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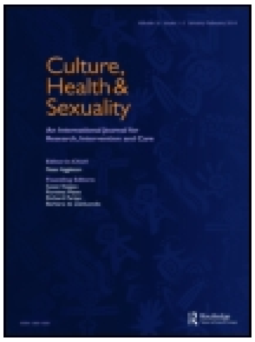

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Health and identity-related interactions between lesbian, bisexual, queer and pansexual women and their healthcare providers

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ABSTRACT
Disclosure of sexual identity among sexual minority women is related to better outcomes and improved quality of care. The existing literature on sexual minority women's experiences of identity disclosure and related interactions with healthcare providers draws little distinction between different groups of sexual minority women, despite the different barriers, stigma and health outcomes that exist between them. This paper presents factors influencing identity disclosure and describes the characteristics of interactions that sexual minority women have with their healthcare providers around sexual identity and health. Using a mixed-methods approach, both qualitative and quantitative data were gathered using an online survey. The sample included lesbian, bisexual, queer and pansexual women from across the USA. Qualitative and quantitative data were analysed concurrently, and qualitative themes were quantified and integrated into quantitative analyses. Identity disclosure, reasons for disclosing identity and characteristics of interactions with providers varied by identity, but often overlapped. Bisexual and pansexual participants were significantly less likely to disclose identity than lesbian participants. There were no significant differences related to age or ethnicity. Findings from this study have the potential to inform ethical medical practices and improve healthcare quality among sexual minority women.

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Introduction

Sexual minority individuals often have poorer mental and physical health outcomes compared to heterosexuals (Mayer et al. 2008). However, knowledge of the extent of these disparities is limited as collecting data on sexual identity in health research, while becoming more common, is not yet standard practice (Sell and Holliday 2014). Often, sexual minority women are grouped together without differentiating based on identity. As a result, health

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researchers are unable to parse potential differences between identity subgroups, making it difficult to assess which, if any, sexual minority women experience which health outcomes (Bauer and Jairam 2008).

Compared to what is known about health behaviours and outcomes of individuals who identify as lesbian, far less empirical evidence exists on the health of those with more marginalised sexual identities, including bisexual, queer and pansexual women. Given that a larger population of women identify as bisexual compared to other sexual minority identities (Gates 2011), as well as findings that bisexual women have worse health outcomes than lesbian women (Fredriksen-Goldsen et al. 2010), there is a need to address this gap in the literature. Moreover, because sexual identity labels are cultural products with different social values and attached privileges (Ault 1996), the meanings of these identity categories and their relationships to one another are not static. The landscape of sexual identity is changing, with identity categories moving away from, and indeed pushing against, a fixed-reference point of gender. As pansexual and queer[1] become more common (Rupp and Taylor 2013; Vaccaro 2009) it is important to acknowledge these identities in both research and the clinical setting.

Health disparities among sexual minority women are multiple and result from a variety of determinants. Research consistently finds lower rates of gynaecological care among bisexual and lesbian women compared to heterosexual women (Brown et al. 2015; Charlton et al. 2011; Hutchinson, Thompson, and Cederbaum 2006). Among sexual minority women, bisexuals have low STI testing rates compared to queer women, while lesbians have lower Pap and STI testing rates compared to both queer and bisexual women (Germanos, Deacon, and Mooney-Somers 2015). Beyond testing, rates of STI transmission are higher among bisexual women and lower among lesbians than among queer women (Logie, Navia, and Loutfy 2015). Importantly, these disparities are not caused by a sexual minority identity, but are often distally influenced by the stigma of minority status (Meyer 2003). While homophobia is frequently used to describe interpersonal stigmatising behaviours faced by all sexual minorities, 'biphobia' is a distinct phenomenon and these different stigmas influence groups of sexual minority women differently (Friedman et al. 2014).

Additional determinants of these disparities include access to and utilisation of care. Insurance status, income level and gender differentially structure individuals' access to healthcare, in addition to factors such as race and ethnicity, residency (rural versus urban), age and physical ability (Agénor et al. 2015; Jillson 2002). Access to care remains a significant barrier to health among sexual minority women and, even when accessible, utilisation – particularly of preventive healthcare – is low (Bonvicini and Perlin 2003). Two utilisation-related barriers to care are fear of discrimination from, and previous negative experiences with, healthcare providers (Roberts 2001; Scherzer 2000; Stevens and Hall 1988, 2001). Lesbians and bisexual women who report discrimination from their providers are less likely to seek preventative care (Rankow and Tessaro 1998). Whether this holds true for queer or pansexual individuals is unknown.

Aside from knowledge about the existence of bias and discrimination related to sexuality during interactions with clinicians, little is known about the content of these interactions, though given persistent health disparities, knowledge of a patient's minority identity is clearly clinically relevant. Disclosure of sexual identity is related not only to satisfaction with care, but to better healthcare outcomes and improved healthcare quality (Bergeron and Senn 2003; Neville and Henrickson 2006; St. Pierre 2013; White and Dull 1997), and is easily facilitated by provider-side measures, including intake paperwork, asking about identity as part of a routine visit or taking a sexual history.

Study aim

In an effort to improve healthcare quality for sexual minority women, this study aimed to extend the available literature on the experiences of sexual minority women in healthcare by exploring: (1) factors related to identity disclosure, (2) the content of clinician-patient interactions related to identity-disclosure and (3) potential differences and similarities between sexual identity groups, including queer and pansexual.

Methods

Study design

Using a mixed-methods approach, we collected both qualitative and quantitative data using an online survey instrument. Previous studies have effectively utilised online surveys with open and closed-ended items for data collection among similar populations (Schick et al. 2015), as well as treated responses to open-ended items as qualitative data (Baldwin et al. 2016; Koh, Kang, and Usherwood 2014). The study used a concurrent nested or 'within-stage mixed-model' design (Johnson and Onwuegbuzie 2004). Both qualitative and quantitative data were collected in one phase, but quantitative methods guided the project (Creswell et al. 2003).

Integration of qualitative and quantitative methods occurred at multiple points in this study: (1) during data collection through the inclusion of open-ended questions designed to address exploratory research questions on a structured instrument (Creswell et al. 2003); (2) during analysis through transforming qualitative themes into quantitative items; and (3) during the interpretation of findings, when qualitative and quantitative results were explored for convergence of findings. This iterative integration allowed us contextualise findings and offer a more nuanced picture of clinician-patient interactions, particularly around sexual health (Creswell and Clark 2007).

Recruitment

Recruitment messages directed at lesbian/gay, bisexual, pansexual and queer-identified women as well as trans and genderqueer individuals were distributed online via websites, LISTSERVS, and social networking sites (e.g., Twitter and Facebook). Organisations focused on lesbian, gay, bisexual, trans and queer health, general sexual health and other sexuality-focused issues (e.g., The Fenway Institute) were targeted for disseminating recruitment messages. Cisgender women (assigned female sex at birth who live as women) identifying as lesbian, bisexual, pansexual or queer, as well as trans and genderqueer individuals who were at least 18 years of age and US residents, were eligible to participate in the study.

Recruitment messages included a brief study description and a link to the online eligibility screener. Participants who met the eligibility requirements and consented to participate were directed into the survey. The survey took approximately 25 minutes to complete (M = 26.53, SD = 16.33). Upon completion of the survey, participants were guided to a separate online database where they could provide an email address if they wished to enter in a draw with a 1-in-15 chance of winning a US$25.00 electronic gift card. Study protocols were reviewed and approved by the Institutional Review Board of Indiana University, Bloomington.

Measures

In addition to items capturing sociodemographic data, participants were asked both open-ended and forced-response questions regarding interactions with their healthcare provider about sexuality and sexual health. We defined healthcare provider as 'the medical professional you see most often for your healthcare needs (when you get sick, when you need a health exam), your main healthcare provider.' These items included an open-ended question adapted from St. Pierre (2013), asking participants 'What kinds of things would influence your decision to tell a new healthcare provider how you identify your sexuality?' Participants were then asked a number of questions about how, if ever, they had been asked about their sexual identity or behaviour during a healthcare visit (e.g., intake paperwork, by staff members, by their provider). Finally, there were two open-ended questions through which participants were asked to tell us about an interaction with their provider about their identity that had gone well and a time when it had gone poorly.

Analysis

Statistical analyses were conducted in SPSS (Version 22) on a restricted sample of cisgender participants. Trans and genderqueer individuals were excluded from these analyses because of unique differences in identity-related interactions with their providers, which were beyond of the scope of this manuscript. Demographic characteristics are reported using descriptive statistics. Pearson chi-squares were run to determine the presence of significant group differences related to identity disclosure, followed by a binary logistic regression to examine whether sexual identity was associated with identity disclosure. Pearson chi-squares were also run to determine the presence of significant group differences related to identity and interactions with clinicians. To adjust for multiple comparisons, the Holm-Bonferroni correction procedure[2] was applied to the interpretation of data.

Open-ended items were analysed following the principles of semantic, social constructionist thematic analysis (Braun and Clarke 2006). Following a careful review of the data, the primary coder generated initial analytic codes and developed a codebook. Two coders independently coded the data and discrepancies in coding were discussed between the three coders until consensus was reached. Themes were developed from organising and refining codes and these themes were reviewed, refined and subsequently defined for presentation. Each qualitative theme was transformed into a categorical variable and added to the dataset. If participant narratives were assigned a theme in our qualitative analyses, they were coded for the variable for quantitative analyses. Again, Pearson chi-squares were conducted in order to assess group differences within open-ended descriptions of healthcare experiences; Fisher's exact test statistics are reported where frequencies were low.

Results

Sociodemographic characteristics

In all, 354 participants met the inclusion criteria for this study. Table 1 presents the sociodemographic characteristics of the sample. The mean age of the sample was 32 (age range: 18–66), with 85.4% (n = 302) of women under the age of 40. Participants who identified as bisexual (n = 107, 30.2%), queer (n = 105, 29.7%) or lesbian (n = 96, 27.1%) were nearly evenly distributed, while 13.0% (n = 46) of participants identified as pansexual. The majority of respondents were White (n = 306, 87.4%) and 46.0% had a graduate degree (n = 163).

Tests of difference (Chi-Square, ANOVA) were conducted to discern significant differences between groups related to demographic characteristics. These differences were related to ethnicity, education and age. More bisexual ($\chi^2[1] = 9.875$; $p = .002$), but fewer lesbian women ($\chi^2[1] = 7.430$; $p = .005$) were of Hispanic origin. More bisexual participants had a BA, but not an MA ($\chi^2[3] = 9.89$; $p = .020$). Finally, queer ($M = 29.66$, $SD = 10.18$, $p < .001$), pansexual ($M = 29.00$, $SD = 32.60$; $p < .001$) and bisexual ($M = 31.46$, $SD = 9.17$; $p < .000$) women were younger than lesbian women ($M = 37.08$, $SD = 11.59$; $p < .001$). No differences were detected related to income, rurality or race.

Table 1. Demographic characteristics.

Characteristics	$N = 354$	%
Age		
18–24	62	17.5
25–29	98	27.7
30–39	142	40.1
40–49	26	7.3
50+	26	7.3
Sexual identity		
Bisexual	107	30.2
Queer	105	29.7
Lesbian	96	27.1
Pansexual	46	13.0
Race		
White	306	87.4
Black	18	5.1
Asian	16	4.6
Multiracial/Other	10	2.9
Ethnicity		
Non-Hispanic	321	91.2
Hispanic/Latina	31	8.8
Education		
Less than a BA	70	19.8
Bachelors degree	120	34.0
Masters degree	117	33.1
PhD, MD, JD	46	13.0
Income (US$)		
< 25,000	78	22.7
25–39,000	55	16.0
40–54,000	49	14.2
55–84,000	73	21.2
85,000+	89	25.9
Residency		
Rural	34	9.7
Suburban	124	35.4
Urban	192	54.9

Factors influencing identity disclosure

Most participants ($n = 315$, 88.9%) provided information about factors that would influence their decision to disclose identity to a healthcare provider. Perceived relevance to the visit was the most widely acknowledged reason for disclosure ($n = 104$, 33.0%). The forms of care the participants felt were relevant were most often related to sexual and reproductive health, though mental health was also discussed. A subset of participants ($n = 38$, 12.0%), who were 'always disclosers', felt that their sexuality was necessary information for any and every provider. For example, Participant 96 discloses 'Every single time!' because 'they are treating me, and I am a lesbian every single day of my life' (44 years old, Washington). Lesbian participants were more likely to be 'always disclosers' ($\chi^2[1] = 21.68$; $p < .001$) and less likely to cite relevance to the visit or sexual health as reasons for disclosure ($\chi^2[1] = 7.96$; $p = .025$).

Simply being asked by a provider or on intake paperwork was a crucial factor for 26.9% of participants ($n = 85$). One participant explains that she would be reluctant to identify without being asked first, saying 'It would be hard for me to disclose my sexuality unless I was directly asked … and asked something more than "do you sleep with men, women, or both"' (Participant 189, queer, 25 years old, California). The language used to ask was key to disclosure for many participants ($n = 31$, 9.8%), who indicated that if a provider or a practice used inclusive language they would be more likely to disclose. If a provider were to 'ask about pronouns and partners in a gender-neutral way,' notes Participant 235 (lesbian, 30 years old, Massachusetts), she would be more likely to discuss her sexuality. Others described identifying to correct a provider's assumption of their heterosexuality. Such an assumption often occurred in situations where providers did not have any information related to the patient's sexual history or identity (for example on an intake form) or did not consult such information when it was provided. Bisexual participants were less likely than others to describe this as an influence for their disclosure ($\chi^2[1] = 4.356$; p=.045). Of the respondents, 54.3% ($n = 176$) reported never having been asked to identify on an intake form or by a staff member at their provider's office, and 74.7% of respondents reported that they had not been asked by their provider ($n = 240$).

Participants also described 'reading' the provider or the practice to determine how a disclosure would be met. In our sample, 19.4% participants ($n = 61$) described looking for 'clues' to a provider's acceptance in the physical space of the office or in their provider's behaviour. For example, if 'they had Fox News on the TV in the waiting room', Participant 321 (lesbian, 55 years old, Massachusetts) would be unlikely to disclose. Participants described reading provider attitudes to determine if they were 'open', and listening for 'code words that make me feel uncomfortable', for example 'othering language' and 'judgement about sex acts' (Participant 233, queer, 36 years old, California). Others ($n = 20$, 6.3%) mentioned that the age, gender and sexuality of their provider would influence their decision to identify. Specifically, participants described being more likely to identify if the provider was a woman, younger or lesbian, gay, bisexual, transgender or queer themselves.

There were significant differences in disclosure related to identity ($\chi^2[3] = 33.979$; 1.10, $p < .001$). Table 2 presents the results of a binary logistic regression conducted to determine whether identity was associated with disclosure. Age, race, ethnicity and provider specialty were included as covariates in the model. Compared to lesbian participants, the odds ratios suggest that bisexual participants are 6.2 times less likely to identify ($p < .001$), with a 95% confidence interval of 2.37, 15.38 and pansexual participants are 7.0 times less likely to

Table 2. Odds of not disclosing to provider.

Characteristic	Odds ratio	95%CI
Age		
18–24	3.945	0.888, 17.533
25–29	2.273	0.565, 9.140
30–39	1.604	0.435, 5.906
40–49	1.922	0.360, 10.250
50–69	–	
Race		
Black	3.548	0.865, 14.553
Asian	0.686	0.211, 2.231
Other	2.614	0.375, 18.232
White	–	
Ethnicity		
Hispanic/Latina	0.349	0.106, 1.149
Non-Hispanic	–	
Sexual identity		
Bisexual	6.040*	2.372, 15.384
Queer	1.756	0.653, 4.726
Pansexual	7.063*	2.287, 21.811
Lesbian or gay	–	
Provider type		
General Practitioner	1.448	0.757, 2.772
Obstetrician/Gynaecologist	–	
Intercept	0.076	0.021, 0.273

Note: $^{*}p < .001$

identify (p < .001) with a 95% confidence interval of 2.28, 21.81. The difference between queer and lesbian participants was not significant.

Characteristics of clinician-patient interactions

In order to better understand the characteristics of clinician-patient interactions related to sexual identity, we asked participants to tell us about a time when such an interaction went well and a time when it went poorly. Descriptions of interactions with providers that went well were provided by 56.5% (n = 200) of participants. For many (n = 66, 33.0%), an interaction went well when identity disclosure was met with a neutral response. Participants described providers who 'acted professional' or 'did not bat an eye' during these conversations. One queer participant described an interaction with a women's health nurse practitioner who 'was not judgemental or *confused* about the fact that I … have sex with people of more than one gender … I didn't feel judged or like I had to explain about my identity or behaviours' (Participant 41, 32 years old, New York).

While some desired little to no reaction from their providers, others (n = 27, 13.5%) described an interaction having gone well when their clinician explicitly acknowledged their identity and responded positively:

> I explained my female partner and I are getting married and considering having a child but I had concerns about my age. My provider congratulated me, asked about our wedding, told me she was very happy that all people can marry now and … made a referral for a fertility specialist and encouraged us to also consider adoption because we will be great parents. (Participant 37, lesbian, 39 years old, Oregon)

Participants felt validated when providers showed such support, including when they allowed partners to accompany them during the visit. Lesbian participants were more likely to describe these experiences as having gone well ($\chi^2[1] = 10.42$, $p = .007$),

Participants also characterised an interaction as having gone well when the provider demonstrated knowledge of lesbian, gay, bisexual, transgender and queer-specific health issues, particularly around sexual health and safety ($n = 23$, 11.5%). This was significant for queer participants ($\chi^2[1] = 7.51$, $p = .048$). One participant described a visit during which, after explaining that she had female sex partners, she was 'offered relevant protection like dental dams and gloves in case I wanted them' (Participant 87, queer, 29 years old, Indiana). Another participant noted that it is 'a bonus is if they [the provider] can offer queer-specific information to me' (Participant 61, queer, 27 years old, Washington). Among our sample, 7.5% of women ($n = 15$) described conversations about sexual health that went beyond discussing STI risk as having gone well. And, just as the use of inclusive and gender-neutral language was a factor influencing disclosure, it was also a characteristic of a positive interaction with no significant differences related to identity.

Finally, several participants ($n = 22$, 11%) indicated that almost all of their interactions go well because they are able to navigate into care they know will be accepting, for example at 'a feminist health care collective that specifically deals with LGBTQ-identified folks' (Participant 57, queer, 21 years old, Illinois).

The ability to choose between multiple providers and access a community of individuals who can make recommendations evince differences in socioeconomic status and other markers of privilege that exist within groups of sexual minority women. One participant recognised such a position of privilege, saying that with her providers 'I've been supported and been able to talk frankly about it, it's never been an issue. I am also White, well-off, and cisgender, and have lived in well-off and liberal neighbourhoods near universities' (Participant 254, bisexual, 34 years old, Washington). Being able to access this kind of care was significant among queer participants ($\chi^2[1] = 8.66$ $p = .003$), who described utilising their social networks, living in lesbian, gay, bisexual, transgender and queer-friendly regions of the country and having access to lesbian, gay, bisexual, transgender and queer or feminist health centres.

A smaller number of participants ($n = 105$, 29.6%) provided accounts of interactions that went poorly. These interactions exist on a continuum from heteronormative – wherein heterosexuality is structured as a social norm and patients are assumed heterosexual – at best, to heterosexist – in which a cultural ideology of sexual stigma against nonheterosexuality is reproduced within the clinical interaction, including derogatory or discriminatory comments about a patient's sexuality – at worst (Herek 2004). The assumption of heterosexuality was described by 24.7% of participants ($n = 26$), and correcting this assumption was a common experience participants described as having gone poorly ($n = 18$, 17.1%). Being presumed to be straight was more likely to be described in this context by queer-identified participants ($\chi^2[1] = 11.83$, $p = .001$). Importantly, this was named as a frustration by patients who had supplied the practice with the information on their intake paperwork or who had been a patient at the practice before.

Providers' assumptions of heterosexuality were often accompanied by an assumption of carelessness regarding birth control, which was reported by 20.9% ($n = 22$) of participants. One participant provided an account of such an experience, saying:

> At a first visit with a new-to-me GYN, I was asked [about my] sexual history. She asked about number of partners and use of protection, but nothing about gender of partners. I got a 10-min

> lecture about why it was important that I start taking birth control, because I wasn't on it and I reported that I didn't use protection with my partner. When I was finally able to break in, I explained why I didn't really need birth control … she was a little taken aback. (Participant 130, queer, 36 years old, Georgia).

While lesbian participants were more likely to describe receiving 'lectures' about pregnancy and birth control ($\chi^2[1] = 8.03$, $p = .025$), this experience was described by participants of all sexual identities. Women who reported these interactions described feeling that providers regarded them as untrustworthy and irresponsible, though bisexual participants less frequently described such interactions ($\chi^2[1] = 7.11$; $p = .018$).

Beyond a lecture, participants also reported being made to take pregnancy tests despite indicating no history of penile-vaginal intercourse or not having a sex partner they could become pregnant with ($n = 6$, 5.7%). Participant 57 described an interaction with a nurse who 'forced me to get a pregnancy test, despite the fact that I told her my partner was trans identified/didn't have sperm, and therefore couldn't get me pregnant' (Participant 57, queer, 21 years old, Illinois). Even when seeking care for issues completely unrelated to reproductive health, some participants reported having to take a pregnancy test before receiving care. One participant described an interaction like this, saying 'No matter how often I said 'there is no possibility that I am pregnant. I am here because my foot hurts,' she refused to look at my foot and kept insisting on a pregnancy test' (Participant 144, bisexual, 29 years old, New York).

Participants also reported having their sexuality dismissed by a healthcare provider ($n = 15$, 14.2%) or having phobic comments directed at them ($n = 7$, 6.7%). One participant was told by her health provider that bisexuality and pansexuality 'are not true sexualities and are just simply experimentation' (Participant 92, pansexual, 24 years old, Indiana). Another participant's provider 'insisted I receive treatment for my "same-sex attraction"' (Participant 161, pansexual, 27 years old, Washington).

Whereas possessing specific knowledge about sexual health made for interactions that went well, 12.4% ($n = 13$) of participants described interactions with practitioners who lacked knowledge on sexual health as having gone poorly. These interactions involved discussions related to sexual health wherein providers fundamentally misunderstood the myriad possibilities for what 'sex' might mean outside the heterosexual context (Sanders et al. 2010). For example, participants described interactions with providers who could not conceive of how a woman could be sexually active with no risk of pregnancy, or who responded to the disclosure of one lesbian participant by saying 'Oh, I'll put you down as not sexually active' (Participant 321, lesbian, 51 years old, Massachusetts). Other participants ($n = 15$, 14.2%) reported that often, with very little to no information about their sexual behaviours or sexual safety methods, providers would assume they were either at increased risk of STI or no risk of STI because of their identity.

Discussion

This study of sexual minority women in the USA found that identity disclosure to providers, factors that influence disclosure, and clinician-patient interactions related to identity vary between groups of sexual minority women, but often overlap. Our results contribute specificity to the field, as much of the existing research among sexual minority women relies on undifferentiated samples (Mosack, Brouwer, and Petroll 2013; Polek, Hardie, and Crowley

2008). Understanding the factors that influence disclosure provides direction for improving patient-clinician communication.

An important factor prompting disclosure among our sample was being asked by their provider. Unfortunately, consistent with previous research finding that practitioners are often reluctant to ask patients about their sexual orientation (McNair, Hegarty, and Taft 2015), a large number of our participants indicate never having been asked about their sexual identity. As well, commensurate with previous research, lesbian participants in our study were more likely to disclose than bisexual or pansexual participants (Durso and Meyer 2013). This difference may result from the relative acceptability of lesbian identity compared to other sexual minority identities, as heterosexual, homosexual and bisexual have achieved the status of 'natural kinds' (Vrangalova and Savin-Williams 2012, 85).

The salience of sexuality to participants' self-identities could also explain differences in disclosure. A previous study on sexual minority women found that the centrality of sexual orientation to one's identity is related to disclosure. None of the bisexual women in this study sample were 'identity-defined', in contrast to the lesbian participants who were frequently identity-defined (McNair, Hegarty, and Taft 2012). Further, research has found that bisexual individuals are more likely than lesbian or gay individuals to feel uncomfortable when accessing health services because of their identity, and this discomfort may inhibit disclosure (Browne, Bakshi, and Voss 2014). As disclosure is related to improved satisfaction and health outcomes, lack of disclosure among pansexual and bisexual participants may signal continued poor health outcomes and less satisfaction with care (Bergeron and Senn 2003; Durso and Meyer 2013; Stein and Bonuck 2001). Similar to the findings of a previous study (Saulnier 2002), lesbian participants in our sample were more likely to describe a positive response to identity disclosure as an interaction that went well, and this too is likely related to the salience of their sexual identity.

We found that bisexual women were less likely to disclose to correct an assumption of heterosexuality, or to report provider's 'lectures' about birth control as going poorly. Such interactions may not be interpreted as particularly problematic by participants for whom birth control and pregnancy are more relevant issues because of the possibility of other-sex partners, though sexual minority women, regardless of identity, may have other-sex partners (Bailey et al. 2003). Queer participants were more likely than others to describe a provider's assumption of their heterosexuality as an interaction that went poorly. Such a finding is unsurprising given the rejection of heteronormativity embedded within queer sexual identification. No statistical difference emerged in clinician-patient interactions related to pansexual identity after correcting for multiple comparisons. Nevertheless, their inclusion in the sample contributes to the sparse literature on pansexuality.

Our findings suggest two ways of improving healthcare for sexual minority women. The first is drawn from the importance of shared values, such as social philosophy and political persuasion, in developing the clinical relationship (Lawlor and Braunack-Mayer 2004; Veatch 1991). Being asked was the second most frequently named factor in disclosure decisions, and the very act of asking patients questions about sexual history or identity can demonstrate that a clinician is open to their sexual minority patients (Althof et al. 2013, 31). Also, participants described listening for gender-neutral language and reading the physical space of the practice and mannerisms of the physician to gauge how their disclosure would be met. Other studies have found similar influences on identity disclosure (St. Pierre 2013; Wilkerson et al. 2011). By providing the means for disclosure that clearly indicates their acceptance of sexual diversity, clinicians can facilitate disclosure for those who are passive rather than active disclosers (Koh, Kang, and Usherwood 2014). A previous study (McNair, Hegarty, and Taft 2015) on clinical interactions with a similar population provides a number of suggestions to facilitate identity disclosure, including direct questions about the matter as well as demographic questions that may clarify a patients' sexuality for their provider. We agree with the strategies, and suggest including an open-ended question for identity disclosure on in-take forms coupled with provider-facilitated discussion.

The concept of shared values helps contextualise interactions that went well. Many queer participants noted that they always had positive interactions because they had access to providers who shared their 'feminist' or 'LGBTQ-friendly' values. Responding positively to a patients' identity and understanding their sexual and reproductive health demonstrates the value that providers have for diverse sexuality (Lawlor and Braunack-Mayer 2004). Clinicians can demonstrate the value they place on sexual diversity by exhibiting better informed and more holistic understandings of sexual health. Moreover, because sexual minority patients more frequently disclose when their healthcare visit is related to sexual or reproductive health (Eliason and Schope 2001), formal medical training and continuing medical education need to better equip providers with knowledge of the sexual repertoires, behavioural possibilities and sexual health needs of sexual minority women.

The second basis for improving care is drawn from the emphasis on professionalism. The negative interactions we documented resulted from omissions of professional responsibilities by clinicians. As outlined in the *Physician Charter* (American Board of Internal Medicine Foundation 2002), which sets standards for ethical medical behaviour, these responsibilities include two which we contend are areas for improving interactions. The first, a commitment to professional competence, tasks physicians with maintaining the knowledge and skills necessary for the provision of quality care. The second, a commitment to improving access to care, tasks physicians with reducing barriers to equitable care within the healthcare systems (ABIM 2002). Other clinicians, including advance practice nurses and nurse practitioners, have similar professional responsibilities (American Nurses Association 2015).

The frequency with which participants reported the assumption of their heterosexuality, often during a pregnancy and STI risk-assessment, demonstrates lack of knowledge and skill in the provision of quality care and inhibits the clinician-patient relationship (McNair, Hegarty, and Taft 2015). Frequently in our study, patients were asked 'Are you sexually active?' and then 'Are you on birth control?' A 'yes' to the first question and a 'no' to the second led to assumptions of heterosexuality, unprotected penile-vaginal intercourse and risk of pregnancy. The structure of this interaction led providers to regard their sexual minority women patients as irresponsible, and, in the words of multiple participants, 'lecture' them about birth control. Such heteronormativity leads to poor interactions with providers (Fish and Bewley 2010; Saulnier 2002), exemplifies one of the social processes involved in compulsory heterosexuality (Rich 1980) and confirms the necessity of providing patients the opportunity to establish, when necessary, both identity and behaviour. Knowledge of sexual health and history are foundational components of ethical medical care for sexual minority women. The findings from this study, coupled with previous research, demonstrate the necessity of prioritising collecting information on the sexual identity and sexual history of patients, and the responsibility of providers to ask these questions (Power, McNair, and Carr 2009).

Further, recent research finds that young sexual minority women are at greater risk of unplanned pregnancy than heterosexual women (Lindley and Walsemann 2015). These findings underscore the need to alter the ways in which contraception and sexual safety issues are addressed, as it is a pressing health issue and a hallmark of negative interactions with providers. In changing how these questions are asked, clinicians can demonstrate their commitment to professional competence.

It must be said that disclosure of sexual minority identity may not be necessary in every clinical setting and may even be detrimental to care, as exemplified by our participant's interactions that went poorly. We maintain that in many situations this knowledge can enhance the clinical relationship and the provision of care, but risk to patient must be considered within the context identity disclosure (McNair, Hegarty, and Taft 2012, 2015). It is counterproductive for providers to elicit the information if the disclosure is met with bias. Experiences of phobic treatment and microaggressions within the clinical interaction point to the need for medical education to acknowledge and alter provider biases (Bostwick and Hequembourg 2014). Healthcare providers are trained within a system shaped by cultural norms, and the systemic exclusion of lesbian, gay, bisexual, transgender and queer healthcare education in medical curricula results in providers who lack knowledge crucial to patient care. The organisations responsible for educating medical providers shoulder responsibility in addressing these issues through culturally competent curricula (Hollenbach, Eckstrand, and Dreger 2014).

Finally, while holding providers to a high standard of professionalism is one way to improve the quality of care, it insufficiently addresses systemic bias within the healthcare system (Johnson, Mimiaga, and Bradford 2008). Focusing solely at the provider or clinician-level does little to address treatment that occurs due to policies that mandate, for instance, pregnancy tests regardless of a patient's sexual behaviour. As managed-care becomes the standard model of healthcare delivery, enhancing the clinician-patient relationship is supplanted by an expectation of increased labour productivity and providers have less autonomy in the provision of care (Gabe, Bury, and Elston 2004; Numerato, Salvatore, and Fattore 2012).

Our findings should be considered alongside the limitations of the study. Despite an effort to recruit a racially, ethnically and socioeconomically diverse group of participants, our sample is limited by homogeneity. The makeup of our sample was certainly influenced by our methodology, as online surveys oversample White and highly educated people (Andrews, Nonnecke, and Preece 2003). However, in a population-based survey of the demographic makeup of lesbian, bisexual and gay adults, the sample was younger, more frequently White and had more formal education than the US adult population (Herek et al. 2010). As we were not establishing population parameters, our online survey tool was useful in allowing us to access an often hidden population (Meyer and Wilson 2009). Further, the nature of our survey tool, an anonymous questionnaire with open-ended questions, meant that we were unable to probe participants for clarification. Additionally, as this is cross-sectional data, results might be subject to recall bias and we cannot be certain of the directionality of the relationship between sexual identity and disclosure.

Conclusion

Taken together, our results support increasing educational opportunities around the different sexual health needs of diverse groups of sexual minority patients to ensure that clinicians have the knowledge and skills required to provide quality care. Our results also support reconsidering the standard operating procedure for determining if a patient is pregnant or at risk of STI that is respectful of their sexual identity and behavioural history. Finally, our results further support including sexual identity and behaviour disclosure opportunities on intake forms using gender-neutral language.

Notes

1. Pansexual indicates attraction to people of all genders or that attraction is not determined by gender. Queer challenges the traditional heterosexual/homosexual/bisexual paradigm, often used to trouble assumptions of sexuality. Distinct from queer sexual identity, genderqueer is a label used to identify one's gender outside of the binary gender system.
2. The Holm-Bonferroni method is a sequentially rejective multiple test procedure with multiple-level significance alphas dependent on the number of statistical comparisons and their rank order (Aickin and Gensler 1996; Holm 1979).

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