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Health Care Experiences of Lesbian Women
A Metasynthesis

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Lesbian women experience discrimination within the health care system that leads many to cautiously navigate a heteronormative system. This metasynthesis offers a richer contextual understanding about lesbian health care experiences. The 4 overarching themes that emerged are: (*a*) sizing up the provider and the environment, (*b*) to say or not to say: "paradoxes of disclosure," (*c*) reactions to provider's assumptions, (*d*) and acknowledging my partner. Lesbian women perceive their health care experiences based on the nature of the relationship with the provider. These women are more likely to seek care from health care providers who acknowledge, affirm, and respect a woman's sexual identity, cultural beliefs, and family structures. **Key words:** *family health care*, *focus groups*, *gay*, *grounded theory*, *homosexual women*, *lesbian health*, *lesbian health care*, *narrative analysis*, *phenomenology*, *primary care experience*, *qualitative research*, *self-disclosure*, *women health care*

LESBIAN WOMEN encounter many challenges when seeking quality health care. Primary health care providers across all practice settings provide primary preventive, secondary, and tertiary health care services to lesbian women even when they are unaware of the patient's sexual orientation. Many different factors affect the perceptions of health care encounters between lesbian women and their providers. In the past decade, some studies have shown that lesbian women who feel free to disclose their sexual orientation contribute to higher satisfaction and adherence to care,[1–3] whereas earlier research did not support this relationship.[4] In many of these previous studies, women who encountered homophobic practitioners reported adverse experiences. The health care provider's attitude toward a nonheterosexual identity is important to lesbian women when they choose a provider.[1,2,5,6] Lesbian women view their health care experiences as either positive or negative based on the nature of the relationship they have with their provider. Other factors have been shown to contribute to how lesbian women perceive each health care encounter and a synthesized and clearer understanding emerges through the following metasynthesis of qualitative studies related to lesbian women's health care experiences.

Most research about lesbian women's health care experiences has been quantitative by design; however, the real essences of these experiences are often best captured in qualitative studies. The purpose of this metasynthesis is to offer an integrative/interpretive review of 14 qualitative studies about lesbian women's health care experiences. When similarity exists between the studies, a metasynthesis evolves through a reciprocal process of translating the metaphors, meaning the phrases, terms, or concepts of each study into the other.[7] Through this intermingling, often

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Statement of Significance

What is known or assumed to be true about this topic?

Lesbian women continue to encounter discrimination when seeking health care services from providers who are insensitive and less educated about their health care needs. These women often delay seeking health care if they have previously experienced nonaffirming care. Many health care providers continue to practice based on heteronormative assumptions.

What this article adds?

This metasynthesis provides a broader understanding of factors that influence lesbian women's health care experiences. Lesbian women form positive or negative perceptions about the provider's verbal and nonverbal communication at the first meeting and continue throughout the health care encounter. Creating affirming and trusting milieus in which to provide care is essential for lesbian women to form positive impressions of their health care experiences. Providers who extend an affirming, open-minded, and respectful presence during a visit are viewed positively by lesbian women.

a richer contextual understanding emerges to extend clearer insight into the phenomenon of interest.

Gaining clearer insight into lesbian health care experiences accomplishes several aims. First, it educates nursing, with its long history of silence on topics of sexual and gender minorities about the psychosocial and physical health care needs of this vulnerable and marginalized population.[8] Next, it increases awareness among health care providers about the importance of creating affirming environments to support lesbian women who want to disclose their sexual orientation, discuss sexual health issues, or include their partner in the health care visit. Lastly, it beckons the nursing profession to assume a leadership role among all health care providers to develop and educate others on more culturally appropriate approaches to use when communicating and caring for lesbian women.

During the past 5 years, findings from several qualitative studies have shown that lesbian women continue to receive health care services from providers who are insensitive and less educated about their health care needs, while others have had more positive experiences compared with previous years.[5,9–12] Acknowledgment of these more supportive encounters suggests that for some lesbian women, tides of change may be occurring. This change might indicate that health care providers are better educated about the health care needs of lesbian women and are using more culturally appropriate approaches when caring for them. In contrast to these recent findings, data from studies conducted during the 1980s and 1990s showed that lesbian women had predominantly negative health care encounters and attributed those experiences to homophobia and pervasive heteronormative assumptions among health care providers.[13–18]

In the past decade, there has not been a published metasynthesis of lesbian women's health care experiences. Stevens[18] conducted an extensive review of the literature on lesbian health care research published between 1970 and 1990 that included 28 studies. All of the studies were published in the United States. Nineteen studies addressed lesbians' perceptions of their health care experiences, and the remaining 9 focused on the health care provider's attitudes toward lesbian clients. Of the 19 studies about lesbian women's perceptions, 12 were quantitative and used questionnaires, 6 used structured and unstructured interviews, and 1 utilized both approaches. More qualitative research concerning lesbian health care experiences has been published outside the United States including Canada, the United Kingdom, Norway, Ireland, and Australia.

METHODS

Procedure

The following online databases were searched for scholarly, qualitative research studies published between 2000 and 2017: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline via PubMed, PsychInfo, SCOPUS, and ProQuest Dissertations and Theses. Databases' keywords used in the searches were *lesbian health*, *lesbian healthcare*, *gay, lesbian women, women healthcare, self-disclosure*, *primary care experience*, *family health care*, *qualitative research*, *grounded theory*, *phenomenology, narrative analysis,* and *focus groups.* Hand searches were also conducted by referring to the references of recent studies about lesbian health care experiences. One unpublished dissertation by Dinkle[19] met the inclusion criteria.

Inclusion criteria for this metasynthesis required each study to be of a qualitative design and focus primarily on lesbian women's health care experiences during either a primary care visit or hospitalization with or without her same-sex partner. The health care experience could have occurred in a health care provider's office, clinic, or hospital setting and reflected the care provided by physicians or nurses. A few studies indicated participants younger than 18 years; however, only data from participants who were at least 18 years or older were included in this synthesis. This process required reading each study in its entirety and just using data from participants who were identified as being 18 years or older. No studies about adolescent lesbian health care experiences were included. Studies could be published in the United States or other countries and disciplines other than nursing.

The search process resulted in 14 qualitative studies on lesbian health care experiences in different health care environments that provided care by nurses, physicians, or both. The resulting sample was composed of studies published by researchers across several different disciplines inside and outside the United States. One study published by McNair et al[5] included children of the lesbian participants; however, only data from participants 18 years and older were used. Eight studies had participants who identified as partnered or married to a woman and met the other inclusion criteria.

Sample

A total of 14 qualitative studies comprised the sample for this metasynthesis, including 300 lesbian women from 7 countries. Every study addressed lesbian health care experiences based on encounters with either a physician or a nurse who provided care in different settings. Five studies were conducted in the United States; however, only 2 were done by nurse researchers in nursing,[12,19] another was in medicine,[9] sociology,[20] and psychology.[21] The study by Dinkle[19] was an unpublished dissertation in nursing. In all, 9 studies were published outside the United States, 2 from New Zealand, 2 from Norway, 2 from the United Kingdom, and 1 from each of these other following countries: Canada, Ireland, and Australia. Four studies conducted outside the United States were in nursing. Methodological characteristics of each study included in this metasynthesis are shown in Table 1. Demographic characteristics of participants for the studies included in this metasynthesis are displayed in Table 2. Four different qualitative research designs were used in these studies either separately or in combination with another. Phenomenology was the most common (n = 5), followed by descriptive qualitative (n = 5), grounded theory (n = 2), focus groups (n = 1), and 1 that used focus groups and in-depth interviews (n = 1).

Data analysis

For this metasynthesis, Noblit and Hare's[7] metaethnographic approach was used to synthesize qualitative studies about lesbian women's health care experiences. To ensure rigor and transparency of the process, this researcher consulted with a nurse scientist

Table 1. Methodological Characteristics of Qualitative Studies Included in the Metasynthesis

Author	Year	Discipline/Country	Qualitative Research Design	Interview Technique	Data Analysis
Barbara et al[9]	2008	Medicine/the United States	Focus groups	Structured	Miles and Huberman[37]
Bjorkman and Maulterud[10]	2009	Public health/Norway	Descriptive	Web-based survey, open-ended	Malterud[38]
Cherguit et al[22]	2012	Psychology/the UK	Interpretive phenomenological	Semistructured	Smith et al[39]
Dinkle[19]	2005	Nursing/the United States	Phenomenology	Semistructured	Streubert[40]
Duffy[23]	2011	Sociology/Ireland	Phenomenology	Unstructured	Dinkins,[41] Van Manan[42]
Ejaife and Ho[21]	2017	The United States	Qualitative	Open-ended	Not specified
McIntyre et al[24]	2010	Anthropology/Canada	Descriptive qualitative	Semistructured	Hsieh and Shannon[43]
McNair et al[5]	2008	Multidisciplinary/ Australia	Grounded theory	Structured	Strauss and Corbin[44]
Munson and Cook[25]	2016	Nursing/New Zealand	Descriptive qualitative	Semistructured	Thomas[45]
O'Neill et al[26]	2013	Nursing/New Zealand	Descriptive qualitative	Semistructured	Thomas[45]
Platzer and James[27]	2000	Nursing/the UK	Focus groups	In-depth, semistructured	Kitzinger[46]
Scherzer[20]	2000	Sociology/the United States	Grounded theory	Structured	Strauss and Corbin[47]
Spidsberg[11]	2007	Nursing/Norway	Phenomenology	Unstructured	Ricouer[48]
Williams-Barnard et al[12]	2001	Nursing/the United States	Phenomenology	Unstructured	Colaizzi[49]

Table 2. Demographic Characteristics of the Participants for Study Included in the Metasynthesis

Study	Sample Size	Age Range, y	Relationship Status	Education	Race/Ethnicity
Barbara et al[9]	32	24-65	Not specified	Not specified	22 white; 6 African American; 1 Native American
Bjorkman and Malterud[10]	128	18-60+	80% partnered; 26% single	28% primary/secondary, 67% bachelor's/master's, 5% unknown	Not specified
Cherguit et al[22]	10	33-51	Partnered comothers	Not specified	7 white; 1 Welsh; 1 British; 1 Anglo Indian
Dinkle[19]	15	>50	Not specified	Not specified	Not specified
Duffy[23]	4	23-50	3 partnered; 1 single	Not specified	Not specified
Ejaife and Ho[21]	1	24	Not specified	Not specified	Black
McIntyre et al[24]	7	44-55	1 married; 5 partnered; 1 single	Some college, 2 master's degree	6 white; 1 Asian
McNair et al[5]	36	29-62	36 lesbian parents; 20 children	Not specified	11 Anglo-Australian; 2 Aboriginal; 8 European; 2 Asian; 1 Latino
Munson and Cook[25]	6	23-47	4 lesbian; 2 bisexual	5 completed university	Not specified
O'Neill et al[26]	8	Early 30s to late 40s	2 nonbiological mothers; 5 biological mothers; 1 biological and nonbiological mother	University studies 6 diplomas; 2 master's	8 European descent
Platzer and James[27]	35	16-74	23 interviewed; 10 lesbian focus groups; 2 mixed gay/lesbian group	Not specified	Not specified
Scherzer[20]	8	18-21	6 lesbian; 2 bisexual	4 some college, 3 high school, 1 did not complete	3 white; 1 African American; 2 Latinas; 2 Multiracial
Spidsberg[11]	6	Not specified	3 in relationship; 3 living with partner; total of 8 children ages 6 wk to 4 y	Not specified	Not specified
Williams-Barnard et al[12]	4	18-23	Not specified	Undergraduate students	4 white, non-Hispanic

who has expertise in conducting qualitative research. Table 3 outlines the steps used to synthesize the data in this study. Metasynthesis is used to deepen our understanding of a phenomenon of interest by integrating research findings from qualitative studies about the same substantive aspect.[28] The particular method used to conduct the metasynthesis depends upon the purpose and end product of the project.[29] Regardless of the technique employed, the process of synthesizing interpretations of findings across studies sculpts a newer conceptualization than the original results revealed. Noblit and Hare consider reciprocal translations, meaning similarity among study findings, a unique form of synthesis that involves translating study metaphors, in other words, the phrases, terms, or concepts into one another because they "protect the particular, respect holism, and enable comparison."[7(p28)]

The challenge lies in the ability to carefully balance the analysis of study metaphors to provide sufficient detail without losing sight of the original interpretations.[7] Each study was read several times to more fully understand and identify the various metaphors to describe lesbian women's health care experiences. Then, a list of metaphors used in each study was created and compared with the other studies. This iterative process revealed many similar metaphors between the studies to support the process of reciprocal translations. These translations were synthesized to show that the whole was more than the sum of its parts. In essence, a metasynthesis must synthesize interpretations of qualitative research by "carefully peeling away the surface layers of studies to find the hearts and souls in a way that does the least damage to them."[29(p370)]

RESULTS

Four overarching themes emerged from the reciprocal translations. Table 4 displays the result of how the metaphors of the 14 studies were translated into each other and resulted in the following themes: (*a*) sizing up the provider and the environment, (*b*) to say or not to say: "paradoxes of disclosure," (*c*) reactions to provider's assumptions, and (*d*) acknowledging my partner (see the Figure). These 4 themes (see Table 4) identify phases of a health care encounter that lesbian women must cautiously navigate. There is an opportunity for the health care provider to

Table 3. Steps of Noblit and Hare's Metasynthesis Process

(a) Identify a phenomenon of interest to study.[7]
(b) Decide what qualitative studies pertain to the phenomenon of interest.[7]
(c) Read the qualitative studies and repeat the process as needed to give full attention to the metaphors of each study.[7]
(d) Determine the interrelatedness of the selected studies by creating a list of the study metaphors and juxtapose them to make assumptions about one of 3 possible relationships between them. "(1) the accounts are directly comparable as 'reciprocal' translations, (2) the accounts stand in relative opposition to each other and are essentially 'refutational'; or (3) the studies taken together represent a 'line of argument' rather than reciprocal or refutational translation."[7]
(e) Translate the study metaphors into one another in an adequate manner to "maintain[s] the central metaphors and concepts of each account in their relation to other key metaphors or concepts in that account".[7]
(f) Synthesize translations in a manner to show that the whole is more than the sum of the individual parts. There is potential for 2 levels of translations. The translations as a whole are considered 1 level. A second level of synthesis is formed when different metaphors can be incorporated into others.[7]
(g) Express the synthesis through text, music, video, or drama.[7]

Table 4. Individual Study Metaphors as Linked to 4 Overarching Themes

Study	Sizing Up the Provider and the Environment	To Say or Not to Say: "Paradoxes of Disclosure"	Reactions to Provider's Assumptions	Acknowledging My Partner
Barbara et al[9]	*Positive*: Maintaining eye-to-eye contact; available relevant health information; prefer lesbian or gay practitioners; nonbiased intake forms *Negative*: Prejudicial attitudes	*Negative*: Fear, anxiety; lie about sexual activity; lie on intake form; fear abandonment after disclosure	*Positive*: No assumptions about sexual identity or history, nonjudgmental approach asking about sexual history asking direct questions *Negative*: Incomplete sexual history; asking heteronormative based questions	*Positive*: Partner referred to by name allowing partner into examination when requested *Negative*: Refused request for partner presence
Bjorkman and Malterud[10]	*Positive*: Open attitude, supportive, nonjudgmental, knowledgeable about health condition *Negative*: Uncertainty, unanswered questions; attributing physical and psychological illness to sexual identity	*Positive*: Provider facilitates disclosure process; opportunity to disclose on own *Negative*: Being told lesbian orientation is a phase	*Positive*: Lack of negative comments, explicit support by provider *Negative*: Preconceptions, having to justify self; was asked heterosexually focused health questions	N/A

(*continues*)

Table 4. Individual Study Metaphors as Linked to 4 Overarching Themes (*Continued*)

Study	Sizing Up the Provider and the Environment	To Say or Not to Say: "Paradoxes of Disclosure"	Reactions to Provider's Assumptions	Acknowledging My Partner
Cherguit et al[22]	*Positive*: A perception of having a positive experience was often based on a comparison to the experiences of other lesbian families' negative experiences *Negative*: Innate fear of the health care system despite some positive experiences; anticipated prejudice and discrimination	*Positive*: Focused on self-acceptance and confidence of self within the health system; felt more accepted when they disclosed their relationship at the beginning *Negative*: Ambivalent feelings at times when searching for an identity as a mother	*Positive*: Paved a path to visibility within the health care in an effort to be role models for future lesbian parents *Negative*: Maintaining low expectations of the health care system in an effort to protect self from the effect of negative experiences	*Positive*: Being treated as an equal parent; health care providers' implicit *Negative*: Feeling invisible and excluded due to organizational heteronormativity that did not recognize comothers
Dinkle[19]	*Positive*: Skilled communicator; competent, caring committed; open to diversity, affirming signs posted in office; respectful safe, private, trustworthy holistic care, can navigate the health care system limits referrals *Negative*: No safe zone symbols—triangles; no pictures of same-sex couples in waiting room	*Positive*: Open disclosure, live honestly with self; disclose when asked; identify partner on intake form *Negative*: Inhibited; fear repercussions; guarded fear disparaging remarks during pelvic examination, disclose if partnered, let provider assume sexual identity	*Negative*: Assuming heterosexual identity; questioning virginity during pelvic examination; feeling violated, and raped	*Negative*: Discriminated against when partner present, partner's presence ignored

(*continues*)

Table 4. Individual Study Metaphors as Linked to 4 Overarching Themes (*Continued*)

Study	Sizing Up the Provider and the Environment	To Say or Not to Say: "Paradoxes of Disclosure"	Reactions to Provider's Assumptions	Acknowledging My Partner
Duffy[23]	*Positive*: Patient-centered health service; asking whether I want someone to stay with me during the examination	*Negative*: Alienated; substandard care; disclosure not treated confidentially	*Negative*: Assuming virginity after denying history of sexual intercourse with a man	*Positive*: Inviting partner into examination when requested; involving in care *Negative*: Feeling alone; vulnerable; frightened during hospitalization, refused allowing partner to stay
Ejaife and Ho[21]	*Positive*: Opportunity to disclose sexual orientation on an intake form rather than being first asked in an interview; addressing sexual orientation when relevant to treatment	*Positive*: Provide an option to not disclose sexual orientation *Negative*: Assumptions and prejudices of health care providers of the patient based on race, gender, and sexual orientation	*Negative*: Being minimized or dismissed as an individual; providers viewing sexual health as the ability to get pregnant; stereotype of black lesbians being hypersexual	N/A
McIntyre et al[24]	N/A	*Positive:* Empowered; ability to advocate for own health *Negative:* Forced to disclose, provider insists on need for pregnancy test	*Negative:* Denied a Pap test after denying history of sexual intercourse	N/A

(*continues*)

Table 4. Individual Study Metaphors as Linked to 4 Overarching Themes (*Continued*)

Study	Sizing Up the Provider and the Environment	To Say or Not to Say: "Paradoxes of Disclosure"	Reactions to Provider's Assumptions	Acknowledging My Partner
McNair et al[5]	*Positive*: Affirming, open-minded, respectful, and validating; convey sense of normalcy about family	*Positive:* Private strategy, choosing intentional silence to protect partner and children; disclose to promote honesty; avoid confusion; role model attitudes for children, proud approach "present a united front" *Negative:* Passive approach forced into silence during homophobic social contexts; increased vulnerability for nonbirth mother	*Positive:* Feeling safe; more likely to disclose when relationship with provider perceived positive *Negative:* Vulnerability enabling assumptions to prevail, resort to deception regarding relationship; feeling dishonest	*Negative:* Nonbirth mother rendered invisible, excluded from decision-making withholding information, feeling vulnerable when son was hospitalized
Munson and Cook[25]	*Positive:* Presence of forms that acknowledged sexual orientation across a continuum; posters about safer sex for lesbian women *Negative:* Standard documentation focused heterosexual women	*Positive:* Positive experiences after having disclosed sexual orientation; developed a tolerance to encountering less than ideal care *Negative:* Difficult to predict future, positive experiences with new providers when disclosing sexual orientation	*Positive:* Prior positive encounters with health care providers were more likely to positively influence future encounters *Negative:* Discomfort when not asked about sexual orientation when provided health information; navigate with uncertainty	N/A

(*continues*)

Table 4. Individual Study Metaphors as Linked to 4 Overarching Themes (*Continued*)

Study	Sizing Up the Provider and the Environment	To Say or Not to Say: "Paradoxes of Disclosure"	Reactions to Provider's Assumptions	Acknowledging My Partner
O'Neill et al[26]	*Positive:* Proactively sought health care professionals who were affirming and sensitive to needs of lesbians; encountering empathetic staff *Negative:* Encountering a nurse who was not sensitive or friendly toward the lesbian couple	*Positive:* Empowered to fully disclose sexual orientation at the first health care encounter to avoid assumptions of heterosexuality *Negative:* Emotionally exhausting to constantly have to decide whether or not to disclose sexual orientation to health care provider	*Negative:* Feeling like a desexualized and discounted when health care providers assume only one member of the relationship is the parent	*Positive:* Acknowledgment of both women as parents without reference to one as the "daddy"; safe and comfortable with nonjudgmental health care providers *Negative:* Reference to sleeping with a man so that the children would know who the father is; failing to acknowledge the couple or lesbian identity
Platzer and James[27]	*Negative:* Ignorance of health care provider about health needs and concerns; homophobic responses by provider	*Negative:* Having to balance vulnerability with maintaining self-esteem; awkward silences after disclosure	*Negative:* Humiliated, embarrassed; judgmental, negative attitudes; questioned about sexual practices during pelvic examination	N/A
Scherzer[20]	*Positive:* Attentive to emotional needs and well-being; feeling connected with health care provider	*Negative:* Fear judgment about sexual practices, marginalized, stigmatized, loss of voice	*Positive:* Erode barriers, provide biomedical and holistic care services, empowered to negotiate own health	N/A

(*continues*)

Table 4. Individual Study Metaphors as Linked to 4 Overarching Themes (*Continued*)

Study	Sizing Up the Provider and the Environment	To Say or Not to Say: "Paradoxes of Disclosure"	Reactions to Provider's Assumptions	Acknowledging My Partner
	Negative: Insensitive to my sexuality; judgmental attitudes		*Negative:* Create and perpetuate barriers to care; power struggles; physical and emotional trauma, disrespect, abuse	
Spidsberg[11]	*Positive:* Open-mined; having a lesbian health care provider; most encounters with midwives *Negative:* Noncaring attitudes, referring to my baby as a "donor child"	*Positive:* Being open, yet not overly assertive *Negative:* Keeping closeted due to feelings of vulnerability, not knowing medical rights	*Positive:* Confident about self during interactions *Negative:* Paranoid regarding provider communication; sexual identity becoming the focus instead of pregnancy; withdrawing support after learning my sexual identity	*Positive:* Acknowledging my partner *Negative:* Ignoring partner's presence; not introduced at antenatal classes
Williams-Barnard et al[12]	*Positive:* Asking for seeking care; being informed about lesbian health issues *Negative:* Treating me as an "object" rather than normal human being; initially questioned about birth control	*Positive:* Emancipatory feeling; promotes a better relationship with provider *Negative:* Stressful living secretive life; history of bad experiences; pervasive feelings of guilt, "living this lie"; distrust of medical profession prevents disclosure	*Positive:* Provided information *Negative:* Fear substandard care would occur if provider learned sexual identity	N/A

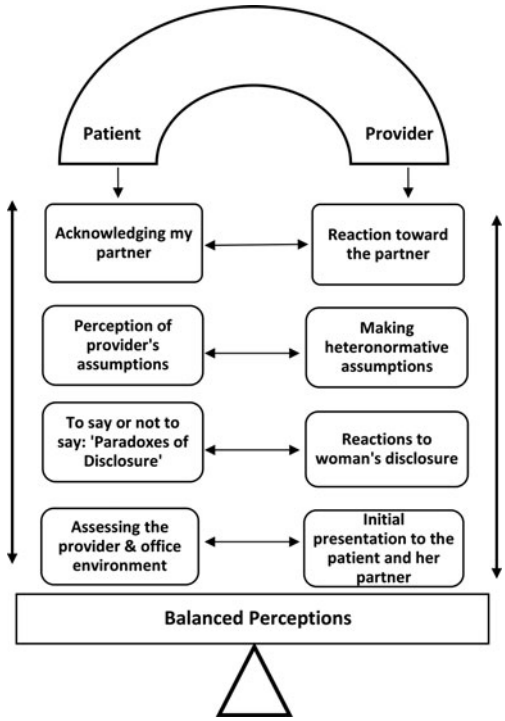

Figure. Patient-provider balancing of perceptions during lesbian women's health care experiences. Lesbian women and their health care providers begin forming perceptions of each other when they first meet. These perceptions continue throughout the entire visit. Women form positive or negative perceptions about the provider's verbal and nonverbal communication when they first enter the practitioner's office that continues throughout the encounter. The 4 themes of this metasynthesis are represented by the blocks on the left side of the figure and represent lesbian women's perceptions. The blocks on the right side represent the health care practitioner's behavior and communication with the women and their partners when present. The point at which the patient's and provider's perceptions merge creates a common ground for shared understanding.

demonstrate culturally affirming communication and behaviors during each of these phases. In synthesizing the translations, it was clear that lesbian women formed either positive or negative impressions of each visit. The nature of the interactions with a health care provider and the environment in which they received care influenced the women's impression of the visit. The following descriptions provide greater insight into the 4 themes describing lesbian women's health care experiences. Examples of positive and negative impressions appear throughout the descriptions of each theme.

Sizing up the provider and the environment

Thirteen of the studies included metaphors to suggest this theme. Lesbian women who anticipate a health care visit frequently employ protective measures to help minimize adverse or uncomfortable situations during a visit. Our health care system and its providers often reinforce the barriers that vulnerable and marginalized people struggle to negotiate.[20] Research has shown that a significant number of lesbian women do not seek traditional health care services because of prior negative encounters.[9] Some lesbian women preferred to see a provider who was openly gay or lesbian because they believed that a heterosexual provider would demonstrate prejudice toward them.[9] To minimize the chance of a negative encounter, some women contacted different providers' offices to determine their receptiveness to treating a lesbian patient.[11] For example, one lesbian couple who relocated to another town during their antepartum desired an open-minded provider who was willing to care for them for the remainder of their pregnancy. They referenced a telephone directory and shared the following account, "And then we just listened without making a concrete decision . . . because nobody would say in a direct manner that they were against it. But we listened to their voices, and finally, we picked out a medical office."[11(p480)] Women in Barbara et al's[9] study shared that they assessed a provider at the beginning of a visit for certain nonverbal behaviors such as maintaining eye contact when obtaining a health history. The following represents a similar situation: "When I was looking for a primary care physician, I would go and hope that there would be an eye to eye interview, and the test would be, when I came out to the doctor, what their reaction was."[9(p54)] Nonverbal communication also

included the appearance of the office environment such as posted safe zone signs, pink triangles, or rainbow stickers to indicate an affirming environment.[30] Women who used these more proactive approaches strived to mitigate anxiety and fear before meeting a new provider.

Lesbian women had more positive impressions of their visit when asked whether someone would be accompanying them to the appointment and whether they wanted the person present during their examination.[23] These practice environments were more patient-centered and affirming. Providers who extended an open-minded and respectful presence during a visit were viewed positively by lesbian women. The following statement illustrated a sense of normalcy for a lesbian family: "I'm [the physician] so glad I met you because I've never known a lesbian family before and I would have had all these terrible ideas ... I can see you really love your child."[5(p98)] In Scherzer's[20] study, women expressed that feeling connected with their health care provider was an important aspect of a positive health care encounter. Other women positively perceived providers who were informed about their health condition and who explored the basis for presenting symptoms rather than relating all physical and psychological illness to sexual orientation.[10] Participants in Dinkle's[19] study identified the following 7 characteristics of an ideal provider: skilled communicator, competent, open to diversity, caring, committed, respectful, and created a safe and trusting environment.

Women perceived the health care encounter negatively when the provider made prejudicial and homophobic remarks. Some women expressed concern when a provider was uninformed about their health needs or seemed disinterested in them as a person.[27] This demeanor created communication barriers between the women and their provider during the visit. A dramatic quote by one woman demonstrated one provider's dismissive mannerism when she said, "No matter what I wanted to bring up; migraine, hot flashes, fatigue, anemia; she switched it to saying that being a lesbian had to be very hard ... I changed doctors."[10(p241)] When the woman left the visit feeling uncertain about her care or having unanswered questions, she formed negative impressions about her experience. Another participant in Bjorkman and Malterud's study shared a slightly different perspective of her provider when she described the following encounter:

> I was very physically ill without understanding that I was mentally exhausted ... doctor that I came to understood quickly that my physical illness was caused by something other than a virus, and she gave me a close and good follow-up. She was actually the first one to put into words emotions and difficult things linked to identity.[10(p241)]

In contrast to this experience, a woman from another study shared a different perspective on a positive experience when she explained the following story:

> I went to a pretty good doctor this time, she was really nice ... She actually talked more about some of my emotional things, like are you getting enough rest, and has anything changed ... my menstrual cycle had been a little funky, so she had asked me about my sleeping habits my eating habits, and was anything new in your life, and I told her about all this new stuff, so I got to talk to her, I felt good about that, that was good.[20(p96)]

In all 3 of these examples, the women identified either the presence or absence of an attentive provider to their concerns. In the first situation, the woman thought the provider very quickly assumed that her sexual orientation was the cause of all her worries. In the second scenario, the woman was receptive to the idea that her mental exhaustion might be linked to her sexual orientation. In the third circumstance, the provider listened and focused less on the woman's lesbian identity as the basis for her presenting symptoms. This holistic approach made a positive impression on the woman.

To say or not to say: "Paradoxes of disclosure"

The paradoxical nature of self-disclosure or "coming out" has shown that what one woman identifies as a positive reason to disclose her sexual orientation another woman may view as negative. All of the studies in this metasynthesis addressed varying viewpoints of self-disclosure to a health care provider. This range of perspectives suggests that the "coming out" process for women is highly individualized, and based on either previous positive or negative encounters with providers. A woman's decision of what approach to use is influenced by her worldview, knowing herself, and past experiences with health care providers.[5,11,20,23,24–26] Dinkle[19] identified 4 categories of disclosure among the women she interviewed that included no disclosure, only disclosing when asked, allowing the provider to assume without verifying, and disclosing by referencing the partner on the intake form. Many different factors influenced women's decisions to disclose their sexual orientation, including previous homophobic encounters, occupation, physical and psychosocial contexts, partner status, and perceived social and spiritual support.[19]

McNair et al[5] found women used private, proud, or passive strategies when disclosing their sexual orientation to a health care provider. Lesbian women used more private strategies when they did not believe that their sexual orientation was pertinent to the visit. One woman declared, "Straight people don't have to justify their story, and I don't have to justify mine."[5(p101)] Women who used a proud strategy wanted to be honest and authentic to themselves and their children yet realized doing so exposed them to potential discrimination.[5] Some women echoed a proud approach in several studies of this metasynthesis.[11,12,19]

Often, women who were comfortable disclosing their sexual orientation felt more emancipated and believed that this feeling aided them in having a more positive experience with their health care provider.[12] One woman expressed the following sentiment that reflected the view of other participants: "It just stops seeming so bad, and you start seeing the good things. [Coming out] was a really wonderful feeling, I just felt really emancipated . . . in control . . . independent . . . big freedom."[12(p133)] Women in Spidsberg's[11] study believed that a positive approach to self-disclosure was to be open but not overly assertive. Those who were comfortable disclosing to a health care provider wanted to live their lives as openly and honestly as possible[19,23] and to remain free of the incarcerating effects of internalized homophobia. Such conviction is rooted in a strong sense of knowing oneself.

The women in this sample who chose a passive approach to disclosure were less concerned about health care providers knowing their relationship status and sexual orientation compared with women who used private or proud strategies. In fact, some women were so reticent that they did not correct erroneous provider assumptions. As one couple in McNair et al's study candidly shared the following belief:

> Jo: No one ever asks. They probably just assume . . . and if they assume I'm Mum [Mom] that's fine. I don't feel any great need to say, "Well, actually I'm not his Mum," but . . .
>
> Bridget (birth mother): Because in that situation you are, you know.
>
> Jo: Yeah, I'm his parent.[5(p104)]

In this situation, it felt safer for the couple not to correct the assumptions because they understood that the nonbirth mother had no legal right to make health care decisions concerning the child.

Lesbians describe their "coming out" as either positive or negative depending on how their health care provider reacted after learning this information. Women who felt uninhibited when disclosing their sexual orientation felt empowered,[24] whereas those who were guarded remained fearful of negative repercussions by their provider.[9]

A participant in Barbara et al's study expressed her reluctance to disclose when she

said, "For a long time I would sort of lie . . . when I was asked about sexual activity." [9(p53)] Another woman from the same study expressed similar sentiments when she said:

I mean, it's just horrible to think that women have to continue going to the doctor and be afraid with the doctor about who they are because I think there's just too many things that impact on us. And having that freedom, that ability to talk about who you are is very important.[9(p53)]

One lesbian couple in McNair et al's[5] study had chosen intentional silence regarding disclosure and viewed this strategy positively because they believed it protected them and their children. In contrast to this silent approach, another couple observed their life together in a more open manner. This couple described the following health visit they had during the antenatal period:

Ella: I think we have a charmed experience of lesbian parenting.

Sally: Even in the hospital we never had any problems whatsoever.

Ella: It was never a problem.

Sally: We were "bang" out there straight away.

Ella: Before the nurse even sat down in her seat, it was like, "Hi, I'm Ella, and this is Sally. Sally is the one giving birth."

Ella: . . . That was the spiel, and I think, really, after the third nurse, they all knew we were lesbians . . . We had heard similar stories.[5(p103)]

Women who felt more negative or anxious disclosing their sexual orientation feared being marginalized and stigmatized by homophobic practitioners.[6,9,19] Others thought they regularly had to balance vulnerability with maintaining their self-esteem when deciding to disclose.[27] When a health care provider demonstrates specific impertinent activities during an office visit, women interpreted the actions as rude and thought that the provider was uncomfortable discussing the topic of sexual orientation. Activities that lesbian women found disrespectful included shuffling papers, not maintaining eye contact when talking, moving around the examination room while women were speaking, or quickly changing the subject of discussion when the woman asked a question related to her sexual orientation.[27]

Some women feared being told that being a lesbian was merely a phase.[10] After hearing such a comment women felt dismissed and invalidated and attributed the remark to the provider's lack of understanding about sexual orientation. In other instances, women described feeling abandoned by their provider after they disclosed their lesbian identity. It is unethical for a health care provider to abandon his or her patient when providing care, yet this occurred to one woman during an office visit when she described the following dialogue:

They said, "Do you think you could be pregnant?" I said, "No." He said "Are you sure?" It got to the point where he was very annoying. I said, "I am a lesbian, ok." He turned around very upset and left the room. Then, another doctor came back and finished the examination.[9(p52)]

The different pathways to disclosure are fluid and do not imply that one approach is better than another. Ultimately, women chose strategies for disclosure they perceived limited their vulnerability and risk of being stigmatized. Lesbian women were more apt to shift between different strategies based on past and present circumstances and their value system. For most lesbian women, the act of "coming out" is individualized rather than scripted and is regulated by temperance.

Reactions to provider's assumptions

In all of the studies, women shared experiences where they had to cope with different provider assumptions during a health visit. Most of the assumptions these women described centered on questions about marital status, use of birth control, sexual history, and habits. The manner in which providers asked questions often conveyed a heteronormative view. When this perspective influences questioning, it leaves few options for

lesbian women to respond and frequently results in negative perceptions about the experience. In one situation, a woman felt as though she had been violated during a pelvic examination when she described the following conversation with a physician:

> One thing that he did is asked me if I was a virgin at the time . . . and I said yes, and he said, um "well I thought so, I could barely get three fingers in." I'm going what the fuck are you doing and why was that . . . I didn't feel safe at all . . . I had already been, felt like I had been raped.[19(p61)]

When providers assume that a woman is sexually active exclusively with men and asks about birth control,[9,23] or tells a woman that having a Pap smear is unnecessary when she denies being sexually active with a man,[24] it leaves lesbian women feeling they have to disclose their identity when they might not feel ready. Disclosure under these circumstances often results in negative impressions of the visit. One woman had a physician who advised her against having a Pap smear when she shared the following:

> I knew a fair amount about the HPV virus and stuff like that. I've never had sex with men so I mean that, when she [doctor] said that [I didn't need a Pap] I just kind of thought well it makes sense but I really didn't think much more about it.[24(p891)]

This example raises issues of self-advocacy and the importance of lesbian women to feel empowered to question provider recommendations relevant to their health. When women are forced to disclose their sexual orientation under vulnerable circumstances, they are less likely to return and subject themselves to similar negative encounters.

Women described positive experiences when they encountered practitioners who made no assumptions and created a safe environment for them to disclose. Examples included asking questions on the intake forms that were more neutral and nonassuming. One woman shared how joyful she was in the following experience:

> I mean, from the very beginning with the forms, they asked, "Do you live with someone?" "Who is this person to you?" They just didn't make any assumptions. They asked some really basic questions. Every one of them surprised me . . . And it was such a joy to think that they had really taken the time to think that I wasn't widowed or divorced, or that I did have a partner.[9(p56)]

Other women also perceived the health care experience positively if the practitioner refrained from making negative comments when the women shared personal events in their lives. A woman in Bjorkman and Malterud's study expressed how appreciative she was after visiting her general practitioner:

> I saw my GP during a difficult period in my private life, among other things the breakdown of a relationship with a male partner, and starting a relationship with a girl. I wanted to praise the GP for an open attitude and understanding. It was important for me to feel accepted and he was open about the issue.[10(p241)]

Acknowledging my partner

Seven of the studies discussed including the woman's partner during a health visit. Women positively perceived acknowledgment of their female partner when communicated in a professional manner. For example, calling a partner by her name[9,11] and offering the patient the option to invite her partner into the examination,[5,9,23] and validating the role of the birth mother[11] were seen as affirming measures that some providers used to create safe environments for their patients. Women in Spidsberg's[11] study described being in caring hands as they described positive experiences throughout their pregnancy. Simple gestures as shaking hands with both partners, and congratulating them on a healthy pregnancy conveyed support and validation for both women.[11] One couple was pleased when the nurses in the intensive care unit placed a heart-shaped sign on their infant son's cot labeled with both their names as the mother.[11] In another situation, a nonbirth mother recanted the following conversation she had with the pediatrician about breastfeeding the baby:

Looking into my eyes he says, "are you going to breastfeed?" Just like that, like it was the easiest thing in the world, that both of us nursed the baby. And then he continued, "Men can breastfeed too, . . . it's just not that common." I must say, it came as a shock to me, I wasn't quite there. He was so incredibly engaged in the thought of me breastfeeding too.[11(p482)]

Negative experiences resulted when providers ignored the woman's partner,[11] denied a request to have the partner present,[9,23] discriminated against the partner when she was present,[19] and invalidated the role of the nonbirth mother.[5] One woman described a frustrating and deplorable experience when the hospital staff denied her request to have her partner with her in the hospital emergency department:

But they refused to let her go back while I was being treated. And, I complained, but I was also very sick at the time too. It was much harder for me to be pushy about it. After the episode was over, I received a questionnaire from the ER asking about my care. I let them have it about how deplorable I thought that was . . . We have each other's health care power of attorney. But in emergency situations, you don't always carry the paperwork with you everywhere. I felt like we had to go above and beyond what would normally be required of people in order for me to have the support of her being by my side.[9(p57)]

Other women in this sample described similar circumstances like this that left the partner feeling insignificant and invisible. One participant in Duffy's study shared how isolated and terrified she felt during a hospitalization knowing that she had no immediate relatives who could visit or stay with her:

. . . I was absolutely terrified and very, very ill . . . and I had told them that Finnesech was my partner and put her on my form as next of kin. I was told that she couldn't come in with me . . . it was a very frightening experience to be stuck on my own, . . . just having nurses not really wanting to treat me . . . let alone touch me.[23(p340)]

Not having her partner present during this frightening hospitalization marred any opportunity for the health care provider to make a positive impression. Although this study was conducted in Ireland,[23] similar events occurred in the United States prior to the federal legislation in January 2011 allowing same-sex couples to decide who they wish to have visited them and to make health care decisions on their behalf. Prior to this legislation, same-sex couples could be refused the right to visit their partner during hospitalized in the United States.

DISCUSSION

The 4 themes to emerge from this metasynthesis of 14 qualitative studies offer a more comprehensive understanding of the health care experiences of lesbian women and provide direction for clinical practice and further research. The themes of *sizing up the provider and the environment*, *to say or not to say: "paradoxes of disclosure," reactions to provider's assumptions,* and *acknowledging my partner* identify important periods during a health care encounter when lesbian women are likely to form positive or negative impressions of the experience after interacting with their provider. With a broader understanding of factors that influence these women's health care experiences, practitioners can use more culturally affirming communication techniques to mitigate negative perceptions. Providers are encouraged to reflect on each of the themes in this metasynthesis, and question whether they exhibit behaviors that contribute to negative or positive health care experiences by lesbian women.

Many studies have identified factors that influence lesbian women's health care experiences and include issues regarding disclosing sexual identify, navigating heteronormative assumptions, and encountering providers who are not well informed about lesbian women's health care needs.[1,2,18,31–33] Results from this metasynthesis support these findings and identify circumstances when these factors hinder or facilitate positive perceptions of provider interactions and the care provided. Based on the overarching themes from this metasynthesis, recommendations

are offered to help promote affirming and respectful communication between health care providers and lesbian women.

Sizing up the provider and the environment

Creating affirming and trusting milieus in which to provide care is essential for lesbian women to form a favorable impression of their health care experiences. Providers should assess the places in which they practice and critically reflect on the following questions. How welcoming is the environment for lesbian women? To what extent do the reception staff and providers demonstrate affirming and culturally appropriate care when interacting with lesbian patients? Are there safe zone signs, posters, and literature in the waiting rooms to convey support for patients of diverse sexual orientation and gender identities? These actions will help lesbian women perceive a safe and supportive environment when they enter the practice environment.

To say or not to say: "Paradoxes of disclosure"

Not all health care providers ask about their patient's sexual orientation; instead, women convey this personal characteristic themselves.[9] Some women have had negative experiences when disclosing their sexual orientation to a provider and may be more reluctant to share this information with a new provider. Health care providers should ask all patients about sexual orientation on intake forms and in the context of conversations about sexual health,[34] while remaining attentive to a discussion about confidentiality and privacy.[35] Providers who use inclusive language on all intake forms and ask rather than make assumptions about their patients are more likely to encounter lesbian women who are more comfortable sharing information about their sexual orientation.[2,9,10,36] Practitioners who develop caring and trusting relationships with their lesbian patients, and explain why knowing sexual orientation is relevant to providing care, help create more affirming and less threatening environments in which to disclose this information.[10] When a woman discloses her sexual orientation to the health care provider, the practitioner's immediate nonverbal and verbal response to this information is critical. If the woman perceives the provider's response as negative or disrespectful, she is less likely to return or to disclose this information to future providers.[11,27] In fact, some may delay future care because of such adverse reactions.

Reactions to provider's assumptions

Heteronormative assumptions continue to dominate most health care environments; however, providers are asked to consider the implications of these assumptions during a health care visit.[9,11,27] Lesbian women are aware of assumptions made in the context of their care; therefore, the onus of responsibility to not assume does fall to the health care provider. For example, it is preferred to ask a woman in what way she is related to whoever accompanies her to a visit and allow her to decide how to respond. Acknowledging a woman's partner is an empowering and affirming act for lesbian women. Health care providers are encouraged to critically reflect on how their heteronormative perspectives can negatively influence a lesbian woman's health care experience.

Health care providers should understand the power shifts that occur during interactions can result in perceived prejudice and lead some lesbian women to delay or avoid seeking health care. Avoiding or delaying health care contributes to health disparities. Providers must also realize that some women have had previously traumatic experiences with providers. These experiences include hearing unprofessional comments during a pelvic examination and feeling as though they were sexually violated during a pap smear. A lesbian woman who feels respected and is asked to share her health concerns before being questioned about her sexual activity and the need for birth control is more

likely to trust her provider. Creating affirming and trusting milieus in which to provide care is essential for lesbian women to believe their provider and form a positive impression of their experiences. These actions will also help decrease vulnerability and stigma.

Acknowledging my partner

It is important for some lesbian women to bring their partner or spouse to a health care visit. If she identifies the woman as a "friend," "partner," or spouse as in, "she is my wife" and requests her presence during the health care visit, allow her. Reception staff should also be respectful of this request. Acknowledging a woman's partner is an empowering and affirming act for lesbian women. Modifying the health care environment to convey a more welcoming milieu for these women will help decrease their vulnerability and fear of being stigmatized and marginalized.

The point at which the patient's and provider's perceptions merge creates a common ground for shared understanding, meaning there is an opportunity to engage in an affirming and respectful dialogue between them. Lesbian women face many barriers when they enter the health care system. They learn to adapt by cautiously navigating a health care system that is conditioned by heteronormative perspectives. These women are more likely to seek health care services when they encounter practitioners and environments that affirm their sexual orientation, cultural beliefs, and family structures. Practitioners who are proactive and incorporate culturally appropriate practices when providing care to lesbian women help create nurturing, patient-centered environments in which supportive relationships can flourish. Noblit and Hare remind us that "a meta-ethnography is complete when we understand the meaning of the synthesis to our life and the lives of others."[7(p81)]

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