

# Doctoring gay men

*Exploring the contribution  
of General Practice*

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**Research Report**

# Acknowledgements

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Our greatest debt is owed to the men who took part in these studies. In 2003, 14,551 men resident in England, Wales, Scotland and Northern Ireland took part in the *Gay Men's Sex Survey*, and a further 41 were interviewed in-depth about their experiences of health service utilisation. Without their willingness to share their experiences so honestly with us, research like this would not be possible.

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# Contents

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<b>1.</b>	<b>Introduction</b>	<b>1</b>
1.1	Research background	1
1.2	Policy background	2
1.3	Quantitative survey methods	3
1.4	Quantitative survey sample demographics	4
1.4.1	Area of residence	4
1.4.2	Ethnicity	4
1.4.3	Migration and length of residence in the UK	5
1.4.4	Age	6
1.4.5	Formal education	6
1.4.6	HIV testing history	6
1.5	Qualitative survey methods	6
1.6	Qualitative sample demographics	7
<b>2.</b>	<b>Quantitative survey</b>	<b>8</b>
2.1	Health service utilisation	8
2.2	Registration with a GP practice	9
2.3	Disclosure to staff at GP surgery	9
2.4	Reason for last visit to a GP	11
2.5	Service acceptability	12
2.5.1	Acceptability of last visit by disclosure to GP	12
2.5.2	Acceptability of last visit by reason for visit	13
2.6	Demographic variation	14
2.6.1	Variation by area of residence	14
2.6.2	Variation by ethnic group	15
2.6.3	Variation by length of residence in the UK	15
2.6.4	Variation by age group	16
2.6.5	Variation by formal education	17
2.6.6	Variation by HIV testing history	17
2.7	Factors associated with sexual health being reason for last GP visit	18
2.7.1	Using a GP surgery for a sexual health check-up	18
2.7.2	Using a GP surgery for HIV testing	19
2.8	Summary	20

<b>3.</b>	<b>Gay men's relationships with their GP</b>	<b>21</b>
3.1	Choosing a GP practice	21
3.2	Environment and atmosphere of the practice	22
3.3	Roles of GPs	23
3.4	Relationship with the GP: men with no medical conditions	24
3.5	Relationship with the GP: men with long-term illness (not HIV)	25
3.6	Relationship with the GP: men with diagnosed HIV infection	27
3.7	Discussion	29
<b>4.</b>	<b>Disclosing sexual identity to a GP</b>	<b>31</b>
4.1	Men with no medical conditions	31
4.2	Men with long-term illness (not HIV)	35
4.3	Men with diagnosed HIV	38
4.4	Discussion	40
<b>5.</b>	<b>Presenting to the GP with sexual health symptoms</b>	<b>41</b>
5.1	Men with no medical conditions	41
5.2	Men with long-term illness (not HIV)	46
5.3	Men with diagnosed HIV	49
5.4	Discussion	51
<b>6.</b>	<b>Conclusions and recommendations</b>	<b>52</b>
6.1	Talking about being gay in clinical settings	52
6.2	A gay GP or a good GP?	54
6.3	Sexual health promotion in General Practice	55
	<b>References</b>	<b>56</b>

# 1 Introduction

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Primary care is the first point of contact with the NHS for many people. It includes services provided outside hospitals by general practitioners, practice nurses, community nurses, health visitors, dentists, opticians, pharmacists *etc.* This report is concerned mainly with gay and bisexual men's experiences of, and interactions with General Practice (GP) surgeries. Two concerns prompted this research. First, research which continually indicates that men are less likely to access primary care services than women (Lloyd & Forrest 2001; Manfield *et al.* 2003) which contrasts with unreported findings from our *Gay Men's Sex Survey* (henceforth GMSS) revealing relatively high uptake of primary care services among gay and bisexual men. Second, recent government policy (Department of Health 2001; 2002; 2003a; 2003b) has sought to increase the role of GP staff in delivering sexual health services.

This report addresses three main questions. First, what are the patterns in usage of GP and other health services among gay and bisexual men across the UK? Second, what factors mediate their use and disclosure of their sexuality to their GP? Finally, what factors need to be taken into account when we consider the GP surgery as a site for sexual health services? This research not only investigates the various ways in which gay and bisexual men regard their relationships with their doctors and other General Practice staff, but also examines the many barriers to direct communication about sexuality in GP surgeries.

In this chapter, we provide an overview of the main policy developments and research regarding gay men and GPs. We also include a presentation of our research methods and the demographics of our two samples.

## 1.1 RESEARCH BACKGROUND

The health inequalities debates of the 1980s (Department of Health 1980; Wilkinson 1986) gave rise to a body of academic and practice-oriented literature which examined the different ways men and women interacted with health promotion interventions (Hunt & Annandale 1999). Much attention was paid to the percentages of men registered with and attending GP surgeries (Lloyd & Forrest 2001; [www.menshealthforum.org.uk](http://www.menshealthforum.org.uk); [www.workingwithmen.org](http://www.workingwithmen.org)). Other work explored how differences in health-seeking behaviour lead to poorer health outcomes for men at a population level (O'Dowd & Jewell 1998; Toerien & Durrheim 2001; Khadra & Oakeshott 2002; Manfield *et al.* 2003; Wilkins & Baker 2004). While women are socialised in an environment which encourages them to seek help, submit to medical surveillance and discuss their health with each other (Harding 1997; Bendelow 2000; Bush 2000), men tend to demonstrate traditional individualised masculinity by disregarding risk, pain and illness (Cameron & Bernardes 1998).

Research about the health needs and behaviours of gay and bisexual men demonstrates that health inequalities are likely to exist between gay men and adult men generally, for example, in terms of rates of alcohol and drug use, smoking and psychological morbidity (see D'Augelli 2004; Green 2003; King *et al.* 2003). Moreover, qualitative research into gay men's use of and attitudes towards General Practice in the UK (Cant 1999; Webb 1999) establish a number of dominant themes including difficulties around disclosure of sexuality. Research conducted in the UK has demonstrated that between 41% and 44% of gay men have not disclosed their sexuality to their GP (Wadsworth & McCann 1992; Fitzpatrick *et al.* 1994; Webb 1999). It has been suggested that such non-disclosure indicates gay men's lack of trust in their GP (Bains & Cross 1997; Scott 1998), usually based on concerns about how information is recorded in medical notes and the uses to which it is put (for example whether or not it is made available to financial institutions or employers). In a smaller number of cases, men fear a negative response from their doctor.

Poor communication about sex and sexuality between gay men and doctors in a General Practice environment has negative outcomes. First, an opportunity to intervene in sexual risk behaviour relating to HIV and STI exposure is missed where discussion of sexual behaviour is absent (that is, while the vast majority of gay men use their GPs, many also access sexual health services through genito-urinary medicine (GUM) clinics). Second, poor communication and lack of disclosure may make gay and bisexual men feel that their sexuality is an outlawed aspect of their identity within the General Practice setting. This 'homosceptic' (Cant 1999) environment contributes to the development of a conviction among gay patients that gay sexuality is somehow distinct from experiences of health, illness and well-being. Thus the opportunity to discuss factors such as relationship concerns, bereavement, drug and alcohol use, or a host of other health issues related to sexual identity is absent. With such significant barriers to an individual's capacity for open and honest communication with his doctor, it is argued that gay men (and lesbians) do not 'seek needed preventive screening tests and other early interventions, or delay seeking treatment for acute health conditions – thus exacerbating acute and chronic conditions' (Jillson 2002: 155). Ultimately this results in unequal access to quality primary health care for gay and bisexual men and other sexual minorities, as large numbers feel unable to share important lifestyle and sexual health issues with their health providers.

Research concludes that despite the continued assertion that sexual identity is key to gay men's health (sexual or otherwise) and hence their care in General Practice contexts (Webb 1999; Cant 1999; Matthews & Fletcher 2001), doctors frequently feel that such issues are best dealt with elsewhere. International research findings indicate that doctors lack confidence in their own skills to deal with matters of sex and sexuality adequately, fearing that enquiries will only embarrass the patient (Bluespruce *et al.* 2001). Yet Australian research indicates that patients would be happy to discuss sexual health at the GP surgery if their doctor initiated the conversation (Ward & Sanson-Fisher 1995). Thus, doctors miss the opportunity to discuss sexual risk behaviours with those subsections of the population most likely to be involved in HIV exposure and existing sexually transmitted infections remain undiagnosed (Ward & Sanson-Fisher 1995). Apart from strict consideration of clinical morbidity, the situation amounts to a denial of sexuality and sexual health in the General Practice context.

Partly in response to such research, a number of documents have emerged in the UK on sexual health in primary care, both for the general patient population and for gay and bisexual men in particular. These take two forms: academic-style texts and research reports on the factors contributing to the success (or lack thereof) of sexual health interventions in the GP context (Curtis *et al.* 1995; Jewitt & Bonell 1995; Carter *et al.* 1998; Cant 1999; Webb 1999) and resources – such as training packs – which contain practical advice about developing the sexual health role of GP surgeries (Bains & Cross 1997; Levy 1997; Scott 1998; Adams 2001). Most of this literature is focussed around adapting the behaviours and concerns of practice staff in relation to sex while broadening the range of sexual discourses and interventions that are deemed acceptable in the General Practice setting.

## 1.2 POLICY BACKGROUND

In the past three years, England's Department of Health (DoH) has issued several policy documents concerned with NHS sexual health and HIV services (Department of Health 2001; 2002; 2003a; 2003b).

The *National strategy for sexual health and HIV* (DoH 2001) lists a number of elements of sexual health service that "current good practice recommends should be available in every GP setting". Termed 'level 1' services, for men they include: sexual history taking and risk assessment; HIV testing and counselling; assessment and referral of men with STI symptoms; and hepatitis B immunisation. The strategy recommends remedial action on the currently inconsistent provision of sexual health services by gradually building the sexual health capacity of primary health care teams in terms of skills, access, standards and the improved availability of training and education.

The strategy's subsequent *Implementation action plan* (DoH 2002) undermined any expectation that all 'level 1' services should be provided straightaway by all General Practices. It stressed instead that the priority should be to ensure that the "local community" has ready access to sexual health services through a range of appropriate settings, including General Practice, family planning and GUM clinics. The stated aim became to develop and modernise sexual health services within primary care, over time.

Further government guidance emerged within *Effective commissioning of sexual health and HIV services* (DoH 2003a) which set out a ten-year plan for the implementation of the original strategy. It suggests primary care practices should negotiate the pace of change with primary care trusts (PCTs) and aim towards providing the full range of 'level 1' elements, which will also be available on a self-referring basis from 'dedicated' sexual health providers.

Underpinning these recommendations was the notion that accredited *General Practitioners with Special Interest in Sexual Health* would be available within PCTs to provide specialist sexual health services within GP settings. Yet in a brief guidance document (DoH 2003b) about this accreditation process, the impression is given that all GPs were currently expected to be providing 'level 1' service. This position is reconfirmed in a recent review of the new GMS contracts that will apply to the majority of general practitioners in England (Independent Advisory Group for Sexual Health & HIV 2004: 7) that states these 'essential' services must be provided by contracted GPs. Similar to the *Implementation Action Plan* (DoH 2002) and the *Commissioning Toolkit* (DoH 2003a), this review mentions that the resource and training needs of staff to deliver such services will have to be addressed, but unlike these earlier documents, the newsletter of the Independent Advisory Group (2004) implies that service delivery expectations are immediate and that skills development is a priority rather than a longer-term goal. Ultimately, the confused and conflicting positions reflected across these documents mean that the role of the individual GP in sexual health provision for the entire population – including gay and bisexual men – remains unclear.

### 1.3 QUANTITATIVE SURVEY METHODS

The quantitative data reported in chapter 2 is taken from the *Gay Men's Sex Survey 2003*. The survey was carried out during the summer of 2003 by Sigma Research in partnership with 150 health promotion agencies across the United Kingdom. This report complements the main report from the 2003 data (Reid *et al.* 2004) and data from previous surveys (Hickson *et al.* 2003; Reid *et al.* 2002; Hickson *et al.* 2001; Weatherburn *et al.* 2000; Hickson *et al.* 1999; Hickson *et al.* 1998).

The *Gay Men's Sex Survey* uses a short self-completion questionnaire to collect a limited amount of information from a substantial number of men. The questionnaire was produced as a small (A6) booklet which was self-sealing for Freepost return. In 2003, 36,904 copies of the booklet were directly distributed to gay men and bisexual men by 139 HIV health promotion and gay agencies. Recruitment was open for a four month period (July to October 2003). Booklets were returned stamped by 68 different agencies. The average (median) number of booklets returned per agency was 14 (range 1 to 310).

Overall, 3,909 booklets were returned via Freepost to our offices, giving a completion and return rate of 10.6% of those booklets that we distributed to agencies. 4.1% of these booklets were excluded from analysis because the respondent was not UK-resident, did not have sex with another man in the last year – and did not intend to in the future – or was under 14 years of age.

Recruitment to GMSS also occurred via the internet. The questionnaire was available for completion on-line via a specific website <[www.sigmasurvey.org.uk](http://www.sigmasurvey.org.uk)>. The existence of the on-line version was substantially promoted by two major gay commercial internet service providers – and 27 community and health promotion web-sites. The web version was available for completion online for four months (July to October 2003). During these four months we received 12,716 responses. 15% of responses were excluded from analysis because the participants were not UK-resident, did not have sex with another man in the last year – and did not intend to in the future – or were under 14 years of age.

## 1.4 QUANTITATIVE SURVEY SAMPLE DEMOGRAPHICS

This section describes the sample of 14,551 men resident in England, Wales, Scotland and Northern Ireland. For a comparison of demographic variables by recruitment source see the main report for 2003 (Reid *et al.* 2004).

### 1.4.1 Area of residence

First we consider where men lived. Men were asked which country they lived in, and if they lived in the UK, which Local Authority they lived in. For regional comparisons in this report we use seven large geographic areas: four English Health and Social Service Directorates, also Wales, Scotland and Northern Ireland. Our website contains downloadable data reports that give summary findings for smaller geographic units.

Area of residence	No. of men	% of all men
<b>Northern Ireland</b>	<b>340</b>	<b>2.3</b>
<b>Wales</b>	<b>568</b>	<b>3.9</b>
<b>Scotland</b>	<b>1042</b>	<b>7.2</b>
<b>England</b>	<b>12601</b>	<b>86.6</b>
London	3434	23.6
North (England)	2819	19.4
South (England)	2649	18.2
Midlands & Eastern (England)	2636	18.1
Directorate unknown (England)	1063	7.3
<b>Totals</b>	<b>14551</b>	<b>100.0</b>

### 1.4.2 Ethnicity

Men were asked *What is your ethnic group?* and allowed to indicate one of the 16 options replicated from the 2001 UK Census (Office of National Statistics 2003). *Other* answers were allocated to categories according to Office of National Statistics instructions. Full details of the ethnic origins of the questionnaire sample are available elsewhere (Reid *et al.* 2004).

For group comparisons in the rest of this report we use six groups: Asian / Asian British; Black / Black British; White British; White other; mixed ethnicities; and other ethnicities (including Chinese). Categories are collapsed as follows : Black African (38), African-Caribbean (91) and any other Black background (17) to Black or Black British; Indian (163), Pakistani (6), Bangladeshi (2) and any other Asian background (28) to Asian or Asian British; and White Irish (509) and any other White background (997) to White other.

Ethnic group (n=14,498)	% (n)
<b>White British</b>	84.0 (12177)
<b>White Other</b>	10.4 (1506)
<b>Mixed</b>	1.9 (270)
<b>Other ethnic group (inc Chinese)</b>	1.4 (200)
<b>Asian or Asian British</b>	1.4 (199)
<b>Black or Black British</b>	1.0 (146)

### 1.4.3 Migration and length of residence in the UK

All men were asked both which country they were born in and, if they were born outside the UK, how long they had lived in the UK. While 88% of all men were born in the United Kingdom, 114 countries of birth were listed overall. For the purposes of this report countries of birth (outside the UK and Republic of Ireland) have been re-coded to continents, with North and South America kept separate. Further detailed analysis of these data is available in Reid *et al.* (2004)

Country/continent of your birth (n=14,470)		No. of men	% of all men
UK	England	10401	72.3
	Scotland	1220	8.5
	Wales	659	4.6
	Northern Ireland	441	3.0
Elsewhere	Republic of Ireland	168	1.2
	Europe	562	3.9
	Africa	256	1.8
	Asia	241	1.7
	North America	206	1.4
	South America	59	0.4
	Oceania	177	1.2

On average, migrants to the UK had lived in the UK for 7 years (median 84 months, range 1 to 699 months). Men born in the Republic of Ireland had lived in the UK longest (median 122 months, range 2 to 576 months) and men born in South America had been resident in the UK the shortest time on average (median 63 months, range 2 to 577 months). The table below shows the number of years men had lived in the UK, broken down into four time periods.

Time living in the UK by Country / continent of birth	% less than 1 year	% 1- 3 years	% 4 – 10 years	% over 10 years
Republic of Ireland	8.3	12.5	28.6	50.6
Europe	6.1	12.7	41.6	39.6
North America	15.3	17.2	26.1	41.4
Africa	8.6	18.8	34.8	37.9
Asia	10.8	16.7	33.8	38.8
South America	8.5	23.7	47.5	20.3
Oceania	14.1	15.8	39.0	31.1
<b>Overall</b>	<b>9.4</b>	<b>15.5</b>	<b>36.1</b>	<b>39.0</b>

Overall, a quarter of men born outside the UK, had been resident in the UK less than three years (9.4% less than a year, 15.5% for 1-3 years). Men from North America and Oceania were most likely to have migrated to the UK in the last year. Men from South America were the most likely to have migrated to the UK in the last 3 years (32.2%) and were least likely to have lived in the UK for over 10 years.

#### **1.4.4 Age**

The average (mean) age of the whole sample was 33 years (standard deviation (sd) = 11.5, median 31, range 14 to 90). While a very wide age range was recruited, half were aged between 24 and 40.

#### **1.4.5 Formal education**

Men were allocated to one of three groups on the basis of their highest educational qualification. Those with no qualifications (4.8%) or O-levels / CSE / GCSE (20.2%, usually leaving education at 16) were classified as having *low* educational qualifications. Those who indicated a degree or greater (44.3%) were classified as having *high* educational qualifications. Most of the remaining men were classified as having *medium* (30.6%) educational qualifications, including all those with A-levels or equivalent (22.7%) and the majority of those with *other* qualifications (7.9%).

#### **1.4.6 HIV testing history**

Men were asked, *Have you ever received an HIV test result?* and were given three possible answers (*Yes, I've tested positive; Yes my last test was negative; and No, I've never tested for HIV*). Overall, 6.3% had tested positive, 49.6% tested negative and 44.1% had never tested for HIV.

### **1.5 QUALITATIVE SURVEY METHODS**

The qualitative data presented in chapters 3 to 5 was generated from in-depth interviews with a sample of 41 gay and bisexual men.

The recruitment process was complex. Recruitment was controlled along the following demographic variables: residence (half residing in London and half residing in Wakefield or Leicester); age (equal distribution over five age bands – under 20s, 20s, 30s, 40s, over 50s) and health status (a third with no medical conditions, a third with a long-term medical condition other than HIV and a third with diagnosed HIV).

In all, 41 gay and bisexual men who were currently registered with a GP were recruited from two sources. First, men who completed GMSS 2003 on-line were invited to take part in qualitative research by means of a link at the end of the survey. Men who were interested were directed to a further, short, qualifying questionnaire, which if they qualified, was sent direct to Sigma Research. Second, CHAPS partner agencies in Leicester and West Yorkshire were approached to recruit into specific sub-groups of gay men. All respondents were paid £20 cash for their participation which consisted of a one-off face-to-face interview.

A limited reflexive methodology was used in the design and administration of interviews. A focus group was convened to inform the design of a semi-structured interview schedule. Focus group participants (six in all) were recruited through the internet version of GMSS 2003. The interviews were conducted by three trained interviewers who met regularly to discuss the content of the schedule and to debrief. The schedule was regularly revised as a result of these discussions. Interviews lasted between one and two hours. With the consent of respondents they were audio tape-recorded and fully transcribed. Interviews covered men's use of health services and their experiences of these services with special emphasis on the following topic areas: current health and health seeking behaviour; use of health services; experience with GPs; HIV treatment and care; private health care; occupational health care; GUM services; and knowledge and experience of HIV prevention technologies.

Each interview transcript was summarised. These summaries were used by three researchers working independently to generate themes and conduct a full thematic analysis. Various tests and further analyses were conducted to check internal reliability of initial analyses. A separate analysis was conducted of transcripts in the three 'health status' sub-groups: men with no medical conditions (NMC), men with long-term illness (LTI) and men with diagnosed HIV (HIV+).

## 1.6 QUALITATIVE SAMPLE DEMOGRAPHICS

The characteristics of the sample of 41 men who participated in the in-depth qualitative interviews was broadly similar to the large quantitative survey sample. Their average age was 36 (compared to 33 in the quantitative survey), though this varied across the health status groups. Just over half (56%) were London-resident, with the remainder split equally between residence in Leicester and Wakefield. Three quarters (76%) were White British with the remainder split between White other, Asian/ Asian British and Black / Black British. Compared to the large survey sample, the qualitative sample included a higher proportion of men with no formal educational qualifications (12% compared to 4.8%) or with 'O' levels or equivalent (27% compared to 20.2%). Consequently the qualitative sample included a lower proportion of men with degrees (27% compared 44.3% in the survey sample).

The conditions reported by men in the long-term illness (LTI) group included: mental health difficulties (3); diabetes (2); blood disorders (2); cancer (2); digestive disorders (2); respiratory disorders (1); multiple sclerosis (1); asthma (1); chronic back pain (1); asperger syndrome (1).

	All men (n=41)	No medical condition (NMC) (n=13)	Long-term illness (LTI) (n=16)	Diagnosed HIV (HIV+) (n=12)
Age range	18 – 83	19 – 61	18 – 83	30 – 60
Average age (median)	36	28	45	38
London-resident	23	8	8	7
Leicester-resident	9	2	5	2
Wakefield-resident	9	3	3	3
White British	31	7	14	9
White European	4	1	2	2
Asian or Asian British	3	2	0	1
Black or Black British	3	3	0	0
No educational qualifications	5	0	2	3
'O' levels or equivalent	11	3	6	2
'A' levels or equivalent	14	5	4	5
Degree or more	11	5	4	2
Never tested for HIV	12	4	8	–
Tested negative	17	9	8	–
Tested positive	12	–	–	12

# 2 Quantitative survey

This chapter examines health service utilisation, particularly in relation to General Practice, among the men who took part in a large quantitative survey (GMSS 2003). It also examines disclosure of sexuality or (homo)sexual behaviour in General Practice settings and satisfaction with services.

## 2.1 HEALTH SERVICE UTILISATION

Gay and bisexual men appear to be relatively common users of GP services with almost a third (32.1%) having attended in the last month and another half (46.7%) having attended within the last year, but not the last month. Overall, more than three quarters (78.8%) of gay men had attended a GP surgery in the last year.

<i>When was the last time you went to a GP surgery/ local doctor ...</i>	<b>In the last month N=4605</b>	<b>In the last year N=6688</b>	<b>More than a year ago N=2806</b>	<b>Never N=267</b>
For any reason	32.1	46.7	19.5	1.9

If we consider only the 92.0% of men currently registered with a GP (see section 2.2) then 81.5% had been to a GP in the last year (33.8% in the last month and 47.7% in the last year but not the last month). In a comparable sample of 623 English-resident gay men recruited from various community sources, GUM and snowballing, 92% were registered with a GP and 81.7% of these had visited their doctor in the previous year (Fitzpatrick *et al.* 1994).

Compared to all adult males in the *National survey of NHS patients* (Boreham *et al.* 2002) our sample were marginally more likely to have visited their GP in the last month (32.1% compared with 28%). However, gay men who had not visited their GP in the last month were less likely to have visited them in the last year compared to all adult males (46.6% of gay men had been in the last year but not the last month, compared to 70% of all adult males).

All men were also asked *In the last year what other health services have you used?* They were allowed to tick as many responses as applied from the list outlined below. GP surgery was not included as an item in this question but data is shown for comparison.

<b>Health services used in the last year (N=14,551)</b>	<b>%</b>
GP / local doctor	78.8
Pharmacy	58.1
Dentist	56.6
Optician	39.5
GUM clinic	26.6
NHS Direct (telephone)	20.0
Hospital accident and emergency unit (A&E)	18.7
NHS walk-in centre	11.6
HIV (out-patients) clinic	9.8
Complementary / alternative therapy clinic	9.7
Private health care clinic	6.9

A further 4.3% of men gave an *other* answer which could not be categorised. These included mental health, psychiatric and drug and alcohol services and AIDS service organisations. Other answers referred to hospital services (including stays in hospital as in-patients and a wide variety of out-patient clinics) or to medical professionals such as chiropodists, nutritionists and physiotherapists. A few men mentioned information services such as magazines, web-sites (in particular the NHS Direct website) or private health services.

GP surgeries were the single health service most likely to be used by gay men (with 78.8% having been in the last year). This was followed by opticians, dentists and pharmacies (with 40-60% having used them) and then by genito-urinary medicine (at 26.6%) and NHS Direct (20%). No other service was used by more than a fifth of all men in the last year. Demographic variation in selected health service utilisation are described in section 2.6 below.

Overall, rates of health service utilisation appear relatively high compared to all UK-resident adult males (Boreham *et al.* 2002). Compared to all adult males, in the last year our sample were more likely to have visited Accident & Emergency (18.7% compared to 12%); used NHS Direct (20.0% compared to 6%); used an NHS walk-in centre (11.6% compared to 2%); and to have used a private doctor (6.9% compared to 4%).

## 2.2 REGISTRATION WITH A GP PRACTICE

The *National Survey of NHS patients* (Boreham *et al.* 2002) suggests that 99% of all adult males are registered with a GP practice.

In our large sample, 92.0% of all men were registered with a GP practice. This figure matches precisely that reported by both Fitzpatrick *et al.* (1994) and Webb (1999), from samples of 623 and 544 English-resident gay men. Demographic variation in GP registration are described in section 2.6 below.

## 2.3 DISCLOSURE TO STAFF AT GP SURGERY

All men who were currently registered with a GP were asked *Do the staff at that surgery know you have sex with men?* The answers offered were *no, yes, and don't know*. Overall, just over a quarter (27.5%) of all men registered with a GP stated that the staff at that surgery knew they had sex with men. A further 17.8% stated that they did not know or were unsure. Hence, over a half (54.7%) of all men registered with a GP surgery stated that the staff at that surgery did not know they had sex with men. Demographic variation in responses to this question are described in section 2.6 below.

Disclosure of homosexual activity among all men registered with a GP (N=13,244)	%
Staff at GP surgery KNOW you have sex with men	27.5
NOT SURE if staff at GP surgery know	17.8
Staff at GP surgery DO NOT know	54.7

The proportion of gay men that are 'out' to the staff at their GP surgery was lower than previous literature suggests. In Fitzpatrick *et al.* (1994), 56% of 623 English-resident gay men who were registered with GP had disclosed their sexuality in that context. Two thirds (67%) had volunteered the information themselves, and other reported means of disclosure were: doctor asking; another doctor or clinic telling the GP; someone else, such as family member had told the doctor. Similarly, in Webb (1999) 42.1% of 544 English-resident gay men who were registered with GP had disclosed their sexuality in that context.

All men who were currently registered with a GP were asked *Are you, or would you be, happy for the staff at the GP surgery to know you have sex with men?* The answers allowed were *no* and *yes*. Men who answered *no* were asked *Why not?* and allowed to write a short answer. Overall, 39% of all

GP-registered men were, or would be, unhappy for the staff at their specific surgery to know they had sex with men (and 61% were or would be happy for them to know). Because of the wording of the question it is important to consider 'happiness' (with the actual or prospective knowledge of GP staff) in the context of actual knowledge of same sex activity.

Happiness with disclosure of homosexual activity by actual disclosure among all men registered with a GP (N=13,244)	Staff KNOW	NOT SURE if staff know	Staff DO NOT know
NOT happy for the staff to know	4.2	25.4	60.7
HAPPY for the staff to know	95.8	74.6	39.3

The quarter (27.5%) of men who stated the GP surgery staff knew they had sex with men were relatively happy that information was known – only 4.2% were unhappy that staff knew they had sex with men. Among men who were not sure or did not know if the staff at their surgery knew they had sex with men, not being happy with that prospect was more common: a quarter (25.4%) said they would be unhappy if the staff knew. Finally, among the majority (54.7%) of men who stated that the staff of their surgery definitely did not know they had sex with men more than half (60.7%) would not be happy if their homosexual practice was known. Overall then, a third (33.3%) of all men who were registered with a GP said the staff at that GP surgery did not know they had sex with men AND they would be unhappy if they did know.

Below we examine the reasons for not being happy with staff at GP surgeries knowing that respondents had sex with men. The analysis was based on the relatively short answers to the question *Why not?* when men answered *No* to: *Are you, or would you be, happy for the staff at the GP surgery to know you have sex with men?*

The four key reasons to emerge from the analysis were broadly categorised as: about me; about the service or practice; about the specific likely consequences for medical records and the impact on financial options; and a more generic concern about the consequences in terms of stigma and discrimination based on heterosexism or homophobia. The latter two categories both concern the possible consequences of any disclosure and could be collapsed together. The table (below) shows the proportion of answers fitting each of these four themes according to men's answers to the question: *Do the staff at that surgery know you have sex with men?*

<i>Why are you not happy for the staff at the GP surgery to know you have sex with men? (themes)</i>	ALL UNHAPPY (N=3686)	Staff KNOW (n=109)	NOT SURE if staff know (n=417)	Staff DO NOT know (n=3001)
About me	39.4	22.0	21.6	41.4
About the service / practice	31.5	45.0	43.9	29.9
Consequences (medical records, financial implications esp. insurance)	12.2	11.9	13.2	12.2
Consequences (stigma and discrimination)	16.9	21.1	21.3	16.4

Overall, well over a third (39.4%) of all men who were (or would be) unhappy for the staff at their GP surgery to know they had sex with men, cited reasons about themselves – the majority would be shy, embarrassed or uncomfortable. This view was especially common among men who were not 'out' to all their family or friends or were married or had children or lived in a small town or rural area. This reason for not being happy was especially common among men who said GP staff did not know they had sex with men. That is, a fifth (22%) of men who had disclosed were not happy because they were personally uncomfortable with that information being known, while two-fifths (41.4%) of men who had not disclosed cited this as a reason.

Another third (31.5%) of men who were (or would be) unhappy for the staff at their GP surgery to know they had sex with men, cited reasons about the specific service or practice at which they were registered. Many simply argued that it was not the staffs' business or it was irrelevant to their medical care in that context. Concerns about confidentiality were paramount here, though they were generalised, and might have related to misconceptions rather than a full understanding of primary care policies or practices. A relatively small proportion of these men cited specific reasons concerning their actual doctor or other surgery staff – some felt unhappy disclosing to male (or female) doctors; others had concerns relating to the (old) age of their doctor; or their religion ("Catholic"; "Muslim"); or ethnicity ("Indian"). This reason for unhappiness at disclosure was especially common among men that said staff did know they had sex with men (45.0%). Most commonly they had disclosed to their doctor but were less happy that it had been recorded in their notes and / or could be seen by other practice staff.

Another third (29.1%) of all men who were (or would be) unhappy for the staff at their GP surgery to know they had sex with men, cited reasons relating to the potential consequences of their disclosure. This included concerns about access to financial services (especially insurance) and some more generalised concerns about having their sexual preference noted in their medical records (12.2%). This reason for unhappiness was equally common among men that had disclosed and those that had not. A larger proportion (16.9%), felt they would be stigmatised or discriminated against as a consequence of any disclosure in their General Practice. Men revealed a general sense that they would be stigmatised and though few mentioned homophobia directly, more noted being treated differently or feeling staff were prejudiced. This reason for unhappiness was most common among men that said staff knew (or might know) they had sex with men.

## 2.4 REASON FOR LAST VISIT TO A GP

All men that reported attending a GP surgery within the last year were asked *Why did you make your last visit to a GP surgery / local doctor (whether NHS or private)*. They were allowed to tick as many responses as applied from the list below (63.5% ticked just one reason).

Reasons for LAST visit to a GP surgery / local doctor N=11,160 men who had been to their GP in the last year	%
Feeling unwell – had symptoms of an illness	56.0
Prescription / prescription renewal	28.2
Monitoring of an existing condition	20.7
General check-up (no symptoms)	13.4
Blood test (other than HIV)	11.8
To get a referral elsewhere	9.1
Vaccination	8.7
<b>Sexual health check-up</b>	<b>4.7</b>
<b>HIV test</b>	<b>4.1</b>
Insurance / mortgage / legal / job purposes	2.8
Accompanied someone else	2.7
Dietary advice / monitoring	2.6

A further 2.4% gave an *other* answer which could not be categorised. The majority of these did not give any further information, though some specified having gone to register with a new GP or to discuss smoking cessation.

More than half (56.0%) had last been to their GP surgery because they were feeling unwell, with a further quarter (28.2%) attending for a prescription or prescription renewal and a fifth (20.7%)

attending to monitor an existing condition. One-in-eight (13.4%) had last been for a general check-up. Most notable, perhaps were the findings concerning sexual health check-ups and HIV testing. Overall, 7.1% last went to their GP for either a sexual health check-up or an HIV test or both. This included 2.3% (n=255) who went for an HIV test only, 1.9% (n=208) who went for a sexual health screen including an HIV test and 2.8% (n=315) who went for a sexual health screen but not an HIV test. Demographic variations in use of GP surgeries for these two reasons are outlined in section 2.7.

## 2.5 SERVICE ACCEPTABILITY

All men that reported attending a GP surgery in the last year were asked three questions about the acceptability of the service. The questions were: *Thinking about that visit, indicate whether you disagree or agree with the following statements:*

- *the staff listened carefully to what I said.*
- *I was treated with courtesy and respect.*
- *the staff seemed to know their job well.*

Satisfaction with last visit to GP among men who had been in the last year (N=11,123)	The staff listened carefully to what I said	I was treated with courtesy and respect	The staff seemed to know their job well
% Strongly agree	29.8	34.2	30.7
% Agree	49.9	52.1	51.8
% Not sure	10.2	6.7	11.2
% Disagree	7.9	5.4	4.8
% Strongly disagree	2.3	1.6	1.5

Overall satisfaction was relatively high with more than three quarters agreeing with each statement and less than 10% disagreeing with any. Agreement with the statement *I was treated with courtesy and respect* was particularly high (at 86.3%) compared with *The staff seemed to know their job well* (at 82.5%) and *The staff listened carefully to what I said* (at 79.7%). Among all GP-registered adult males in the *National survey of NHS patients* (Boreham *et al.* 2002), 79% answered *all the time* to a question that asked *How often your GP treats you with courtesy and respect*, and a further 13% answered *most of the time*. Hence, while gay men seem broadly satisfied with staff and services received in GP surgeries, it remains possible that they were less satisfied than the wider adult male population.

In GMSS 1998 we asked identical questions about the acceptability of genito-urinary medicine (GUM) services to men that had used them in the last year (see Hickson *et al.* 1999). Overall satisfaction with GUM services was somewhat higher than with GP services. Agreement with the statement *I was treated with courtesy and respect* was similar (at 87% for GUM compared to 86.3% here); as was agreement with *The staff listened carefully to what I said* (82% compared to 79.7% here). However, agreement with the statement *The staff seemed to know their job well* was somewhat higher for GUM (88% compared with 82.5% here).

### 2.5.1 Acceptability of last visit by disclosure to GP

The following table shows how the proportion of men disagreeing (*strongly disagree* and *disagree*) with the three statements concerning service acceptability varies according to whether they had disclosed their homosexual activity in the GP surgery. Where there is a statistically significant difference, figures are underlined where they are significantly lower and **bolded** where they are significantly **higher**.

Satisfaction with last GP visit by knowledge of (homo)sexual activity in that practice.	% of all men	Do the staff at that surgery know you have sex with men?		
		Yes (N=3136)	Not sure (N=1870)	No (N=5397)
% DISAGREE WITH: Staff listened carefully to what I said	10.1	<u>8.6</u>	9.6	<b>11.1</b>
% DISAGREE WITH: I was treated with courtesy and respect	7.0	<u>5.5</u>	7.1	<b>7.8</b>
% DISAGREE WITH: Staff seemed to know their job well	6.3	5.5	6.4	6.7

Men who had disclosed their homosexual activity to staff at their GP surgery were significantly less likely to disagree with the first two statements regarding service acceptability but not the third. This suggests that men share their sexuality with quality services, where they expect that service to attend to what they say. Conversely men do not share their sexuality with poor services where they do not feel safe and where they are not confident about the response they will receive or the confidentiality with which information will be handled. If this is the case, a service claiming never to have had a gay client may be considered a poor service.

### 2.5.2 Acceptability of last visit by reason for visit

The following table shows how the proportion of men disagreeing (*strongly disagree* and *disagree*) with the three service acceptability statements varies according to the reason for their last GP visit. Reasons for last GP visit cited by less than 4% of all men are excluded. Again, figures are underlined where they are significantly lower and **bolded** where they are significantly **higher**.

Satisfaction with last GP visit by reason for attendance (N=11,053)	Reason for visit	% DISAGREED <i>Staff listened carefully to what I said</i>	% DISAGREED <i>I was treated with courtesy and respect</i>	% DISAGREED <i>Staff seemed to know their job well</i>
Feeling unwell - symptoms of an illness	YES	<b>10.9</b>	<b>7.7</b>	<b>7.1</b>
	NO	<u>9.1</u>	<u>6.1</u>	<u>5.4</u>
Prescription / prescription renewal	YES	9.9	<u>5.7</u>	5.7
	NO	10.2	<b>7.5</b>	6.6
Monitoring of an existing condition	YES	9.1	6.2	5.3
	NO	10.4	7.2	6.6
General check-up (no symptoms)	YES	<u>7.3</u>	<u>5.3</u>	5.4
	NO	<b>10.6</b>	<b>7.3</b>	6.5
Blood test (other than HIV)	YES	8.8	<u>5.0</u>	5.3
	NO	10.3	<b>7.3</b>	6.5
To get a referral elsewhere	YES	11.5	8.0	7.2
	NO	10.0	6.9	6.3
Vaccination	YES	<u>7.3</u>	6.1	6.3
	NO	<b>10.4</b>	7.1	6.3
Sexual health check-up	YES	<u>6.3</u>	5.2	4.2
	NO	<b>10.3</b>	7.1	6.5
HIV test	YES	7.8	5.4	5.9
	NO	10.2	7.1	6.4

The most obvious and consistent finding was that men who last attended their GP surgery *feeling unwell – with symptoms of an illness* were significantly more likely to disagree with all three statements concerning service acceptability. In contrast men attending for general check-ups and (to a lesser extent for *prescription renewal* and *vaccination* or a *blood test other than HIV*) were more likely to rate the service as acceptable. Broadly speaking men attending without a new (and undiagnosed illness) were less likely to disagree with any of the statements concerning service acceptability.

Men attending for sexual health check-ups were significantly less likely to disagree that *staff listened carefully to what I said* and the same difference approached significance for *staff seemed to know their job well*. Responses to the statement concerning courtesy and respect followed a similar pattern. The same pattern was observed with regard to HIV testing but none of the differences were statistically significant. This suggests that men utilising their GP for sexual health check-ups and HIV testing were no more likely to be dissatisfied, than men attending for other reasons. Indeed, as with other check-ups or reasons for attendance not related to immediate ill-health, there was some indication that men were more likely to be satisfied.

## 2.6 DEMOGRAPHIC VARIATION

### 2.6.1 Variation by area of residence

The table below outlines variations in health service utilisation by where men lived in the UK.

AREA of RESIDENCE * % used service in last year ~ % yes	London	South	Mid & East	North	Wales	Scotland	Northern Ireland
* GP / local doctor	<u>75.8</u>	80.1	<b>80.6</b>	80.5	79.6	77.8	76.5
* GUM clinic	<b>34.7</b>	25.5	23.3	26.2	23.2	22.6	22.9
* NHS Direct (telephone)	20.9	20.7	21.5	23.5	19.9	8.9	5.6
* Accident & Emergency (A&E)	17.9	18.0	19.4	21.2	21.1	15.8	18.5
* NHS walk-in centre	<b>16.6</b>	9.9	9.8	13.8	3.9	4.8	5.6
* HIV (out-patients) clinic	<b>18.4</b>	8.0	6.6	7.6	5.5	6.0	3.5
~ Registered with a GP surgery	<u>86.4</u>	93.2	94.5	94.4	<b>95.4</b>	93.4	92.5
~ Staff at GP surgery KNOW you have sex with men	<b>31.8</b>	28.0	25.0	29.2	21.2	23.4	<u>20.7</u>

Health service utilisation varied according to men's area of residence, though not in any consistent pattern. Men in London were most likely to use GUM, HIV out-patients clinics and NHS walk-in services (which only exist in England). However, they were least likely to use a GP / local doctor. Men resident in Mid and East England were most likely to have used their GP in the last year.

Registration with a GP surgery was significantly less common among men resident in London. The London-resident sample had a higher proportion of men in their 20s and 30s and was far more ethnically diverse. It also included relatively high proportions of migrants from outside the UK, and men who have been resident in the UK for a relatively short time. GP registration was most common in men resident in Wales, although outside of London the differences were small.

Disclosure of homosexual activity to staff at GP surgeries followed the opposite pattern. Men in London were most likely to have disclosed (31.8% had), followed by men in the other English regions (25.0% to 29.2%). Men resident in Scotland (23.4%), Wales (21.2%) and Northern Ireland (20.7%) were least likely to have disclosed to their GP.

## 2.6.2 Variation by ethnic group

The table below outlines variations in health service utilisation by ethnic group.

ETHNICITY * % used service in last year ~ % yes	White British	Other White	Mixed	Asian/ Asian British	Black/ Black British	Other
* GP / local doctor	78.9	77.5	75.9	78.5	79.4	73.0
* GUM clinic	26.2	30.5	29.3	<u>22.6</u>	<b>31.5</b>	25.5
* NHS Direct (telephone)	<b>20.6</b>	17.9	15.6	19.6	<u>11.0</u>	16.5
* Accident & Emergency (A&E)	19.1	17.9	<b>21.5</b>	13.1	<u>11.6</u>	13.5
* NHS walk-in centre	10.9	14.4	<b>21.5</b>	15.6	<u>13.0</u>	18.0
* HIV (out-patients) clinic	9.2	14.6	<u>8.5</u>	5.5	<b>17.1</b>	10.5
~ Registered with a GP surgery	<b>93.4</b>	84.0	85.0	89.8	88.1	<u>81.9</u>
~ Staff at GP surgery KNOW you have sex with men	27.5	<b>30.0</b>	28.8	<u>14.0</u>	18.9	24.2

Health service utilisation varied according to men's ethnicity but not in a straightforward pattern. There is no variation in use of GPs by ethnicity. However, Black men were least likely to use all other health services except GUM and HIV out-patients, which they were most likely to have used in the last year.

Registration with a GP surgery was significantly more common among White British men, especially compared to men of other White and other ethnicities. These two groups had a disproportionate number of adult migrants and men resident in the UK for a relatively short time.

Disclosure of homosexual activity to staff at GP surgeries was most common among other White, mixed race and White British men. It was significantly less common among Asian men, an observation which accords with findings from GMSS 2002 (Hickson *et al.* 2003).

## 2.6.3 Variation by length of residence in the UK

The table below outlines variations in health service utilisation by length of residence in the UK.

LENGTH of RESIDENCE in the UK, for men NOT born in the UK * % used service in last year ~ % yes	less than 1 year	1-3 years	3-10 years	Over 10 years
* GP / local doctor	74.5	76.9	74.7	78.0
* GUM clinic	<u>8.2</u>	22.7	29.5	<b>32.6</b>
* NHS Direct (telephone)	<u>7.6</u>	14.5	17.4	<b>20.3</b>
* Accident & Emergency (A&E)	<u>7.6</u>	16.0	17.4	<b>18.2</b>
* NHS walk-in centre	<u>10.1</u>	<b>20.8</b>	19.4	11.7
* HIV (out-patients) clinic	<u>8.9</u>	9.7	<b>19.2</b>	16.0
~ Registered with a GP	<u>50.0</u>	72.7	83.7	<b>91.1</b>
~ Staff at the GP surgery KNOW you have sex with men	<b>39.2</b>	<u>23.7</u>	27.8	32.0

Health service utilisation varied according to men's recency of arrival in the UK. The most recent arrivals (those resident less than 12 months) were least likely to use most of the health services (except GPs). They were also least likely to be registered with a GP. On average, men who were registered with a GP had been in the UK for longer (mean = 156 months, sd = 101) than those who were not (mean = 78 months, sd = 144). Men who had been in the UK 12 months or less and had registered with a GP, were most likely to say that the staff at the GP service knew that they have sex with men.

#### 2.6.4 Variation by age group

The table below outlines variations in health service utilisation by age.

AGE group	< 20	20s	30s	40s	50s
* % used service in last year ~ % yes					
* GP / local doctor	81.2	79.0	<u>77.3</u>	<u>77.3</u>	<b>84.8</b>
* GUM clinic	<u>17.3</u>	27.9	<b>30.9</b>	29.1	21.8
* NHS Direct (telephone)	17.0	<b>25.8</b>	20.7	14.2	<u>11.0</u>
* Accident & Emergency (A&E)	<b>23.2</b>	20.5	17.9	16.8	<u>16.3</u>
* NHS walk-in centre	13.4	<b>15.1</b>	11.3	8.7	<u>7.9</u>
* HIV (out-patients) clinic	<u>4.7</u>	7.8	12.7	<b>13.0</b>	9.0
~ Registered with a GP surgery	94.8	<u>88.5</u>	91.9	95.4	<b>96.5</b>
~ Staff at GP surgery KNOW you have sex with men	<u>13.8</u>	24.5	32.2	<b>33.0</b>	31.5

Health service utilisation varies according to men's age in a relatively predictable pattern. Men aged 50 or more were most likely to use their GP, but least likely to have used NHS direct, Accident & Emergency, and NHS walk-in centres. Men under 20 were most likely to have used A&E, and men in their 20s were most likely to have used NHS Direct and NHS walk-in centres. GUM clinic use is most common among men in their 30s and HIV out-patient clinics among men in their 40s.

Registration with a GP surgery was significantly less common among men in their 20s (and to some extent 30s), compared to men under 20 or over 40. Men in the 20-39 age range are most geographically mobile and relatively healthy. Many of the men under 20 can be assumed to still be registered with 'family' doctors, especially if they are still resident in the area they grew up in. Men over 40 are more prone to ill-health and hence more likely to be registered with their GP. Disclosure of homosexual activity to staff at GP surgeries increases with age, up to the age of 50 and then decreases slightly. Men under 20 were least likely to have disclosed (13.8% had).

### 2.6.5 Variation by formal education

The table below outlines variations in health service utilisation by education.

<b>EDUCATION</b> * % used service in last year ~ % yes	<b>low</b>	<b>medium</b>	<b>high</b>
* GP / local doctor	<b>80.5</b>	78.7	<u>77.5</u>
* GUM clinic	<u>24.2</u>	24.9	<b>29.3</b>
* NHS Direct (telephone)	18.8	20.6	20.5
* Accident & Emergency (A&E)	<b>21.0</b>	20.0	<u>16.6</u>
* NHS walk-in centre	11.5	11.5	11.8
* HIV (out-patients) clinic	9.9	<u>8.7</u>	<b>10.5</b>
~ Registered with a GP surgery	<b>93.6</b>	92.6	<u>90.8</u>
~ Staff at GP surgery KNOW you have sex with men	<b>29.4</b>	<u>25.0</u>	28.1

Health service utilisation varies according to education in a very predictable pattern. Men who left education at 16 with 'O' levels or less were most likely to have used their GP and to have used A&E. Men with degrees were most likely to have used GUM and HIV out-patients clinics. Use of NHS Direct and NHS walk-in centres did not vary by education.

Registration with a GP surgery was significantly more common among men with lower educational qualifications, as was disclosure of homosexual activity to staff at GP surgeries.

### 2.6.6 Variation by HIV testing history

The table below outlines variations in health service utilisation by HIV testing history.

<b>HIV testing history</b> * % used service in last year ~ % yes	<b>Tested Positive</b>	<b>Tested Negative</b>	<b>Never Tested</b>
* GP / local doctor	78.4	<b>82.8</b>	<u>73.9</u>
* GUM clinic	<b>51.7</b>	41.8	<u>6.1</u>
* NHS Direct (telephone)	<b>24.0</b>	22.7	<u>16.5</u>
* Accident & Emergency (A&E)	<b>24.6</b>	19.7	<u>17.0</u>
* NHS walk-in centre	13.2	<b>13.6</b>	<u>9.2</u>
* HIV (out-patients) clinic	<b>78.8</b>	9.5	<u>0.3</u>
~ Registered with a GP surgery	<u>89.6</u>	91.8	<b>92.6</b>
~ Staff at GP surgery KNOW you have sex with men	<b>60.3</b>	36.3	<u>13.2</u>

Health service utilisation varies according to men's HIV testing history in a predictable pattern. Men with diagnosed HIV were most likely to have used all the health care services except GP and NHS walk-in centres. Men who had tested negative for HIV were most likely to have used their GP and to have used NHS walk-in centres. Men who had never tested for HIV were least likely to have used any health service.

Registration with a GP surgery was significantly more common among men who had never tested for HIV, especially compared to men with diagnosed HIV infection. Disclosure of homosexual activity to staff at GP surgeries was most common among men with diagnosed HIV, followed by men who had tested negative for HIV.

## 2.7 FACTORS ASSOCIATED WITH SEXUAL HEALTH BEING REASON FOR LAST GP VISIT

Among men who had been to their GP in the last year (N=11,293 or 78.8%), 7.1% cited HIV testing or sexual health screening as the reason for their most recent visit. This included 2.3% (n=255) who went for an HIV test only, 1.9% (n=208) who went for a sexual health screen including an HIV test and 2.8% (n=315) who went for a sexual health screen but not an HIV test.

Basic statistical analysis suggests that attending for sexual health screening or HIV testing was associated with being younger, living in London, being from an ethnic minority and a relatively recent immigrant to the UK. The following outlines a more sensitive statistical (multiple logistic) analysis.

### 2.7.1 Using a GP surgery for a sexual health check-up

A sexual health check-up being the reason for last GP visit was independently associated with being younger, living in London and being an immigrant to the UK. It was not independently associated with being a member of an ethnic minority.

**Being under 30 years of age:** Compared to older men, those under 30 were 1.7 times more likely to have been seeking a sexual health check-up on their last GP visit (95% CI 1.4–2.1). Controlling for residence, country of birth and ethnicity, the odds ratio (OR) remained at 1.7 (95% CI 1.4–2.1).

- A sexual health check-up being the reason for last visit to a GP was most common among teenage men and became less likely with increasing age.

<b>Age groups</b>	<b>Odds ratio</b>	<b>95% CI</b>
<20	3.88	2.15–6.99
20s	3.65	2.14–6.22
30s	2.63	1.53–4.52
40s	1.85	1.03–3.35
50+	1	..

**Living in London:** Compared to men living elsewhere, those living in London were 1.5 times more likely to have sought a sexual health check-up on their last GP visit (95% CI 1.2–1.9). Controlling for country of birth, ethnicity and age, the odds ratio remained at 1.5 (95% CI 1.2–1.9).

- Among White British men (N=7385), those living in London (19.2%) were 1.5 (95% CI 1.1–1.9) times more likely to have been seeking a sexual health check-up on their last GP visit, compared to those living in the rest of the UK.
- Among White British men under 30 years of age (N=3427), those living in London (13.9%) were 1.7 (95% CI 1.1–2.5) times more likely to have been seeking a sexual health check-up on their last GP visit, than were those living in the rest of the UK.
- Among all ethnic minorities (N=1385) those living in London (50.0%) were 1.6 (95% CI 1.1–2.5) times more likely to have been seeking a sexual health check-up on their last GP visit than were those living in the rest of the UK.

**Migrating to the UK:** Compared to men who were born in the UK, those born elsewhere were 2.1 times more likely to have been seeking a sexual health check-up on their last GP visit (95% CI 1.7–2.6). Controlling for ethnicity, age and residence, the odds ratio was 1.7 (95% CI 1.2–2.4).

- Among the White British men (N=7385) those who were born outside the UK (3.2%) were 1.9 (95% CI 1.2–3.1) times more likely to have been seeking a sexual health check-up on their last GP visit, compared to those born in the UK.

- Among all ethnic minorities (N=1385) those who were born outside the UK (57.5%) were 1.6 (95% CI 1.0–2.4) times more likely to have been seeking a sexual health check-up on their last GP visit, compared to those born in the UK.
- Among all men born outside the UK (N=1034), and controlling for age and ethnicity, a sexual health check-up being the reason for their last GP visit was most common among men who had arrived in the UK in the last 3 years.

<b>Length of time resident in UK</b>	<b>Odds ratio</b>	<b>95% CI</b>
up to 12 months	2.49	1.14–5.42
1 to 3 years	2.54	1.34–4.81
3 to 10 years	1.83	1.05–3.17
Over 10 years	1	..

**Being in an ethnic minority:** Compared to White British men, ethnic minority men were 1.9 times more likely to have been seeking a sexual health check-up on their last GP visit (95% CI 1.5–2.3). Controlling for age, residence and country of birth, this association was **not significant**.

### 2.7.2 Using a GP surgery for HIV testing

An HIV test being the reason for the last GP visit was independently associated with being younger, living in London and being an immigrant. It was not independently associated with being a member of an ethnic minority.

**Being under 30 years of age:** Compared to older men, those under 30 were 2.0 times more likely to have been seeking an HIV test on their last GP visit (95% CI 1.6–2.5). Controlling for residence, country of birth and ethnicity, the odds ratio remained at 2.0 (95% CI 1.6–2.5).

- An HIV test being the reason for last visit to a GP was highest among men in their twenties and teens and became less common with increasing age.

<b>Age group</b>	<b>Odds ratio</b>	<b>95% CI</b>
<20	3.91	1.98–7.75
20s	4.37	2.36–8.10
30s	2.73	1.45–5.12
40s	1.6	0.80–3.21
50+	1	..

**Living in London:** Compared to men living elsewhere in the UK, those living in London were 1.8 times more likely to have been seeking an HIV test on their last GP visit (95% CI 1.5–2.2). Controlling for country of birth, ethnicity and age, the odds ratio was 1.4 (95% CI 1.1–1.8) for all men.

**Migrating to the UK:** Compared to men who were born in the UK, those born elsewhere were 2.9 times more likely to have been seeking an HIV test on their last GP visit (95% CI 2.3–3.5). Controlling for ethnicity, age and residence, the odds ratio was 1.8 (95% CI 1.3–2.5).

Among men born outside the UK (N=1034), and controlling for age and ethnicity, HIV testing being a reason for last GP visit was higher among men who had arrived in the last few years.

<b>Length of time resident in UK</b>	<b>Odds ratio</b>	<b>95% CI</b>
up to 12 months	2.43	1.08–5.47
1 to 3 years	3.09	1.59–6.03
3 to 10 years	2.08	1.15–3.76
Over 10 years	..	..

**Being in an ethnic minority:** Compared to White British men, ethnic minority men were 1.7 times more likely to have been seeking an HIV test on their last GP visit (95% CI 1.0–2.8). Controlling for age, residence and country of birth, this association was **not significant**.

## 2.8 SUMMARY

- 92.0% of all gay and bisexual men were currently registered with a GP.
- Three quarters (78.8%) of all gay and bisexual men had visited a GP surgery in the last year. Just over a quarter (26.6%) had accessed GUM in the same period (and a 20% had used NHS Direct).
- Only a quarter (27.5%) of all men registered with a GP stated that the staff at that surgery knew they had sex with men. Over half (54.7%) stated that the staff at their surgery did not know they had sex with men.
- A third (33.3%) of all gay and bisexual men who were registered with a GP said the staff at that GP surgery did not know they had sex with men AND they would be unhappy if they did know.
- Overall satisfaction with GP services was relatively high with more than three quarters of all men agreeing with three statements about service acceptability (and less than 10% disagreeing with any).
- Overall, 7.1% of men last went to their GP for either a sexual health check-up or an HIV test or both. Using your GP for sexual health check-ups or HIV testing was most common among men who were younger (under 30), lived in London or were an immigrant to the UK. It was not associated with being a member of a Black or minority ethnic group.

# 3 Gay men's relationships with their GP

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In chapters 3, 4 and 5 we describe the outcomes of the in-depth qualitative study described in chapter 1. In this chapter we describe the process of selecting and registering with a GP. We then examine how men in our three health status sub-samples relate to their GP: that is, those aspects of their GP practices they value and what makes a 'good' GP. In chapter 4 we explore how and why men disclose their homosexual activity or sexual identity to their GP and how this affects their relationship. In chapter 5 we examine how and where men present with a range of symptoms and concerns relating to sexual health. Finally, chapter 6 is an overall summary of both the qualitative and quantitative studies with recommendations.

## 3.1 CHOOSING A GP PRACTICE

The length of time men had been registered with their primary care providers varied from a few months to thirty years. Men who had been with their surgeries longer tended to be more satisfied with them, though the relationship between satisfaction and length of use was varied.

All men were registered at a practice (an entry criteria for the study) and in most cases, men saw their original reason for registration as a precaution against ill-health. A couple of men reported needing to register because of mortgages or financial services but most simply felt registration with a primary care service was sensible. Some men had sought to register at a practice that had been recommended, usually by neighbours, friends in the same area or partners. These men tended to value practices that had a good reputation especially for good staff and a warm, caring environment.

*What makes [a surgery] good?*

**Very good front of house staff: child-oriented, friendly, warm environment. Very mixed clientele. Relatively young and caring doctors.**

*And in terms of that particular surgery then, how [did you find it]?*

**Recommendation from a neighbour.**

**Aged 51, White European, No medical condition (NMC)**

One man picked his practice because it had a reputation for all-female staff and many others cited a preference for a female doctor. Some men with diagnosed HIV asked at their HIV clinic for recommendations for 'HIV-friendly' GP surgeries.

*How did you pick the surgery you are at now?*

**The GU recommended them because they are HIV-friendly in the sense that you are not ostracized for being positive, but they have no knowledge of HIV whatsoever.**

**Aged 30, White British, HIV+**

However, it was far more common for men to not be very discriminating in terms of their search for a surgery. Often, they picked the one that was closest or the first one that took them irrespective of whether or not it had a good reputation. Others felt that they had no choice saying that they felt obliged to choose the surgery that was closest to home.

*So how did you decide to go to that particular surgery?*

**I didn't really have much choice to be honest. Because the way that the NHS system works I had to choose whatever's nearest to my area to where I live [...] I would like to change GP because their opening hours are not very good.**

**Aged 28, Asian, NMC**

Some men had spent several weeks searching for the surgery where they eventually registered, because many surgeries were over-full.

Men reported a variety of experiences around initial registration with a primary care practice. Some reported no formal registration process except for notification of the transfer of their medical records. Others reported questionnaires and 'well-man' checks on registration (or first visit). These tended to involve questions about smoking and drinking; a measurement of weight and height and a medical history; and sometimes blood-pressure, cholesterol and blood and / or urine tests for diabetes etc. Many men reported 'tests', the purpose of which could not be recalled – or were never known. Where 'well-man' checks were undertaken it was still common to hear that 'personal questions' were not asked (meaning sexual history taking).

*So within the process of registration at that surgery do you remember if they did anything like a personal history check or a medical history?*

I can remember being weighed and my height [checked]. There was a question about how much I drank and ate and whether I exercise.

*Anything there about sexuality or sexual history?*

No... Probably asked my marital status at the time, nothing other than that.

Aged 51, White European, NMC

### 3.2 ENVIRONMENT AND ATMOSPHERE OF THE PRACTICE

The majority of the men expressed dissatisfaction with the infrastructure of the primary care practice (dissatisfaction with staff and doctors was far less common – see below). In particular, the atmosphere of reception rooms was often reported to be very tense with low levels of comfort, complaining patients and lots of noise.

*Do you think that much effort has been put into making the surgery accessible?*

They have ramps for wheelchairs but otherwise it is shabby and looks grim. It has grey carpet, greyish walls and the reception is behind glass so you have to yell through it to be heard.

Aged 34, White European, HIV+

Some men felt the experience of using their GP surgery was so unpleasant that they had to be very ill to go there. This was especially common where there was no appointment system since the waiting times could be particularly long.

[...] I live in a high South Asian population area and it's pretty grim in there. I mean I've always said I have to be really unwell to go there [...] there's absolutely no idea of what sort of time you could be sitting there for. There isn't an appointment system. You're advised to turn up before nine o'clock. And if you turn up after that you're sent away and told to come back before one o'clock for the afternoon surgery.

Aged 30, White British, NMC

Uncomfortable waiting rooms were especially problematic in very busy practices, because the pressure on staff meant they often appeared unfriendly. Coupled with waiting times of up to two weeks for non-emergency appointments this led to gross dissatisfaction with primary care as a service (though not necessarily with doctors themselves). Overall, therefore, men complained about their surgeries because they were busy, noisy, overcrowded, under-resourced etc. They recognised that these complaints were probably shared by all patients. That is, there was nothing about their dissatisfaction that was linked to their sexual identity.

The receptionists are terrible, they are terrible with everyone except for the exceptionally elderly.

*What makes them terrible?*

Well you ring up and ask for an appointment and usually when you are asking for an appointment you want some answers pretty quickly and they say, 'Oh a week on Thursday'. Then they say 'oh you can see another doctor tomorrow'. I want to see my own doctor for

purposes of continuity of service. I just think, 'Oh you know you get up and you are feeling ill and you have to go to the doctors and you just know that you are going to feel worse by the amount of aggression you are going to get and the long wait to see the doctor and then when you do see him you are in and out like lightning'.

Aged 36, White British, HIV+

We asked men the extent to which their surgeries were geared towards a particular population group (such as women and children, for example). The majority felt that the atmosphere of the surgery reflected that of their local neighbourhood rather than being particularly amenable to one group. Indeed most felt that everyone attending was probably equally dissatisfied.

*Is there a sense that you have about who the surgery is designed around?*

I would say it's designed just for the local community in that immediate area. So I don't think there is a particular target audience. It's just for people who live in the streets around. That's my impression.

Aged 41, White British, NMC

An exception to this was men's criticism of the literature (magazines, posters, leaflets) in the waiting room. Men felt that this was especially geared towards families. None reported ever finding any useful literature on sexual health that was pertinent to gay men.

I think it's definitely a family-orientated surgery. Not that the interior and the ambience is any particular way, but I think you know when you go to, say you go to Mortimer Market Clinic, even though its tucked away behind office blocks it seems a lot brighter, there's plants there's magazines. There's gay magazines. You know they know who their clientele is and although they have the old hard chairs and stuff like that it's kind of a safer environment. Where this is I don't know who it is targeted towards but it's not targeted to me as in young, Black, gay or otherwise.

Aged 27, Black Caribbean, NMC

### 3.3 ROLES OF GPs

Men usually articulated the role of their GP as diagnosing and treating general problems. The doctor was considered to be predominantly concerned with general health and 'minor ailments'. Usually this involved a specific concern, though some recognised an advice-giving or health promoting role. Many saw their GP as the first point of contact for diagnosis of illness but their capacity to refer on for specialist diagnosis or treatment was also valued.

Well they're obviously the first step on many paths aren't they. Sometimes they're a journey in themselves. Very often they're just the three bus stop journey until you get onto the big train that takes you a lot further [...] They're for minor ailments and they're there to refer you to people who know more about a particular thing than they do.

Aged 44, White British, NMC

While dissatisfaction was not common, many men expressed a desire for a 'full medical check-up', both as a reassurance and to give them the opportunity to attend to diet, exercise and other health-related imperatives. While some described checks on first registration, these were variable in length and depth. Some men had asked for a check-up and been told it was not necessary, others were insufficiently assertive to ask in the context of their busy practice.

*What do you think about the idea or the concept of check-ups in general?*

I think... well I think the big problem with the health service is that they're always firefighting aren't they. And I think if only there were the resources to give everybody regular check-ups, so that nobody felt 'I'm wasting the doctor's time here when he's got all those poor old biddies in the surgery waiting'. It would be lovely for the patients and it would also no doubt be cost effective. Because all kinds of things would be picked-up early on and sorted out.

Aged 44, White British, NMC

Others did not ask for a check-up because they felt that the cost to the practice (and the NHS) would be too high and prevention of illness was not a priority.

### **3.4 RELATIONSHIP WITH THE GP: MEN WITH NO MEDICAL CONDITIONS**

Men with no medical conditions tended to describe their relationship with a practice rather than an individual doctor. They usually did not have a substantial relationship with an individual general practitioner. They tended to value their relationship with 'the practice', rather than a specific person. This lack of concern about an individual relationship with one doctor was usually attributed to the fact that they attended the surgery infrequently and usually with minor illnesses or infections.

**I'd be happy to see anybody [...] in that eight years [I've] perhaps only seen her about three times or so. If that. It happens to be have been the same person... But I've made clear I'm happy seeing any doctor, it doesn't worry me.**

**Aged 41, White British, NMC**

This attitude was also pragmatic. Many reported lengthy waiting times for appointments, and a perception that by not demanding to see a specific individual they would be seen more promptly.

In addition to seeing their doctors relatively infrequently, men with no medical conditions tended to have very short consultations with them. As a consequence many were relatively certain that their doctor – and the other staff of the surgery – would not recognise them without their medical notes, or even with them. Some found this impeded their health care because their doctors had no idea of their medical history without reference to their notes. However, most were sanguine, if not comfortable with their GP knowing little about them.

***How well do you think your GP knows you?***

**I doubt he would even recognise me [...] No it's just one of those things that you just kind of accept – you know you can't change it [...] I thought that pretty much everyone has the same sort of experience, you know [...] I think also there's a lot of social problems that sort of happen with these doctors who have large groups of communities to take care of and so on, and you know older populations as well. And very small practices and they are just really stretched which I think is down to they don't have the time to put in the kind of care.**

**Aged 27, Black Caribbean, NMC**

Although relatively few men had built up a long-term relationship with their doctor, trust in their doctors was high and satisfaction with their treatment was relatively common.

***Are you satisfied with your doctor?***

**Yeah he's a good doctor, yeah.**

***So his communication skills are OK?***

**Yeah anything I can't understand he explains it for me. He pulls it down a bit if I am like 'I don't understand'.**

***How much time does he spend with you? Do you feel like its always enough time?***

**Yeah sometimes it's too much actually cause there are loads of patients outside. It's nice though to know that they are there for you all the time. When I go I get a proper check-up and all that.**

**Aged 21, White British, NMC**

Almost all men with no medical conditions felt that their doctors were medically competent, though some recognised that this was an assumption, since they had insufficient experience to actually judge. While not all necessarily assumed that their doctor would have much knowledge of sexual health matters, this was not usually considered a major problem. Professionalism was important to men with no medical conditions, as were good communication skills and a favourable 'bedside manner'. If they were dissatisfied with their doctor the focus tended to be on poor communication, or doctors who rushed them or were inattentive to their specific needs.

I think he has very poor social skills. I don't think he's a bad doctor as such and he probably knows what he's doing. But I just sit down and it's very quiet. He asks me a few questions. Only what's absolutely necessary for him to know. And then writes down notes most of the time on his card. And then at the end of it says what I need to do. Like writes down a prescription and that's it. Go away. That's it.

Aged 28, Asian, NMC

While such substantial dissatisfaction was uncommon, men who were unhappy with their relationship with their doctor – or practice – tended not to act on that dissatisfaction. None of the men with no medical conditions reported ever having complained about their treatment in General Practice, though some had thought about doing so. While many men had felt they had grounds for some dissatisfaction, most recognised the enormous pressures of time and money. Others, simply had too much deference for the role of general practitioner to pursue a complaint.

I do feel a deference which is bred into me by what I saw with my parents. If ever the doctor made a home visit he never left without bags of tomatoes or runner beans from the garden. He was an honoured and special visitor. And I still retain some residue of that and I'd find it very hard to complain. Unless he was absolutely appalling [...] And I'd find it very hard to argue back if I thought he was wrong or negligent or anything.

Aged 44, White British, NMC

As a consequence, men with no medical conditions who felt that their relationship to a doctor was problematic either avoided that doctor but stayed with the practice, or found a new practice. Alternatively, they tolerated the relationship because their everyday need for health care was insufficiently important to face the upheaval of finding a new practice.

### **3.5 RELATIONSHIP WITH THE GP: MEN WITH LONG-TERM ILLNESS (NOT HIV)**

We have seen that men with no medical conditions tended to have a limited relationship with their GP based on the diagnosis and treatment of discreet minor symptoms. They were unlikely to develop anything beyond a cursory relationship with their GP. Men with long-term illnesses differed as they had ongoing contact with specialist clinical services which also involved their GPs. We are interested in men with long-term illnesses because their experiences show how relationships with GPs develop and the role that sexuality plays in these relationships.

The 16 men with long-term illness were compelled, one way or another, into an ongoing relationship with their GP. All but three had found ways of making this relationship work. That is, all but three men had functional ongoing relationships where their GP was actively involved in the management of their condition and their health maintenance generally.

When men first found that they were experiencing symptoms, they turned to their GP. In a minority of cases they found their GPs unsatisfactory and in two cases they had changed GPs.

*Can you tell me briefly about the terrible GPs in the past?*

This is also quite a while ago, this was [...] when I moved to South London... And that was when I was having symptoms of my MS and you know I was very concerned and upset and I think I broke down in the surgery once. And he said 'well what does it matter anyway if you know'. Because I suspected it was MS. Again it runs in my family unfortunately. And he just said, 'Well what does it matter anyway if you know whether you've got MS'. He was reluctant to refer me to a specialist. And that really upset me at the time.

Aged 39, White European, Long-term illness (LTI)

When they were diagnosed with a long-term illness, their priorities changed and they paid more attention to their GP. That is, after initial acute care, or diagnosis, they needed to deal with their GP for their treatments. At this point, establishing a productive relationship with a GP became important.

Well I suppose when I first started going I wasn't too concerned about seeing the same person every time [...] now I see the same person [...] I've become fussier, yes. It's quite important to me now that I have a GP that knows me to some extent. And I don't want to see a different person every time I go to the GP. [It's important that] they get to know me a bit and my background and also for me to see a face that I'm familiar with [...] because my health is more pressing now.

Aged 39, White European, LTI

Feeling comfortable with the GP was mainly a matter of trust and confidence in that person as a doctor. Questions of competence and professionalism were important. Trust in a clinician's competence to manage illness was dependent on a number of factors. In general, men did not expect their GP to have the knowledge and resources to entirely manage often complex conditions. What was more important was their doctor's willingness to work cooperatively with other specialists and themselves in the management of their condition. In this respect, a GPs willingness to research and explain complex procedures or drug regimens was important.

*Do you find that you can ask them questions about things and they're happy to...*

Yeah. I mean they've put me on to what's that stuff to give up smoking... Is it Zyban? [...] And the doctor was actually a locum who put me on that. And I said well I'm quite wary about taking Zyban because of the interaction between Zyban and the drugs that I'm taking now. Because Zyban can cause seizures. Especially if you're taking any of the Diazepam, Temazepam sort of range of drugs. So he went away and researched it all for me and he came back to me with a wad of papers and said, 'Well do you want to have a read through that and then come back and if you're happy to go on Zyban I'm happy to put you on it. But I want you to be happy about going on it as well.' So yes there is quite a good interaction between the two of us.

Aged 46, White British, LTI

In addition, a GPs active monitoring of treatments and evident concern for the patients' overall health was appreciated. This respondent's GP regularly reviews his treatments and seeks out those with fewer side effects.

*Do you feel that you trust her?*

Oh yes. Totally. Totally. If she said something you know she's gone into it. [...] And she will tell you [...] she went into it all with me [...] And she said you know you're on quite a lot of pills. You shouldn't be on all this I don't think. So what I'll do is take you off that and when you go for the assessment tell them.

Aged 65, White European, LTI

Trust in a GPs competence and professionalism was built over time and through experience.

Well not since my heart attack. Like I said it's taken a year. In that year I've had quite a few occasions where I've just been very scared and worked up about things. And I've had angina, or I thought I had angina. And like on one occasion he sent me to hospital to have an ECG. And he's been quite flexible. He's put up with it. I think realising that you do go through a process where you know you're very scared initially and, you know, you get a lot of false alarms or you think you've had a heart attack. But he's been very supportive and understanding.

Aged 39, White European, LTI

Often trust emerged through the negotiation of power between patient and doctor. This respondent recounted how he asked for two Viagra pills in contradiction to prescribing guidelines (and his doctor's opinion) that one pill per week was sufficient. He described the incident as a turning point in his relationship with his doctor.

*What do you think has been most helpful in you and your doctor developing your relationship?*  
It's been gradual. And I think possibly the fact that I insisted on having two tablets of Viagra had something to do with it. Because I didn't accept what he said and I pointed out to him that for me this was to do with [...] I'm sensible [...] you know it was to do with integrity for me. And possibly that's where it started to change. But, you know, I don't know exactly. It's improved gradually and I think certainly with the heart attack I've been seeing him a lot more. And he's been supportive when I've seen him because of anxiety. And he's been understanding. And that's helped a lot.

Aged 83, White British, LTI

In contrast, the three respondents who were unhappy felt their GP was not listening to them, being off-hand or flippant, or seeing them as a task to be dealt with.

*Tell me about the differences between the doctor you've clicked with and the one where it hasn't gone so well?*

I realise that the female doctor that I saw at first was quite flippant and a little careless in some of the things she said to me. I thought it was a little dangerous to say the things she did to me, someone who's mentally ill. And then others seemed like they really cared and they were friendly and they had people skills. I think that's probably the main difference. Some seem really kind of task-oriented and not bothered by me or you know how I felt. Where some really cared about me and secondary to that was important to deal with my symptoms.

Aged 22, White British, LTI

Therefore a GPs capacity to listen to the patient, take his concerns seriously and value his opinions on his own condition emerged as a central factor in any relationship of trust.

### **3.6 RELATIONSHIP WITH THE GP: MEN WITH DIAGNOSED HIV INFECTION**

The majority of men with diagnosed HIV had disclosed their HIV infection to their GP. Two men had not disclosed their HIV status because they did not trust their GP or found the GP's attitude arrogant or condescending. Although the men with long-term illness found that the quality of their relationship with their GP improved as they dealt with their illness, the opposite was true for men with diagnosed HIV. Only three of the twelve men with diagnosed HIV had what might be described as a constructive or good relationship with their GP. For the remainder, their relationship with their GP had deteriorated or, more correctly, atrophied since they were diagnosed with HIV.

In part this was due to their regular attendance at HIV out-patients clinics, both for health checks and treatment. Most men with HIV preferred to have all their health needs addressed at HIV clinics because they believed that GPs did not know a great deal about their condition. As it can be difficult to know whether any symptom is HIV-related or not, most men went to their HIV clinic as a first port of call, rather than their GP.

*I suppose what I think is I don't really see them [GP staff] as my primary health care people anyway. They are kind of there for stuff that I don't think is either big enough to take to the clinic.*

*So in a year how often would you see your GP?*

Two or three times [for] regular stuff like I have a flu jab every year and I suppose just anything else that came up [...] I'd use the HIV clinic first really rather than use the GP.

Aged 32, Asian, HIV+

As a result, men felt their GPs did not know very much about their personal life and circumstances. As they attended GP surgery infrequently, they tended not to disclose personal information to their GP and GPs tended not to ask questions about their life. Consequently the men with HIV usually did not think their GP would be able to recognise them on sight, which was similar to the views of men with no medical conditions. Increasingly, men were being instructed by HIV clinic staff to use their GP more for certain procedures such as vaccinations.

I should imagine I will be [...] using [...] the actual facilities at the GP clinic more so now. For instance whereas I used to get my flu jab at the hospital, I'm going to the [GP] next Friday. Whereas I get my Hep jabs or travel vaccines at the hospital, I will now get those at the [GP]. So I think there's a tendency to switch some services that are aimed at gay men who are HIV or HIV people in general from hospitals back to their GP. As I said earlier I think the problem is going to be whether the GPs can cope with that.

Aged 46, White British, HIV+

Whether their GP can cope with HIV was a real question for many of the men. Some made this relationship functional by using their GP in tandem with their HIV specialist. For example, some would request advice from their HIV clinic about treatment for various ailments which they relayed to their GP. Thus, the patient became the main point of contact between GP and clinical specialist.

I tend to go [to GP] and say 'I've spoken to them at [HIV clinic] and I would like this. They said they can't prescribe it because it's not within their budget and they told me to come and get it off you'. And he'll just write it. I mean I might not have spoken to [HIV clinic] all of the times, but, you know, I would have checked out what it is so it's fine. I guess he knows I'm sensible.

Aged 36, White British, HIV+

A major area of concern, however, was the fact that GPs were perceived as being too busy to respond effectively to even minor HIV-related conditions. Hence, the scheduling of appointments was an issue for most men. For some it was unacceptable to wait two weeks for an appointment with their GP, and some felt that having HIV should give them some priority due to their compromised immune system.

The major problem is trying to get a timely appointment. That's one of the reasons why I don't really access a GP service because it's as if you've got to make an appointment to be ill. You've got to know that you're going to be ill two months in advance to be able to get an appointment [...]. I don't feel that they provide an appropriate system when there is a potential of something rapidly developing from a common cold to a major chest infection [...] a common cold in a normally healthy person doesn't quite progress in the same way as a common cold would in someone who's immune compromised.

Aged 44, White British, HIV+

Many found the amount of time they had to wait in the waiting room unacceptable also.

It's a very busy practice and the waiting times can be very long [...] Even though you've made an appointment, my appointment last week was I think nine thirty and I went in at ten fifteen because the previous patient most probably needed a longer consultation [...] Where I live tends to be a very high proportion of elderly people anyway. I think I would say about 60 or 70% of the patients that use the local GP are over 70 / 80 years of age. So they most probably access it on a more regular basis and spend longer with the doctor.

Aged 46, White British, HIV+

Finally, having no continuity of care (in the sense that they could not be guaranteed to see the same doctor twice) was a further disincentive to using their GP surgery.

I had about a year where I never managed to see the same doctor twice [...] I suppose the only times I went weren't for scheduled appointments so I ended up seeing whichever doctor was available that day.

Aged 32, Asian, HIV+

In only two cases had the relationship between the respondent and his GP entirely broken down. In both cases, it was not a case of homophobia or HIV-phobia from the GP, but rather that they lacked communication skills and were perceived as arrogant, rude or patronising.

*How do you get on with your GP?*

Fine, but he patronises me. [It] infuriates me sometimes, but he's a doctor so I don't tell him. I tell everyone else. No he says things like, 'Well I realise you're having medication, but your

quality of life is pretty crap'. You think, 'Yeah I knew that, thanks [laugh]. Thanks, cheers for that.' That's what your doctor's telling you. OK [laugh].

Aged 36, White British, HIV+

Conversely, two men had established constructive long-term relationships with their GP. One had perceived a more positive attitude in the GP since he was diagnosed. He felt that he was given more time with his GP, taken more seriously and consequently felt he was being treated well.

Another acknowledged that his GP had some training in HIV care, liaised closely with his HIV clinician and was willing to follow-up referrals quickly. He found him very helpful and professional.

**It's quicker sometimes to get to the GP for infections and things, because he's had a bit of HIV training, he's gone to a lot of seminars and that. He does liaise with my specialist quite a bit and it's sometimes quicker to go there and get a check there and get a quick eight thirty appointment.**

*So he'll treat you for most things then?*

He'll treat me for most things that he knows and he will refer me to specialists. He will chase them up very quickly for me and if I haven't heard I can ring up and say I haven't heard anything and he'll chase it up quickly.

*So does your GP contribute towards the management of your HIV?*

I would say sort of like 50/50, because I mean we have a case conference as well. It was three monthly and now it's gone to six monthly [conference with] different specialists – three different specialists [and] the GP.

Aged 34, White British, HIV+

### 3.7 DISCUSSION

What is striking about our analysis so far is the extent to which gay men's needs and concerns around their GPs have little or nothing to do with their sexuality. In short, gay men are likely to have the same requirements and concerns as all other adult men.

The majority of our respondents did not seek out gay or even 'gay-friendly' GPs. Indeed, the question of sexuality seems to have been far from their minds when they selected and registered with a GP who were, on the whole, chosen because of their geographical proximity or ease of access. Men did express dissatisfaction with their GP practices (as opposed to their GP). However, such dissatisfaction is likely to be shared with everyone in the waiting room. That is, waiting times, lack of resources and overworked staff and a lack of the availability of check-ups or preventative medicine.

Men with no medical conditions had a cursory relationship with their GP. The majority of them found this state of affairs satisfactory. If they had to see a doctor, they tended to go for the first one available rather than wait. If they had a specific complaint, it generally concerned the doctor's approach or professionalism. That is, men disliked being rushed or feeling that they were not being listened to by their GPs. However, such concerns are likely to be shared by most other patients.

Men with long-term illnesses needed to have a more developed interpersonal relationship with their GPs. Again, their main concern was that their GP be both competent and understanding. Above all, they valued their GPs capacity to work with them and their specialists and to share responsibility for treatment and care. Moreover, men felt it was important that they were listened to and treated with respect by their GP and that their own expertise around their condition is valued. Men found that a relationship of trust with a GP had to be negotiated, and built-up over time. Again, it is unlikely that gay men with long-term illness differ from other individuals with the same condition in relation to their basic relationship with their GP.

HIV presents a unique challenge to the relationship between a gay man and his GP. As HIV is a complex condition with comparatively well-resourced acute and chronic provision, it tends to be managed entirely within hospital out-patient settings. Men found that, as HIV affected all areas of

their health, their primary relationship developed with their out-patient physicians and staff rather than their GP practitioners. As a result, in the majority of cases, relationships with GP practices atrophied. This would seem to be preferable for the men themselves since they could access better resourced and more specialised care from their HIV out-patients clinic. Some GPs might also be happy to lessen their patient load and not have responsibility for a patient with such a complex (and costly) condition. What is lacking are accounts of real partnership working between GP, patient and HIV physician. This situation is changing, but it seems to be down to the efforts of proactive patients to manage such relationships.

# 4 Disclosing sexual identity to a GP

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In this chapter, we explore how and why men disclose their (homo)sexual activity or sexual identity to their GP. Here we investigate the extent to which they considered their sexuality relevant to their relationship with their GP, the factors which influenced their disclosure and the way they went about disclosing. We also examine the effects of disclosure on the relationship between patient and GP and assess what GP surgeries might do to facilitate disclosure. We start with an analysis of the accounts of men with no medical conditions. We move on to men with long-term illnesses and close with an examination of the accounts of men with diagnosed HIV.

## 4.1 MEN WITH NO MEDICAL CONDITIONS

As noted in chapter 3, the majority of the men with no medical conditions stressed that their GP knew relatively little about their personal lives. In the absence of any pressing medical needs, relationships with GP surgeries – and with specific GPs in particular – were irregular and did not involve much rapport. They were functional. In this context, only two out of 13 men had disclosed their homosexual activity or sexuality to their GP.

Of the two men that felt their GP knew they were gay, one had disclosed directly and always did so (despite having had a homophobic response from a previous doctor). He felt his sexuality was highly relevant to his health and the service his doctor gave him.

**... I've always told my previous doctors that [I'm gay]. I've never worried that it would somehow count against me or stop me getting a job or this, that or the other. I've always wanted my doctor to know as much about me as possible in order to serve me better [...]  
Nearly everybody I have any kind of relationship with knows that I am gay because it is such a central, core part of being me.  
Aged 44, White British, NMC**

The other had disclosed his sexuality when he had been depressed in the past. He assumed that his GP had noted his sexuality in his medical record. However, he had never sought to establish whether or not this was so, and he did not find this remotely problematic.

**About fifteen or twenty years ago I was very depressed and I went to the doctors and told him why I was depressed and it was because of my sexuality. And he wrote it down. So I'm assuming they've read it. Actually when I say, 'Yes she does know' I'm assuming she's read my notes. And therefore she knows.  
[...] Well how do you feel about that? That there's something written down over there that's about you. Would you like to see them or?  
No I don't really care actually [...] I'm quite open you know. Everyone knows I'm gay. So, one more person doesn't hurt.  
Aged 35, White British, NMC**

For the remainder of the men with no medical conditions, non-disclosure was a function of their limited relationship with their doctor. Within this context, most did not see how their sexuality was relevant to their treatment. Therefore, they had no reason (or opportunity) to disclose. The notion that it was simply a lack of relevance to general health that ensured that the vast majority of healthy men had not disclosed, was supported by evidence of disclosure to other medical professionals. Men had disclosed in hospital out-patient settings, apart from GUM.

*So do either of them [GP doctors] or the reception staff know that you're gay?*

No. It's never come up. Although I don't know if my hospital notes were passed on. I don't think they would. When I went to the hospital where the tests were done I had to tell one of the doctors [that I was gay]. Because he did ask about my sexual preference [...] because it was Hep. B [...] he just needed to find out [...] whether it was from birth [childhood in Asia] or sexual activity.  
Aged 28, Asian, NMC

Moreover, several had also disclosed to occupational health professionals or private doctors.

*...the [difference in] standard between that private doctor and my GP was tangible.*

*And did you tell that works doctor about your own sexuality? Did they know that you were gay?*

Yeah.

*Tell me a bit about what made it different and what made you be able to disclose your sexuality in that context as opposed to your current GP?*

I think they took the time to actually look around... rather than me just presenting this is what's wrong with me. They took a time to find out what could perhaps be causing what was wrong with me.

*Do you think [discussing your sexuality] was relevant?*

I think elements of it were relevant. I mean they were concerned to know if my partner at the time was being supportive. And I think that was a very valid question [...] It opened up lifestyle rather than just biology.

Aged 30, White British, NMC

In these cases, disclosure was sometimes necessary, but more commonly a consequence of a deeper and more profound interaction. That is, occupational health and private medical staff had more time and took more interest in the person, rather than the medical condition that faced them. For men with no medical conditions, this type of interaction was largely absent from their relationship with their NHS GP.

Therefore, the limited nature of their relationship with their GP meant that men rarely saw the necessity or indeed had the opportunity to disclose their sexuality to their doctor. However, our quantitative findings (see chapter 2) indicate that men's attitudes towards disclosure to their GP is far from neutral. That is, among men who had not disclosed, there was considerable reticence to have their doctor know that they were gay. Further analysis of our qualitative data shows that such anxiety around disclosure seems to centre on their doctor's (or other practice staff's) potential reaction to disclosure. That is, men simply do not know how their doctor might respond and quite understandably, in the absence of any evidence to the contrary, assume the worst and choose either to conceal their sexuality or to not actively volunteer information. In some cases, they recognise that such non-disclosure may impede their relationship with their doctor. Fear of heterosexism and homophobia were clear throughout the accounts, though they were rarely directly articulated.

*Is there a particular reason why you've decided not to disclose [your sexuality to your GP]?*

I think there is. Because if she asked me who I live with I said flat-mate and not partner. It would be because I thought she... it's hard to describe. I don't think she'll be unhappy about it or horrible about it. I just think she wouldn't... it wouldn't be normal for her [although] I know that her [reaction] would be better than the other people who work in the surgery [...] I wouldn't want it to be in my record because I have a feeling that the other doctors there would think it even less normal.

Aged 23, Asian, NMC

The following respondent illustrates this quandary very well. He felt his sexuality was relevant to his health, but not enough to take the chance of getting a negative reaction from his GP. He thought he would get better care if he was 'out' to his GP, because they would understand his needs better, but he believed that if he were to tell his GP he was gay they may not want to treat him.

Disclosing would make it a lot easier to speak more freely about things that are going on if [...] that issue was part of his general knowledge about me. But it's difficult casting those sorts of things into such a short formal meeting like that which you have with a GP, you know. If I speak of my personal circumstances I normally would speak of my partner. Now either he can make the assumption or he can ask me outright. In which case he'll get an answer. But I'm kind of of the opinion that it wouldn't even cross his mind.

Aged 30, White British, NMC

Fears regarding a negative reaction were often based around men's assumptions of their doctor's religious beliefs, moral codes or due to a feeling that their doctor was culturally different to them.

I think he's, obviously I'm stereotyping, obviously, but because he is old there is going to be a problem and because he's a Sikh there's a whole religion thing there which I don't think would cross over to his profession. But I just don't want to go there on a personal level really [...] I am sure whether he knew I was gay or not he would give me the best care that he's able to give, which, in fact, is pretty poor anyway. Yeah, I guess its kind of like when you work with colleagues and stuff like that you know that they have to do the best that they can whatever sexuality you are it puts a slant on things and you don't want people to grudgingly be doing things.

Aged 27, Black Caribbean, NMC

Therefore, whereas the cursory limited nature of the normal GP consultation does not facilitate disclosure, fear of homophobia or heterosexism will certainly, over time, impede the development or enrichment of a patient's relationship with his GP. That is, the consultation is never likely to be anything other than cursory and limited.

As a consequence of such limited interpersonal interactions, many men with no medical conditions had little evidence on which to judge the potential heterosexism of General Practice staff. Some felt that given their lack of knowledge of the individuals working in their practice, more effort should have been made to show what the equality or confidentiality policies of the practice were.

*... do you think that you would prefer to have a GP who was a gay man himself?*

No. But I would prefer a GP that does have some homosexual credential of some description.

*What counts as homosexual credential?*

That sounds really, really obtuse doesn't it [laugh]. It could be something as small as just in the reception there is X, Y or Z service provided for an at risk group... [something] That I could kind of relate to in a way.

*So something that's signals ...*

They're aware. [That] there's an awareness – some people have equity policies posted or confidentiality policies that mention sexuality or gay men.

*Do you think that would be enough or would you be happier to actually see a service based there [for gay men]?*

No, no. I think a notice would be fine.

Aged 30, White British, NMC

The final factor influencing disclosure for men with no medical conditions was their concern regarding how their sexuality would be recorded on their medical records. Their level of concern varied. Moreover, their understandings of the process of note keeping, who had access to their notes and what guidelines or legislation governed confidentiality in primary care were also very variable. Some men recognised that their own understanding of the confidentiality policy of their General Practice was poor. Others had specific concerns about their practice's confidentiality policies based on what they had observed.

I think the general demeanor of the place could do with, you know, tightening up. There seem to be medical records everywhere. On the floor and with files spilling out of files. And, you know, if I'd have had a notion to I could have read half of someone's medical records. [It makes] you think, that. But it also gives me an impression of the standard of care and confidentiality that's on offer. You know if there isn't confidentiality in a doctor's surgery then where is there? And if they can't take care about that what else can they take care of?  
Aged 30, White British, NMC

The majority of men trusted their GP and the surgery staff with regard to confidentiality in the surgery. However, many did not plan to disclose their sexuality because of the implications they believed this might have in relation to financial services. Many men had a generalised concern that other institutions could access their written medical records – especially in relation to mortgages, life insurance and other financial services. Unusually in these qualitative interviews there were large differences based on age. Relatively young men were usually not particularly concerned about the confidentiality policies of their GP surgery.

*Have you ever had any kind of reason to think about the way that the medical information that your doctor holds about you [...] gets stored or how it's recorded?*

No. Because I mean the only time I see those records is when I've been to see the GP and see them on the desk. It's never actually occurred to me how they would be kept.

Aged 19, White British, NMC

Older men, however, were often very concerned with confidentiality especially in relation to written records. As some recognised themselves, they were of a generation that had direct knowledge of discrimination against gay men especially in financial services. Other older men often had first-hand experience of considering their sexuality when applying for mortgages, life insurance or other financial products. However, since the vast majority had never disclosed their sexuality to a GP they did not necessarily have a thorough understanding of either the process for third-parties accessing their medical records or the likely consequences of disclosure.

*Do you have any idea if insurance companies or mortgage companies or those kinds of financial institutions would have access to your medical records at all?*

I know from when I had my mortgage and stuff that you have to sign a thing saying that they can ask your GP questions. But I don't think they can actually look at your records... I'm sure that's to do with HIV...

*So if you're in a situation where your sexuality is in your medical notes and you've ticked a box saying yeah you can talk to my GP about anything that's in my notes. Would you see that there's potentially an issue there in terms of...*

I don't actually think that they have a right to phone my GP and say 'is he gay?' Because that is not a medical issue. They can phone up and say 'has he got HIV or does he have heart disease?' But asking him 'is [name] gay?' isn't a medical question. So if I found out they did I'd be really... well I'd probably act on it. Because it's not a medical condition.

*... at the beginning in the eighties that's exactly what the insurance companies wanted to know. They were going ...*

I remember. I think I actually lied on my first form saying I wasn't gay. Because they'd assume that I would have HIV. Which is ridiculous. And I think my life insurance policy was the only company at that time who didn't ask HIV questions.

Aged 35, White British, NMC

Concern about recording and confidentiality as they relate to financial services led most men to reject the notion of testing for HIV in a General Practice setting.

One of the men that had previously disclosed his sexuality to a GP, remained deeply unhappy that this ensured that he also had to have a (negative) HIV test before he could get a mortgage.

Well I can remember, years ago having to have an HIV test to get a mortgage. And I can remember burning with fury at the injustice that there's a blanket requirement for all gay men [...] I'd have thought that, at least to some extent, that will have gone away.  
Aged 44, White British, NMC

Others, had been similarly discriminated against when they answered truthfully any questions about their sexuality during the process of applying for financial products or services.

Men who had not experienced direct discrimination reported similar concerns as a result of witnessing the experience of friends and partners. However, these indirect concerns were often relatively vague and were rarely accompanied by a current understanding of legislation or policy that controls access to medical records.

Well from about 20 years ago I used to work for a Lesbian and Gay Switchboard for a couple of years. And times have changed a lot. But at that time one of the frequent pieces of advice that we discussed ... was about making sure that when it came to applying for insurance ... you didn't declare that you had had an HIV test because that may prevent you getting insurance and being turned down for insurance. It would then be a big problem. In terms of getting a mortgage and so on and so on. So I got used to that advice. And in fact it came up not too long ago with my financial advisor and had a bit of hoo-hah to do with this, independently of the doctor. So perhaps it's that kind of mind-set.  
Aged 41, White British, NMC

Very few men understood that they had the right to be consulted on the ways in which items were added to their medical records, and not many more understood that they could access records and challenge the way in which items were recorded. While some understood they could examine their medical records, none of those that had not disclosed had ever done so.

In summary, men with no medical conditions had many disincentives to disclosure. On the one hand, the possibility of a negative reaction from their doctor (or other practice staff) made the option of non-disclosure preferable. On the other, fears about confidentiality within the surgery and as it related to financial institutions and potential employers was allied to a lack of knowledge regarding their individual rights with regard to consultation and privacy. Conversely, there were no incentives to disclose. Their doctors did not ask them and did not make known to them any policy regarding confidentiality or diversity. In short, although men may have unfounded fears, they experienced no interventions to allay them.

## 4.2 MEN WITH LONG-TERM ILLNESS (NOT HIV)

The men with long-term illnesses differed from those with no medical conditions in that all but one had a doctor that knew he was gay. Only one actively concealed his sexuality. The reticence of this elderly (83 year old) man was associated with his feelings regarding privacy around sexuality in general. Formerly married, his closest friends did not know he was gay and for him, there was a disconnection between his sexuality and the rest of his life, including his health. He felt it was appropriate to conceal his sexuality despite consulting his GP for erectile dysfunction.

*Why don't you tell the doctor?*

There's no reason to [...] He's seeing me for myself. But for no other reason. I told him, mind you, that I can't get an erection [...] Which he can't account for. That's why he gave me those tablets.

Aged 83, White British, LTI

For all the other men with long-term illnesses, the question of whether or not to disclose was profoundly influenced by their relationship with their doctor which tended to be more developed.

Again a minority disclosed their sexuality to their doctor because they had a general and political policy that anyone who was going to be closely involved with them should know. For the majority, however, their sexual identity became gradually known through general interaction. That is, they did not seek to hide their sexuality and, with increasing involvement and trust, their sexuality came to be understood. For example, the following respondent assumes that most people he meets would know, sooner or later, that he was gay. He neither hides nor discloses it. His relaxation about his sexuality means that he has never actually questioned whether his doctor knows he is gay but never censored himself in front of his doctor.

**I'm assuming he [doctor] knows I'm gay. Because [...] my partner was registered at the same practice and I told my GP when I was going through the divorce so to speak, that I had split up from my partner and [...] you know even though I haven't told them in so many words, you know, I'm very relaxed in my attitude about my sexuality.**

**Aged 39, White European, LTI**

Just as he had not told his doctor in so many words, it was not necessary for his doctor to acknowledge that he was gay, merely for him not to change his attitude and treat the whole question with equanimity.

A key factor that influenced whether or not men disclosed their sexuality was whether they saw it as relevant to their health. All but one man felt that it was. The following respondent compares his GP to the consultant he sees for his multiple sclerosis.

**It's just that when I see my GP it's ... I feel it's important that he knows about my lifestyle. Because there are things in my lifestyle that are related to my health. So I think it's an important thing to know. To have all the information and with my specialist it's not always relevant.**

**Aged 39, White European, LTI**

Other men feel that aspects of their lifestyle should be known to their GP as they might affect their health or treatment. For example, some believed that the amount of sex they had was relevant to the quick diagnosis of minor conditions.

**Because then... I suppose he's better equipped. Like when I got the herpes, to be able to tell me straight away that it was that. And a suitable medicine for it.**

**Aged 68, White British, LTI**

For some men, the process of disclosure was about getting the most out of a GP and developing their capacity to give them a better service. The following respondent reports that the openness with his GP as regards his sexuality was two-way. He felt that his GP (who was heterosexual and roughly his own age) seemed progressively more comfortable talking about his sexuality.

***What do you think his attitude is towards homosexuality?***

**Well I really don't know actually. I suspect he's more comfortable. He's become more comfortable over the last few years. But I really don't know. I don't know what his attitude is. It feels to me I get a good feeling about it now. I feel more relaxed talking about my private life.**

**Aged 39, White European, LTI**

In contrast to these men were two who suffered from long-term mental health difficulties – both were dissatisfied with their GP. Their sexuality was relevant to their health, but in different ways. The first reported feeling reticent to talk of his sexuality in front of his GP and many other doctors because he suspected they would draw a pathological connection between his sexuality and his mental health difficulties. Thus he was concerned both about being stigmatized around his sexuality and his mental health difficulties and he felt the two came together in a way which reinforced the general stigma he felt in health care settings.

I think there's a hidden agenda in the medical domain and it's that those with kind of... who are either gay or bisexual more often have mental problems. And certainly the psychiatrist I believe he felt that my mental illness was attributable to my sexuality and nothing more. So I resent having to say that I'm kind of gay. Because I don't want them to think 'Oh OK some sort of personality disorder, gender crisis, so therefore he would be mentally ill'. I think I deserve to be treated as somebody who's mentally ill, regardless of my sexuality.  
Aged 22, White British, LTI

The second man with mental health difficulties made a clear connection between his sexuality and his depression. He was asked why it was important that his doctor knew not only that he was gay, but also about the difficulties associated with being gay.

**[Being gay] affects you mentally more than anything really, I'd say. Because you only see other gay people when you go out and stuff. You can't just walk through the street and just meet other gay people. Because practically everyone else is like heterosexual [...] in a way it can make you feel a bit of an outcast. Because... just because of your sexuality.**  
Aged 27, White British, LTI

He felt that his GP had no interest in his life generally, including his sexuality. Because he suffered from depression, he needed a GP who would treat him in an integrated way. Because, for him, his sexuality (like everything else) was connected with his depression, he needed a GP who was going to take account of that. He had not found one.

The men with long-term illness had less concern regarding confidentiality of their notes than the men with no medical conditions. With a couple of exceptions, they had little idea about their rights or the policies in General Practice regarding confidentiality of, and access to, notes. However, in the vast majority of cases, this was not a concern. All those who had critical illness or disability insurance had already taken advantage of it. Younger men were not at the point of thinking about insurance or mortgages and the older men had generally paid off mortgages already.

*Do you have any life insurance, mortgage or unemployment cover?*

**I've got no life insurance, I've cancelled that when I bought my house. I've got some sort of health insurance type of thing.**

*When you got your mortgage did they want to know anything about your HIV status?*

**I don't know if they asked me. That was quite a long time ago [...] I started buying my first house and just moved my mortgage from one house when I brought a new one, to the same mortgage company. So that would have been twenty years ago [...] Though the current one I bought outright about ten years ago.**

Aged 51, White British, LTI

For these men, their concerns about disclosure shifted to whether it was relevant to their condition or their care. That is, unlike the men with no medical conditions, their sexuality was already known to their GP and it was now a question of whether or not other doctors or medical staff needed to know. This respondent had already described an incident where a nurse intimated to him that she knew he was gay. He felt that it was irrelevant for her to know.

*How do you feel about the idea that say the urologist would be reading a note that this person is homosexual or gay?*

**I would feel very angry if it wasn't relevant. To put it on a piece of paper and it wasn't relevant. But of course I don't see any pieces of paper. Because I don't ask to see any papers. You know I suspect that something might have been written in a letter to my GP. But to be honest I can't... I don't care.**

*You don't care at all?*

**I don't care enough, no. Yes, I care, but I don't care enough. You know when I'm confronted with [the nurse] that's when I get upset. And I say, 'you know it's not relevant'.**

Aged 39, White European, LTI

### 4.3 MEN WITH DIAGNOSED HIV

Like those with a long-term illness (and unlike those with no medical conditions), the majority of men with diagnosed HIV infection felt that their GP knew about their sexuality. Similar themes emerged. First, disclosure to a GP was influenced by the nature and quality of the relationship with that GP. Second, how men chose to disclose and for what reason was dependent on the extent to which they saw their sexuality as relevant to their health.

Three men had not disclosed to their GP and would prefer them not to know. In two cases this was because they feared a negative or homophobic reaction from their GP or surgery staff.

**I wouldn't go openly in declaring it, for two reasons. One is the staff – the receptionists are of a certain age and therefore one immediately thinks that they'll have a certain view of life and they probably haven't. Maybe I'm being a bit unfair to them. I suppose it's a bit like telling your mother 'I'm gay' [...] that's again the reason why I suppose some people don't tell their doctors they're gay or HIV positive.**

**Aged 49, White British, HIV+**

The third man simply did not respect his doctor. He avoided consulting his GP saying he lacked basic interpersonal skills and never listened to him or treated him with respect.

Of the remainder, a small minority of men had told their GP about their sexuality as a matter of policy, like men in the other groups. For the majority, disclosure had occurred as their relationship with their GP developed. That is, their sexuality eventually came up in conversation. Like the men with long-term illnesses, increased contact with their GP eventually brought a wider understanding of the respondent's life, including his sexuality.

***Did you disclose or did it just come up in conversation?***

**Well I think it says in my notes that I live with my partner anyway.**

***Did you disclose to the other doctor then?***

**Yeah! I mean I've never really come out. I've never found it necessary. [laugh] In that I think I'm quite... I'd like to think I'm quite openly gay.**

***How did it go with the first doctor?***

**Yeah it was fine [...] she asked me something and I said 'Oh my boyfriend thinks this'**

**Aged 32, Asian, HIV+**

None of the men with diagnosed HIV reported overt negative or homophobic reactions or responses from their GP. Overall, GPs were seen as acting in a professional manner.

The nature of disclosure was influenced by the extent to which men felt that their sexuality was relevant to their health care. Overall, the men with diagnosed HIV were most relaxed about whether or not their GPs knew they were gay. Many felt strongly that their GP ought to have a basic knowledge about their lives (who they lived with, their intimate relationships etc.). However, a distinction must be drawn between this and their attitudes towards their health needs in terms of their sexuality. Men were at pains to point out that their health needs as they relate to GPs were unlikely to be influenced by their sexuality. They were concerned that they were treated with professionalism and competence and they were especially concerned that they were treated equally in comparison to heterosexual patients.

***Do you think your sexuality is relevant to your doctor?***

**No [...] Because patients should be treated the same, they should all be looked at with the same risk factors. They should all be looked at with the same level of detachment. They should all be looked at with the same level of appraisal. There are very very few, if any, specific points which differ in people's health, between gay, straight, lesbian, bisexual.**

**Aged 32, White British, HIV+**

As most of the men with diagnosed HIV had disclosed their sexuality and their HIV status they were not overly concerned about confidentiality of their medical records at the surgery. Most also trusted their GP to conform to confidentiality policies, although they were generally not very well informed about either such policies or their rights regarding them. Only a few men have actually asked to read their medical files at their surgery.

Two men had concerns that their GPs had confidential information on the front of their medical files including their HIV status in large print. One challenged this and the GP rectified it.

**Actually on the front of my notes it was written 'HIV-risk' because that was written on the front, back in the '80s. 'HIV-risk and hepatitis risk'. I got them to them to cover it over on the front of my notes [...] And the notes were just left on the top of the counter top. I'm sorry, get that removed now!**

**Aged 32, White British, HIV+**

The second man had not had the confidence to insist on having it removed and was waiting until he found a new GP.

**I do have a problem that in big red letters on the front of my GP notes it says 'HIV positive – AIDS in brackets'. And I don't see that is so necessary to be on the front of my notes on the envelope of my notes with my name, my address, for anybody to see. But I don't really have a big problem with it. I just don't think it's so necessary, I know, they should know.**

***Is that something you've ever raised with them?***

**No, I was hoping that when my notes got sent to my new GP I could then say, 'That envelope's looking really really tatty and I don't really like that being on the front of it' and he'd change it for me. It would make me a lot happier if it wasn't on the front [...] I know it's got to be there or a dangerous infection sticker that doesn't actually say what infection, just, you know, protect yourself.**

**Aged 36, White British, HIV+**

In contrast, two other men recognised examples of good practice regarding confidentiality of their notes. In the first instance, a consultant breached confidentiality when he wrote to the respondent's GP informing her of her patient's sexuality and HIV status.

**My neurologist who saw me because of the stroke business sent my GP a letter saying I was HIV positive and gay. So my GP wanted to see me and that's why I went [...] My GP fortunately is very good and has basically taken the letter out of the files and put it into a cupboard box in the doctor's surgery.**

**Aged 30, White British, HIV+**

The second case involves a GP who provided a medical reference for employment.

**There was only one point when I started my current job, they asked for a medical check because I'd been off work for two years [...] I was really concerned that they were going to mention it in the report that the GP had to give. But in fact the GP said, 'There's no reason why this person shouldn't do this job' and just left it at that.**

**Aged 32, Asian, HIV+**

## 4.4 DISCUSSION

Disclosure of sexual identity or homosexual activity can be seen as an indicator of the quality of the relationship between a gay man and his GP. For men with no medical conditions, the limited nature of the relationship with their GP does not facilitate disclosure. It simply does not come up in short and infrequent consultations. Men with long-term illnesses and men with diagnosed HIV infection were alike in that the majority had disclosed to their GP. Here disclosure was an indicator of the depth and quality of the relationship.

This analysis tells us much about how disclosure comes about and why it does not. It is difficult to talk about disclosure in this context because it is an intervention against an assumption. That is, men perceive (usually quite rightly) that unless they overtly say otherwise, others will assume that they are heterosexual. For those who do not 'disclose', they are in effect choosing to let this assumption go. Mainly because they do not feel that the limited nature of the relationship with their doctor merits an intervention of disclosure. This is likely to be the case with most individuals with whom they come into contact. The exception to this is a small minority of men in all three groups who are what we might call 'political disclosers' (that is, they disclose their sexuality on principle to all those people with whom they have any interaction).

For the majority however, disclosure is merely part of an increased relationship with the doctor (as it is with all other people with whom they come into contact). In other words, as the doctor gets to know more about you, he or she will also find out that you are gay. Thus for the majority of the men who have an ongoing relationship with their doctor (those with long-term illnesses and HIV infection), disclosure occurs 'naturally' and is seldom an active intervention. The majority of these men report having no problem with their doctor knowing they are gay and feel that it enriches the relationship and therefore their capacity to work together to manage their conditions. Indeed, it is arguable that the relationship of care they need to establish with their doctors would be untenable without disclosure of sexuality (amongst a range of other things).

We might be content therefore to say that gay men do not need to disclose to their doctors until they have to establish a more intimate relationship of care with them and at this time, disclosure will occur smoothly as part of this process. However, to do so is to ignore the underlying anxiety many men clearly felt around disclosure. Anxiety expressed by men with no medical conditions centred on a perception of a difference between the self and the doctor. This may be as little as knowing (or assuming that) one's doctor is heterosexual to ascribing one's doctor with certain religious or cultural beliefs. It is the uncertainty regarding the reaction of the doctor which provides the final disincentive to disclosure.

Again, we might think that this is a relatively minor matter as the relationship with the doctor is generally cursory. Those who have (by necessity) deeper relationships with their doctor have, on the whole, disclosed with little problem. However, such anxieties and concerns ensure that any relationship with a GP is likely to remain cursory. That is, it impedes development of a relationship and over time, could prove detrimental to the patients' care. Anxiety is often expressed through concerns over confidentiality, especially as this relates to the purchase of financial and insurance products. However, what is striking are the levels of confusion regarding both their own rights and the practices of financial institutions and doctors.

For GP surgeries, the question of disclosure is easily addressed. There are many opportunities for surgeries to make it known to all patients that they will treat them equally regardless of sexuality (for example equality or diversity statements displayed in waiting areas or distributed during the registration process). A discreet indication that a doctor will welcome any disclosure a patient feels he wants to make and that such disclosure will prejudice neither the quality of care nor the doctor's manner would be sufficient to put most gay men at their ease. What is striking about our analysis is that with a few notable exceptions, the majority response of doctors to disclosure was either neutral or positive.

# 5 Presenting to the GP with sexual health symptoms

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We have seen in the previous chapter that differences in the quality of the relationship between patient and GP have a fundamental effect on men's capacity to disclose their sexuality. Thus, for men with long-term illnesses, disclosure of sexuality takes place within the context of a relationship which is developing and for the most part functional. For men with no medical conditions, there is little space for this relationship to develop and the rarity of interaction combines with men's fears around their doctor's possible reaction and their concerns over confidentiality to lead to non-disclosure. Men with diagnosed HIV fall somewhere between these extremes – most had disclosed their sexuality (and HIV infection). However, their relationship with their General Practice staff was rarely very fundamental to their health care.

In this chapter, we explore the relationship between sexuality and primary care further by examining how and where men present with a range of symptoms and concerns relating to sexual health. This analysis allows insights into the way different services are perceived and used by gay men and the factors which influence which services are used in which ways. As in the previous chapters, we deal with the men with no medical conditions first, then men with long-term illness and men with diagnosed HIV infection.

## 5.1 MEN WITH NO MEDICAL CONDITIONS

Although few men in this group had disclosed to their GP or primary care providers, some had received sexual health services in a GP surgeries. Two men had tested for HIV through their GP. The first did so without disclosing his sexuality but after disclosure of multiple sexual abuse. He was a young, relatively recent migrant to the UK and was unaware of GUM services. Although the service was entirely satisfactory to him he would use GUM services in future.

*Why did you decide to use your GP instead of the GU?*

I wasn't aware... as I said, yeah, I wasn't aware.

*Did the doctor talk to you about why you wanted [the HIV test] or anything?*

No. We never talked about that. Just like I said well I would want to be tested now. But well I've been [sexually] abused before and I just don't know whether I got infected. You know. You don't have a choice if someone attacks you [...] So that's it. And I think he was understanding. So he carried [out] the test.

Aged 19, Black African, NMC

The second had always disclosed his sexuality to his GPs and had been tested for HIV in two different GP settings. Although he was aware of the range of GUM services available to him in London, he was more concerned with familiarity than anonymity. On both occasions the service was acceptable to him.

And I did say, 'Could I have a [HIV] test'. And he did ask why and I did say that I'd been unsafe. And he did say, 'Have you thought about all the counselling you're supposed to have before you do it'. He certainly did all that.

Aged 44, White British, NMC

Finally, a younger man had received a full sexual health screen from the practice nurse at his GP surgery which had a pre-existing relationship with his family. Although the nurse reassured him that none of their interaction would be recorded on his medical notes, he decided not to include an HIV test in the screening as he felt this might have an impact on his later prospects for financial services.

I'd just come out of a relationship. I just... basically for peace of mind. I was like I'll just go for the tests before I came to university [...] I'd never had unsafe sex and I'd never had penetrative sex before. So I was like 'OK I'm pretty sure I'm clear of everything', but I just want to get it done. So I had gonorrhoea, chlamydia [tests] and there was another one, but it wasn't HIV.

*Why did you go to that particular nurse? What was it about her?*

Because me and my sister are quite close. And my sister had used her before [...] I didn't tell her I was gay [...] she asked me a lot of questions about how many times I'd had sex [with women and with men] in the past six months.

*So she's obviously had some kind of... some training about sexual history ...*

Yeah! [laugh]

*OK. And how did she give you the results?*

I had to go back and make an appointment a fortnight later [...] She had the results in front of her and she went 'OK I'm just going name the test and tell you whether it's come up with any results'. And so she just did that. And there was no hesitation or anything. It was just like 'no, no, no'. And that's it. [laugh]

*Have you ever had any concern about how information about you might be recorded or used or kept?*

[...] when I went to see the nurse practitioner she said, 'Anything you tell me when I'm talking to you, rather than medical conditions, will not be noted on your file'. I was like 'alright'. So like the fact that I'd slept with one man would not be there.

Aged 19, White British, NMC

These three men were the exception to the rule however. The overwhelming majority of men with no medical conditions reported extreme reluctance to present to their GP practice with sexual health concerns. Several men related accounts where they had attempted to do so, but had 'lost their nerve' at the last minute.

I went to see [the GP] once [with a genital rash] and I couldn't actually do it. Years ago. And I think I said I'd got a toothache or something [...] I was a bit concerned it was an STD. But it was just a rash.

*So do you remember what ended up happening instead of talking to the GP about it? Did you go elsewhere?*

No, I put Savlon on it. [laugh]

Aged 35, White British, NMC

Other men presented with symptoms where disclosure of sexual practice would have been relevant, but did not disclose such activities to their doctor. The following man presented with haemorrhoids and, though he recognised receptive anal intercourse may be part of the cause, did not disclose that he engaged in the activity.

When I went to see her for the piles it was, kind of, like this is happening and there's like ten reasons why this could be happening and half of these reasons could be my sexuality [...] and they didn't know that about me. I would be quite happy with not having too much information in one place and like spread it around a bit so no one gets too much information.

Aged 27, Black Caribbean, NMC

Likewise, another man with a persistent sore throat that had not responded to antibiotics did not mention his concern that it may be an STI.

*Do you think that the doctors there know that you're gay?*

No, not at all [...] I've never had any illness that could be related. I mean with the throat thing I was a bit worried for a while. I was a bit like 'Oh!' but I waited for the doctor to see what it was before I went saying anything. And I suppose deep down I probably was a bit worried about what he might think and what I might have to have.

Aged 19, White British, NMC

We have seen in chapters 3 and 4 that men with no medical conditions have a cursory relationship to their GP practice and relatively little experience of active monitoring their health. This facilitates a relatively shallow relationship where disclosure rarely occurs. We have also seen that men felt a substantial disincentive to disclose their gay identity. The symptoms we have mentioned above require them to go further and discuss in detail, not only their sexuality, but also their sexual practices with their GP. It was clear that the majority of men found this prospect unacceptable. Questions of stigma around their sexual practices come to the fore. Some men voiced concerns that medical practice has a history of pathologising both homosexuality and homosexual activity. Thus, they were understandably sensitive when their homosexual activity led to a pathological symptom. In the following case, the respondent made the point that he was generally 'out' socially, but once his sexuality entered the medical arena (and questions of his sexual health were raised), he felt suspicious that he was open to being pathologised and thus stigmatised.

*So what do you think are the barriers [to presenting sexual health matters to one's GP] at the moment?*

**... in this case it isn't about me. It's about how society is [...] and the way society functions. That's one area of my life that I'm [...] quite careful about. Even though in terms of my lifestyle I'm out to everybody, my colleagues, my family, my friends and it's not an issue. But obviously it is an issue [with my doctor] because [...] I'm conscious who I've spoken to about whether I'm gay or not [...] Sexual health and so on [is] something that I like to have some measure of control over [...] Until sexuality... in this case specifically homosexuality doesn't have the stigma that it has for some people [...] there's a long way to go.**

**Aged 41, White British, NMC**

The question of the pathologising of homosexuality within medical discourses and practices cannot be underestimated. We might assume this to be an 'old' problem, largely eradicated with changes in policy, practice and a liberalisation in the attitudes of doctors. However, it was very much alive in the ways in which gay men organised their service use and saw their health (sexual and otherwise). However, the effects of such pathologisation were more complex and, on the surface, more benign than we might imagine.

We asked men with no medical conditions when they would see it as appropriate for them to intervene and make their sexuality known to their GP. The majority said that they would only see this as necessary if they had a good medical reason to do so. That is, a health concern related to their sexuality. Overwhelmingly, this was seen to be the testing, diagnosis and treatment of sexually transmitted infections.

*Have you ever thought about telling [your GP] that you're gay?*

**I haven't had reason to do so. Perhaps if I'd had a health concern, if I'd gone to see [GP] – which isn't likely I suppose – to do with perhaps wanting an HIV test. But I wouldn't go to my doctor to do that. But were I to do so then I probably would try and tell her the whole story. I wouldn't mind telling her I was gay – I should think.**

**Aged 41, White British, NMC**

Thus, within the GP surgery, sexuality became relevant only if it was related to a pathological symptom (an illness). This was entirely consonant with the relationship that these men (and indeed most people) would have with their GP. They do not see their GP unless they are ill and their GP responds by diagnosing and treating their illness as quickly as possible. For example, they would never consider drawing attention to their diet unless they were suffering diet-related symptoms (gut pain, weight gain or loss etc.). Likewise, they would never consider drawing attention to their sexual practice unless they were suffering related symptoms (NSU, syphilis etc.). In short, for the most part, we present to our GP as a set of basic physical symptoms (and often, what makes a GP good or bad is their capacity both to treat the symptoms and to see past them to the whole person presenting with them).

However, all symptoms are not equal. Some symptoms are seen as signs of irresponsibility or lack of personal control (for example, smoking related symptoms, obesity *etc.* – see Gostin 1997; Katz 1997) and are thus becoming increasingly stigmatised. Other symptoms have always been the subject of stigma. A prime example of these are sexually transmitted infections. Overwhelmingly, these men would not consult their GP with symptoms related to their sexuality because, by definition, such symptoms were stigmatising.

*What are the reasons for [not presenting to GP with sexual health symptoms]?*

Because I still think people perceive sex as dirty. And I'd like my GP to see me as Mr [name] who has the bad jaw. Not the gay man who's had so many partners in the last twenty five minutes and, you know, does this and does this and has had crabs seven times and all this sort of thing. I'd like them separated.

Aged 35, White British, NMC

This above quote speaks to a very particular fear that homosexuality (and indeed, any sexuality that deviates from monogamous heterosexuality) would be seen as 'dirty' and 'irresponsible' by society at large and by extension the GP. Thus, the respondent, quite understandably, did not wish to discuss his sexual behaviour with his GP because he did not want to be seen as dirty. The following respondent makes a distinction between an examination of his penis or his anus by his GP (which he would find acceptable) and discussion about his sexual practice. In this case, he did not want to be seen as irresponsible.

*... thinking about the current GP that you have now, if he needed to examine your anus, [or] ... do a urethral swab, all that kind of thing, would you feel comfortable going to him?*

I would feel comfortable. Because I've never known him to be anything less than totally professional. And very charming and pleasant on a sort of superficial, cocktail party level.

*Do you think that you'd be able to speak to your doctor now about the kind of sex that you have?*

[...] Oh. It's very interesting. I mean I feel ashamed you see because I've had unsafe sex. And I think whoever I was saying it to, a relation, a friend, a straight doctor, a gay doctor, a woman doctor, I would feel embarrassed. Because I have not done as well as I could have...

*So you would be anticipating a response from them?*

Well I think their response would be completely professional and neutral or even kindly. Because that's how they're meant to do it. I don't know whether I – possibly with another gay man because we all know what we're like on occasions. It might be a little easier perhaps. But the problem would be within me. Because I always try to do my best at everything and I'm very hard on myself when I don't. And I've not done as well as I could have by taking risks with my health. So I'd be embarrassed with virtually anybody.

Aged 44, White British, NMC

Like many men, it is precisely their GPs 'ordinariness', their integration with society and the community that makes them inappropriate to discuss extra-ordinary issues such as sexual responsibility. This man would feel ashamed discussing these issues with anyone *including* his GP. Thus, the extent to which homosexuality and homosexual practice is stigmatised in wider society will be reflected within the General Practice context.

Men tended to contrast their GP surgery with their GUM clinic when it came to dealing with symptoms allied to their sexual health. The divide between the GP surgery (where all health symptoms are initially diagnosed, treated or patients referred) and the exceptionalism of the GUM clinic (which is self-referring, anonymous and specialises only in the diagnosis and treatment of clinical symptoms relating to sexual activities) allows men to keep their sexuality sequestered from their overall health care. For many men this was preferable. It is worth looking therefore at how men perceive their GUM service and what they value about it.

... And there's the whole stigma of sexual problems in any case. Which, maybe thinking about it, I would have considered demeaning to bring to a [GP] surgery. Almost like a lapse of lifestyle which means you have caused a silly and unnecessary problem in an overloaded environment.

*OK. So there's a sort of moral imperative there to a degree?*

I think so. Certainly GU clinics always used to be dark and damp basements and everybody would be there with their tail between their legs. Probably for women as well. That seems to have changed. Certainly [clinic name] is a much more lively, understanding, hopeful, colourful environment. And there is no stigma at all.

*Aged 51, White European, NMC*

GUM services were seen, in opposition to GP services, as places where the normal standards of sexual probity were suspended. That is, they were seen as 'non-judgemental' and therefore less stigmatising. Thus, men could discuss their sexual practices with relative ease.

*If I was to turn round and say, 'I've shagged seven people today and six yesterday and I was in the toilets and saunas the day before'. I don't expect them to bat an eyelid. If I said that to my GP she'd probably throw me out.*

*Aged 35, White British, NMC*

Overwhelmingly, GUM clinic staff were characterised as having substantial personal experience in dealing with "these problems" everyday. Thus, irrespective of their own sexuality, they could be trusted not to be disapproving of (homo)sexual practices or any ill-health that arose from them.

*[GUM staff] deal with 'that sort of thing' everyday really. I mean if I wandered into my [GP] surgery whether it was this doctor or any of the others that I have seen and said you know 'I'm gay, I have this, I'm worried about this, you know and I want to be tested' and everything, and I was as blatant as that I think they would just be horrified. It would take them a good minute or two to catch their breath and just be like 'OK lets deal with this'.*

*Aged 27, Black Caribbean, NMC*

The GUM clinic was constructed as a specifically sexual place. This construction had several variants. For some, this was because, regardless of their sexual practices, everyone was there because they were experiencing difficulties.

*... me and my partner were sitting in the waiting room and there was just so many different types of men. I was expecting it to be full of gay men. I didn't actually realise that straight men use the clinic as well. But it was quite obvious there were quite a few there.*

*Aged 19, White British, NMC*

For others, it was a place where sexual minorities or those with traditionally stigmatising identities or conditions went.

*Yeah, I mean you know prostitutes go in there [to his GUM clinic]...*

*Aged 27, Black Caribbean, NMC*

Most men considered them to be 'gay space', or at least a 'sexualised' space, where sexual ill-health was the norm and no overt stigma was attached to it.

*...it's funny because – Oh I don't know. I must have been ten times altogether and you get hit on every single time while you're there. And it's like, 'you're in a sexual health clinic, you really think I'm going to date you?' [laugh]. You're obviously here for a reason [...] I think I feel more comfortable because I can relax you know. It's like when you go to a bar... I very rarely go to a straight bar because I feel more comfortable in gay bars.*

*Aged 35, White British, NMC*

What this belies is a very fractured notion of health and health treatments. That is, for men without medical conditions, doctors are there solely to treat symptoms (rather than holistically maintain health or manage an illness). As a consequence disclosure in General Practice was rare and

anonymity was actively sought when addressing sexual ill-health. This separation of sexual (ill) health and general health was profound, but difficult for men to articulate.

**I think there is a separation [between general health and sexual health]. How that defines itself I don't think I know myself yet [...] But it's almost instinctive [...] It's a very bizarre one isn't it. I mean I had cystitis when I was about ten I think it was and I got checked out by the GP then. I think if I were to have cystitis again now I'd be OK with the GP... But because I am a gay man my instinct would be to go for the GU clinic. Just to see if, you know, is that just a symptom of something worse that's going on.**

***OK. So you think about it differently because it could relate to sex and if it does relate to sex then you want to be in an environment where...***

**Where I can talk fairly freely about the kind of sex I get on with.**

**Aged 30, White British, NMC**

However, the equation of symptoms allied to sexuality with GUM medicine also tied it to pathology and stigma. That is, as GUM clinics were there to treat sexually transmitted diseases, they immediately cast homosexuality as intrinsically unhealthy or pathological. Questions of promiscuity and unpleasant stigmatising symptoms were brought to the fore. What was clear about all these accounts was that the presence of the GUM clinic did nothing to ameliorate men's sense of a broader stigma attached to their homosexuality. Rather, in a paradoxical way, by sequestering sexual symptoms to a specialist space where the normal rules of sexual probity were suspended, it strengthened those rules (and hence stigma) in other settings such as GP surgeries. In short, whilst GU services provide an excellent individual service, their capacity to reduce overall stigma must be questioned.

## **5.2 MEN WITH LONG-TERM ILLNESS (NOT HIV)**

The men with long-term illness had a deeper and richer relationship with their GP surgery because of greater need and closer involvement. As a result most had disclosed their sexuality to their GP. However, questions of stigma related to sexual ill-health influenced where they went with various complaints and the types of disclosures they made.

For the majority of men with a long-term illness, that illness was having an effect on their sexual or emotional (intimate) life. Most discussed their sexuality with their GP because they were experiencing permanent or intermittent erectile dysfunction (usually as a result of various medications).

***Do you and your GP discuss various aspects of your sexuality? Things like... if it's part of the symptom or...***

**When it was coming to talk about the problem... as in the last ten years the nerve damage started to come into it. And then I started to find it hard to get erections. I would then get depressed and perhaps go to him and talk to him about that and he would then send me off to a hospital to see... he'd refer me to the hospital to see a specialist in that area [...] So there was a question of having intercourse with my boyfriend or something like that would come into it.**

**Aged 51, White British, LTI**

One man was suffering from stress related to his personal relationships.

**I think he knows I'm gay because when I had this trouble with the family I took... yes I think I took some letters to the surgery and he diagnosed me as having anxiety. Which I certainly did. The trauma with this boy harassing me...**

**Aged 68, White British, LTI**

Men valued doctors who responded to disclosures regarding their sexuality in the same way they responded to other disclosures: with professionalism and clear competence. That is, it was not important whether doctors necessarily enjoyed talking about sexuality. Nor was it important that

they knew much about gay lifestyles or sexuality. Rather, it was important for them to be open and aware, to listen to the patient when he told them that his sexuality was relevant in this instance and to treat the patient with respect.

Men took the same range of concerns/ symptoms to other medical specialists who were treating their conditions. For example, some of the men suffering from erectile dysfunction reported their difficulties to specialists and as a result accessed other hospital services. The following respondent talks of accessing urology services. However, he makes a distinction between his consultant (who he sees to manage his MS); his GP (who dealt with his health and well-being more holistically); and the urologist he accesses for support concerning erectile dysfunction.

**I've never told my [MS] consultant, who I see once a year. I don't know if they know.**

***So it's not the same as your GP [knowing]?***

**No.**

***Why is it different than your GP knowing?***

**Well I suppose it's very specialist isn't it, the MS? It's specialist symptoms and relapses and GPs it's more general. You know like when... like for instance when I split up with my partner, that was relevant that he knew about it [...] Because I was going to see him with you know complaints of... you know stress-related complaints and so it was relevant that he knew of my home situation...**

**Aged 39, White European, LTI**

Another respondent was referred to a psychologist through his diabetes clinic, who in turn gave him assistance in coming out.

**The doctors there who would deal with me would know that I was gay. Because that all came up when the problem with the results of the diabetes effecting my body [referring to erectile difficulties]. And that brought all that out [...] It was through [hospital name] that they referred me to their sexual psychologist. Because it might [not] be the diabetes that was causing the problem [...] when I said I had a lot of problems with becoming gay and maybe that played on my mind. Because I'd never had any problem with girls so they said see a psychologist to talk about it and the fact that I was a very shy person and had difficulty meeting people. And that was before I found out I was gay. And of course when I found out I was gay I started getting into male relationships. I would go and discuss those things.**

**Aged 51, White British, LTI**

The three men who were unhappy about their GPs all relied heavily on other clinical services with varying degrees of success. For example, one who suffers with mental health difficulties compares an accident and emergency liaison psychiatrist he saw after a suicide attempt, to his own psychiatrist. He told the A&E psychiatrist that he was gay.

**... he kind of went, 'OK'. And kind of nodded his head. And I think he was gay himself. And I didn't know if he was doing that because it was like the penny dropped. Oh that's why you're kind of ill. And I hope that wasn't the case. Or maybe he appreciated and he could relate to me and so I don't really know.**

**Aged 22, White British, LTI**

Another makes up for deficiencies in his GP practice through his close relationship with the consultant and staff at his oncology clinic. He feels his treatment there is more integrated than at his GP.

**... when I go along [to my oncologist] we have general chats and when I go and see him. And he says, 'What are you doing tonight'. And 'Oh I'm going out with my boyfriend for a meal or whatever'.**

**Aged 18, White British, LTI**

It was clear therefore that men with long-term illnesses were not averse to discussing aspects of their sexual and emotional life with their GP and other doctors or specialist staff. However, the types

of symptoms they were willing to discuss did not include sexual interactions (or infections) nor anything that required detailed discussions of their sexual lives. In other words, men took different types of sexual health symptoms to different services and they only took those which were most stigmatised – sexually transmitted infections – to their GUM clinic.

The overwhelming majority of men attended or would attend a GUM clinic for procedures and tests relating to sexually transmitted infections. Men continued to attend GUM clinics, even when they were significantly dissatisfied with the service they received there.

**... the doctor and the nurses there are quite good. But the whole set up is awful [...] You used to have to make an appointment. Now under their new scheme you can just walk in. But you can wait there for hours. And if you happen to miss hearing your name called then as far as they're concerned you've walked out.**

**Aged 51, White British, LTI**

Men were proactive in finding a GUM service that suited them (where this was possible). Men attended GUM clinics for a range of reasons. First, they assume that if they did present to their GPs with sexually transmitted infections, they would be referred on to their GUM clinic anyway. That is, unlike all other specialist services, GUM is open access. Therefore men would prefer to cut out the need to see a GP, especially if they are symptomatic and needed treatment quickly. The GP was seen as merely adding to the protracted waiting time for GUM appointments.

**You wouldn't go to your doctor for STDs and things I don't think. Because he would have to send you off to a clinic to be checked out.**

**Aged 51, White British, LTI**

Men with long-term illnesses displayed the same deep reservations about discussing their sexual history and sexual risk practices with their GP as the men without medical conditions.

**I would prefer not to see a GP full stop for any sexual health matters. It's down to discretion and, almost kind of, people-skills that you need. And it might be quite a sensitive issue. And I don't want to come up against it with a doctor who doesn't deal with these sorts of things very often. I'd like to speak to somebody who understands more.**

**Aged 22, White British, LTI**

Like the men with no medical conditions, they saw the GUM clinic as a place where a non-censorious attitude towards sexuality was adopted.

***Are there other differences?***

**No. They're very just in to that. Their own special sphere. They're not asking any other questions. They're very business-like.**

***So their approach is the same.***

**Yeah. Yeah. It's very clinical.**

***Professional.***

**It's very... sterile really.**

**Aged 51, White British, LTI**

Interesting in this respect are the kind of genito-urinary or rectal complaints men did bring to their GP. Most made distinctions between those that were related to STIs (which they would bring to their GUM) and those which were not related to STIs (which they brought to their GPs).

**I've been to my GP on one occasion [...] when I came back from abroad and I had the itches [...] And it's turned out to be some sort of crabs or something [...] probably been caught travelling on ferry boats between the Greek islands. You catch something off the blankets you know basically [...] Because I knew I didn't have any sex with anyone for those two weeks.**

**Aged 39, White European, LTI**

Most telling in this respect was that none of the men who suffered from erectile dysfunction had ever considered taking these symptoms to a GUM clinic.

**...except when it came to a problem with my diabetes and my sexual organs, then I would discuss that with my GP. I wouldn't go and discuss that with a GU clinic because it's not the sort of expertise that they would have.**

**Aged 51, White British, LTI**

Therefore, the effects of stigma inherent in the practices of the men with no medical conditions persist, in a more nuanced way, in the practices of the men with long-term illnesses. That is, despite having disclosed their sexuality and often discussed symptoms and difficulties associated with their sexual practice both with their GP and with other specialists, men with long-term illnesses still bring symptoms associated with sexual risk to their GUM clinic. They do so because such symptoms remain stigmatised and therefore unacceptable in a GP context. Although, their reasons for bringing these symptoms to GUM clinics were also connected to the GUMs specialism (carrying out procedures and tests), they are also related to the GUM's capacity to suspend the normal rules of sexual probity (in other words, to be 'non-judgemental').

GPs were seen as managing general health. What was absent from the accounts of GUM given to us was any notion that their use and experience of GUM care was related to other aspects of their health or their illness. That is, there was no notion of 'sexual health' and no sense in which GUM might be integrated with or even overlap with either their other specialist care or the care they received from their GP. This, in spite of the fact that a sizeable proportion of men suffered from ongoing erectile dysfunction related to their illnesses or treatments.

### **5.3 MEN WITH DIAGNOSED HIV**

Like those with other long-term illnesses, men with diagnosed HIV were more open with their GPs about their sexuality. However, such men also had a range of places to go to in order to get symptoms allied to sexual health treated. When it came to such symptoms, similar themes emerged regarding the division of different types of symptoms to different health practitioners. However, men with HIV could also consult their HIV specialists and nursing staff. This introduced a further dimension to their care. The construction of one symptom in different ways to suit different practitioners is illustrated well in the case of the following man who consulted both his GP and his GUM clinic with anal warts. The condition was extreme and, at the time of interview, he was on a waiting list to have them removed under general anaesthetic. However, when he first presented to his GP, he presented them as haemorrhoids.

**I thought they were haemorrhoids to start with. They [GP] didn't look, it was my mistake. I said I think I've got haemorrhoids, so he gave me gel for haemorrhoids which seemed to work. And then finally after a few months of that I said, 'This isn't working'. And they actually took a look and said, 'Oh they're not haemorrhoids or anything like that'. The last time I went was about the anal warts just to ask the GP's advice even though I was going to the GUM clinic anyway. Just to see if there's anything she could do to help relieve the pain and she gave me some nappy rash cream [...]**

***Have you ever considered telling her that you're gay?***

**No, I wouldn't tell her I'm straight either.**

***In terms of the anal warts don't you think that might make it more urgent if she knew that you were gay?***

**Why? It shouldn't do. Presumably heterosexual people can get anal warts.**

**Aged 49, White British, HIV+**

Likewise, there can often be confusion as to whether a symptom is an STI or related to HIV. In the following case, the respondent considered taking a bowel problem to his GP. Because the wait for an appointment was so long, he presented it at his regular appointment with his HIV clinician who diagnosed it as chlamydia.

I had a really bad bowel problem and I just thought it was either a side-effect of the medication or it was something related to HIV. I hadn't had chlamydia before when I first got it so I went to the doctor and my doctor's appointment was another three weeks so I just left it thinking well it's not that bad but it just got worse and worse. When he [HIV clinician] examined me it was chlamydia that was causing the bowel problem. I wasn't aware that I had contracted chlamydia. Then he suggested that maybe I ought to go every three to six months and have a full MOT anyway [...] Well the HIV clinic deals with everything that's related to HIV. I go every three months and have a complete sexual check-up because I still am active sexually.

Aged 46, White British, HIV+

Other men with HIV showed a similar reticence to consult their GPs with symptoms related to sexually transmitted diseases. All the men with infections chose to attend either their GUM clinic or their HIV clinic to have the STIs diagnosed and treated. HIV and GUM clinics are often located in close proximity or are actually the same clinic. Therefore, men tended to treat both services as interchangeable. The men with diagnosed HIV were distinct from the rest of the men interviewed in that their long-term illness (HIV) was usually managed within an HIV (GUM) out-patients context, with little or no input from their GP.

*In the last two years how often would you have gone to the GUM do you think?*

About twice I think. In any case it's a bit redundant because the GU and the [HIV] clinic are in the same building.

Aged 30, White British, HIV+

Moreover, they often receive GU services as part of their HIV health care.

If something is wrong with me and I'm going to see my consultant on Monday and he says 'Is there anything wrong with you?' and I say, 'I've got this or that and I don't know what it is'. He looks and says 'I think it might be this'. He will then treat it and deal with it there and then, rather than sending me to the GU clinic.

Aged 46, White British, HIV+

Men valued both their GUM and HIV clinics in that they were 'non-judgemental'. Like the men in the other two groups, they did not feel stigmatised when they presented with symptoms allied to sexually transmitted infections. Similarly, men with HIV reported that they felt uncomfortable consulting their GP about an STI.

*In terms of the GU would you expect a GU clinic to provide services that are different from those that your GP provides?*

Yes I suppose so because they should have more advice on sexual transmitted diseases and things. They should be able to offer you counselling there [...] I think if you have to be honest about whatever sexual activity you're taking part in, to find out the root cause of why you've caught a particular STI. I don't think they should be judgmental about what you're doing because that's your choice whether you want to do a certain thing or not. I've only encountered it once at the GU clinic where I thought a doctor was judgmental about my sexual life but nine times out of ten they're fine about it. Because I think they're there to look after you and to treat you and maybe offer advice or whatever. But I don't think they're there to actually preach to you.

Aged 46, White British, HIV+

What is clear from these accounts is that these men have a choice of places to obtain treatment of STIs. Moreover, their HIV care, general health care and GUM care was often highly integrated.

## 5.4 DISCUSSION

We have seen in chapter 4 that there continues to be a stigma attached to disclosing one's sexual identity to a GP. The stigma enacted in the GP consulting room is merely a reflection of the stigma attached to homosexuality in broader society and results from the association of gay identity with transgressive homosexual practices. This chapter examines the even greater stigma attached to the presentation of pathological symptoms (such as an STI). Our analysis highlights the difference between disclosure and discussion of one's identity as a gay man (within a social or interpersonal context) with a GP and consulting a GP with pathological symptoms related to homosexual practices.

The majority of men in all groups were reticent to consult their GP with symptoms which resulted from their sexual practices and interactions (symptoms of sexual ill-health) preferring instead to take these to GUM settings where the normal rules of sexual probity and judgement are lifted.

The experiences of the men with long-term illnesses highlight the distinction between sexuality related to health and sexuality as the cause of pathology or sexual risk. Here the men discuss with their GP sexual symptoms which are a result of their conditions or their medications (such as erectile dysfunction) rather than symptoms which result from the sex they have (such as STIs).

The case of men with HIV adds a further dimension. Because they access their HIV clinic (which often takes over their care) through their GUM clinic (which is often in the same place), there is a strong link between their specialist care provider (HIV clinic), their general care provider (often also the HIV clinic) and their GUM clinic (often in the same building or sharing staff with the HIV clinic). However, all too often, the one player missing here is the GP who usually falls out of the care loop for men with diagnosed HIV.

# 6 Conclusions and recommendations

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In this study, we aimed to provide data which would enable us to comment on the acceptability of GP services for gay men, especially in relation to 'level 1' sexual health services. Before we draw conclusions or make any recommendations, it is necessary to elaborate on the distinction we drew in the introduction of this report: that is, between gay men's views on general health services and sexual health services.

## 6.1 TALKING ABOUT BEING GAY IN CLINICAL SETTINGS

The question of whether sexuality is relevant to health for gay men is vexed. From a health promotion and social care perspective we would say it is because it influences quality of life and individual capacities to maintain or maximise health. From a clinical perspective, homosexual activities also make men particularly vulnerable to a range of sexually transmitted infections including HIV. Moreover, it is important to understand the exact nature of those sexual activities to diagnose and treat symptoms properly.

However, when we turn to generic primary care services, especially General Practice, the majority of gay men have not disclosed their sexuality and many insist that their sexuality is not relevant to their relationship with their GP. This study shows that for men who do not have a medical condition (those who have a limited relationship with their GP), the fact that they are gay is rarely raised and their GP is unlikely to know of their sexual identity or practice. The fact that a patient is gay may emerge, relatively unproblematically, when his relationship with his doctor deepens (when he is diagnosed with a long-term illness or in some cases with HIV). His being gay emerges along with a range of other facts about his personal or intimate life.

In the context of the cursory, limited relationship enjoyed by most men with their GP, it is hard to see where exactly the question of a man's sexual identity fits. How might men talk about their sexuality? How much talk is appropriate and what is the most appropriate response of the GP? One way of understanding this difficulty is to see that no matter how he does it (whether told directly, slipped into the conversation or merely implied), telling his doctor (or indeed anyone else in health settings) is always a *disclosure*: an action which challenges the range of assumptions made by individuals in social settings. Gay men are reticent to make this disclosure for a range of reasons. Men are concerned about safeguarding their privacy, about negative reactions, about confidentiality in notes, about being seen as deviant or even as foolish or of making a fuss over something which has limited relevance to the illness they are presenting with. The problem is, unless the disclosure is made, the GP and the other surgery staff will assume that the patient is heterosexual. It is important therefore to attempt to clarify the place of gay identity in the GP consulting room. To do so, it is important to disentangle a number of elisions and confusions.

The first is the elision between gay (or bisexual) identity and homosexual behaviour. That is, between who someone *is* and what they *do*. If we do not make this distinction, we risk maximising the detrimental affects of stigma related to both gay identity and homosexual practices and consequently not improving services. This distinction becomes clearer when we compare the situation of a gay man to his heterosexual counterpart. If a heterosexual man happens to mention to a doctor that he has (or does not have) a wife or (female) partner, we would be hard-pressed to call this a particularly intimate disclosure. However, for a gay man to mention that he has a (male) partner is a relatively intimate disclosure. We heard repeatedly, men say that their sexuality is or

is not relevant to their health or their relationship with their doctor. It is likely that heterosexuals would say the same. However, they might also say it *is* relevant that their doctor knows whether or not they have children or live with a partner.

This comparison provides us with a key to understanding the specific problem of disclosure for gay men in GP (and other NHS) settings. Heterosexuals can talk about their family, children *etc.* without an immediate mobilisation of the question of their *sexuality* relating to their sexual practice. Their heterosexuality is taken for granted (this is not to say that cultural differences between doctor and patient may colour their perceptions of what a family should be) and essentially banal. This is precisely the way in which heterosexism operates, on the basic assumption that 'normal' lives are lived heterosexually, with little regard for the notion that other 'normal' existence might take place out of that paradigm. Thus for gay men to mention their intimate life is *immediately* connected with revelations that are directly tied to 'deviant' sexual practice. Most gay men do not want to risk eliciting such imagery with a relative stranger in a clinical setting where they are already in the disempowered role of being a patient. The question becomes therefore: how can a gay man talk about his intimate life (his biological family, his domestic arrangements, the presence or absence of a partner, his social life) to a medical practitioner without such a conversation being immediately framed as a *disclosure* of his *sexuality* and his *sex life*?

The problem lies not with the gay men nor with their doctors, but in the way that any discussion of a gay men's personal life is framed in a social and cultural context and re-constituted through institutional settings such as a GP surgery. This relates to the second elision. Because health care is oriented towards diagnosing and treating pathological symptoms and meeting need, disclosures within GP settings are cast within this overall discourse of need or clinical pathology. In other words, it is difficult to tell your GP something without immediately connecting the disclosure to a need or a pathology. Thus, the elision from a disclosure to a need or a pathology becomes automatic in a setting geared almost entirely to diagnosing ill-health. Quite appropriately, the majority of gay men are concerned about having their sexuality constructed in such a way. This is directly reflected through their discussions about the loss of control that they might have over the outcomes of their disclosure once it is made (*ie.* it might be recorded in their notes and then non-clinical staff might find out and make judgements, or it could affect insurance applications *etc.*). In this way the broader social stigma attached to homosexuality is continually maintained by social practices whereby gay men feel they may have less to lose if they simply keep all revelations about being gay within a quite select and accepting circle. Ultimately, this can be regarded at the individual level as quite a rational response to a hostile social environment, and change needs to be initiated through widespread cultural adaptation.

There is a third and final factor which inhibits disclosure of sexuality to GPs and that is GUM services. Gay men are used to attending GUM clinics to have ill-health associated with their homosexual practices diagnosed and treated. GUM services exist in an environment where the stigma or moral opprobrium attached to homosexual practices are suspended in order to treat such symptoms. The sequestering of symptoms allied to sexuality solely to GUM services has three major effects. First, it reinforces a connection between talking about your gay identity in a clinical setting and the presence of clinical pathology (such as an STI) or detailed analysis of sexual practices (such as sexual history taking). Thus, to talk about being gay is to talk about sex or pathology, not about your day-to-day life and the dominant framework of pathology is strengthened rather than challenged. Second, GUM also allows gay men to treat their sexuality as something separate, related only to their genital health and perceived as not having a role in their general health. Finally, by lifting moral opprobrium or being 'non-judgemental', GUM services strengthen the expectation that it is somehow less acceptable to talk about gay sexuality in other clinical settings and that perhaps, men should expect to be judged in those settings.

The experiences of the men with long-term illness shows us that, on an individual basis, these problems around disclosure are easily resolved. The ease with which men's sexuality emerges in relation to their day-to-day life and (for the most part) the positive response of the doctor should alert us to the fact that the problem of disclosure is more symbolic than real. That is, disclosure is a problem until it occurs. Then, it emerges that it probably should not have been a problem in the first place. Men with long-term illness show us how sexuality can be talked about within a GP setting without questions of need, pathology or moral judgement being mobilised.

## **6.2 A GAY GP OR A GOOD GP?**

For the most part, the men in both our qualitative and quantitative studies found their GP services satisfactory. Their GP served their purpose to a greater or lesser extent. Men with no medical conditions expected to see their GP as little as possible for as short a time as possible, and only when they had 'routine' illness. Men with long-term illnesses expected their GP to be a partner in their treatment and care. The majority of men with HIV were relatively unconcerned about their GP because they received the majority of their care elsewhere. For the most part, men's expectations of their GP were low, and this was especially common with regard to sexuality or sex. This finding confirms the results of prior research (Cant 1999; Webb 1999; Klitzman & Greenberg 2002).

Very few of our respondents wanted a gay GP or even a GP who was versed in 'gay lifestyles'. Rather they wanted a good GP. Alongside professionalism and knowledge, personability and communication skills were highly prized. A good GP is a doctor who can see both the symptom and the person, who appears to listen and comprehend and who does not make the patient feel demeaned or rushed. A good GP is willing to recognise the limits of his or her understanding and refer on where appropriate. A good GP takes an interest in the patient's life. Finally, a good GP should be able to understand the patient's life and lifestyle despite cultural, religious or moral differences between patient and doctor. When men expressed satisfaction with their GP it was invariably with reference to the above qualities rather than some intrinsic 'gay-friendliness'.

A bad GP will make all of his or her patients feel uncomfortable (including the gay ones) through an inability to communicate, through being too rushed or through being dismissive of the patient. When men complained about their GP, it was often because they had these attributes rather than a perception that they were homophobic. In short, a bad GP will never have the chance to show whether or not he or she is homophobic because the patient is unlikely to disclose to them.

We might conclude therefore, that what makes a GP 'gay-friendly' is his or her capacity to communicate effectively with the patient. To the extent that this is the case with the individual doctor, it is also the case with all of the surgery staff (especially nurses and receptionists). A large part of making people feel at ease within their GP surgery is letting them know that they will be treated equally and respectfully. This needs to be made clear to all patients including gay men. It is up to every practice to ensure that all patients know that they will be treated equally and with respect by all staff regardless of their sexuality (whether or not they choose to disclose it directly). A GP surgery which cannot guarantee this and which cannot communicate it to its patients is simply not offering a good enough service. There are numerous resources available which underscore these points and detail the specific ways in which GP settings can improve access to equitable health care for all of their clients including gay men (Bains & Cross 1997; Carter *et al.* 1998; Scott 1998; Webb 1999; Cant 1999; Adams 2001).

We are saying nothing new when we conclude that the acceptability of GP services to gay men could be increased by:

- increasing all clinic staff's capacity for meaningful communication with patients.
- requiring all GP practices to develop and prominently display equality policies, statements and guidelines which explicitly include sexual orientation.
- requiring all GP practices to adhere to clear guidelines around confidentiality and patient notes and to make those guidelines clear to patients.
- requiring all staff to act according to these guidelines.

Such interventions are likely to increase acceptability of GP services to all patients including gay men.

Alongside such interventions it is important to address gay and bisexual men directly concerning their rights in primary care contexts. Gay men and bisexual men have every right to be concerned about heterosexism and homophobia in NHS settings. However, many men understood poorly – or not at all – their rights regarding access to their medical notes or that they could challenge how items had been (or would be) recorded. Without a thorough understanding of the process of recording information on their notes and what rights of access non-NHS agencies had (especially in respect of financial services) many men recalled horror stories from the 1980s and 1990s where men were denied financial services such as mortgages and life insurance or had to pay inflated prices for such products. Historical fears, and lack of clarity on their rights, had a huge impact on many men's willingness to even consider disclosure of sexual identity or sexual practice in a GP context. These fears should be addressed in national information campaigns targeted at gay men and bisexual men.

### **6.3 SEXUAL HEALTH PROMOTION IN GENERAL PRACTICE**

The Department of Health wants to increase the capacity of General Practice surgeries to provide 'level 1' sexual health services to men (see section 1.2 for an overview of the relevant documents). For men these include: sexual history taking and risk assessment; HIV testing and counselling; assessment and referral of men with STI symptoms; and hepatitis B immunisation.


In order to achieve this, the Department of Health will need to attend to two major impediments to change. First, it will need to find direct means of addressing the social stigma that prevents gay men from disclosing their sexuality to their GPs. Second, they will need to be particularly mindful of the ongoing role that GUM services play in broader public and clinical perceptions of homosexuality as fundamentally pathological. For example, if the GUM clinic is allowed to maintain its current 'exclusive' rights over the sexual domain, then it is unlikely that GP practice will ever manage to take the whole patient (*inclusive of his sexuality and his homosexual practice*) into its care. The existing boundaries, and to some extent the protectionism that is evident in these clinical settings, will prevent any sense among patients that they have a real choice about how and where to get their sexual health needs met.

We suggest that to a large extent, an initial means through which the first barrier of broader stigma should be breached is the creative, thoughtful, and mandated application of the recommendations made above in section 6.2. As for the second barrier of structural and symbolic boundaries between GP surgeries and GUM clinics, we recommend that active steps need to be taken in order to increase the levels of communication among staff in these different settings. The GP with Special Interest in Sexual Health initiative appears to be an ideal place to begin this process. To develop an ongoing and synergistic relationship between these two sites for sexual health services, we envisage cross-training programmes and professional networks aimed at skill-sharing around specific topics such as: sexual history taking within the context of new patient registration; or reception skills and waiting area practices which are inclusive for a range of sexually diverse clients.

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