

Applying Leadership to Facilitate Physician-Patient Communication and Promote Health in the Lesbian Community

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ABSTRACT

Lesbian women experience health inequalities primarily related to their experiences of discrimination, homophobia, and the assumption of heterosexism. This milieu of experiences can lead to an avoidance of routine health care, screening, and non-disclosure of sexual orientation to physicians. Lesbians may participate in some health risk behaviors more than heterosexual women leading to an increase in risks for certain cancers, cardiovascular disease and HIV. Lesbians who discuss their sexual orientation and behavior with their physician report feeling more comfortable, experience better communication, and are more likely to seek routine medical care. Although the medical community has been making a shift away from the medical model of a paternalistic physician-patient interaction, incorporating the concepts of the relational leadership model would facilitate a more open exchange. This model focuses on all parties involved becoming a part of the leadership process, regardless of title or role. It is vision-driven with an ultimate goal of uniting people for a common purpose. The relational leadership model was named to emphasize that the focal point of the leadership process is on relationships. The relational leadership model encompasses five concepts that can be applied to the physician-patient relationship with regard to facilitating a more open communication.

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Introduction

Disclosure of sexual orientation is important to the health of lesbians (White & Dull, 1998). Women who are out to their health care providers have improved health seeking behavior and are more likely to seek early and preventive care. They are also more comfortable discussing personal issues (Steele, Tinmouth, & Lu, 2006). A woman's inability to disclose sexual orientation may lead to an avoidance of health care, a delay in needed care, as well as failing to obtain preventive care and screenings (White & Dull, 1998). The health care needs and issues of lesbians are unique and different from heterosexual women and are important to the physician in diagnoses and treatment (Bonvicini & Perlin, 2002). Lesbians often report dissatisfaction with the health care they receive. This compromised satisfaction leads to the need for a closer examination of the relationship and dialogue between physicians and Lesbians (Bonvicini & Perlin, 2002). Enhancing physician-patient communication to create an environment of acceptance would promote a greater exchange of information vital to the health of Lesbians. The relational leadership model shifts the focus onto creating a healthy environment and away from the more traditional foundation of a positional, authoritarian leader. The emphasis is on each member working together toward needed change and

for a common goal (Komives, Lucas, & McMahon, 2006).

Significance of the Problem

Although there are an estimated 2.3 million women in the United States who identify as Lesbian, there are surprisingly few data that focus on health issues that are unique to them (Marrazzo, Coffey, & Bingham, 2005). Some community-based health studies have shown that lesbians have unique health needs as they are more likely to choose behaviors that increase their risks for breast and cervical cancers, to smoke, to use alcohol more heavily, and to participate in unsafe sex (Steele et al., 2006). They may also have a higher body mass index than heterosexual women increasing their risk for a number of cancers as well as cardiovascular disease (White & Dull, 1998). Despite these behaviors, Lesbians are less likely to seek out preventive care including pap smears, mammography, and clinical breast exams (Steele et al., 2006).

Many physicians as well as other health care professionals "maintain a position that Lesbian health is synonymous with women's health, secure in their belief that it is unnecessary to identify women as Lesbian..."(McNair, 2003, p.643). In a literature review conducted by Bonvicini and Perlin (2002), studies regarding the attitudes of physicians toward

lesbian patients indicated their beliefs reflected those of society at large. Mathews, Booth, and Turner (1986) found that 39.4% of physicians admitted to being uncomfortable providing care to gay or lesbian patients. In a survey by Schatz and O'Hanlan (1994), 67% of health care respondents felt they had witnessed gay or lesbian patients receiving substandard care resulting from their sexual orientation. A number of studies that were reviewed addressed gay patient satisfaction and reported physicians to be insensitive to their unique health needs and risks (Schatz & O'Hanlan, 1994; White & Dull, 1998). A survey conducted of American medical schools reported 3 hours and 26 minutes as the average amount of time spent on studying homosexuality (Wallick, Cambre, & Townsend, 1992), thereby leading to the conclusion that physicians are "inadequately trained to counsel patients about a broad range of sexual issues" (Bonvicini & Perlin, 2002, p.117). Another literature review suggests that between 35% and 87% of lesbians do not disclose their orientation to their health provider (Barbara, Quandt, & Anderson, 2001). Many lesbians report a belief that their health provider lacks knowledge about their unique health issues (White & Dull, 1998). Barbara et al. (2001) suggest that a Lesbian's decision to self-disclose to a physician is affected by their perception of the clinician's attitudes toward homosexuality. Many women perceive negative attitudes among their health providers and hesitate to return for further care (White & Dull, 1998).

The recent surge of health communication research has prompted the realization that these skills are important and determine to some extent, the effectiveness of health care (Ballard-Reisch, 1990). "Quality communication between physicians and patients has been linked to patient satisfaction, compliance with treatment regimes, and enhanced recuperative abilities" (Ballard-Reisch, 1990, p.91). Bonvicini and Perlin (2003) outline four barriers to effective communication between physicians and gay/lesbian patients: clinician attitudes, medical training, clinician level of skill/confidence, and mistaken clinical assumptions. The application and adoption of the relational leadership model would address each of these barriers and promote effective communication between physicians and lesbian patients. In the past, the physician was seen as the expert and the patient seen as being in need of that expertise. These prescribed roles lead to an authoritarian and paternalistic attitude that gives physicians disproportionate, if not sole power (Ballard-Reisch, 1990). The inadequacies of traditional models of communication have slowly been shifting to a more participatory form (Ballard-

Reisch, 1990). Applying leadership would facilitate a more rapid holistic approach to the communication process, thereby resulting in a more productive physician-patient relationship.

Factors Related to or Affecting the Problem

"Historically, American society has both accepted and supported the paternalistic nature of the physician-patient relationship" (Ballard-Reisch, 1990, p.92). Ballard-Reisch sums up the disadvantages of this type of interaction in a quote by Wegmann (1988): "Paternalism breeds dependency, undermines autonomy, and sometimes results in humiliation" (Ballard-Reisch, 1990).

In the 1950s, the legal system started to question whether patients had the right to know what physicians were prescribing for them as well as to decide the appropriate course of action. The subsequent litigation was the beginning of how informed consent developed (Ballard-Reisch, 1990). It was this desire for patients to understand and participate in the decision making process about their health care that started the shift in physician-patient interaction (Ballard-Reisch, 1990). In the 1960s, research established the importance of communication between physicians and patients (McAdoo, 2008). It has only been within the past decade though, that medical organizations are acknowledging this importance (McAdoo, 2008). Following a major project by the Institute of Medicine to examine all aspects of health care, an objective was created to "develop a working culture in which communication flows freely regardless of authority gradient" (McAdoo, 2008, p.288). The Association of American Medical Colleges (AAMC) also has developed communication objectives that requires students to demonstrate "the ability to communicate effectively, both orally and in writing, with patients, patients' families, colleagues, and others with whom physicians must exchange information in carrying out their responsibilities" (McAdoo, 2008, p.289).

In 1994, a survey by the Gay and Lesbian Medical Association demonstrated that there exists a substandard level of care for the gay and lesbian community (Hosaka, 1999). In 1999, the Institute of Medicine released its first study on lesbian health. "... The study confirms that Lesbians face unique challenges from a medical community that is often insensitive and ignorant about Lesbian health issues" (Hosaka, 1999 p.). Mainstream medicine is starting to realize the need to address lesbian health through special outreach programs, research, and medical school curricula (Hosaka, 1999).

In light of the increasing evidence of some health disparities for lesbians, a study was conducted to

assess the extent in which U.S. schools and colleges of public health were addressing this issue (Corliss, Shankle, & Moyer, 2007). Less than 50% of the schools offered domestic partnership benefits even though they had nondiscrimination policies that included sexual orientation. Of the departments surveyed, 41% were conducting research related to gay or lesbian health, but most focused on HIV and AIDS. Only 10% reported having had a student complete a doctoral dissertation on a gay or lesbian health issue and less than 9% had offered a course that taught gay or lesbian health in the past two years (Corliss et al., 2007). This study indicates that “contrary to official American Public Health Association policy, public health schools seldom offer planned criteria that address comprehensive Lesbian, gay, bisexual, and transgender health” (Corliss et al., 2007, p.1024).

The medical profession is reaching a time when it needs to start thinking beyond traditional values. More effective communication skills are essential to the continued progression of health care as a whole, but more specifically, to the health of cultural minorities. The nature of the relationship between physicians and their patients determines the effectiveness of that interaction. Equitable access to health care is necessary in working toward the elimination of health disparities. For the lesbian community to receive regular health care, there needs to be a sense of acceptance and openness. Physicians need to be more skilled to feel confident and comfortable in addressing the needs of their lesbian patients. Lesbians need to feel an air of acceptance, and be secure in their physician’s skills. Communication needs to evolve to provide a non-judgmental atmosphere in which physician and patient can work together.

Implications for Leadership

Leadership has been defined as “a relational and ethical process of people together attempting to accomplish positive change” (Komives et al., 2006, p.74). Is this not the very essence of the physician-patient relationship? The relational leadership model was named as such to emphasize that the focal point of the leadership process is on relationships (Komives et al., 2006). “Relational leadership involves a focus on five primary components. This approach to leadership is purposeful and builds commitment toward positive purposes that are inclusive of people and diverse points of view, empowers those involved, is ethical, and recognizes that all four of these elements are accomplished by being process-oriented” (Komives et al., 2006, p.74). Each of the five components can be viewed through a holistic framework addressing knowledge, skills, and

attitudes. These three aspects are interrelated as knowledge influences thought, which in turn influences action. Each of these aspects affects the other two (Komives et al., 2006).

Leadership is purposeful

It is important for all those involved to be drawn together to work toward a common vision that each individual can relate to (Komives et al., 2006). Working toward a common goal requires that each member participates equally. All members need to find common ground to facilitate positive change. An important aspect of change is that there is movement away from the status quo (Komives et al., 2006). “The relational leadership model supports positive change... that improves the human condition and that does not ... harm others” (Komives et al., 2006, p.83).

Knowledge-attitudes-skills. This component rests on a shared sense of values and a common purpose (knowledge), having a “can do” attitude with a commitment to social responsibility (attitudes), and identifying goals and a vision (skills) (Komives et al., 2006). This approach would help in developing an awareness of the health disparities to the Lesbian community to work toward providing equal access to care.

Leadership is inclusive

The emphasis here is on making every member feel equal, welcome, comfortable, and listened to while focusing on equal involvement (Komives et al., 2006). There is value on individuality and diversity, respecting others, being able to listen with empathy, and having the ability to view a situation from various perspectives (Komives et al., 2006). The organizational culture should also be one that communicates the worth and value of each individual (Komives et al., 2006).

Knowledge-attitudes-skills. The foundation is in knowing one’s own attributes and attitudes as well as understanding others’ differing perspectives (knowledge), being open to difference and valuing equity (attitudes), and having good listening skills as well as being able to view issues from different perspectives (skills) (Komives et al., 2006) . This component could be applied to much needed communication skills among physicians, and the need for tolerance and acceptance. Increased training on the lesbian culture and health issues would help to eliminate common misconceptions and promote a more open dialogue.

Leadership is empowering

Empowerment involves creating an environment in which all members are encouraged to recognize that they have a right and responsibility to express ownership in the group’s process. No individual’s power is as strong as the power resulting from the

group as a whole, regardless of formal position or title (Komives et al., 2006). Humiliating members, making them feel marginalized or that they do not matter, is a direct contradiction to empowerment and should be avoided (Komives et al., 2006). "Empowering organizations seek to eliminate fear or humiliation and operate on trust and inclusivity" (Komives et al., 2006 p.95).

Knowledge-attitudes-skills. This component incorporates an understanding of the dynamics of power as well as how policies or procedures either promote or block empowerment (knowledge). Members need to demonstrate self esteem, valuing others' contributions, and a willingness to share power (attitudes), as well as sharing information, affirming others, and promoting self leadership (skills) (Komives et al., 2006). This view would help Lesbian patients to feel accepted and not judged, and to be able to communicate their health needs and share necessary information with their physicians. It would help to create an environment in which Lesbians would feel comfortable to disclose their sexual orientation and address the issues that are unique to them.

Leadership is ethical

This model is dedicated to morality, virtue, and values. It "emphasizes ethical and moral leadership, meaning leadership that is driven by values and standards that is good- moral- in nature" (Komives et al., 2006, p.97). It is not merely understanding the difference between right and wrong, but always pursuing what is right. For the purpose of this model, ethics is defined as standards or rules that govern behavior (Komives et al., 2006). Ethics is considered central to leadership requiring a commitment to doing the right thing because without it leadership cannot emerge (Komives et al., 2006).

Knowledge-attitudes-skills. The emphasis is on understanding how values develop and how systems influence justice (knowledge). Members need a commitment to socially responsible behavior, to value integrity, and to establish a sense of personal character (attitudes). Necessary attributes would include having courage, and being reliable and trusting (skills) (Komives et al., 2006). Taking an objective look at the current practices within the various health care settings, and how they contribute to the health disparity for lesbians could be addressed with this focus. It would offer insight into areas that would benefit from change. It is within this framework that physician attitudes toward lesbian patients can be addressed to end discrimination and substandard care.

Leadership is process oriented

This component refers to how the members go about being a group. The focus is on how decisions

are made, tasks are handled, as well as the intention behind it. Participants interact with each other and work together to accomplish change (Komives et al., 2006). There is an awareness of the dynamics between the people involved (Komives et al., 2006). There are five essential processes to this component: collaboration (along with cooperation creating a conducive environment), reflection, feedback, civil confrontation, community building (acting inclusively and empowering others) and meaning making (a cognitive and emotional understanding of the world with respect to one's place in it, as well as the realities as perceived by others) (Komives et al., 2006).

Knowledge-attitudes-skills. It is necessary to understand that the process is just as important as the outcome (knowledge). Participants need to value the process as well as the outcomes (attitudes), and have the ability to collaborate, reflect, give and receive feedback, and participate in meaning making (skills) (Komives et al., 2006). This view would help Lesbian patients to feel more satisfied with their health care experiences which in turn would prompt them to return for further care. Their use of preventive care and screening would increase and the health disparity would be lessened.

Conclusion

By incorporating the framework offered by the relational leadership model, communication between physicians and lesbian patients would be greatly enhanced allowing for a more open exchange of information. A partnership would emerge in an environment of acceptance, without discrimination and false assumptions. Health care issues would be addressed more accurately and treated with sensitivity and respect. As a result, lesbians would gain more access to needed health care that would address the issues that are unique to them.

References

- Ballard-Reisch, D. (1990). A model of participative decision making for physician-patient interaction. *Health Communication*, 2(2), 91. Retrieved from http://pdfserve.informaworld.com.proxy.usf.edu/772262_751306483_785835443.pdf.
- Barbara, A., Quandt, S., & Anderson, R. (2001). Experiences of lesbians in the health care environment. *Women and Health*, 34(1), 45-61. Retrieved from http://www.haworthpress.com.proxy.usf.edu/store/E-Text/View_EText.asp?a=4&fn=J013v34n01_04&i=1&s=J013&v=34.
- Bonvicini, K., & Perlin, M. (2003). The same but different: Clinician-patient communication with gay

and lesbian patients. *Patient Education and Counseling*, 51(2), 115. Retrieved from <http://www.ucm.es/info/rqtr/biblioteca/Psicologia%20salud%20y%20glbt/the%20same%20but%20different%20clinician%20patient%20communication%20with.pdf>.

Corliss, H., Shankle, M., & Moyer, M. (2007). Research, curricula, and resources related to lesbian, gay, bisexual and transgender health in US schools of public health. *American Journal of Public Health*, 97(6), 1023-1027. Retrieved from <http://ovidsp.tx.ovid.com.proxy.usf.edu/spb/ovidweb.cgi?QS2=434f4e1a73d37e8ca7de0ecd0679e58a7211ac618c13d6ce0500a60ae670c7652cb8717dd5aca975d27f4aa07d44ee6995e69f83bdfbdb4f71cf3642be47c31b5e7a0d4f802318c4c5a6a71ec643b199aa7682d644c4cd9f5c892af8e259e6d6d139a3aab37e0e174371b8b1ca2e3fe3e97e1a6b91830d1ed15f303331070ac669122c90a7b926093ec9c06017c916929ec54f0483b63b0c7cf0f85cfd6d8a07bb96f4c011299f5f8943a79dd36afebfff61a8f0bbcd532ebb8e84458ad2bf2e2023dbfbd2619ea04944b7040eb0791656cf6e50e9373566d08510d07e7f7a43186f8d2a3848f1448cf231409b1a6115de9e33383cdd5390a288a39c9019606ae>.

Hosaka, T. (1999, January 19). Lesbian study lauded by health activists; institute of medicine report viewed as laying groundwork for future efforts. *The Washington Post*, pp. Z09. Retrieved from <http://proquest.umi.com.proxy.usf.edu/pqdweb?index=1&did=38161430&SrchMode=1&sid=1&Fmt=3&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1205240192&clientID=20178>.

Komives, S., Lucas, N., & McMahon, T. (2006). The relational leadership model. In *Exploring leadership: For college students who want to make a difference* (2nd ed., Chap.3, pp. 73-114). California: Jossey-Bass. Retrieved from <http://www.nclp.umd.edu/include/pdfs/Exploring%20Leadership%20II%20-%20Chapter%203.pdf>.

Marrazzo, J., Coffey, P., & Bingham, A. (2005). Sexual practices, risk perception and knowledge of sexually transmitted disease risk among lesbian and bisexual women. *Perspectives on Sexual and Reproductive Health*, 37(1), 6-12. Retrieved from <http://www.jstor.org/stable/3657144>.

Mathews, W., Booth, M., & Turner, J. (1986). Physicians' attitudes toward homosexuality-survey of a California County Medical Society. *The Western Journal of Medicine*, 144, 106.

McAdoo, B. (2008). Physicians: Listen up and take your communication skills training seriously. *Hamline Journal of Public Law and Policy*, 29(2), 987-998. Retrieved from http://vnweb.hwwilsonweb.com.proxy.usf.edu/hww/results/results_single_ftPES.jhtml?DARGS=/hww/results/results_single.jhtml.16.

McNair, R. (2003). Lesbian health inequalities: A cultural minority issue for health professionals. *Medical Journal of Australia*, 178, 643-645. Retrieved from http://www.mja.com.au/public/issues/178_12_160603/mcn10852_fm.pdf.

Schatz, B., & O'Hanlan, K. (1994). Antigay discrimination in medicine: Results of a national survey of lesbian, gay and bisexual physicians. San Francisco (CA). *Gay and Lesbian Medical Association*.

Steele, L., Tinmouth, J., & Lu, A. (2006). Regular health care use by lesbians: A path analysis of predictive factors. *Family Practice*, 23, 631-636. Retrieved from <http://fampra.oxfordjournals.org.proxy.usf.edu/cgi/print/23/6/631>.

Wallick, M., Cambre, K., & Townsend, M. (1992). How the topic of homosexuality is taught at US medical schools. *Academic Medicine*, 67, 601-603.

White, J., & Dull, V. (1998). Room for improvement: Communication between lesbians and primary care providers. *Journal of Lesbian Studies*, 2(1), 95-110. Retrieved from http://www.haworthpress.com.proxy.usf.edu/store/E-Text/View_EText.asp?a=3&fn=J155v02n01_07&i=1&s=J155&v=2.

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