Caring for Lesbian Health:

a resource for health care providers, policy makers and planners

BRITISH COLUMBIA

Ministry of Health and
Ministry Responsible for Seniors

Caring for Lesbian Health:

a resource for health care providers, policy makers and planners

Prepared by Maria Hudspith
in conjunction with
the Minister's Advisory Council
for Women's Health

September 1999

BRITISH COLUMBIA

Ministry of Health and
Ministry Responsible for Seniors

Canadian Cataloguing in Publication Data

Hudspith, Maria
Caring for lesbian health

Includes bibliographical references: p.
ISBN 0-7726-4026-2

1. Lesbians - Medical care - British Columbia.
2. Lesbians - Health and hygiene - British Columbia.
I. British Columbia. Minister's Advisory Council on Women's Health. II. British Columbia. Ministry of Health and Minstry Responsible for Seniors
III. Title.

RA.564.87.H82 1999 362.1'086'64309711 C99-960340-X

Table of Contents

Acknowledgments

This project would not have been possible without the vision and commitment of the Honourable Penny Priddy, Minister of Health and the ministerial assistant, Donna Cameron.

Thank you to the staff at the Women's Health Bureau and the members of the Minister's Advisory Council for Women's Health for their support.

I would particularly like to thank barbara findlay and Louise Hager, members of the Lesbian/Bisexual Cancer Support Group at the B.C. Cancer Agency, for their dedication to this project. They provided inspiration, by courageously sharing their insights and stories.

Appreciations to Effie Henry, Robin Barnett, Anne Marie McGinnis, Dr. Liz Whynot, Dr. Penny Ballem, Louise Hager, Sook C. Kong and Rita Scott for assistance with editing.

Introduction

Recent research in epidemiology, clinical care and psycho-social fields has indicated the need to explore lesbian health needs and address barriers to wellness (Solarz, 1999). It is estimated that up to 10 percent of women are lesbian, although estimates vary depending on how the category of lesbian is defined (Laumann, in Solarz, 1999). Lesbians are mothers and daughters, young and old, members of Aboriginal, immigrant, visible minority and dominant cultural communities. Lesbians live with disabilities and are able-bodied, come from all class backgrounds and live in both rural and urban areas. Some lesbians are transgendered. To be responsive to all members of our communities, we need to address the specific needs and issues of diverse groups.

Don't make assumptions about me or anybody else. Take your chalkboard and wipe it clean every time you enter into conversation with a new patient. Go in with clear eyes and pure heart, understanding that we are all persons, even though the way we are in the world is different. When we are cut, we all bleed.... You might say you don't have time. I say time is relative. There is always time to treat other people like human beings.

(Stevens, 1998)

The World Health Organization states that health is a basic human right (WHO Constitution, 1946), recognizing that all people deserve equal access to health services and quality care. Everyone has the right to be treated with respect, and to receive care in a setting free from discrimination. However, lesbians may encounter difficulty accessing health care. Lesbians who come from other marginalized communities (visible minority, immigrant or Aboriginal communities for example) face additional barriers.

The steps we take to make health care accessible to lesbians are building blocks for making the system respectful of difference and attentive to the needs of other groups. These steps are not about special interests; they are the foundations of good practice and reflect our broadening concept of health and our belief in health as a human right for all.

Glossary of Terms

Closeted/Out: Being "closeted" means not disclosing one's identity. "Coming out" is the process of first recognizing and acknowledging one's lesbian, gay or bisexual orientation to oneself and then disclosing it to others. This may occur in stages and is often a non-linear, life long process. An individual may be "out" in some situations or to some people and not to others. Some may never come out to anyone other than themselves and their intimate partners.

Gender Identity: One's psychological sense of oneself as male or female.

Heterosexism: The institutionalized assumption that everyone is heterosexual or should be; the belief that heterosexuality is innately right or superior to any other sexual orientation or identity.

Homophobia: The irrational fear or hatred of, aversion to, or discrimination against gays and lesbians.

Lesbian: A woman who forms affective and sexual relationships with other women. Some women who partner with women may not identify as lesbians. Some labels that were once derogatory have been reclaimed by lesbians and used with pride, such as dyke or queer. Some labels are culturally specific such as Two Spirited, referring to lesbians of Aboriginal heritage.

Sexual Orientation: The capacity to develop intimate emotional and sexual relationships with people of the same gender (lesbian or gay), the opposite gender (heterosexual) or either gender (bisexual). Orientation is separate from sexual identity or behaviour.

Sexual Behaviour: What a person does sexually. A woman's sexual behaviour can be different from her sexual orientation. Some lesbians may have sex with men to conceive children, to conform to societal expectations of heterosexuality, for desire or to make money.

Sexual Identity: How a person defines herself. Sexual identity may not be congruent with sexual behaviour or orientation.

Transgender: A term used to describe the continuum of individuals whose gender identity and expression, to varying degrees, does not correspond to their genetic sex. This may refer to transsexuals (an individual who has changed their sex through surgery, hormones) or to people who, because of their non-conventional gender presentation, may be seen as transgender (ie: a woman with a masculine presentation who may be seen by others as male but sees herself as female).

Why is lesbian health important?

Human rights legislation (both provincial and federal) exists to protect lesbians, gay men and bisexuals from discrimination on the basis of sexual orientation. While this protection has not been *written into* the Charter of Rights and Freedoms, the section pertaining to Equality Rights has been held to prohibit discrimination on the grounds of sexual orientation. However, sexual minorities still encounter both systemic barriers and interpersonal expressions of homophobia in society. In the health-care context, some hospitals and care providers are starting to bring policies and practices in line with human rights law. They are doing this by expanding definitions of family beyond biological kin, providing training on diversity and developing specific programs to meet the needs of lesbians, gays and bisexuals.

Why should we work to make the health care system accessible to lesbians? Fundamentally, the system needs to be responsive to, and inclusive of everyone. There are health problems that may be more prevalent among lesbians or for which risk factors and interventions may be different. Many lesbian health issues could be remedied by improving access to care and by working towards recognition and equality in the health system.

When I was a teenager, I was always too afraid to come out. How could I trust doctors and nurses? Didn't they have weird ideas about lesbians being sick and perverted? I had so many questions about why I was feeling different and was being harassed at school. My father beat me up when he found out. I needed to talk to somebody and I thought maybe health professionals would be able to help... but they never gave me any openings.

(Stevens, 1995)

Making care safe for lesbians means:

- health care providers get accurate information about their patients, so they can make more informed diagnostic and treatment decisions.
- patients are treated in a holistic manner, and their definitions of family/caregivers are respected.
- energy that may be spent on staying in the closet gets spent on healing.
- social determinants of health, like systemic discrimination and recognizing how multiple oppressions (like racism and homophobia) intersect are acknowledged.

The Historical Legacy of Homophobia in Health Care

At the turn of the 20th century in North America and Europe, bio-medical models were used to define normalcy and deviance, particularly around issues of sexuality. Western medicine and science built on the history of the Church and tied concepts of bodily disease to those of aberrant morality (Stevens and Hall, 1991). Same-sex attraction and behaviour was defined as a disease and thought to be the result of genetic anomalies. Being gay or lesbian was considered dangerous and contagious, and many lesbians and gay men were confined in psychiatric or criminal asylums.

Throughout the late 19th and 20th centuries, the medical establishment theorized about the exact nature and cause of homosexuality. Lesbians and gay men were studied and "treated" by doctors who aimed to identify and to cure. Many "scientific" studies were based on "data" from popular novels, tabloids, and from interviews with prison inmates and sex trade workers. Physicians developed lists of physical characteristics that could be used to detect lesbianism (i.e., wide shoulders, greater height and firmer muscles). Behaviours that could be considered unconventional or gender-inappropriate (i.e., involvement in skilled labour, sports, or social movements, dedication to career) were also considered part of the diagnostic criteria for lesbianism (Stevens and Hall, 1991). These so-called scientific definitions of lesbianism worked together with social stereotyping and prejudice to demonize lesbians.

The Impact of This Legacy

This historical legacy has informed the policies and practices of health care and continues to influence lesbians' experiences with the medical system. Indeed, research on lesbians' experiences with health care providers demonstrates the unique struggles that lesbians face (Denenberg, 1995, Rosser, 1993, Stevens, 1995). Most fundamental is the question of being "out", or disclosing one's lesbian identity. While it is assumed that honesty, respect and confidentiality are the cornerstones of the patient-health care provider relationship, this is often not the case for lesbians, for whom the disclosure of a lesbian identity may have negative consequences.

A study of nurse educators in the United States found that 25 percent of participants saw lesbianism as "immoral" and "wrong" and 52 percent believed that lesbians should undergo treatment to become heterosexual (Rankow, 1995). These attitudes are not left at the doors of operating rooms or clinics, but affect the quality of care that lesbians receive. Discrimination impacts every aspect of health care interactions from a woman's decision to access care through to the health care provider's diagnosis and treatment. A recent survey of The American Association of Physicians for Human Rights found that 67 percent reported knowing of instances where lesbian, bisexual or gay patients had been refused care or had received substandard care because of their sexual orientation (Rankow, 1995).

The presumption that all women partner with men guides the policies and practices of health care and renders lesbians invisible. This invisibility directly affects their health and the care that they receive. To ensure that adequate care is provided, lesbians must often make a declaration of their sexual identity or sexual practices. This disclosure may be met with disgust, fear, hostility, or misunderstanding, and the anticipation of such a reaction may discourage a woman from being out. The fear of receiving homophobic treatment means that some lesbians pass

as heterosexual in health care settings, providing incomplete or inaccurate information in an effort to camouflage their lesbian identity. This carefully constructed charade often results in misdiagnosis and improper treatment, as well as discomfort and anxiety for the patient. The irony of disclosure is great as a Vancouver woman noted; *"If I allow the presumption of heterosexuality to go unchallenged, I risk receiving inappropriate care due to misinformation. Yet if I am out, I fear antagonism, disgust or potential medical mistreatment".* In an effort to avoid this negotiation of identity, many lesbians simply go without medical care.

Lesbian Health Issues

Lesbians share many health concerns with heterosexual women and also have unique health issues (Solarz, 1999). While there is some evidence of epidemiological trends among lesbians, the determinants of compromised health status or poor utilization of health services are often systemic barriers: homophobia, among both society and care providers, and heterosexist bias in health policy or practice (O'Hanlan, 1997). These barriers are compounded for lesbians who are disabled, members of visible minority or Aboriginal communities, or economically disadvantaged.

Some health issues that impact lesbians:

Breast cancer and other cancers:

The incidence of breast cancer among lesbians is unknown, although some studies claim that it is up to 3 times higher than in heterosexual women (Rosser, 1992). Epidemiological evidence suggests that lesbians may be at greater risk for breast cancer due to having fewer pregnancies and having children later in life, heavier alcohol consumption, higher body mass index and less access to prevention/ treatment such as breast examinations by a physician (Solarz, 1999). Lesbians, like women of colour and other oppressed groups, may also be at risk for late diagnosis and therefore greater mortality from cancer (Maunter Project Fact Sheet).

My friend died because she was not able to self-diagnose her cancer early enough to save her life. She was an intelligent, capable, articulate woman. But as a lesbian, health care was not a place where she felt welcome. She never went. She never learned about doing breast exams. Her cancer got too advanced.

(Stevens, 1995)

- **Mental Health:**

> ***I came out at a time when being gay was both illegal and a mental illness. I was sent to a psychiatrist when I was 13 because my mother didn't think I acted like a "proper" girl. I was eventually confined in a psychiatric hospital when I was 17. That's hard to shake, an experience like that. I mean, I'm in my sixties now and I still have anxiety when I interact with the health care system.***
>
> ***(A Vancouver woman)***

Although diagnosed mental illness is no more common among lesbians than heterosexual women, societal homophobia has implications for the mental health of women who partner with women (D'Augelli, 1989, 20). Lesbians may suffer rejection from families, friends, religious communities and co-workers. They may be the targets of hate crimes, including verbal and physical attacks, and may be denied housing, custody of children (their own or their partners), employment, or health care. The impact of societal rejection if one is out, and the burden of maintaining a secret identity if one is not, can lead to isolation and depression (Denenberg, 1995). The historical linking of homosexuality and mental illness by the psychiatric system still haunts many lesbians, particularly older women. In focus group discussions, some lesbians acknowledged not getting medical care for fear of disclosing their lesbian identity and being involuntarily treated for mental illness by homophobic care providers (Vancouver/ Richmond Health Board, 1997).

Substance use:

Studies on substance use demonstrate a correlation between societal marginalization and substance misuse (Bushway, 1991). Some studies have shown higher use of alcohol, cigarettes and other drugs among a sub-population of lesbians (Hall, 1992). These studies found that lesbians tended to use psychoactive substances to cope with isolation and societal and internalized homophobia.

Sexually Transmitted Diseases and Vaginal Health:

Lesbians appear to be less likely to receive regular pelvic exams than heterosexual women (Solarz, 1999). A number of factors influence this including heterosexist bias in screening procedures, fear/discomfort on the part of the patient, and the misconception on the part of both patients and health care providers that STDs cannot be transmitted through woman-to-woman contact (Denenberg, 1995). Given that pelvic exams are the main screening device for sexually transmitted diseases, many lesbians do not get appropriate preventive care or medical treatment. Documented incidence of sexually transmitted diseases such as trichomonas, chlamydia, and gonorrhea are much lower among lesbians than among heterosexual or bisexual women, but they still occur (Fisher, 1995).

This nurse practitioner was doing a history on me and she was asking about pregnancies, so I thought it was a good time to tell her I was a lesbian. When I said lesbian, it just took this nurse completely off guard. She started spelling it out loud as she wrote it in my chart: l-e-s-b-i-a-n. A nervous smile came over her face and she couldn't recompose herself. She left the room. I heard her talking to someone in the hallway. And when she came back in, this other person was peering in at me from behind the door. There I was, half-dressed. I was humiliated.

(Stevens, 1995)

HIV/AIDS:

Lesbians are at risk for contracting HIV through sharing needles for injection drug use, through alternative insemination with unscreened semen and through unprotected sex with male or female partners. There has been widespread debate about the possibility of woman-to-woman transmission of HIV through sex. Some studies have found higher rates of HIV among women who have sex with women than exclusively heterosexual women, although these statistics are affected by study participants who are behaviourally bisexual and who use injection drugs (Solarz, 1999). Although initial HIV prevention efforts were targeted at risk groups (according to the U.S. Center for Disease Control guidelines) lesbianism was not considered a category of risk (Glassman,1995). This invisibility left lesbians out of the analysis and obscured the issues for women who have sex with women. While this silence has recently begun to shift, research studies have found that medical practitioners are often doubly ignorant around the issue of lesbians and HIV (Glassman,1995, Stevens, 1994).

Pregnancy and Parenting:

Many lesbians are mothers with children from previous heterosexual relationships, children who are adopted or children conceived through alternative insemination. It is estimated that between 23 and 50 % of lesbians have been pregnant and have children (Johnson in Fisher,1995). While there is no demonstrated difference between children raised in lesbian families and those raised in heterosexual

My partner and I have a son. Whenever we take him for health care, they assume I must be somebody else. Never two women with a child, even when I refer to him as son and he calls me Mama. The doctors and nurses only talk to my partner. They don't look at me. When we confer with each other, they seem surprised. Then they are uncomfortable, fidgeting, nervous. The onus is on us to overexplain that we are both our son's parents.

(Stevens, 1995)

ones, lesbians and their children have the added stress of dealing with societal discrimination (Denenberg, 1995).

Violence in Relationships:

Abuse is an issue of power and control and impacts lesbians. Although there is increasing awareness of this issue in lesbian communities, there is still a pervasive silence about lesbian battering and abuse. Lesbians who experience abuse are less likely than heterosexuals to seek help in the medical system and are less likely to turn to shelters (Saunders, 1999). Research has shown that when lesbians do reach out for help, the violence is often minimized and framed by care providers as "mutual aggression" (Scherzer, 1998). This silencing is particularly evident in cases of sexual assault (Orzek, 1988). Societal homophobia and sexism exacerbates the fear and shame that lesbian survivors of abuse and lesbian perpetrators experience.

I can't tell my parents... I'm just waiting until I graduate and then I can move out. Sometimes if we're watching TV, my parents will make comments when stuff comes on about lesbian or gay issues. It's pretty clear that if they ever found out, they'd kick me out of the house. I know another girl who couldn't deal with lying anymore. She told her dad, who threw all her stuff out her bedroom window and told her to leave. She's living on the street in Vancouver now.

(A Victoria youth)

Youth Issues:

Developing a positive sexual identity can be particularly challenging for lesbian adolescents because of societal homophobia, heterosexual bias in educational curriculum and a lack of role models (Solarz, 1999). Lesbian and gay youth are 2-3 times more likely to commit suicide than their heterosexual peers, accounting for 33 % of youth suicides (Feinleib in Simkin, 1993). It is estimated that up to 40% of youth on the streets are gay or lesbian, turning to the streets

after being forced out of family homes because of their sexual orientation (Remafedi et al., 1991). This places gay and lesbian youth at a high risk for addiction, mental health issues and a host of other health problems.

Aging:

Older women who partner with women must cope with invisibility: older lesbians are often assumed to be widows of heterosexual marriages or "spinsters". Cultural silence about aging and sexuality means that older women will likely not be questioned about their sexual behaviour or orientation (Rankow, 1995). Some lesbians who come out later in life risk rejection by their families, including adult children and grandchildren. Older lesbians who lose their partners grieve without societal recognition of their significant loss (Isaac and Herringer, 1998).

What We Can Do

Tips for Health Planners and Policy Makers

- Review and revise all policies, forms and patient literature to eliminate heterosexual bias and non-inclusive language. Revisit the implementation and efficacy of confidentiality policies and procedures. Change forms from "single, married, divorced or widowed" to include "same sex partnership" or provide a line for the patient to fill in their relationship status.

- Allow space for the patient to define whom they want involved in their care (i.e., leave a blank line for patients to identify an emergency contact or to identify their partner if they wish). *The British Columbia Health Care (Consent) and Care Facility (Admission)* Act provides that in cases where the patient is unable to make her own health choices, a lesbian partner can be designated by the patient to fulfill this role. This is because in the Act:

  "Spouse" means a person who

  (a) is married to another person and is not living separate and apart, within the meaning of the Divorce Act *(Canada), from the other person, or*

  (b) is living with another person in a marriage-like relationship and, for the purposes of this Act, the marriage or marriage-like relationship may be between members of the same sex.

- Form an advisory committee made up of staff, patients and members of the community to address issues of diversity. Promote grassroots involvement of lesbians in health planning and in developing appropriate strategies for outreach efforts.

- Be an ally. Challenge heterosexism and oppression of lesbians and gays wherever you see it. Homophobia in any form, and in any setting, will not end unless we each take the responsibility

for providing an alternate model of beliefs and behaviours. Simply saying, "Your language offends me" or, "I wish you wouldn't use those kinds of words around me" can make others shift their perspectives. If challenging a colleague's or patient's homophobia directly feels too risky, there are other things we can do: arrange a staff training on diversity, establish an advisory committee to address issues of discrimination or even leave an article on homophobia in the staff lounge.

Tips for Physicians and Health Care Practitioners

- Be patient-centred. Avoid making assumptions about gender or sexual identity or about sexual/health behaviours. Let the patient tell you about herself and her issues.
- Take thorough histories, using inclusive language. Ask questions about sexual behaviour, not sexual identity. Instead of asking "Are you sexually active?" try "Are you currently sexually active? If so, are you active with men, women or both?". Instead of "What form of birth control do you use?", try "Do you need to use birth control?". This opens the door for all patients to talk about their sexual histories and behaviours without fear of a negative response. Be non-judgmental in response to the information that the patient gives you.
- Ask open-ended questions to solicit information about psycho-social stressors and supports. This demonstrates sensitivity and a holistic approach to health.
- Screen for, address and treat patient concerns linked to mental health and substance use. Recognize the impact that societal oppression has on these health issues. Screen for, address and treat concerns related to abuse and violence, whether domestic, sexual or bias-related.
- Make referrals with sensitivity. If your patient has trusted you and come out as a lesbian, keep this in mind when referring to other practitioners. Try to refer to providers who are sensitive to issues of diversity.

- Let your patients know you care about diversity. Some health care providers have found that having magazines on lesbian issues in their waiting rooms or displaying a policy statement has helped lesbian patients to feel welcome.

(Tips section adapted from Tools for Change,
The Mauntner Project for Lesbians with Cancer)

For more information:

The Vancouver Women's Health Collective
(604) 736 5262

The Mautner Project for Lesbians with Cancer
(202) 332 5536
mautner@aol.com

Gay and Lesbian Medical Association
http://www.glma.org

National Gay and Lesbian Health Association (USA)
http://hpb1.hwc.ca/datapcb/datawhb/index.html

Women's Health
http://hpb1.hwc.ca/datapcb/datawhb/index.html

Bibliography

Bushway, Deborah J. (1991). Chemical dependency treatment for lesbians and their families: The feminist challenge. In *Feminism and Addiction,* edited by Claudia Bepko. New York: Haworth.

Cassidy, Roberta and Hughes, Tonda. (1995). Lesbian health: barriers to care. In *The Annual Review of Women's Health, Volume 3,* edited by Beverly McElmurry and Randy Spreen Parker. New York: National League for Nursing Press.

D'Augelli, Anthony. (1989). The development of a helping community for lesbian and gay men: A case study in community psychology. Journal of Community Psychology 17 (18): 18- 9.

Denenberg, Risa. (1995) Report on lesbian health. Women's Health International 5 (2): 81-91.

Glassman, Carol. (1995). Lesbians and HIV disease. Journal of Gay and Lesbian Social Services. 2(3\4): 61-74.

Hall, Joanne. (1992). An exploration of lesbians' images of recovery from alcohol problems. Health Care for Women International 13:181-198.

Isaac, Barbara and Herringer, Barbara M. (1998). Lesbian Pass/ages: Invisible Lives and Issues of Community. In *Gateways to Improving Lesbian Health and Health Care,* edited by Christy M. Ponticelli. New York: Haworth.

Lehmann, J.B., Lehmann, C.U. and Kelly, P.J. (1998). Development and health care needs of lesbians. Journal of Women's Health 7 (3): 379-387.

Mathieson, Cynthia. (1998). Lesbian and bisexual health care. Canadian Family Physician 44: 1634-1640.

McInnis, Anne Marie and Kong, Sook C. (1998). *Your Everyday Health Guide: A Lesbian, Gay, Bisexual and Transgender Community Resource.* LGBT Health Association. Vancouver, BC.

Messina, Susan and Zurn, Amelie. (1997). *Tools for Caring About Lesbian Health.* The Maunter Project for Lesbians with Cancer. Washington, D.C.

O'Hanlan, Kate. (1997). Homophobia and the health care system: Solutions for the future. In *The Lesbian Health Book: Caring for Ourselves,* edited by Jocelyn White and Marissa Martinez. Seattle: Seal Press.

Orzek, A. M. (1988). The lesbian victim of sexual assault: Special considerations for the mental health professional. Special Issue: Lesbianism: Affirming non-traditional roles. Women and Therapy 8 (1-2).

Rankow, Elizabeth. (1995). Lesbian issues for the primary care provider. Journal of Family Practice. 40 (5): 486-491.

Remafedi, G., Farrow, J., Deisher, R. (1991). Risk factors for attempted suicide in gay and bisexual youth. Pediatrics. 8 (6).

Rosser, Sue. (199). Ignored, overlooked or subsumed: Research on lesbian health and health care. National Women's Studies Association Journal 5 (2): 183-203.

Saunders, Judith M. (1999). Health problems of lesbian women. Journal of Emerging Nursing Care of Vulnerable Populations. 34 (2).

Scherzer, Teresa. (1998). Domestic violence in lesbian relationships: Findings of the Lesbian Relationships Research Project. In *Gateways to Improving Lesbian Health and Health Care,* edited by Christy M. Ponticelli. New York: Haworth.

Simkin, R.J. (1993). Creating openness and receptiveness with your patients: overcoming heterosexual assumptions. Canadian Journal of Ob/Gyn and Women's Health Care 5: 484-489.

Simkin, R.J. (1991). Unique health care concerns of lesbians. Canadian Journal of Ob/Gyn and Women's Health Care 5 (5).

Solarz, Andrea L. (1999). Lesbian Health: *Current Assessments and Directions for the Future.* Washington: Institute of Medicine.

Stevens, Patricia. (1998). The experiences of lesbians of colour in health care encounters: narrative accounts for improving access and quality. In *Gateways to Improving Lesbian Health and Health Care,* edited by Christy M. Ponticelli. New York: Haworth.

Stevens, Patricia, E. (1996). Lesbians and doctors: Experiences of solidarity and domination in health care settings. Gender and Society 10 (1): 24-41.

Stevens, Patricia. (1994). Lesbians' health-related experiences of care and noncare. Western Journal of Nursing Research 16 (6): 639-659.

Stevens, Patricia. (1994). HIV prevention education for lesbians and bisexual women: a cultural analysis of a community intervention. Journal of Social Science and Medicine, 39 (11): 1565-1578.

Stevens, Patricia. (1993). Health care interactions as experienced by clients: Lesbians' narratives. Communicating Nursing Research 26 (1): 93-100.

Stevens, Patricia E. and Hall, Joanne M. (1991). A critical historical analysis of the medical construction of lesbianism. International Journal of Health Services 21 (2): 291-307.

Stevens, Patricia E. and Hall, Joanne M. (1988). Stigma, health beliefs and experiences with health care in lesbian women. IMAGE: Journal of Nursing Scholarship 20 (2): 69-73.

Trippet, Susan. (1992). Reasons American lesbians fail to seek traditional health care. Health Care for Women International 13:145-153.

Vancouver/Richmond Health Board. (1997). Proceedings from the Gay, Lesbian, Bisexual and Transgender Health Conference. Vancouver.

Winnow, J. (1992. Lesbians evolving health care: cancer and AIDS. Feminist Review 41:65-68.

World Health Organization. (1946). Constitution of the World Health Organization. New York: International Health Conference.

992.PC.WB.075.0178
09/99