Do Ask, Do Tell

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As a consequence of bias and ignorance within the medical profession, lesbians and gay men frequently receive suboptimal health care. Knowledge of each patient's sexual orientation and behaviors is critical for the development of a productive therapeutic relationship, accurate risk assessment, and the provision of pertinent preventive counseling. However, clinicians often forget to ask about this information, and many lesbians and gay men are reticent to reveal the truth. I present vignettes from my personal experiences as a lesbian patient and doctor to illustrate the importance of creating an environment in which such disclosure can occur and to portray the challenges and rewards of coming out as a gay physician.

Ann Intern Med. 2002;137:341-343. **www.annals.org**

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I juggle many hats in my life: mother, partner, doctor, and educator. Like all my female colleagues, my experiences as a daughter, sister, patient, and student have influenced my approach to each of these roles. But I am also lesbian, and this fact has shaped my life profoundly. It underlies my decision to become a primary care doctor; select women's health as an area of clinical expertise; and commit myself especially to improving the lives of lesbians, gay men, and people from other minority groups.

It is a challenge to be lesbian in our society. People assume that a young woman is straight, will marry, can get pregnant if she is sexually active, and will have children. This progression is "normal." Anything else is different and may be perceived as abnormal, wrong, or bad. Historical and continuing records of harassment, assaults, and homicides against lesbians and gay men abound. The medical profession itself has viewed homosexuality as a disorder; aversion techniques, hormone administration, shock treatment, castration, and even lobotomy have been used as purported "treatments" (1). I feel fortunate that I have never been the target of clearly overt actions because of my sexual orientation.

Insidious effects of prejudice affect my life deeply, however. Imagine how it feels to hear yet another gay joke or to open the paper to confront yet another antigay news story. Examples include the U.S. military's "don't ask, don't tell" policy, repeated referenda that limit the civil rights of lesbians and gay men (even compared with other minority groups), and the opposition of many religious organizations. Many lesbians and gay men find it difficult to avoid internalizing some of these homophobic attitudes. As a consequence, shame and fear are common emotions, and we are more likely to be isolated; engage in risky behaviors; suffer from stress-related health conditions, substance abuse, or depression; and attempt suicide (2).

Finding help is not easy. It is hard to trust other people, even health professionals, when one anticipates disapproval. Doctors share the same biases as the rest of society and are frequently ignorant about lesbian and gay health issues. I have often been disappointed with the medical care I have received; several examples from my experience as a lesbian patient are illustrative.

As a teenager, I reacted to the emergence of attraction to other girls with a jumble of conflicting feelings: excitement, fear, fascination, and horror. When I tried to broach the topic cautiously with my family doctor, he laughed and said, "Don't worry about that; it's just a phase a lot of girls go through." He meant to reassure me, but his comment trivialized and dismissed me instead. An important opportunity was missed to explore and validate my feelings.

By age 15, I was overwhelmed and isolated and made a suicidal gesture that might have had grave consequences. The psychiatrist to whom I was referred believed that same-sex attraction was a sign of stunted psychological development. His attitude perpetuated my notion that something was wrong with me; I stifled exploration of my identity during 2 ensuing years of therapy. I eventually found the support I needed when I met a lesbian couple who listened to me, encouraged me to be myself, and demonstrated that it was possible both to be lesbian and to pursue the goals I wanted in life—a committed relationship, a family, diverse friends, and a deeply challenging and rewarding career.

In college, I consulted a physician for evaluation of vaginal symptoms. She asked if I was sexually active (yes), whether I was using contraception (no), and whether I was trying to conceive (no). Before I had a chance to explain, she began to talk about birth control options and the importance of using condoms to prevent sexually transmitted diseases. At that point, I was too embarrassed to reveal my lesbianism. I never did ask the question that was on my mind ("Could I infect my lover?") and left, uncomfortable, with an absurd prescription for the pill. Her immediate assumption that I was straight and my reticence to reveal the truth prevented the development of a productive doctor–patient relationship and resulted in inappropriate care.

Later in life, when I disclosed my lesbianism to a new internist, she told me that my risk for cervical cancer was so low that I did not need to have regular Papanicolaou smears. This advice was incorrect. She assumed that my sexual relationships were exclusively lesbian and that the chief cause of cervical cancer, human papillomavirus, cannot be transmitted by woman-to-woman sexual contact. However, sexual identity cannot be equated with sexual

behavior. Some lesbians are celibate, many have male partners, and some have partners of both sexes. Moreover, emerging evidence suggests that several genital infections can be acquired during lesbian sexual activity (3). A detailed sexual history is necessary to understand the situation of each patient, ascertain risks for sexually transmitted diseases, and provide pertinent medical counseling.

As a result of my experiences with doctors who did not know how to communicate effectively, I became interested in ways to break down barriers that prevent gay and other minority patients from obtaining good care. I joined a lesbian and gay speaker's bureau and told my story to students at local high schools, colleges, and medical schools. I believe I helped to enlighten others and demolish some stereotypes. Then, after considering teaching, nursing, psychology, and medicine, I decided that my best course of action was to become a physician.

The medical establishment was an inhospitable place for gay trainees in the 1980s. As recommended by my premedical advisor, I concealed my lesbianism during the medical school application process; I question whether I would have received my "Welcome to the Harvard family" letter if I had been more forthright. Once a trainee, I faced all the challenges that every medical student and resident encounters: trying to master a huge body of knowledge, accepting the enormous responsibility of caring for people, learning to function with aplomb in emergency situations, and competing with others for advancement. In addition, I had to cope with tacit and overt advice that my lesbianism would be tolerated only as long as I kept quiet about it.

Ambivalence about being open is a problem that heterosexual persons can barely comprehend. It arises because of a continuing lack of acceptance of gays by most of the population and the fact that homosexuality is invisible, unlike the minority status of people with different skin color or language. As a consequence, disclosure is a choice left to each gay person.

On the face of it, maintaining silence makes almost everyone happy. I can interact with others without fear of prejudice, and people are spared the discomfort of responding to a sensitive proclamation. But invisibility has many downsides. Self-respect is difficult to preserve when one lies by omission. Silence implies acceptance that, as a member of a minority group, I have nothing valuable to contribute—that I am a "minus." If I selectively omit mention of involvement in activities that could identify me as gay, I cannot highlight all of my accomplishments. If I attend professional social gatherings alone, I miss the opportunity to introduce my partner of 23 years, show our example of a long-term relationship, and provide everyone with a chance to build acceptance.

Secrecy leads to isolation. Whenever I encounter new and unfamiliar situations, I am tempted to watch, wait, and figure out the lay of the land before revealing my lesbianism. Although this strategy feels safe, it produces loneliness. A subculture of lesbians and gay men exists through which clandestine identification takes place. But when secrecy is the paramount mode of operation, people are reluctant to gather together because of guilt by association. Silence limits opportunities for friendship, support, and professional collaboration not only with other lesbians and gay men but also with sympathetic people from the mainstream who share my values and goals.

Secrecy also requires an enormous expenditure of energy. Staying "in the closet" is not a passive process; constant vigilance is required to steer conversations away from personal issues. Of course, people sometimes ask directly whether I am in a relationship. If I deny that I am involved, I enter a vicious cycle of deception. If I admit to having a partner but try to conceal her sex, I have to take great care to avoid the pronouns "she" and "her" in subsequent discussion. Such behavior wastes a great deal of energy that could be channeled productively.

When I remain silent, people make assumptions about me that can be very awkward, especially if they later realize that their beliefs were wrong. When I started to practice medicine, many of my colleagues assumed that I was single because I did not talk about a boyfriend or husband or wear a wedding ring. Some concluded that I was an "old maid by choice"—a woman who had subjugated family to career. Others assumed that I was available, so I had to decline advances. When I became pregnant, nearly everyone assumed that I was married. In a particularly embarrassing moment, the chief of a major service told me in a public forum that he thought he knew my husband!

I have gradually learned that it is advantageous to be open about my sexual orientation. Disclosure is empowering: It allows me to be myself, integrate my public and private lives, voice my opinions, celebrate all of my achievements, and work passionately to increase tolerance and acceptance. I know that I deserve respect and recognize that I serve as an important role model.

Coming out is a process that never ends. Every time I meet someone new, I must decide if, how, and when I will reveal my sexual orientation. I find it simplest to be candid with colleagues from the start, but this approach can be awkward with patients, because it is considered inappropriate to mention intimate personal details in the context of a professional relationship. However, every doctor–patient interaction is built on trust, and I believe strongly that I have an obligation to be honest. Patients often ask me personal questions about my family and how I balance home life and career. Up-front disclosure of my sexual orientation avoids embarrassing people who might otherwise assume that I am straight and ask about my "marriage" or "husband" and allows patients who feel uncomfortable having a lesbian as their physician to choose a different doctor.

In general, I try to communicate who I am nonverbally, by displaying pictures of my family and having gay-friendly posters and health literature in my office. I developed and use an intake form that is inclusive of alternative

lifestyles and avoids the designations "single," "married," "divorced," and "widowed." My name is listed in a lesbian and gay health guide, I give talks to lay audiences on lesbian and gay health issues, and I volunteer free health screening for lesbians and other minority groups in the community. I have also developed and teach a curriculum on lesbian and gay health to medical students and residents as well as to peers at continuing medical education conferences. When I am asked directly about my private life, I answer truthfully.

Reactions to my openness have been mixed, but my experiences coming out as a lesbian health professional have been rewarding overall. When I decided to coordinate a lesbian and gay student group in medical school, I had to identify myself to the administration in order to apply for funding and take the risk of being seen posting notices about group activities. Some flyers were defaced, presumably by other medical students, and I once saw one being removed by a dean. I tried to channel my anger into eloquence and gave a talk to my classmates. Although a few ignored me subsequently and one student began to pray for me every morning before class began, the posters were no longer disturbed and attendance at group-sponsored educational events increased.

Later, as a resident in the early AIDS era, I encountered numerous examples of homophobia in the hospital. There were many antigay jokes; some implied that gay men were getting what they deserved. Some of my peers refused to shake hands with gay patients or put on gowns and gloves before entering their rooms. My coming out stopped the jokes, at least in my presence, and seemed to result in more humane behavior toward people with AIDS-related illnesses.

Over the years, I have received a few lectures on the ills of homosexuality and even a letter stating that people like me should not be permitted to become doctors. However, several gay patients have told me that my visibility enabled them to find me and finally receive the understanding and support they craved. My openness has also allowed gay medical students and residents to identify me as a role model and mentor, and many of my straight colleagues and patients have thanked me for the opportunity to examine their assumptions and biases about gay people.

Somewhat to my surprise, my openness has not harmed my clinical practice. On the contrary, I have many referrals from medical colleagues and hospital administrators who want me to care for their wives and daughters, and I was recognized by *Boston Magazine* as a top internist for women in the February 2001 issue. Coming out has also afforded me some novel professional opportunities. I believe that my openness during an era of emphasis on cultural competence was a factor in my appointment to the Beth Israel Deaconess Hospital Board of Trustees. Likewise, my willingness to speak out has resulted in invitations to participate in a panel discussion on lesbian and gay health at the Massachusetts Department of Public Health and to serve on an advisory board to the American Cancer Society.

Despite these successes, much work still needs to be done. In recent years, Harvard Medical School has taken steps to diversify the racial and ethnic composition of its student body and to increase tolerance and acceptance of its gay community by sponsoring town meeting discussions. However, few minority faculty members have been promoted to leadership positions, and consequently, many of my values and those of minority colleagues remain poorly represented. I strive to promote further institutional change by being visible and voicing my questions and concerns.

A professor at my institution once warned that it is a mistake to "ghetto-ize" one's career in women's health. I take issue with this statement. I believe that my work is not only legitimate but of critical value. My talents include an instinctive ability to understand and empower patients from highly diverse backgrounds and a gift for changing the attitudes and behaviors of medical students and doctors. My work requires courage and resilience, and I believe that the outcomes are as important as the results of basic science research and clinical trials. Challenging clinicians' stereotypes and increasing the sensitivity with which they communicate with people from different cultures will benefit all of their present and future patients. I am proud to be a lesbian physician and educator.

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