LGBT community in a variety of contexts.

School

As previously noted, LGBT adolescents are coming out at a younger age than the previous generation (Lambda Legal, 2013). For many LGBT persons, the coming out process is initiated while they are attending college. For example, Gortmaker and Brown (2006) surveyed 87 lesbian and gay students at a Midwestern college with an enrollment of 22,000. Students were categorized into out and closeted groups based upon their results to answers on an outness scale. The study found both out and closeted students perceived a negative campus climate for LGBT students. Closeted students were far more

likely to hide their identities from faculty, other students, and healthcare providers. Both groups experienced unfair treatment and said they hid their identity from other students because of anti-gay remarks. Additionally, over 30 percent of out students reported seeing anti-gay graffiti four times or more on campus, and out students felt more uncomfortable submitting an LG paper topic in class (22%) than closeted students (7%).

Research demonstrates that the harassment students face during school due to their LGBT identity has negative influences on their health (Bontempo & D'Augelli, 2002; DuRant, Krowchuk, & Sinal, 1998; Russell, Ryan, Russell, Diaz, & Sanchez, 2011). In a survey of 245 young students, Russell et al. (2011) found that LGBT-targeted bullying related to sexual identity or gender expression during school years led to increased young adult depression, risky sexual behavior, and suicidal thoughts. Students who reported high levels of anti-LGBT victimization as teens were 5.6 times more likely to report suicide attempts than those victimized less frequently (Russell et al., 2011); they were more than twice as likely to report being clinically depressed (Russell et al., 2011); and they were more than twice as likely to report having been diagnosed with a sexually transmitted disease in young adulthood (Russell et al., 2011).

Work

Day and Schoenrade (1997) examined the relationship between outness at work and the level of critical work attitudes. They concluded that "out" members of the organization had higher job satisfaction, were more committed to their organization, and felt more accepted within the organization. This research demonstrates the benefits that can come to an individual if they come out in the workplace, but this study focused

mostly on job attitudes. One additional study (Griffith & Hebl, 2002) sought to expand upon Day & Schoenrade's work. In a survey of just over 200 LGBT people, Griffith and Hebl (2002) studied the relationship between self-disclosure and individual differences as well as the potential importance of formal organizations and coworkers' reactions. They confirmed previous research by finding disclosure at work was positively related to higher job satisfaction and lower job anxiety.

The threat of backlash forces gay people into a complex dilemma. First, coming out is often essential to psychosocial adjustment and general psychological well-being and can result in enhanced job satisfaction and better outcomes in the workplace (Griffith, 2002; Rostosky & Riggle, 2002; Orne, 2011). However, on the other hand, if employees are not in a safe space, coming out can make other employees upset, hinder productivity, and create a feeling of isolation from the organization. In some cases, disclosure in unsafe workplaces can lead to discrimination (Badgett, 2001; Hill, 2009). LGBT people face problems if they do not disclose their sexual identity at work and face other problems if they do.

Research also shows that LGBT people who are out at work face health problems (Sears & Mallory, 2011; University of Nebraska Medical Center, 2011). In 2011, in a study of 770 respondents (59.3% had disclosed their sexual orientation at work) the University of Nebraska Medical Center found employees who reported discrimination at work were significantly more likely to report higher rates of depression than those who did not experience job-related discrimination. Other analyses demonstrated LGBT employees reported higher numbers of sick days and generally indicated illness interfered

with their daily activities on more days than those who reported lower rates of depression (University of Nebraska Medical Center, 2011).

Healthcare

A small body of research has begun to emerge pertaining to outness and the quality of healthcare reported by the individual. Prior research suggests the majority of gay people do not disclose their sexual orientation to their primary care physician (Berstein, Kai-Lih, Begier, Koblin, Karpati, & Murrill, 2008; Klitzman, Greenberg, 2002; Polek, Hardie, & Crowley, 2008). However, those that do disclose their sexual orientation report better health outcomes and more health-promoting behaviors (Berstein et al., 2008; Klitzman & Greenberg, 2002; Polek et al., 2008).

For example, Berstein et al. (2008) examined the relationship between disclosure of homosexuality to healthcare providers and self-reported HIV testing among men who have sex with men. The study concluded men who had revealed their sexual orientation to their doctor were more likely to have been tested for HIV. However, 39 percent (175) of respondents did not disclose their sexual orientation, suggesting many of the HIV testing strategies may be missing this large demographic.

In addition, there is some disagreement in the literature as to which group, gay men or lesbians/bisexual women, are more likely to disclose their sexual orientation in a healthcare setting. In 2002, Klitzman and Greenburg used a small, self-report questionnaire of 66 gay men and 28 lesbians at a local LGBT community center to argue that gay men were more likely on average to disclose their sexuality than lesbian/bisexual women. Polek et al. (2008) disagree by suggesting through a slightly larger sample size

of 96 that lesbian women are more likely than gay/bisexual men to reveal their sexual identity to their healthcare providers. This said, both studies fail to acknowledge the possible role that the demographic similarities (i.e., homophily) between the physicians and patients play in the likelihood an individual comes out in a healthcare setting.

Demographics of Physician

Some research has indicated the important role the demographic background of the doctor plays in the patient's attitudes toward quality of care and healthcare choices (Lee, Melhado, Chacko, White, Huebschmann, & Crane, 2008; Klitzman & Greenberg, 2002). We have already seen how Klitzman and Greenberg (2002) used a self-report questionnaire where 66 gay men and 28 lesbians completed the form at an LGBT community center to learn that those who disclosed their sexual orientation were predominately white gay males with white male doctors. This study suggests demographic similarities may play an important role in viewing doctors as LGBT-friendly. For example, lesbians may struggle with disclosure because they are women who are often seen by male doctors, rather than gay men who are often treated by doctors of the same sex. Additionally, gay men who disclosed their sexual orientation to their doctor were more likely to be treated by health care providers (doctors, nurses, and other allied health workers) who respondents thought were gay or bisexual. These and other factors may influence the level of trust established between physicians and patients. Patients often perceive there is less risk involved when disclosing personal information to a recipient who is similar to them. More research needs to be done to explore and test this relationship.

Additionally, Lee et al. (2008) sought to examine the effect certain characteristics of the provider might play in their patient interactions. Using a random sample of 502 people, 32 percent of respondents said they would change providers if they found out their provider was gay or lesbian or even change practices if a gay/lesbian doctor was employed there. Obviously, this study pertains to people who identify as straight or those experiencing internal homophobia—but it offers one indication that patients may value homophily in their interactions with the healthcare system. More research must be done to see how the demographics of the provider affect LGBT patient-provider communication.

Overall, very little research has been done regarding the outness of LGBT youth in their patient-provider relationships. In 2006, Meckler, Elliot, Kanouse, Beals, & Schuster sought to determine the factors that influence young gay people to disclose their sexuality in a healthcare setting. Their study suggests the strongest predictor of disclosure was when sex or sexual health came up in discussion by either party. A majority of students preferred if their doctor just asked them about their sexual orientation. Yet, only 35% of respondents said their doctors were aware of the sexual orientation. The results suggest physicians had not discussed sexuality with most LGB youth in the study and most youth would welcome such a discussion.

Choice of Provider

Relatively little research has been done pertaining to one of the first decisions a patient has to make; that is, the choice of their primary care physician. A pair of British studies (Billinghurst & Whitfield 1993; Salisbury 1989) found the most common factor

influencing the choice of a new doctor was convenience. Yet both studies pertained to patients who had left their previous PCP due to a change in location. Additionally, vastly different medical systems exist in the UK and the US. Thus, it is hard to draw critical conclusions about choosing health care providers when the emphasis on decision making might vary greatly between countries.

Conclusions

Overall, outness must be emphasized when conducting healthcare research with the LGBT population. More specifically, the sexual identity of LGBT youth needs to be discussed with professionals at an earlier age. As the literature noted, sexual minorities face many obstacles during their youth. Yet, at a time when they often need health care services the most, they are not comfortable discussing their sexuality with their doctor (Meckler et al., 2006).

More LGBT patient-provider communication research must be done. Studies should determine how to educate students in medical school and to help elicit conversations surrounding sexuality when they become physicians. More education could further enhance the well-being of LGBT people and reduce health inequities. In particular, very little research has been done with gay community attitudes toward coming out to doctors. If a majority of gay people think their sexuality does not play a role in their health, how do we educate this population about the significant health disparities gay people face and about the importance that outness plays in healthcare satisfaction?

Based on the aforementioned review of literature, the following research question will be investigated, “How does a gay/bisexual man’s choice of primary care physician, influence their level of personal disclosure regarding health?”

METHOD

Participants

Participants in this survey research study were gay/bisexual men over the age of 18. Entry criteria for participation in this study specified that survey respondents needed to be men who self-identified as a sexual minority (non-heterosexual). I reached out to local LGBT groups in the NOVA/DC area to distribute flyers with the link to the online survey at public LGBT events (conferences, meetings, etc.). Finding smaller populations can be difficult, especially for sexual minorities, where the identity often carries a stigma. Thus, since I know many gay/bisexual men, and they also know more from the same demographic, many of the participants were recruited through a snowball sampling method, where respondents encouraged people they knew who met the entry criteria to also participate in the study .

Procedure

An online survey titled, "Choosing A Healthcare Provider: Gay Men's Narratives" was sent to individuals via Facebook and Twitter along with a message explaining that the survey would take roughly five minutes to complete and that the survey results would be kept completely anonymous and confidential. The respondents were encouraged to forward the survey to anyone they knew who fit the participant entry criteria. Participants were given a computer link to the survey, which took them to a message prior to beginning the survey that outlined the purpose of the study along with

some brief instructions. All study recruitment and data collection methods were approved by the George Mason University Institutional Review Board.

The primary recruitment channel used was Facebook. I posted messages on several LGBT groups on Facebook, such as "Equality: Our Name, Our Goal," "LGBT Inclusive," and "I'm Gay And I Love It (LGBT)," which had member totals ranging from 2,800 to over 41,000 Facebook users. Any member of these groups could see the message I posted along with a link to the survey. I made two public Facebook "statuses" that invited people to participate and forward the survey on to as many people as possible. I have 1,026 friends on Facebook and my status was shared a total of 10 times to friends' social networks.

Additionally, on Twitter, I targeted major LGBT groups and public allies who could potentially participate in my survey and retweet my tweet to their large follower bases. Several tweets mentioned national organizations such as the Human Rights Campaign (@HRC), Lambda Legal (@LambdaLegal), and the NOH8 Campaign (@NOH8Campaign). Other tweets mentioned local organizations like the LGBTQ Resource Center on George Mason University's campus (@LGBTQMason). Prominent LGBT allies that I follow on Twitter were also mentioned in several tweets including: self-identified queer activist Johnathan Fields (@JohnnyGolightly) who retweeted my tweet to his 1,991 followers and Dr. D'Lane R. Compton (@drcompton) who is an assistant professor of sociology at The University of New Orleans and self-identified queer activist who retweeted my tweet three separate times to her 2,069 followers.

Finally, I emailed the LGBTQ resource center on George Mason University's campus and requested they email their listserv the survey. I sent the same email to Concordia College, my alma matter, and the University of Nebraska-Lincoln, where I have several different contacts involved with their campus LGBT organization.

Participants could take as much time as they needed to complete the survey. The survey included questions pertaining to demographics, the quality of relationship they have with their PCP, their level of outness to various groups of people, including their doctor, and how they chose the PCP they are currently seeing. Participants were also asked to recount a story as it relates to trust and disclosure with that same healthcare provider (A copy of the survey instrument used in this study can be seen in Appendix B).

Measurement Instruments

Surveys were taken on the Qualtrics online survey platform and consisted of three qualitative sections: 1. demographics, 2. relationship with healthcare provider, and 3. the recollection of a story as it relates to trust and disclosure with the respondent's primary care physician. Eleven specific questions were asked. Most questions were open-ended. Additionally, participants rated their outness to family, friends, and at work using an outness scale which asked the respondent to rate their outness on a scale of 0-100.

RESULTS

Participant Characteristics

Participants in this study were predominantly young males (28.6 mean age) who identified as homosexual (86.8%). Of the 196 initial respondents, 24 were excluded because they did not fit the respondent entry criteria and 172 surveys were used in the final study sample for analysis. Respondents who identified themselves as female or transgender were not included in the analysis because of its focus on gay men. All respondents (172) identified as homosexual or bisexual men.

Outness

How "out" a patient was to their doctor was measured by asking the open-ended question: "How open are you with your doctor about your sexuality, if at all? Why?" Responses were coded into two categories: open and not open. Any response that indicated some level of openness regarding sexuality was coded as "open." In order to be coded as "not open" respondents had to explicitly indicate they chose not to disclose their sexuality to their doctor.

Several respondents answered questions based on their last or future doctor because they did not currently have a primary care physician. Open responses ranged from one word answers (e.g., "yes," "very," "completely") to longer responses such as, "Completely open. I have no reason to hide my personal life," and "very, it was discussed in our first session and he actually asked me to recommend him to my other LGBTQ-identified friends . . . he's sensitive to the specialized needs of the LGBTQ community."

One respondent expressed some hesitancy (e.g., "I'm as open as I need to be."), but was coded as open because he indicated he would be out if necessary.

Respondents' answers which demonstrated they did not disclose their sexuality ranged from short answers (e.g., "no," "not at all," and "I am not open.") to longer responses (e.g., "It has not come up or been necessary to disclose," and "No, I live in a small town and I fear that news of my sexuality would travel faster than I could tell people myself."). Responses that answered "n/a" because they did not have a doctor were coded as missing from the data set for that question. Overall, 139 participants were included in the analysis. A majority of gay men indicated they were open with their doctors about their sexuality (59%) and 41 percent said they had not disclosed their sexual orientation.

There was a statistically significant relationship between age and outness, $X^2(2)=16.336$, $p<.001$. As shown in Table 1, participants who were out to their doctors were more likely to be older (31.8 years old mean) than those who were not open (24.7 years old mean).

Table 1. Percentage of patients open with their primary care physician by age

Age	Not Open w/PCP	Completely Open w/PCP	Total
18-23	**32 (56.1%)**	**21 (25.9%)**	**53 (38.4%)**
24-30	**18 (31.6%)**	**20 (35.8%)**	**47 (34.1%)**
31+	**7 (12.3%)**	**31 (38.3%)**	**38 (27.5%)**

Total	**57 (41.3%)**	**81 (58.7%)**	**138 (100%)**

Note. * = $p \leq .05$, *** = $p \leq .001$

Outness to Family

How out a person was to their family was determined by asking the question: "How out are you to your family?" Respondents were given the ability to move a slider on the screen to "rate" their outness from 0-100, with 100 being completely open. Responses were coded into two categories, "completely open," which was indicated by a score of 100, and "all others," which included all other scores. Only 36.7 percent of respondents were completely out to their family with an average outness score of 73 for all respondents.

There was a statistically significant relationship between outness to family and how out a patient was with their doctor. The higher respondents scored themselves on the outness scale for family the more likely they were to be out to their doctor, $X^2(1)=6.812$, $p<.05$.

Outness to Friends

How out gay men were to their friend group was determined by asking the question: "How out are you to your friends?" In total, 139 respondents answered the question and were included in the analysis. Respondents were given the ability to move a slider on the screen to "rate" their outness from 0-100, with 100 being completely open. Responses were coded into two categories, "completely open," which was indicated by a

score of 100, and "all others," which included all other scores. A majority of respondents were completely open with their sexuality among friends (66%) with an average outness score of 90.

There was a statistically significant relationship between outness to friends and how out a patient was with their doctor. The higher respondents scored their outness to friends, the more likely they were to be out to their doctor $X^2(1)=11.212$, $p<.005$.

Outness at Work

Outness at work was measured by asking participants the question: "How out are you at work?" In total, 138 participants responded to the question and were included in the analysis. Respondents were given the ability to move a slider on the screen to "rate" their outness from 0-100, with 100 being completely open. Responses were coded into two categories, "completely open," which was indicated by a score of 100, and "all others," which included all other scores. At work, 43.3 percent of respondents were completely open, while a majority was not (56.7%). The average outness score was 73.

There was a statistically significant relationship between outness at work and how out a patient was with their doctor. The higher respondents scored their outness at work, the more likely they were to be out to their doctor, $X^2(1)=6.602$, $p<.05$.

Choice of Doctor

Choice of doctor was measured by asking the open-ended question: "How did you choose your doctor?" Answers from respondents were coded into three categories; the first category was accessibility (e.g., cost, location, insurance, etc.), which included responses such as, "Used my health insurance website to find a nearby doctor," "She

worked at my university's health services and I use her because she's been the most helpful," "Assigned via the hospital's 'Find Your Doctor' website," and "Covered under my health insurance." These responses were coded in the same way because neither sexual identity did not play a factor in the selection process nor was a personal referral (either friend, family, or ally) taken into consideration.

The second category was family (e.g., family referral, family doctor, pediatrician, etc.), which included responses such as, "Through my mother," "He was my parent's doctor. When I turned 16, I switched from my pediatrician to a general practitioner," "Was my father's doctor," and "referral from sister-in-law." These responses were coded in the same way because the family, either by referral or healthcare plan, was the primary factor impacting a patient's choice of healthcare provider.

The third category was friends/allies (e.g., friend referral, LGBT resource center, etc.), which included responses such as, "Referred by a close friend," "By looking for a doctor who specialized in LGBT care," "An LGBT resource in Minneapolis, MN," and "referral from a gay friend." These responses were coded in the same way because the LGBT identity was at the forefront of the decision-making process.

Respondents who could not remember how they chose their doctor were coded as missing from the dataset.

Overall, 128 respondents answered the question and were included in the analysis. As shown in Table 2, most gay men indicated they chose their doctor because of accessibility (45%) rather than family (32.5%) or friend/allies (22.5%).

How gay men chose their doctor played a significant role in whether or not they came out in a clinical setting. As seen through Table 2, men who chose their doctor through friends/allies or because of accessibility, were more likely than those who chose their doctor through family to be open with their doctor about their sexuality, $X^2(2)=15.616$, $p<.001$.

Table 2. Method of choosing a primary care provider compared with openness regarding sexuality

	Not Open w/PCP	Completely Open w/PCP	Total
Accessibility	**20 (38.5%)**	**35 (49.3%)**	**56 (44.8%)**
Family	**27 (51.9%)**	**15 (20.5%)**	**42 (33.5%)**
Friends/Allies	**5 (9.6%)**	**22 (30.1%)**	**27 (21.5%)**
Total	**52 (41.6%)**	**73 (58.4%)**	**125 (100%)**

Note. *** = $p \leq .001$.

Age

The age of respondents was determined by asking the open-ended question: "How old are you?" Overall, 177 participants responded to the question. Responses were coded

into three categories: 18-23 years old, 24-30 years old, and 31+ years old. Most participants represented the 18-23 year old category (42%) with an average age of 28.6.

Age was significantly positively correlated with outness. As shown in Table 1, the older the patient was, the more likely they were to have disclosed their sexuality to their doctor, $X^2(2)=16.336$, $p<.001$.

Length of Relationship

The length of time a patient has seen a specific doctor was measured by asking the question: "How long have you been seeing him/her?" Overall, 113 participants responded to the question and were included in the analysis. Responses were coded into three categories: 0-3 years, 4-9 years, and 10+ years. In total, 44.2 percent of gay men had started visiting their doctor within the last three years and 31 percent had been seeing the same doctor for over ten years.

As shown in Table 3, the length of time a patient had been visiting the same doctor did not demonstrate a significant relationship with outness, $X^2(2)=.443$, $p>.05$.

Table 3. Length of time visiting the same primary care physician and openness with sexuality.

Length of Time	Not Open w/PCP	Completely Open w/PCP	Total
0-3 years	**21 (45.7%)**	**28 (42.4%)**	**49 (43.8%)**

4-9 years	**10 (21.7%)**	**18 (27.3%)**	**28 (25.0%)**
10+ years	**15 (32.5%)**	**20 (30.3%)**	**35 (31.3%)**
Total	**46 (41.1%)**	**66 (58.9%)**	**112 (100%)**

Note. * = $p \geq .05$.

Quality of Relationship

How patients described their relationships with their doctors was measured by asking the open-ended question: "Overall, how would you describe your relationship with this person?" In total, 116 people responded to the question. Responses were coded into three categories and were coded once. The first category was professional, which included responses that used the specific word "professional" in their answer (e.g., "Very professional," "Strictly professional," and "Professional, discuss medical issues as they arise.").

The second category was positive, which included responses such as, "Friendly," "Good," "Cordial, I think he's a good doctor," "Great, very communicative," and "exceptional." The final category was distant and/or nonexistent, which included responses such as, "We don't have much of a relationship," "nonexistent," "minimal," and "Distant. It was a small town, so everyone knew everyone else's business. Once I remember him complimenting my role in the high school musical while giving me my physical exam. It was a little strange."

Patients used the word “professional” to describe their relationship with their doctor 16.4 percent of the time. As shown in Table 4, most gay men reported a positive relationship with their doctor (66.4%).

The connection between how gay men described the quality of relationship they have with their doctor and their openness regarding their sexuality was statistically significant, $X^2(2)=7.726$, $p<.05$.

Table 4. Description of relationship with primary care physician and openness with sexuality.

	Not Open w/PCP	Completely Open w/PCP	Total
Professional	**10 (21.7%)**	**9 (13.2%)**	**19 (16.7%)**
Positive	**24 (52.2%)**	**52 (76.5%)**	**76 (66.7%)**
Distant/Non-Existent	**12 (26.1%)**	**7 (10.3%)**	**19 (16.7%)**
Total	**46 (40.3%)**	**68 (59.7%)**	**114 (100%)**

Note. * = $p < .05$.

Qualitative Results

The last question of the survey asked participants to "Tell a story about this doctor as it relates to trust and disclosure." Overall, 81 respondents were included in the analysis because they described an experience. Responses were coded by subject matter of the answer and tone of the message (i.e., positive or negative). Descriptions were not limited to one code per answer. Several themes emerged from the responses.

Positive Experiences

When responding to this question, most (77.8%) gay men chose to retell a positive experience they had with their doctor, many of which suggested their doctors were sensitive and/or knowledgeable about gay identities.

A 19-year-old respondent said, "When I asked my doctor to be tested because I had been sexually active, she immediately gave me a quick run through of safe sex practices and told me about her brother who shares the same identity as I do. She applauded me for being so brave to tell my friends and family and especially my doctor, with my mother in the room."

This person's experience suggests coming out to your doctor can lead to a positive health experience. In this case, the patient chose to disclose and the doctor disclosed information as well to make the patient feel comfortable and affirmed for having disclosed his sexual orientation.

A 44-year-old man who had been seeing his doctor for the last three years said, "Although he himself is a straight man, he doesn't have any issues discussing or understanding gay sexual health. I find him so open that I have to remember that he is not gay himself."

Primary care physicians do not need to explicitly express support of one's identity for patients to feel comfortable. In instances like this, gay health is not seen as a separate discussion, but a holistic approach to health.

A 58-year-old respondent who had been seeing his physician for one year said, "When I met this woman, she asked if I was in a relationship. I said, 'I am married.' She asked 'to a man or a woman?' The rest was very easy. She never gave any hint of being uncomfortable or wishing to avoid talking about sexual issues and concerns."

Some doctors incorporate the use of gender-neutral language or ask patients to specify in order to deliver the best care possible. Here, the patient suggests by not referencing stereotypical health concerns of gay men (i.e., STDs, HIV/AIDS, etc.) the doctor was exhibiting sensitivity. This response indicates health care providers are becoming increasingly comfortable with discussing sexual identity and sexual orientation. The question also suggests the healthcare system as a whole is becoming less heteronormative.

One 32-year-old man whose doctor was active with the local LGBT community said, " . . . she walked through my medical record with me (I was previously under the care of a different doctor at the same clinic), and she showed me where the previous doctor had marked 'homosexual' as a mental disorder. We walked through my records to make sure they accurately reflected me and my health genuinely."

A growing number of doctors recognize the tenuous relationship that existed between the LGBT and medical community in the past. With a better understanding of LGBT medical history politics, doctors can engage patients in a sensitive and meaningful way.

Outness

Several gay men (11.1%) indicated coming out to their doctor had made a positive impact on their life.

A 20-year-old respondent who described the relationship between him and his doctor as "friendly" said, "When I had bad anxiety, I was able to disclose lots of private information about my personal life and family situation. He was very keen to listen and very helpful in helping me strategize about coping mechanisms."

Gay men often experience mental anguish and even depression when coming out.

Primary care providers may be an outlet closeted gay men do not otherwise have when

discussing their sexuality and how it intersects with their day-to-day life.

A 50-year-old respondent who has seen the same doctor for over ten years said, "My small-town doctor and I have been through the general, gay-centric health screenings, life-threatening cancer, and aging issue. Because of our history and mutual respect for each other, I consider him a friend."

While small-town doctors are frequently stereotyped as being at odds with the gay

community, gay men may be more likely to see the same doctor repeatedly in a small

town. Consistently visiting the same doctor creates a relationship between the patient and

provider that may create new levels of trust for gay patients.

A 46-year-old man who described the relationship between him and his doctor as "wonderful" said, "With my HIV/AIDS doctor, my disclosure of my sexual history ensured that we had the appropriate tests done for STDs and hepatitis which might have been ignored by a regular doctor when I said I was not an IV drug user and hadn't had transfusions or tattoos. My openness allowed them to gauge accurately which tests were appropriate."

Coming out to primary care providers may directly lead to improved health outcomes.

A 27-year-old respondent who found his doctor by researching online for gay-friendly, informed doctors in his area said, "My PCP asks personal questions about my life and sexuality that are important and factors all variables into my overall health. For example, when discussing my sex life, he's asked about my overall mental health so we can target the root cause of any complications. It has meant the world to me as an openly gay man who has not had these types of resources before."

Choosing to disclose one's sexual orientation to the doctor may result in a more holistic

approach to health by doctors, leading to improved care and health outcomes.

Additionally, providers may be able to accurately pinpoint where sexuality intersects with other (many) aspects of a person's health and well-being. This response also indicates PCPs have different strategies for eliciting information pertaining to a patient's sexual orientation and health.

A 56-year-old respondent who described the relationship with his physician as "very open" said, "I have been honest with him since the beginning. At the time I started going to him, I was not out to my family, straight friends or at work, so it was reassuring to be able to have trusted conversations with my doctor."

Several responses indicated doctors increasingly have to play a dual-role of provider and ally. High levels of trust within the patient-provider relationship may allow patients to navigate the coming out process with additional support they may not have otherwise had.

Lack of Self-Disclosure

Several respondents (8.6%) indicated they did not fully disclose their sexuality to their doctor.

A 24-year-old man whose primary care doctor was a family physician said, "My sexuality just never comes up. If it does, it is usually something heteronormative (meaning I have to explain to him I'm homosexual instead). I come from a small town community where everyone knows everyone. Since I'm not out to my family, and I am under my family's health insurance plan, I do not feel comfortable talking about health related issues in regards to my sexuality with my doctor out of fear it going back to my parents. . . . Other physicians that I see only one time, I'm COMPLETELY open to them (since they share no connection or tie to my family)."

Heteronormativity persists within healthcare, especially in smaller communities with less dialogue and awareness about the LGBT community. This response highlights the difficulties LGBT people face while in the closet. Gay patients are forced to hide

information if they do not trust the doctor or if they feel their medical information is not private.

A 25-year-old man who chose his doctor because he was the only one available in his town said, " . . . I was always cautious to keep my sexuality to myself."

Another respondent, who is 29-years-old and has been seeing his PCP for 6 months said, "Recently, my doctor asked if anything has been going on in my life that is markedly different. I chose not disclose the fact that I had recently come out to my family. The coming out process didn't really go well. As a result, I have experienced more anxiety than ever before."

More research and education is needed to determine how doctors should ascertain information about a patient's sexual orientation/behavior. Further, even if quality questions are asked, a patient may still choose not to come out based on a myriad of other factors. In many ways, by disclosing one's sexuality to a doctor, patients are forced to confirm what they may not be ready to do. Thus, if providers begin seeing a patient after the process has started or ask questions too late, patients may never disclose their sexuality for fear of negative repercussions.

An 18-year-old respondent who chose his doctor through family said, "I feel completely comfortable discussing sexual topics (STDs, etc.) with my doctor. She is very understanding and not judgmental at all. I choose to be in the closet about my bisexuality, but if I weren't, it would not negatively affect our relationship in the least."
Coming out to a provider is sometimes correlated with how central their sexuality is to their identity. Patients have personal reasons, outside of their relationship with their doctor, for choosing not to disclose their sexual orientation.

Sexual Health

A large portion of responses (23.4%) mentioned STDs or stories pertaining to sexual health.

An 18-year-old respondent who chose his doctor randomly said, "I told my doctor I was gay for a general STD screening."

Frequently, gay men view their health through a strictly sexual lens. Patients only feel it is necessary to disclose information about their sexuality when talking about sex.

A 19-year-old man who requested a male doctor when selecting a PCP said, "I went in to get tested for an STI a couple months after being sexually assaulted at a party and losing my virginity that way, and he was super supportive and was willing to move forward in any way possible. I told him I didn't want to press charges because I didn't remember much from that night and he was fine with that, and then paid for the tests and treatment for possible STIs himself."

This response further supports the notion of increasing numbers of patients who are relying on their doctor for both social support and medical advice. Providers who develop more in-depth knowledge about patients may improve patients' perception of the relationship as well as improve health outcomes.

A 24-year-old respondent who visits the same doctor as his mother said, "One of my first visits to see him involved my terror and obsession about potential HIV infection. He was very warm and understanding and offered any assistance he could provide and kept my concerns confidential."

The entry point to conversations regarding sexuality in medical settings is often dictated by a patient's attitudes toward STIs and sexual behavior. If patients only feel it necessary to disclose their homo/bisexuality when discussing sex, providers may need to consider this when attempting to elicit information about health.

A 25-year-old respondent who felt he had a "satisfactory" relationship his doctor said, "The doctor was understanding. He just advised me to use protection for a safe sexual act next time."

With the necessary information, providers are able to offer preventative health behaviors that can result in better health outcomes.

Health Outcomes Influenced by Sexuality

A few respondents (3.7%) felt their sexuality did not impact their health.

A 22-year-old who has seen the same doctor his entire life said, “This is not relevant with this doctor, I have never had a non-medical issue to discuss with him.”

Gay men frequently choose not to disclose because they do not feel it is necessary or related to their health.

Another respondent, a 20-year-old, who has seen the same physician since birth said, “I always trust my doctor but there has never really been a need for disclosure as my health has been consistently good.”

Patients often approach their health reactively, rather than taking a preventative approach. Additionally, patients often believe the absence of illness is health.

A 32-year-old who chose his doctor based on what was closest to his house said, “I don’t have a disclosure that relates vis-a-vis my sexuality. It’s not something I’ve actively hidden; I just think it has literally never come up. He’s only asked me about my diet, exercise, and family history.”

Patients may not disclose unless directly asked. More research and training should be performed in order to gauge which strategies are most effective when eliciting information about a sexual identity.

Non-Sexual Health Issues

However, some gay men (18.5%) mentioned other non-sexual health issues they discussed with their doctor.

A 25-year-old who has seen the same doctor for the last three years and describes the relationship with his doctor as “very communicative” said, “I told her how I was feeling depressed. I know that depression and suicide affects a higher % of homosexuals than heterosexuals. She referred me to an LGBT friendly counselor who has been great.”

If a patient discloses their sexuality, providers can refer them to the appropriate level of care. Some gay patients realize that health concerns of the LGBT community are not solely sexual.

A 60-year-old man whose doctor was selected for him through his healthcare plan said, "My doctor was very open and compassionate when I told him about my partner's suicide. He was very caring and nonjudgmental. I felt completely supported by him and could rely on him for supportive counseling and medications as needed."

Gay men encounter difficulties outside the coming out process as it relates to societal stigma and mental anguish. By providing a safe environment to discuss their sexuality, doctors also open up ways to discuss a patients' partner and other aspects of a patient's life.

A 50-year-old respondent who chose his doctor by word of mouth said, "She knows that I am gay and that I am a recovering alcoholic. She is very supportive."

Discussing a patient's sexual identity can include a variety of other issues that gay men experience. This patient supports research, which demonstrates there are higher levels of addiction and alcoholism in the gay community.

Negative Experiences

While most experiences recounted by gay men were positive, other patients (5%) reported dissatisfaction with their healthcare provider.

A 40-year-old who does not currently have a primary care physician said, "I left my last doctor because he turned judgmental when treating me for an STD."

Anti-gay attitudes are not uncommon in healthcare. Gay men's sexual behavior is often viewed as risky and promiscuous.

One 25-year-old man who visits a doctor at his university said, ". . . I hadn't been completely truthful about my sexual history. During one of my STI checks, he asked something along the lines of, 'So you've probably had like what 6 sexual contacts in the past year?' I just agreed because I didn't want to correct him with my actual sexual history number. After I discovered Grindr and other apps, I've been going through a phase exploring my sexuality. I feel like the doctor missed an opportunity to discuss risky behavior with me and ways to be safer like condom use (or the lack thereof)."

Question phrasing is important when discussing matters of health, especially when the topic area may be a sensitive subject. Providers must also realize the context in which patients' behaviors occur (i.e., more gay men are using phone applications to find potential partners and engage in sex.). Knowledge of the sexual-political landscape influencing a patient's behavior could lead to increased understanding and trust.

> A 21-year-old who is not comfortable being out or open with his PCP describes their relationship as "very non-personal" and said, " . . . they assumed I would be having sex with cis women and wanted to make sure I was educated on avoiding unplanned pregnancies. I didn't feel comfortable enough with them to correct them or to ask about other forms of sex and the risks of STDs/STIs related to them."

Primary care providers' heteronormative assumptions about one's sexual identity may lead to less trust and/or quality of care along with potentially more negative health outcomes.

> A 24-year-old whose doctor was assigned to him based on geographic location when he signed up for a guest membership through his father's insurance said, "Basically I am fed up because I have gone into [see] him about 5 times with concerns of chest pain and heart palpitations . . . The doctor minimally checked the problem I had come in for and told me to stop worrying so much about 'every little thing.' . . . I am in the process of trying to find a new GP."

Even if conversations do not explicitly pertain to sexual identity, patients may view doctors negatively based on other factors. Providers could potentially avoid harmful interactions through increased sensitivity to sexuality as it impacts patients' overall health. Additionally, this response highlights the difficult process gay patients must undergo to find a suitable healthcare provider. Gay men are starting to consider a doctor's attitude toward LGBT issues and cultural sensitivity as an essential part of the their healthcare experience.

DISCUSSION

This study examined how several factors impacted levels of sexual identity disclosure for gay/bi men in healthcare settings. Study results indicated that a large portion of the gay community does not have a primary care physician. Of those who do have a PCP, over half were open about their sexuality. Most gay/bisexual men choose their doctor based upon accessibility and several gay/bisexual men surveyed felt disclosure of their sexuality was not pertinent to visits with their PCP. These findings have several important implications for access to care, continuity of care, and health outcomes for gay men.

The study examined outness on a variety of levels. First, older gay/bi men were more likely to be out to their doctor than younger gay/bi men. Few respondents mentioned their age when describing their relationship with their doctor. In the qualitative section, several gay/bi men indicated sexuality does not impact their health (i.e., they did not disclose because they did not have a reason to). As expressed by several respondents, their primary care physician is primarily for non-sexual health issues. Gay/bisexual men bifurcate their healthcare into two categories: general care and sexual health. Sexual health (STD/HIV testing) is reserved for specialists, while general care is reserved for the primary care physician. CPM theory examines the disclosure of private information through the lens of cost/benefit analysis. In many cases, gay/bisexual men

choose whether or not to disclose their sexuality to their primary care physician depending on their perceived level of stigma. People make rules for concealing and revealing information based on level of perceived risk.

This finding supports a facet of CPM theory, which argues people often assume others do not dictate their privacy rules and boundaries in the same ways they do. Essentially, patients perform a cost/benefit analysis to determine whether or not to disclose their sexual orientation; with little knowledge of a PCP's level of knowledge of the LGBT identity and/or attitude toward the LGBT community, patients withhold this information because it poses less of a risk to their healthcare interaction. CPM theory also suggests everyone has rules for maintaining their privacy boundaries. A "rule" of many patients, is their sexual identity must be directly related to the issue being discussed. Thus, patients may not discuss their sexuality identity if they do not feel it relates to the health issue being discussed.

Research studies tend to frame gay/bisexual men's health around STDs and HIV (Koester, 2013). This study supports previous research which indicates gay/bisexual men continue to see their sexual health as the only part of their health impacted by their sexual identity (Koester, 2013). Future research could examine the primary factors that influence the ways that gay/bi men view different aspects of their health, since it appears from this study that gay men may not view their health holistically. Previous research demonstrated the LGBT community faces health obstacles that lie outside the STD/HIV realm, which suggests that there are a range of diverse health issues that gay men should address to maintain their health.

Further research must be done concerning how the age of gay/bisexual men impacts their level of disclosure. In this study, older gay men were more likely to be out to their primary care physicians, which could mean several different things. Initially, this finding could indicate as gay men age they are more likely to be comfortable with their sexuality and therefore have the necessary confidence to approach this topic of conversation. Many gay/bisexual men indicated a high level of trust with their doctors. This finding could also suggest older gay/bi men view their health as more of a priority than younger gay/bi men. CPM theory argues decisions regarding disclosure are made depending on relational and contextual criteria. A gay/bisexual man may choose whether or not to disclose their sexuality based on who the person is, their perceived ability to handle the information, and whether the situation is appropriate. These perceptions are created through lived experience, and vary from patient to patient.

The study findings suggest important implications for health prevention approaches to LGBT healthcare. Based upon many of the qualitative responses, it seems as though young gay/bisexual men see little reason for interacting with the healthcare system. Rather than establishing a long-term relationship with a healthcare provider, younger gay/bisexual men seem to prefer discrete healthcare services, such as HIV tests and STD clinics. Additionally, considering healthcare decisions are shaped by busy doctors' offices and insurance qualifications, gay/bisexual men may not recognize the advantages of consolidating their healthcare needs under one doctor.

This study provides important data about where gay/bisexual men access primary healthcare services. Accessibility (i.e., cost, location, insurance) is the most popular way

gay/bisexual men choose their primary care physician, but several respondents noted they were not out to their doctor because they receive care from the same doctor as the rest of the family. This finding suggests that gay/bi men police their own conversations to avoid disclosing their sexuality. To receive effective healthcare, gay/bi men may need to seek primary care physicians outside their families' social networks.

The study did not find a significant relationship between the length of time visiting a doctor and outness to that primary care physician. However, many of the respondents who indicated a relationship with a doctor for over ten years, were from a younger demographic. These respondents were often referencing their childhood doctor who they have been seeing for their entire life. As previously articulated by CPM theory, disclosures are highly contextual (Petronio, 2013). Future research should delineate between urban and rural areas where gay/bi are accessing their primary healthcare provider. Several gay/bisexual men indicated they had a lack of options for physicians due to their location. Many of those same men avoided conversations about their sexual identity for fear of people in their small towns finding out information about their sexual identity. CPM contends this behavior is known as "boundary turbulence," where co-owners of information do not operate under the same privacy rules (e.g., a family doctor mentions to a family member their son is gay/bi.). Especially when the co-owner of private information (in this case, the doctor) may have personal relationships with those in the same social circle as the patient, the decision to disclose one's sexuality becomes increasingly risky as the patient fears boundary turbulence. This finding could indicate healthcare providers in rural areas must actively engage in discussions about sexuality

and/or patient privacy must be more intensely emphasized during medical school. However, the perceptions of attitudinal beliefs toward homosexuality may prevent gay/bi men from coming out to their doctor regardless of how educated or accepting the physician may be.

The study results highlighted the positive nature of many of the relationships gay/bi men have with their doctors. The positive reported relationship between gay/bisexual men and their primary care physician may reflect a wider level of societal acceptance in our country and indicates healthcare inequality, while still very present, may be decreasing. The ways that gay men described the relationship with their primary care physician was closely linked with their level of outness. This finding supports CPM theory. Patients' level of trust in their primary care physician can be seen as an agreement of the privacy rules dictated by the relationship created between patient and provider. By disclosing his personal information (sexual identity), patients make the tacit assumption that the provider will not tell others due to the sensitive nature of the disclosure. This finding could suggest several things. First, coming out to your doctor may increase the positive perception for both the provider and the patient. The doctor may see this disclosure as a display of trust on behalf of the patient and therefore becomes more sensitive and approachable in conversations regarding health and sexuality. If the reaction is positive, which several respondents expressed, patients may be more likely to disclose risky behavior, even when it does not relate to their sexuality, improving their overall healthcare.

More research must be done regarding how patient-provider conversations about sexuality are elicited. Only a few gay/bi men highlighted how a doctor initiated conversations about sexuality. If primary care physicians are hesitant to address conversations about sexual identity, it might become the job of patients to learn how to appropriately disclose this information. This may be an unfair burden to patients who are not the professionals in the medical context. Especially for gay/bi men who are recently out or closeted, these conversations are foreign and dangerous territory. Thus, doctors must enhance their communication skills to elicit coming out conversations that are not intimidating, but are enlightening.

Finally, this research has potential implications outside the realm of the LGBT community. Many of these findings, such as those respondents who have both a primary care physician and a separate healthcare provider for their LGBT health issues, are not necessarily unique to the gay/bisexual men. For example, patients with mental illnesses may separate their psychological services from other forms of care. Future research is needed to determine if these issues apply to other health concerns and communities.

This study has several limitations. First, while there were 172 completed surveys, many respondents did not respond to every question. This problem could have been avoided with better online survey settings, which could have mandated an answer. Thus, some questions had 118 respondents which is not generalizable or necessarily significant. More time should have been dedicated to the recruitment process. Additionally, this research has the same pitfall that many studies focusing on minority populations struggle with: a convenience sampling method.

Future research projects could partner with healthcare associations to reach a larger population of LGBT respondents who could be randomly selected for representative study samples. Further, because of the low number of respondents in this study there were challenges in performing statistical significance tests. Additionally, many categories of questions had to be downsized into two or three categories. The quantitative parts of this survey did not enable great depth in the answers provided by respondents. Future research might probe more deeply into many of the issues examined in this study to build upon the data collected.

The study also did not utilize an established and validated measure of outness. Instead, this study relied on a rather simplistic 0-100 slider scale for respondents to indicate their level of outness and proceeded to code responses into two group, 0-99, and 100. However, this approach is problematic. What is the difference between someone who is a 95 and a 94? Or a 75 and a 60? Additionally, coding 0 and 99 into the same group suggests that someone who is in the closet is equivalent to someone who is almost completely out. Outness is a wide spectrum and our measure needed to more accurately encapsulate the coming out experience. In the future, a reliably tested scale will be used.

Third, there was a lack of consistency with regard to what primary care physician gay/bi men were actually referencing. Some men described their HIV doctor while others described a nurse at their university. This wide range of possibilities makes findings less generalizable as the study was attempting to focus on primary care physicians exclusively. Also, for the men who did not currently have a primary care physician, they often responded to questions based on their previous doctor.

Fourth, the last question of the survey may not have been as clear as desired. We wanted to give respondents the ability to tell a story about a specific experience they have had with their doctor. Given the lack of quality, in-depth answers, it was difficult to ascertain themes within the answers given by respondents. Future research could focus on a smaller sample size, and use in-depth interviews as a way of capturing the intimate healthcare experiences of gay/bisexual men.

CONCLUSION

The goal of this research was to illuminate the various ways coming out discussions are manifested in healthcare situations. More specifically, I sought to examine the impact coming out has on the interactions and relationships gay/bisexual men have with their primary care physicians. Previous research suggests gay/bisexual men, and the larger LGBT community, suffer from a wide spectrum of health disparities in comparison to the heterosexual community. Many of these disparities have been shown to be identifiable on an individual level with patients and their healthcare providers.

This study suggests coming out plays an important role when it comes to the health of gay/bisexual men and their experiences in the U.S. healthcare system. A majority of gay/bisexual men are open with their sexuality to their doctors, while a significant portion remains in the closet during interactions with providers. Gay/bisexual men tend to choose their doctor based on accessibility. Overwhelmingly, the more out a patient was in their day-to-day interactions outside the healthcare system (e.g., work, family, friends), the more likely they were to choose to disclose their sexuality to their provider. While the length of time spent seeing the same clinician was not a significant factor for choosing to come out, when a patient chose to come out to their doctor, they were more likely to describe their relationship with their PCP in a positive way. Despite a

history of discrimination in medical settings, the men surveyed in this study reported mostly positive experiences with their PCP and trusted them with their private information. Overall, many gay/bisexual men fail to see the importance of coming out to their doctor and conflate "gay" health with sexual health.

However, most research tends to focus on the sexual health of gay/bisexual men, rather than looking at health holistically. This research aims to bolster areas of research pertaining to the health of gay/bisexual men. Doing so allows us to better understand how to address health disparities this community faces and also how to deliver optimal healthcare to every person seeking it. We conducted our research by surveying gay/bisexual men online, asking open-ended questions pertaining to their methods of choosing their primary doctor, their relationship with their primary care physician, and their level of outness in differing capacities.

This study found that only a slight majority of gay/bisexual men have a primary care physician. Most respondents described the relationship they have with their doctor as professional and positive, yet many have not disclosed their sexual orientation to their primary care provider. Some gay/bisexual men found no reason for their doctor to know about their sexuality. For those that did disclose, several respondents argued their healthcare experience was transformed for the better. Age, methods of choosing a doctor, and outness to family, friends, and coworkers were the best predictors of whether or not a patient was out to their primary care physician.

This research highlights the importance a deliberative process can play with healthcare satisfaction. Gay/bisexual men who were out to their doctors most often did

research and specifically chose their healthcare provider for a reason. With consumer-driven healthcare coming to the forefront of our healthcare discussions, it becomes important to recognize what impacts a patient's decision to seek healthcare and from who. Additionally, because of the private nature of sexual identity, this research suggests while a family choosing to receive care from the same provider seems logical, it may not deliver the best healthcare outcomes. Many gay/bisexual men are not comfortable with addressing questions pertaining to sexuality for fear information would be attained by their family, who they may or not may not be out to.

The primary weakness of this research is the lack of a previously tested outness measure. In order to examine outness, a researcher must be able to pinpoint the differences in outness between respondents. This process becomes difficult when the scale used in this study measured outness starting at 1 and ending in 100. A reliably tested outness measure, with a much shorter scale, is necessary to accurately depict the level of outness respondents exhibited among family, friends, and at work.

Future research should focus on further examining how gay/bisexual men make their healthcare decisions. In depth interviews, along with more quantitative approaches, could elicit more nuanced answers from respondents. Hearing stories about healthcare discrimination, interactions with providers, and overall healthcare experiences could impact how we see LGBT healthcare. A continued focus on LGBT health, especially for issues outside sexual health, should be emphasized through specific questioning techniques.

Every person an LGBT individual meets has the potential to be an ally. Despite a growing level of acceptance as it relates to gay rights, there are many still opposed to anyone with a non-heterosexual identity. The healthcare system and its providers are one small facet of things that need to change. Through continued research, we can better design healthcare systems to meet the needs individual health care consumers, especially for members of stigmatized communities (such as the LGBT community), where there are significant health disparities. More effective communication between gay men and their doctors has the potential to improve health outcomes and to enable gay men to live out their lives to their full potential.

This LGBT health communication research holds importance for several different communities. On a policy level, hospitals and healthcare associations must implement LGBT-sensitive training and procedure guidelines to ensure sexual minorities feel comfortable discussing their sexuality with their doctor. Medical settings should tell staff directly of the wide variety of identities they encounter and the importance LGBT issues have on patients' health. Providing pamphlets or information in waiting rooms could be the first step toward integrating a more comfortable atmosphere for LGBT people. Additionally, medical schools need to increase their training with regard to outness and stigma, and the effects it can have a patient. The LGBT community can not be understood in one conversation. Each portion of the community deserves its own unique focus and approach to treating its specific health disparities.

APPENDIX A

INFORMED CONSENT FORM

TITLE OF STUDY: Choosing Your Healthcare Provider: Gay Men's Health Narratives

INVESTIGATOR: Andrew Eilola (218.290.5574)

PURPOSE:
You are being asked to participate in a research study about the how gay men's healthcare provider choice influences their level of disclosure. Please be as honest as possible. There is no penalty for not participating, and **your responses will be kept anonymous**. Returning this survey will be seen as your consent to use your data as part of this study.

PARTICIPANTS:
You are being asked to participate because you are a gay or bisexual male over the age of 18.

PROCEDURES:
If you choose to participate, you will be expected to fill out a survey containing 11 questions pertaining to your relationship and experiences with your primary doctor.

RISKS:
There are little to no known risks or discomforts associated with this study. You might not be open about your sexuality. However, as outlined below, your responses are completely anonymous and cannot be linked to you in any way. This way, you can be honest about your healthcare experiences so we can further understand how healthcare providers can influence level of disclosure and impact overall health. Additionally, you do not need to answer any questions that make you uncomfortable.

BENEFITS:
There may be no direct benefits to you as a participant in this study. However, we hope to improve our knowledge of how gay men's choice of healthcare provider impacts their level of disclosure. A better understanding of this dynamic could identify ways to improve LGBT healthcare as a whole.

CONFIDENTIALITY:
Your responses will be kept completely anonymous. At no point during the survey will you be asked for your name.

COSTS/COMPENSATION:
There will be no cost to you nor will you be compensated for participating in this study.

RIGHT TO REFUSE OR WITHDRAW:
You may refuse to participate or withdraw from the study at anytime without penalty. In order to terminate your participation at any point during the study, you simply need to close out of your browser.

QUESTIONS:
If you have any questions, please ask me. I can be reached at 218-290-5574 and reilola@gmu.edu. You may contact the George Mason University Office of Research Integrity & Assurance at 703-993-4121 if you have questions or comments regarding your rights as a participant in the research. You may report (anonymously, if you so choose) any complaints or comments regarding the manner in which this study is being conducted to the George Mason University Institutional Review Board at 703-993-4121 or by addressing a letter to the Chair of the George Mason Institutional Review Board, c/o Office of Research Integrity & Assurance, George Mason University, 4400 University Drive, MS 6D5, Fairfax, VA 22030.

This research has been reviewed according to George Mason University procedures governing your participation in this research.

ELECTRONIC CONSENT: Please select your choice below.

Clicking on the "agree" button below indicates that:

- you have read the above information
- you voluntarily agree to participate
- you are at least 18 years of age

If you do not wish to participate in the research study, please decline participation by clicking on the "disagree" button.

Agree

Disagree

Version Date: 3/5/14

APPENDIX B

Online Survey

1. Please identify which of the following best describes you:

□ Homosexual

□ Bisexual

□ Heterosexual

□ Unsure

Please answer the following questions:

2. What is your sex? (circle one) male/female/other
3. Are you transgender (circle one) yes/no
4. How old are you? _____ years old

5. Do you have a primary care physician (a doctor you have seen consistently for at least one year)?

6. How long have you been seeing this doctor?

7. Overall, how would you describe your relationship with this person?

8. How open are you with your doctor about your sexuality, if at all? Why?

9. How "out" are you to the following groups of people?

Friends:
Family:
Work:

10. How did you choose your doctor? And if so, what motivated this decision?

11. Tell a story about a visit to this doctor as it relates to trust and disclosure.

Thank you for your time. Your survey is complete.

APPENDIX C

Table 1. Method of choosing primary care physician

	Number of Respondents
Accessibility	**58 (45%)**
Family	**42 (32.6%)**
Friends/Family	**29 (22.5%)**
Total	**129 (100%)**

Table 2. Level of outness with family

	Number of Respondents
Completely Open	**105 (53.6%)**
All Others	**54 (27.6%)**
Total	**159 (81.1%)**

Table 3. Level of outness with friends

	Number of Respondents
Completely Open	**105 (51%)**
All Others	**58 (29.6%)**
Total	**158 (80.6%)**

Table 4. Level of outness at work

	Number of Respondents
Completely Open	**68 (34.7%)**
All Others	**89 (45.4%)**
Total	**157 (80.1%)**

Table 5. Length of time visiting same primary care physician

	Number of Respondents
0-3 years	**50 (25.5%)**
4-9 years	**28 (14.3%)**
10+ years	**35 (17.9%)**
Total	**113 (57.7%)**

Table 6. Respondents' descriptions of relationship with primary care physician

	Number of Respondents
Professional	**19 (9.7%)**
Positive	**28 (14.3%)**
Distant/Non-Existent	**20 (10.2%)**
Total	**116 (59.2%)**

Table 7. Outness with primary care physician

	Number of Respondents
No	**57 (29.1%)**
Yes	**102 (52.0%)**
Total	**159 (81.1%)**

Table 8. Outness at work and openness with primary care physician crosstab

Outness at Work	Not Open w/ PCP	Completely Open w/ PCP	Total
All Others	**39 (69.6%)**	**39 (47.6%)**	**78 (56.5%)**
Completely Open	**17 (30.4%)**	**43 (52.4%)**	**60 (43.5%)**
Total	**56 (40.6%)**	**82 (59.4%)**	**138 (100.0%)**

Table 9. Outness to family and openness with primary care physician crosstab

Outness to Family	Not Open w/ PCP	Completely Open w/ PCP	Total
All Others	**43 (75.4%)**	**44 (68.7%)**	**87 (56.5%)**
Completely Open	**14 (24.5%)**	**38 (48.5%)**	**52 (37.4%)**
Total	**57 (41.0%)**	**82 (59.0%)**	**139 (100.0%)**

Table 10. Length of time visiting primary care physician and openness with sexuality crosstab

Length of Time	Not Open w/PCP	Completely Open w/PCP	Total
0-3 years	**21 (45.7%)**	**28 (42.4%)**	**49 (43.8%)**
4-9 years	**10 (21.7%)**	**18 (27.3%)**	**28 (25.0%)**
10+ years	**15 (32.5%)**	**20 (30.3%)**	**35 (31.3%)**
Total	**46 (41.1%)**	**66 (58.9%)**	**112 (100%)**

Table 11. Method of choosing primary care physician and openness with PCP about sexuality crosstab

	Not Open w/PCP	Completely Open w/PCP	Total
Accessibility	**20 (38.5%)**	**35 (49.3%)**	**56 (44.8%)**
Family	**27 (51.9%)**	**15 (20.5%)**	**42 (33.5%)**
Friends/Allies	**5 (9.6%)**	**22 (30.1%)**	**27 (21.5%)**
Total	**52 (41.6%)**	**73 (58.4%)**	**125 (100%)**

Table 12. Description of relationship and openness with sexuality with primary care physician crosstab

	Not Open w/PCP	Completely Open w/PCP	Total
Professional	**10 (21.7%)**	**9 (13.2%)**	**19 (16.7%)**
Positive	**24 (52.2%)**	**52 (76.5%)**	**76 (66.7%)**
Distant/Non-Existent	**12 (26.1%)**	**7 (10.3%)**	**19 (16.7%)**

Total	**46 (40.4%)**	**68 (59.6%)**	**114 (100%)**

Table 13. Outness to friends and outness to primary care physician crosstab

Outness to Friends	Not Open w/ PCP	Completely Open w/ PCP	Total
All Others	**28 (49.1%)**	**18 (22.0%)**	**46 (33.1%)**
Completely Open	**29 (50.9%)**	**64 (78.0%)**	**93 (66.3%)**
Total	**57 (41.0%)**	**82 (59.0%)**	**139 (100.0%)**

Table 14. Age and openness with primary care physician regarding sexuality

crosstab

Age	Not Open w/PCP	Completely Open w/PCP	Total
18-23	**32 (56.1%)**	**21 (25.9%)**	**53 (38.4%)**
24-30	**18 (31.6%)**	**20 (35.8%)**	**47 (34.1%)**
31+	**7 (12.3%)**	**31 (38.3%)**	**38 (27.5%)**
Total	**57 (41.3%)**	**81 (58.7%)**	**138 (100%)**

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