

# Gay and lesbian physicians in training: a qualitative study

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## Abstract

**Background:** Gay and lesbian physicians in training face considerable challenges as they become professionalized. Qualitative research is necessary to understand the social and cultural factors that influence their medical training. In this study we explored the significance of gay or lesbian identity on the experiences of medical training using naturalistic methods of inquiry.

**Methods:** Semi-structured interviews, focus groups and an email listserv were used to explore professional and personal issues of importance to 29 gay and lesbian medical students and residents in 4 Canadian cities. Data, time, method and investigator triangulation were used to identify and corroborate emerging themes. The domains explored included career choice, "coming out," becoming a doctor, the environment and career implications.

**Results:** Gay or lesbian medical students and residents experienced significant challenges. For all participants, sexual orientation had an effect on their decisions to enter and remain in medicine. Once in training, the safety of a variety of learning environments was of paramount importance, and it affected subsequent decisions about identity disclosure, residency and career path. Respondents' assessment of professional and personal risk was influenced by the presence of identifiable supports, curricula inclusive of gay and lesbian sexuality and health issues and effective policies censoring discrimination based on sexual orientation. The need for training programs to be proactive in acknowledging and supporting diversity was identified.

**Interpretation:** Considerable energy and emotion are spent by gay and lesbian medical students and residents navigating training programs, which may be, at best, indifferent and, at worst, hostile.

In 2 national surveys, 40% of general internists<sup>1</sup> and 50% of internal medicine residents<sup>2</sup> reported witnessing homophobic remarks in the workplace directed toward lesbians and gay men. In another study, one-third of psychiatric and family practice residents and psychiatry faculty were found to be homophobic,<sup>3</sup> and an American Association of Physicians for Human Rights survey found that 17% of gay and lesbian physicians reported being refused employment, medical privileges, referrals or educational opportunities because of their sexual orientation.<sup>4</sup>

Less is known about the experiences of lesbians and gay men in medical training. How do people becoming professionalized as doctors<sup>5</sup> deal with the conflict that may arise between a traditionally conservative profession and a minority sexual orientation? What insights can we obtain from physicians in training as they come to terms with the interface between their professional and personal identities? How can their experiences be used to humanize our educational and training cultures?

The objective of this study was to gain an understanding of the experiences of gay and lesbian physicians in training in Canada. Naturalistic methods of inquiry that focused on interpreting the discussions about social and cultural factors that influence the medical training experience<sup>6</sup> were used throughout the study because we were not testing hypotheses experimentally.

## Methods

Critical appraisal of the literature about attitudes toward gay and lesbian persons in the health care setting helped us to determine which experiences would best be understood

## Research

## Recherche

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[Table of Contents](#)

through qualitative research. Pilot work with 11 participants (6 women and 5 men) involved 3 semi-structured interviews and 2 focus groups. An interview guide was used to sensitively elicit personal and professional issues of importance to gay and lesbian physicians in training, and transcripts of initial meetings were used to formulate 5 domains for further exploration (Table 1).

We recruited additional participants through personal contacts and snowball sampling, augmented by an international moderated listserv of gay, lesbian and bisexual physicians. A total of 7 interviews and 5 focus groups involving 29 people (including those in the pilot study) were conducted in Vancouver, Calgary, Toronto and Hamilton. Data were also collected via the Internet by posting messages on the themes relevant to our study to the gay, lesbian and bisexual listserv for 3 months.

At the beginning of each interview and focus group, confidentiality measures, including data security and anonymity, were discussed and tape recorded. We addressed the 5 domains using prompts to initiate dialogue, and discussion about issues relevant to each individual was encouraged. Interviews were continued until no new themes emerged. Audiotapes were transcribed by an individual not involved with training programs. Documents were analysed inductively using a framework that resulted in the identification of emergent themes and abstraction of cultural configurations and meanings.<sup>7</sup> Our findings were member checked by a sample of participants and gay and lesbian physicians.

Bias was minimized through data, method and investigator triangulation; we used multiple data sources (medical students, interns and residents), different qualitative methods (interviews, focus groups and Internet conferencing) and 3 investigators with different perspectives (a family physician with expertise in lesbian and gay health, an internist-epidemiologist with experience in physician-training environments and a medical anthropologist with expertise in ethnographic studies on risk and vulnerability).

This study was approved by St. Joseph's Hospital Ethics Committee.

## Results

Of the 16 women and 13 men in the study, ranging between 20 and 42 years of age, 20 (69.0%) were medical students. Postgraduate specialties of the respondents included family medicine, community medicine, psychiatry and internal medicine. The following interpretations and quotations reflect the experiences of the gay and lesbian residents and medical students surveyed in this study.

### Career choice

For those who were aware of their gay or lesbian identity prior to medical school, many found it an important factor in their career choice. The majority of respondents believed that their choice to become a doctor was, in part, to "make up" for their sexual orientation. It took several of them a long time to reconcile their career aspirations and sexual orientation before they could imagine becoming a physician.

I was always worried about disappointing my parents because I was gay, so I really wanted to please them in terms of my educational achievement and career goals. I think that was part of the reason I picked "doctor."

However, one resident reported a transformational experience, turning sexual orientation from a personal liability into an asset:

I could be a good role model as a physician, and gay people need gay physicians.

### "Coming out"

Upon arrival at medical school, lesbian and gay trainees navigated a series of perceived threats based on their sexual orientation. Medical students clearly articulated competing tensions between being honest and true to their selves and risking negative reactions from peers or threats to their future career.

I am really tempted to come out but at the same time am still feeling like I have too much to lose if this doesn't go well.

### Becoming a doctor

The art of medicine is mediated predominantly through human relationships, and learning how to think and act like a physician is a major part of medical training. Within the assumptions and prejudices of human interactions, gay and lesbian trainees found it difficult to integrate "gay" and "physician."

**Table 1: Domains of inquiry and questions asked of gay and lesbian physicians in training**

Domain	Questions asked*
Career choice	Is sexual orientation a factor when gay and lesbian individuals choose a medical career?
Coming out	What factors determine whether gay and lesbian physicians "come out" during medical school or residency training?
Becoming a doctor	What are the implications of gay or lesbian identity for physician professionalization?
The environment	How do lesbian and gay physicians in training experience their learning and working environments?
Career implications	How does gay or lesbian identity impact on career planning?

\*These questions were used to prompt the exploration of experiences (within each domain) of gay and lesbian medical students and residents during their training.

I felt there was really a lot of covert homophobia.... I really felt as though I didn't have any place as a gay person in medical school.

The most significant and successful strategy for many struggling with the task of integration was to use professional and peer role models.

I think I was close to suicide, but I was saved by Dr. X who came to my class one day in clerkship and said, "I am a gay doctor myself." I had never met a gay person in my entire life.

The costs of reconciling conflicting identities are considerable.

We extend a lot of energy coping with homophobia that the institution throws at us — a ton of energy that we can turn instead toward making ourselves better doctors.

### **The environment**

As gay and lesbian students worked toward their medical and specialty degrees, attitudes of colleagues and attendings dominated their training experience. Hateful jokes and remarks targeting gay and lesbian patients were common and usually went unchallenged. One resident was caught in the double jeopardy of feeling uncertain of herself and having her internal struggles mirrored negatively in her professional environment.

I was seeing these patients who were gay and who were really not functioning well with life and choosing a drug overdose as the only option. Then I was having to look after them medically and watch the way they were treated on the ward and listen to comments that were made. All these struggles were inside — a sort of a horrendous turmoil.

A major factor in assessing the safety of the environment related to the assumptions underlying the language used. For example, one student clearly recounted a preceptor's inclusive self-introduction in which she did not specify the sex of her significant other. Inclusivity was assessed in other ways, including observations of heterosexist assumptions embedded within the curriculum.

Whenever a health care problem has a gay person it has to do with AIDS or adolescent sexuality. There aren't any heart attack victims or diabetics who happen to be gay.

The usual anxieties about in-training performance were heightened in those who felt that their sexual orientation increased their risk for a negative evaluation.

Everything here is peer evaluated, and I think that's what scares me. And that is unlike any other program I've ever been in, where your not liking my sexual orientation can't hurt me academically. Here it can, and that scares me.

### **Career implications**

As with the decision to enter medical school, gay or lesbian identity had an ongoing influence on career decisions.

I made the decision to do HIV primary care.... I figured it would be easier to be a gay physician in that area than it would be in many others.

The decision about whether to be "out" on residency applications was a common struggle. Medical students were frightened that their sexual orientation would be disadvantageous.

I don't do anything to let people know. A large part of that is spawned from the fear that I won't get a residency spot in a specialty that I want to be in if people know I'm gay.

A common source of anxiety was the prospect of having to practise in a nonurban centre.

I couldn't imagine setting up shop in a small town and being open about my orientation and having that accepted.

Many respondents reflected on how their gay or lesbian identity informed their practice, including their style of communication and their capacity for empathy.

Being gay has profoundly influenced the kind of physician I am. It has forced me to learn the skill of putting myself in outsider's shoes — whatever [whoever] that outsider is. It has forced me to see the linkages between all the forms of discrimination.

Throughout the interviews and focus groups participants reflected on the types of changes required to ensure a better experience for gay and lesbian medical students and residents in the future (Table 2).

**Table 2: Recommendations for medical schools and residency training programs\***

- Clinical and simulated patient problems that include gay or lesbian identity as a normal part of humanity's range
- Enhanced medical school and residency curricula in sexuality
- Institution-sponsored support groups that recognize and allow for the stresses of being gay or lesbian during medical training
- Explicit faculty role models and mentors for gay and lesbian physicians in training
- Written, broadly distributed policies condemning discrimination against gay and lesbian persons with effective reporting and enforcement mechanisms
- Practical institutional measures to address homophobia and heterosexism

\*These recommendations were generated by gay and lesbian medical students and residents during interview and focus group discussions of their training experiences.

## Interpretation

Gay and lesbian medical students and residents reported expending considerable energy constantly assessing their environments, trying to find a balance between self-protection and self-disclosure; this energy represents a net loss to training programs and the profession. We found that those who were coping with their first awareness of themselves as gay or lesbian during their medical training were especially vulnerable. In general, the more comfortable participants were with their sexual orientation, the less stress they experienced.

The decision about whether to be “out” on residency applications is a common struggle that has been documented previously.<sup>8,9</sup> Our findings are consistent with a qualitative study conducted in the United Kingdom<sup>10</sup> that reported most gay practitioners had not openly declared their homosexuality because they thought their career prospects would be jeopardized; reports of gay physicians being turned down for partnerships affirm this fear.<sup>10</sup>

Institutions that are proactive in creating and promoting respectful learning environments are likely to enhance the experiences of students with well-integrated professional and sexual identities.<sup>11</sup> However, a 1991 survey of medical schools in the United States reported that training programs devoted little time to the topic of homosexuality, and it was most commonly discussed in lectures on human sexuality.<sup>12</sup> In our study, trainees who were “out” and comfortable with their orientation described a duty to better educate their peers and lobby for improved curricula and policies.

Participants also believed that their experiences as an outsider could enrich their capacities to be effective clinicians. Potential benefits cited included an enhanced ability to connect to others from a variety of minority groups, recognition of patients experiencing inner conflict, the use of inclusive language and a heightened understanding of the impact of biases in patient care.

To the best of our knowledge, this is the first qualitative study that explored the experiences of lesbian and gay physicians in training. Respondents were from several Canadian programs and at various stages in their training. We explored the context for coming out and the chronology of professionalization as a physician, focusing on domains such as training environments and career choices. In addition, participants generated concrete recommendations to improve medical training programs. Although there is a body of literature on the “coming-out” process<sup>13</sup> and on the process of becoming a doctor<sup>5,14</sup> we found no research on the impact of negotiating the 2 concurrently.

Conscious reflection and investigation of “the status quo” as experienced by gay and lesbian physicians in training is one step toward improving the training system, and this may benefit those learning, those teaching and, ultimately, those receiving care. Our study has several limitations, however. We could not capture the experiences of

people who were unable to talk with us, and we had no strategy for identifying gay and lesbian people who discounted a career in medicine or had dropped out of medical school. Future investigations could target these additional experiences. The design of this study was cross-sectional; additional longitudinal studies might examine how the careers of gay and lesbian physicians evolve over time.

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