

Lesbian Patients' Reflection of Societal Norms in Primary Care—A Qualitative Interview Study in Germany

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Research Article

Keywords: lesbian health, primary care, qualitative research, LGBTQ+

Posted Date: October 9th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-11125818/v1>

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Additional Declarations: No competing interests reported.

Abstract

Background

International research indicates that lesbian patients often face poorer patient experiences and encounter barriers to health care, yet research on this issue remains scarce in the German context, particularly within primary care. This study aimed to explore how lesbian patients perceive and navigate primary care in Germany.

Methods

We used a qualitative, grounded theory-informed approach and conducted 22 episodic semi-structured interviews with lesbian patients in Berlin and Brandenburg, Germany; one participant later withdrew consent, resulting in a final sample of 21. Data were analysed using thematic coding following Flick and type construction according to Kluge.

Results

Across the dataset, participants shared common experiences in the general practitioner (GP)–patient relationship: barriers included heteronormative assumptions, outing pressure, and limited GP knowledge of lesbian health, whereas facilitating factors comprised open communication, inclusive language, and both symbolic and structural signs of support. Within the context of these shared experiences, participants navigated primary care in different ways, reflected in two idealised analytical poles. One, a protective concealment orientation, involved heightened vigilance and anticipated discrimination. The other, an affirmed identity orientation, was marked by greater agency, identity integration, and reliance on personal and social resources.

Conclusions

Our findings align with the minority stress model and the concept of cultural humility. GPs should reflect on their own communication, moving towards open and unbiased communication free of heteronormative assumptions; in addition, structural change is needed, including provider training and national care guidelines, alongside further research.

Trial registration:

Not applicable.

Background

Compared with cisgender heterosexual women, lesbians experience disparities across several health domains, including a relatively high prevalence of somatic conditions such as respiratory, musculoskeletal, and dermatological issues (1–4). Studies have also shown that lesbians are more frequently affected by anxiety, depression, and substance abuse, especially dangerous alcohol consumption (5–9). Interestingly, a study by Grant et al. (10) also revealed a connection between risky alcohol consumption and the expression of one's own identity, suggesting that health-related behaviours may also be associated with how individuals experience and express their sexual identity.

Experiences of discrimination in everyday life based on their sexual orientation, including physical and psychological violence, play a significant role in shaping these disparities (11, 12).

The minority stress model developed by Meyer (13) provides a framework for understanding how social and structural conditions associated with minority sexual orientation can affect mental health. Stigma, prejudice, and experienced discrimination can lead to inequalities in the mental health of lesbian women. Experiences of rejection, whether real or anticipated, concealing one's sexual orientation, and internalized rejection of homosexuality may thereby play particularly negative roles. Frost and Meyer (14) later extended this framework by highlighting that social resources, such as supportive networks and community connectedness, can buffer the impact of minority stress and foster resilience. Importantly, these processes may vary according to how individuals experience and integrate their sexual identity, their available personal and social resources, and the contexts in which sexual identity is disclosed or concealed.

Lesbians face significant barriers and disadvantages in health care and access to health care. In Germany, where they make up approximately 1.3% of the population, they participate less frequently in preventative health checkups and experience discrimination and inadequate care from health care providers (2, 15, 16). Thus, lesbians perceive disclosure as relevant for receiving adequate medical care, but because of their fear of rejection and negative reactions, they do not always share their sexual orientation with health care providers (17). In fact, disclosure may facilitate more individualized health care when patients perceive the interaction as sufficiently safe (18). Factors supporting disclosure are high self-esteem, LGBTQ+ (Lesbian, Gay, Bisexual, Trans, Queer) friends, and social support, whereas strong internalized homophobia and heteronormative assumptions by medical staff decreased disclosure (19, 20). On the basis of the results of their 2017 study, Baptiste-Roberts et al. (21) demanded sensitive health care for lesbians. Together, these findings suggest that disclosure in health care is shaped not only by the potential relevance of sexual orientation to care, but also by anticipated rejection, individual and social resources, and the social context surrounding the patient.

Taking an even closer look at the German context, a more nuanced picture emerges: lesbians experience discrimination in both society and health care (15, 22–26). Furthermore, fewer than half of lesbian patients share their sexual orientation with their health care providers (25). Many general practitioners (GPs) report that they lack sufficient knowledge about how to treat lesbian patients. There is a strong desire among health care providers to overcome their own prejudices and to have more knowledge

about the health issues of lesbian patients, especially regarding STI (Sexually transmitted Infections) care (27, 28). This highlights the need for training and education, as shown in the international literature (12, 29, 30). Even during medical school, there is a desire for training and knowledge transfer in the health care of LGBTQ+ people, as Suen et al. (31) outlined in their research. In Germany, no standardized training is available, while medical students in a nationwide survey report a lack of knowledge and a need for education on that topic (32). Moreover, no dedicated postgraduate training requirements or national care guidelines currently address the specific needs of lesbian patients in Germany. Taken together, these findings point to a gap between the needs of lesbian patients and the knowledge, communication, and structural conditions available to address these needs in primary care.

While Hirsch et al. (25) provided a quantitative account of the current state of lesbian women's primary care in Germany, including low rates of disclosure and infrequent active inquiry by GPs, their findings do not explain what shapes these care experiences from either the patient's or the provider's perspective. Qualitative in-depth research in the German primary care context also remains rare. In particular, little is known about how lesbian patients negotiate disclosure in relation to anticipated discrimination, identity integration, personal and social resources, and the perceived relational safety of the GP encounter. Furthermore, in Germany, GPs are often the first contact point between the health care system and patients, given the absence of a gatekeeping structure. Disclosure may therefore not be merely an individual decision but may be shaped by the interaction between anticipated discrimination, identity integration, personal and social resources, and the relational context of primary care.

This relational perspective is also relevant to the concept of cultural humility(33), originally developed in the context of racial and ethnic diversity in physician training, which shifts the focus from more abstract knowledge about a particular patient group towards ongoing self-reflection and the recognition of power dynamics between the patient and health care provider. As a complementary concept to the minority stress model, cultural humility therefore provides a useful perspective for understanding how provider-related factors may shape patients' experiences of disclosure and care.

Against this background, this study aims to explore how lesbian patients perceive and navigate primary care in Germany, with particular attention to disclosure of sexual orientation, experiences of discrimination and rejection, and the personal, social, and relational factors that shape these experiences.

Methods

This study is reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ).(34) A qualitative approach was chosen to gain deeper insight into and a more nuanced understanding of the lived experiences of lesbian women and their access to health care, particularly primary care, in Berlin and Brandenburg, Germany, including their subjective interpretations and more abstract explanations of specific phenomena. In line with a grounded theory-informed approach, 21 episodic semi-structured interviews were conducted to explore these lived realities (35, 36).

Researcher Reflexivity

The interviews were conducted by the lead author, ASW, a medical doctor at the Institute for General Practice and Family Medicine, Charité Universitätsmedizin Berlin, who identifies as a cisgender, white, queer woman. As part of the doctoral training environment at Charité – Universitätsmedizin Berlin, the lead author attended several courses on qualitative research methods and participated in colloquia in which interview techniques were discussed and practiced prior to and during data collection. No personal relationship existed between the lead author and any of the participants at any point before, during, or after the interviews. To minimise the influence of prior assumptions on data collection and interpretation, the lead author kept a reflexive memo after each interview, documenting initial impressions and methodological decisions; these memos were revisited during coding and discussed within the qualitative research colloquia described below. The co-authors' complementary backgrounds in general practice and qualitative methodology were drawn upon during interpretation to challenge and refine emerging categories.

Recruitment and Sampling

Recruitment material was distributed through lesbian community spaces (e.g., archives, bars, community projects), GP practices in Berlin and Brandenburg, rural church communities, daily newspapers, social media (Instagram, Twitter/X), and NGOs such as the German Federation of Lesbians and Gays+ (LSVD).

Every person who self-identified as lesbian, who was at least 18 years old, lived in Berlin or Brandenburg and spoke German was able to self-register online for the study. Fifty-six self-identified lesbians registered to be contacted, and 46 met our formal inclusion criteria. Overall, 22 lesbians were interviewed; 24 did not respond to our outreach. Maximum variation sampling was attempted; however, a pragmatic approach was ultimately adopted.

Sample

The study sample consisted of 21 participants. Initially the data contained 22 interviews, however one person withdrew their consent. The ages ranged from 23–83 years, with a mean of 42 years. Eighteen of the participants live in Berlin, and 3 live in Brandenburg. Among the 21 participants, 13 were in a relationship, and 9 had children. Their highest level of education varies: 16 have a university degree, and 5 have vocational training. In terms of employment, 13 participants are employed, two are self-employed, none are unemployed, three are retired, and 3 are students. 10 out of 21 mentioned that they are in continuous care with a regular GP.

Data Collection

The interview guide was constructed on the basis of Flick's episodic interview style and reviewed relevant literature, condensing relevant topics (37). This interview format allows for experiential knowledge, which is linked to a specific moment, a so-called "episode." One exemplary question was: Please tell me about your last visit to your GP. Additionally, with specific questions on concrete topics, semantic knowledge can be recalled (37, 38). The guide, containing open and semi-open questions, was then discussed within different qualitative research colloquia and methodological networks, and it was pilot tested with a self-identified lesbian in Berlin.

After each interview, the interview guide was constantly and iteratively adjusted on the basis of re-evaluations and audits. Emerging themes were added, such as discriminatory experiences in the participants' private lives, their perspective on health in general, and the relevance of their own sexual orientation.

At the beginning of each interview, the lead author gave participants a brief introduction to herself, the research project, and her own background.

22 interviews were conducted face-to-face by the lead author, in a place chosen by the participants, either at their home, in public places, or at the Institute for General Practice and Family Medicine at Charité Universitätsmedizin, Berlin, between November 2022 and April 2024. The interview duration varied between 23 and 102 minutes (mean 63 minutes). Only the lead author and the respective participant were present during each interview. No repeat interviews were conducted.

Every interview was followed by a memory protocol written by the main author to capture initial impressions and reflections. The audio-recording of each interview was transcribed verbatim, following predefined transcription rules based on the transcription guidelines of Pehl and Dresing, and after each participant was assigned a pseudonym, identifiable information was anonymized by the main author (39). The pseudonymization list was destroyed after data collection was completed. The main author translated all the participant quotes used in this article from German to English, ensuring that their intended meaning was retained. Claude AI, a large language model developed by Anthropic, was used to re-check the translation of the original interview quotations from German into English; only the pseudonymised version of the quotations, with all identifying information already removed, was processed for this purpose, and the resulting alterations were reviewed by the lead author against the original German quotations to verify accuracy.

Analysis

Data were analysed using a grounded theory-informed approach, according to which data collection and analysis proceed inductively and iteratively, with patterns, concepts, and categories developed through constant comparison (36, 38). Coding was performed solely by the lead author. Data collection and analysis were conducted in parallel, and recruitment continued until no new themes relevant to the

research question emerged from the interviews. Based on this criterion, thematic saturation was considered to have been reached after the 22nd interview.

Thematic coding followed Flick's approach, which includes writing a brief case description after each interview to capture the initial distinctive features and themes of that case (38). Following this approach, three contrast-rich interviews were selected for initial coding to capture a broad range of perspectives and experiences and to provide a diverse basis for developing the initial coding structure. Coding was carried out iteratively: initial coding was followed by axial coding and, eventually, selective coding oriented toward the original research question. Whenever the coding structure was modified, the revised categories and codes were applied to all interviews where relevant, and case descriptions were correspondingly expanded and refined as further interviews were coded, ensuring consistency of the coding scheme over time. Coding was performed using MAXQDA, version 2024, release 24.10.0. For each code, a memo was created documenting the contexts in which the code was applied, together with an illustrative example. In total, 14 main categories and 115 subcodes were generated, comprising 1,403 coded text segments; the coding scheme can be shared upon request.

Building on this coding structure, we identified specific patterns across participants within themes relevant to the research question and conducted case contrastings, followed by type construction according to Kluge (40). From the resulting category system, categories of central relevance to the research question were selected and condensed into overarching meta-categories, which served as analytical dimensions for positioning the individual cases. For this purpose, the relevant codes and corresponding coded text segments of each case were examined in detail, together with the condensed case description, allowing each case to be considered individually in relation to the emerging meta-categories. The cases were then systematically compared and contrasted with one another along these analytical dimensions.

On this basis, two idealised poles representing opposing patterns of behavioural and disclosure strategies were constructed by contrasting cases within the coding system, with the meta-categories functioning as landmarks demarcating the boundaries between them. These two poles were treated as idealised analytical constructs rather than as mutually exclusive empirical groups. Each case was subsequently re-examined against the emerging poles, and the constructed poles were revised and extended where necessary. The analytical spectrum between the two poles was thereby delineated, and the range of positions along this spectrum, together with the themes shared across it, was identified.

Credibility, Trustworthiness and Ethics

Ethical approval

was obtained from the Charité Universitätsmedizin ethical committee, EA1/053/22. Additionally, the study design was developed in alignment with the data protection regulations of the Charité Universitätsmedizin Data Protection Office. Contact information on support structures, such as psychological help (Berliner Krisendienst), was offered in advance.

No financial compensation was offered to the participants. After receiving oral and written information about the study, written consent was obtained from all the participants prior to the interviews. One person withdrew their consent for personal reasons. No personal relationships emerged before or after the interviews between the main author and the participants. To enhance the trustworthiness of the analysis, interim findings were regularly discussed in peer debriefing sessions within qualitative research colloquia throughout the research process. Participants were offered the opportunity to review their transcript upon request. One participant made use of this option and removed passages she did not wish to be included in the analysis.

Participants were not given the opportunity to provide feedback on the study findings.

Results

Across all interviews, participants described several recurring experiences that formed the shared context of lesbian primary care encounters. Regardless of their individual perspectives, they reflected on the significance of their lesbian identity and sexual orientation, particularly in relation to their mental and sexual health. Experiences of actual or anticipated discrimination, the negotiation of disclosure, the development of trust in the general practitioner, and the pervasive influence of heteronormative assumptions—including the recurring pressure to disclose or explain one's sexual orientation—emerged as common themes across the dataset. At the same time, participants differed considerably in how they interpreted, navigated, and responded to these shared experiences. During analysis, participants' accounts therefore did not cluster into clearly distinct groups. Instead, similarities and differences across interviews were examined through qualitative type construction, referred to as pole construction in this study. To capture recurring patterns in participants' strategies of navigating primary care, two idealized poles were developed. These poles represent analytical constructs rather than actual patient groups. They constitute a theoretical condensation of recurring behavioural and disclosure strategies observed in participants' accounts, allowing variation across the spectrum of experiences to be described without reducing participants to fixed categories.

Shared Barriers to Inclusive Primary Care

Participants described several factors hindering adequate health care. A phenomenon of "outing pressure" was mentioned, meaning communicational situations that create pressure to disclose their sexual orientation, sometimes involuntarily, and which is seen as a burden.

"But she [the GP] used some kind of garbled slang term for sexual intercourse. Whether I was having a lot of it with my husband right now? That was really the first sentence, and I said: No, and I'm married to a woman. So, in that brief exchange I outed myself right away, which I otherwise never do. I'm usually very reserved with details like that. But in this case, I was thrown off." L25

This may result from heteronormative questions or forms that implicitly assume heterosexuality and fail to accommodate diverse sexual orientations.

"But symbols do exist, and they carry meaning, and if their only purpose is to help someone find the courage to go to the doctor for an illness that needs to be diagnosed, then by all means they should be used. (...) But that all dies the moment I'm asked at reception for my husband's phone number. Then the rainbow flag out front doesn't help anymore either (laughs)." L3

It is also reported as detrimental if self-disclosure is followed by a negative reaction from the GP.

"And it's annoying when the person [the GP] you're talking to wanders off in their thoughts for 5 minutes and can't concentrate anymore. In addition, especially at the doctor's office, and maybe you have some complaints, it's truly important that they listen, yes, and then they get confused. [By disclosure of the patient]" L9

Several barriers contributed to dissatisfaction with primary care. These included limited GP knowledge of lesbian sexual health, the perception that sexual health concerns were not taken seriously, and experiences of anti-lesbian discrimination.

"I think this kind of holistic view of someone's state of health is maybe especially important for queer people, or especially for lesbian women, because why actually? Because you may have already had the experience (...) that your own sexuality isn't taken seriously, or that there's a certain idea of sexuality that you just don't fit into. (...) And that's exactly why it's all the more important that this is taken seriously and met with openness, because (...) everything else just leads to you not disclosing certain information, not going to the doctor voluntarily when you need something (...). So yes, I do think lesbian health means that certain aspects perhaps need to be brought more into the foreground, or need to be handled with particular awareness." L2

Factors Facilitating Inclusive Primary Care

Participants expressed a shared expectation regarding factors that ease communication between GPs and patients. These factors concern structural aspects of a GP clinic, how GPs deal with queer sexual orientations, and aspects of communication and the doctor–patient relationship. Most importantly, lesbian patients wish to see signs of LGBTQ+ support, such as displaying rainbow flags, informational material on LGBTQ+ health, or inclusive medical history forms with options for voluntary and self-determined disclosure.

"Or (...) you could also, somewhere in the entrance area, on the homepage, wherever, put up [LGBTQ+] symbols, or not hide them, but make them visible, to show: we're open to everyone here (...). I think that could help some people feel more comfortable, or even take that step at all, like: okay, I've got something odd going on, I'm not sure what it is, but I don't want to be stigmatized, and since they seem able to handle that, I feel comfortable making an appointment there now." L3

The absence of heteronormative assumptions emerged as a key facilitator of positive primary care experiences, fostering trust, open communication, and a stronger therapeutic relationship.

"For me, that means there's no underlying heteronormativity constantly present. That there's an initial openness to consider, first, that I'm now seeing a doctor who understands that queer people exist. Those who do not automatically assume a male partner. These are such fundamental, actually small things, but I think they always make a big difference." L16

Across interviews, participants described competence in addressing sexual orientation as an important facilitator of inclusive primary care. They valued GPs who were able to recognize that lesbian identity may influence health concerns, health care experiences, and communication needs, while responding to these issues in an individualized rather than stereotypical manner.

"And when I think about lesbian health, what all falls under that umbrella? (...) Should it be more than just whether this person is physically healthy? However, also, are they well and in harmony with their identity? (...) And no, obviously experiences of discrimination also affect health. And general practitioners, and all doctors, all people, should be aware of that." L18

In addition, professional competence emerged as a key relational resource facilitating inclusive primary care. Participants valued GPs who were able to integrate knowledge of lesbian sexual health, STI prevention, family planning in same-sex relationships, and the potential impact of minority-related experiences on mental health into individualized care whenever these issues were relevant.

"That there's at least some basic knowledge that there are some queer-specific health problems. (...) I don't necessarily expect total knowledge, but I do expect openness towards the other person and an openness to say: Okay, I might not know exactly, but I'll read up on it some more, if necessary." L16

Furthermore, participants described a respectful approach as one that acknowledged and created space for discussions about sexual orientation when relevant. Across interviews, relational competencies such as openness, empathy, and non-judgmental communication were often considered more important than extensive specialist knowledge of LGBTQ+ health.

"Yes, I believe (...) that's one of the most important things for initially fostering trust. (...) However, in regard to a problem where queer identity plays a role, that's even more important to me than professional competence. Because anyone can have professional competence. The question then is, how is this professional competence conveyed in conversation with me? (...) Or rather, is there even an understanding of how my lived reality relates to this professional knowledge?" L16

Finally, participants framed inclusive care not as a matter of specialist provision but as a feature of routine primary care. They described respectful communication, openness, and recognition of individual circumstances as fundamental elements of good clinical practice that should be available to every patient, regardless of sexual orientation.

"And I don't want to be sent elsewhere for a 'special' women's issue, just as little as I want to be sent elsewhere for a special 'queer' issue. I expect that primary care covers all of that." L16

Diverging Strategies in Navigating Primary Care

Beyond these shared experiences, participants differed in how they interpreted, navigated, and responded to primary care encounters. Differences between participants became apparent with regard to identity integration, anticipated discrimination, and the availability of personal and social resources. Rather than forming distinct groups, these differences were conceptualized as two idealized analytical poles representing recurring strategies for navigating primary care. The poles constitute theoretical condensations of participants' accounts and illustrate contrasting ways of managing disclosure, trust, and health care interactions within a shared health care context. The following sections describe these two analytical poles before returning to the broader spectrum of experiences and the factors shaping participants' positions between them.

Protective Concealment Orientation

Accounts associated with this analytical pole were characterized by protective self-management in primary care encounters. Rather than exercising agency over disclosure, participants described their communication as being shaped primarily by anticipated discrimination and prior experiences of stigma, giving rise to a form of heightened vigilance that extended across both everyday life and health care interactions. Rather than reflecting stable personal characteristics, this vigilance is best understood as an adaptive strategy: a learned, situational response to the possibility of rejection or prejudice, instead of a fixed individual trait.

For some participants, this vigilance was rooted in concrete negative experiences within the health care system itself. One participant described a GP consultation in which a physical complaint was reframed around an assumption of heterosexuality, resulting in a line of questioning she experienced as invasive and disorienting:

"I have this canker sore (...) that is inflamed. (...) She [the GP] wanted to check me for sexually transmitted diseases, asking if I'd had oral sex with a man. And I said no. (...) I think, she was sure, that was not true. And tell me I should not feel embarrassed. (...) And that was completely disconcerting. I'm a lesbian. I do not have oral sex with men. And probably something can be transmitted through oral sex with women, too." L21

For other participants, however, vigilance was not primarily anchored in such enacted incidents but operated pre-emptively, shaped by generalized awareness of social risk rather than by any single clinical experience:

"And the external factors are: fine dust, smoking, but also, am I a homosexual person who will categorically be beaten up in the schoolyard or be put in the trash can?" L6

This distinction between vigilance grounded in lived discrimination and vigilance grounded in its mere anticipation recurred across accounts associated with this pole, and both forms appeared to converge on the same outcome: a chronic, low-level scanning of the environment for cues of safety or threat.

"There are always little things like that. Sentences that are said. Strange looks. (...) I never really feel free, (...) to behave the way I want to, or the way I feel. Not even in Berlin. (...) That one has to think two or three times about whether to disclose or share something now." L1

Participants approximating this pole frequently described strategies aimed at minimizing the visibility of their sexual orientation in contexts where heterosexuality was assumed, ranging from withholding information about same-sex relationships to actively presenting themselves in ways that would be interpreted as heterosexual. Several participants reflected on earlier life phases in which they had attempted to conform to heteronormative expectations altogether, including entering heterosexual relationships despite experiencing them as inconsistent with their sexual orientation.

"I really made a huge effort to make myself heterosexual. (laughs) (...) Which of course has an effect on your own health accordingly. Constantly denying yourself. And sometimes also having to deal with aggression directed at you." L6

Importantly, this pattern of concealment did not reflect an absence of desire for openness. On the contrary, participants reflecting this pole often expressed a genuine wish to speak openly about their sexual orientation, their life circumstances, and the impact of navigating a society structured around heterosexual norms, conversations they regarded as relevant to both mental well-being and overall health. This produced a recurring tension: disclosure was simultaneously desired as potentially relieving and beneficial for care, and avoided out of fear of rejection, misunderstanding, or poorer treatment. It was this unresolved tension between wanting to be known and needing to stay protected, rather than concealment alone, that characterized the pole.

This tension shaped communication with GPs in particular. Several participants reflecting this pattern described not having an established relationship with a regular GP, which further reinforced uncertainty during health care encounters. Against the backdrop of prior experiences, whether directly enacted or only anticipated, openly disclosing their sexual orientation was perceived as carrying additional interpersonal risk, and participants described continuously weighing the potential benefits of disclosure against the possibility of prejudice or poorer treatment. Notably, this weighing occurred even in the absence of any concrete negative experience with a given provider, illustrating how anticipated discrimination alone was sufficient to generate the same cognitive and emotional burden as an enacted one.

"Yeah, so what I can well imagine is that, right now, I'm still protecting myself a bit against potential serious discrimination at the doctors. It's not like I've had some experience with my GP that was super unpleasant because I'm lesbian. But I can definitely imagine that if I did have a bad experience, I would genuinely avoid going to the doctor, keep pushing it off again and again, and just not work up the courage to go, simply out

of fear that it would happen again. (...) So, I can definitely see (...) a branch in my life where this becomes an issue, simply on an emotional level for me. That it would then contribute quite strongly to my sense of unease." L19

For several participants, this anticipatory burden translated directly into avoidance behaviour, with appointments postponed or skipped altogether, particularly when disclosure was expected to become relevant to the consultation:

"And I think as a lesbian the question is: okay, do I come out and potentially expose myself to that? Or do I just let them think I'm straight? (...) Because it's about my knee. (...) So I think that's definitely a balancing act. Or do I risk being treated worse? And that might sometimes be wrong, because you can misjudge the situation too. But that's work, those are thoughts that someone who is straight doesn't have to go through. And at the doctors, that would mean you have stress, you have tension, you have extra cognitive work to do, when you're already possibly struggling anyway, right." L21

At the same time, accounts associated with this pole make clear that trust, where it could be established, functioned as the key condition under which disclosure became possible at all. Trust was not assumed but had to be actively signaled by the provider, through non-heteronormative communication, respectful interactions, and explicit indications that sexual diversity would be acknowledged without prejudice:

"(...) It's always the first point of contact in the health care system that most people have. (...) It's also, of course, the first place where trust in the system is either built up or broken down. (...) As soon as I'm with some new doctor, that's always the moment for me to check: okay, does this fit? Do I have trust here or not? (...) I think especially for queer people, who have often experienced discrimination themselves (...) within a health care system that has historically discriminated against us massively, and in the case of trans people still does, it's even more important there. (...) Queer-friendly medicine for me means knowing, as a patient, that I'm sitting across from a doctor who is aware of (...) how my own queer identity, especially my experience within this system, shapes things. But also aware of everything this system has done that was really messed up. (...) What she as a doctor also has to actively work against, in order to create a good situation with me as a patient; a queer patient." L16

For some participants, this need for trust extended into a more fundamental relational requirement, a baseline sense of safety that had to precede disclosure of any kind, medical or otherwise:

"So as a woman living as a lesbian, or a queer woman? (...) I feel I need a kind of basic trust, a foundational trust. Only with someone I trust very, very deeply can I open up and talk about my problems. (...) And for that, I also need the person across from me to have the understanding to respect and accept me in my identity or sexual orientation. (...) And I feel the same way with my gynaecologist, it's a very intimate area, and that's why I think it's really important." L22

Taken together, accounts associated with this pole illustrate how concealment and vigilance, while offering short-term protection against anticipated or enacted rejection, came at a cumulative cost: postponed or avoided appointments, withheld information, and an additional cognitive and emotional burden carried into consultations at moments of pre-existing vulnerability. Rather than a stable disposition, this orientation reflects an ongoing, effortful negotiation between the wish for open, trusting care and the need for self-protection within a system participants did not always expect to meet them safely.

Affirmed Identity Orientation

In contrast to the first analytical pole, accounts associated with this pattern were characterized by a greater sense of agency in navigating primary care. Rather than perceiving disclosure primarily as a source of vulnerability, participants described maintaining control over whether, when, and how their sexual orientation became relevant within health care encounters.

Participants reflecting this pattern described their sexual orientation as an integrated and accepted part of their identity. Although they also reported experiences of discrimination, stigma, and rejection in their private lives, these experiences were generally described as manageable through personal and social resources rather than as fundamentally undermining their sense of self. Consequently, participants approached primary care encounters with greater confidence in communicating about their sexual orientation and health care needs. Many participants also described having access to stable social support networks, including partners, friends, and connections within the LGBTQ+ community. These networks provided emotional support, opportunities to exchange experiences, and practical advice, including recommendations for LGBTQ+-affirming health care providers. Together with their own coping resources, these supportive relationships appeared to facilitate disclosure, strengthen confidence in navigating primary care, and buffer the impact of previous experiences of discrimination.

"Therefore, I have definitely experienced queer people exchanging recommendations for good medical care (...). This can help prevent certain unpleasant situations. (...) If you know, okay, this is a doctor where other people in the queer community have had good experiences, the likelihood is greater that you will feel comfortable there yourself." L2

Across accounts assigned to this analytical pole, continuity of care and trusting relationships with GPs emerged as important facilitators of open communication about sexual orientation. Within these relationships, disclosure was experienced as a routine aspect of patient-centred care rather than a potentially risky event.

"However, I expect, or rather want, a relationship of trust from my general practitioner, my gynaecologist, or any doctor I have to see regularly, so that I can explain my life situation without having to make anything up." L3

Although accounts associated with this pole reflected confidence in communicating about sexual orientation, participants emphasized that this openness was not effortless but relied on personal and

social resources that had been developed over time. Consequently, they expected sexual orientation to be treated as a normal and non-stigmatized aspect of patient-centred care rather than as a source of prejudice or differential treatment. When these expectations were not met and participants experienced discrimination or heteronormative assumptions during consultations, they described changing GPs as an active strategy to preserve trust and ensure access to inclusive primary care.

"No, I would actually change doctors if I noticed that [experience of discrimination]. I work in the health care system, and I know it well enough to find a good alternative that I would like better." L3

Accounts associated with this pole suggest that the GP functioned as more than a health care provider. Trusting and continuous relationships enabled participants to integrate discussions of sexual orientation into routine care, thereby supporting both psychological well-being and the quality of health care experiences.

"And what significance does that have [the GP]? Absolutely crucial. (...) She [the GP] is truly like a rock in my life. She's there, she knows my circumstances (...), and she simply knows so much about me and looks after me kindly and wants to help me. (...) It is like a general sense of trust, that she's there, just as she is." L15

Within this analytical pole, this sense of agency over disclosure enabled participants to engage with GPs as collaborative partners in care. Rather than anticipating judgment or discrimination, participants described consultations as relational spaces in which sexual orientation could be addressed whenever it was relevant to their health care. This allowed discussions to extend beyond biomedical concerns to include minority-related experiences, particularly where these affected psychological well-being or everyday life. Participants described such conversations as an important component of holistic primary care, as they enabled GPs to understand health concerns within the broader context of their lived experiences rather than reducing sexual orientation to an isolated characteristic. Inclusive primary care was therefore experienced not as the provision of specialised services, but as the co-creation of a trusting therapeutic relationship in which patients retained agency over the relevance of their sexual orientation while GPs acknowledged and responded to minority-related experiences whenever these became clinically meaningful.

"And I was lucky, and that's why I'm very happy with the GPs' practice I'm at now, because they take it seriously [lesbian identity] and because, let's say I had mental health problems, I would feel very comfortable discussing them. That wasn't always the case with all the doctors I've seen, and I think this aspect is somewhat neglected in the health care system, especially in general practice, and particularly in relation to queer people." L2

The Spectrum Between the Two Poles

The two analytical poles should not be understood as representing distinct groups of lesbian patients, but rather as defining the boundaries of a broader spectrum of experiences within primary care. They represent theoretical condensations of recurring strategies identified in participants' accounts and serve as analytical reference points for understanding variation in health care experiences. Participants'

positions along this spectrum appeared to be shaped by the dynamic interplay of three interrelated dimensions: the degree of identity integration, the anticipation of discrimination, and the availability of personal and social resources. These dimensions shaped participants' ability to exercise agency over disclosure, establish trusting relationships with GPs, and navigate primary care encounters. Rather than occupying fixed positions, participants moved along the spectrum over time and across health care encounters. Their position was shaped not only by patient-related factors, such as identity integration, the personal relevance of sexual orientation, individual resilience, available coping resources, and supportive social networks, but also by provider-related factors, including continuity of care, the GP's communication style, responses to disclosure, and visible signals of inclusivity. Together, these patient-related and provider-related factors shaped participants' ability to exercise agency over disclosure, ultimately influencing whether primary care consultations were experienced as safe and supportive, or as situations requiring heightened vigilance and self-protection.

Discussion

Framing Within the Minority Stress Model

The idealized protective concealment orientation pole uses avoidance strategies, suffers from fear of discrimination, and experiences actual discrimination and, in some accounts, negative devaluations of their own sexual orientation. This underscores the applicability of Meyer's (13) minority stress model. Our analysis confirms both aspects of distal minority stressors, such as the experience of discrimination, and proximal minority stress processes, such as concealment and the expectation of rejection. Lesbians, such as the protective concealment orientation described above, may use strategies to minimize discrimination and be perceived as heterosexual. However, this may also limit the information available to GPs and thereby constrain opportunities for individualized and holistic care, which would require a biopsychosocial approach that considers all relevant factors, including social factors.

If a GP openly demonstrated sensitivity and knowledge about how experiences of discrimination can affect mental health and how societal reactions towards non-heterosexual people can impact an individual, lesbians associated with this pole might benefit from more adequate and holistic health care. Eventually, the ambiguity between disclosure and the fear of rejection might lead to important health issues being overlooked, while not being perceived in their individuality may provoke a strong inner conflict.

The other pattern, the affirmed identity orientation, also shows signs of minority stress but appears to have greater access to personal and social resources that buffer its impact. As in the theoretical framework mentioned, a close LGBTQ+ community may mitigate the effects of stigma and internalized homophobia, thus fostering resilience.

Rather than constituting purely clinical encounters, GP consultations emerged as social spaces in which broader mechanisms of recognition, inclusion, and exclusion are negotiated through everyday interactions. Whether minority-related experiences become a source of additional burden or can be addressed as part of holistic primary care therefore depends on the relational context co-created by both patient and GP.

Lesbians' Delineated Needs

Broadening the national context, the results can be seen as a confirmation of literature on the changing conditions of health care for lesbians. Law et al. (41) demonstrated that Canadian lesbians in primary care feel similarly insecure about disclosing their orientation towards a GP as they would about coming out in a private setting. Additionally, Marques et al. emphasized lesbians' difficulties with disclosing their sexual orientation towards their GPs because they fear rejection. (19) Our research particularly highlights this with respect to the protective concealment orientation. GPs should therefore inquire openly and sensitively about their patients' sexual orientation when clinically relevant, while ensuring that disclosure remains voluntary and self-determined, in order to address an important health influence that might otherwise remain hidden.

Bjorkman et al. (42) and Lampalzer et al. (24, 26) stated that GPs should be familiar with lesbian-specific topics such as sexual health and STI prevention and should adopt a nonprejudiced attitude toward lesbian patients. In line with this notion, our research adds that interpersonal competence is particularly important in addition to specific knowledge about health care needs. Thus, Martos et al. (43) conclude that lesbian patients prioritize expertise over interactional acknowledgement and appreciation of their lesbian identity. Our results extend and partly contrast with these findings, demonstrating that dealing openly with lesbian identity, in the sense of accepting one's sexual orientation and integrating it into everyday life, has a strong positive effect on the perception of primary care for lesbian patients. Our study highlights the relevance attributed to communication skills, to the point that these skills may be valued and desired even more than specific knowledge about relevant topics, such as STI care.

Our findings resonate with Tervalon and Murray-García's (33) concept of cultural humility, originally developed in the context of racial and ethnic diversity in physician training, which contrasts a finite, masterable body of knowledge with a lifelong process of self-reflection and the ongoing redress of power imbalances within the patient–physician relationship. Although developed for a different context, this distinction offers a useful lens for understanding lesbian patients' care as well: participants repeatedly valued a GP's willingness to acknowledge the limits of their own knowledge over comprehensive expertise in lesbian-specific health topics. This is consistent with the affirmed identity orientation, whose positive relationship with the GP arose not from the provider's specialized knowledge alone but from an interactional stance of openness and respectful engagement, suggesting that the value of professional knowledge depends partly on how it is communicated within the patient–GP relationship.

Our insights regarding the limited effect of visible symbols of inclusivity align with Singh et al.'s (44) work, which emphasizes that affirming care depends on the combination of supportive clinical environments, critical self-reflection among staff, and structurally embedded inclusive practices, not on representation or signage in isolation. Our participants' account of the rainbow flag "dying" the moment a receptionist asks for a "husband's" phone number illustrates precisely this gap between symbolic and structural inclusion: visible markers of openness may lower the initial threshold to seek care, but they may also heighten the discrepancy between the expectation of inclusivity they raise and the actual experience of care when subsequent interactions reveal that underlying institutional practice remains heteronormative. Symbolic measures may therefore be a useful starting point, but they are insufficient on their own and require consistent alignment with staff training and communication routines across the entire care pathway.

Our results are also consistent with Raque et al. 's (45) meta-ethnography on the impact of cancer for lesbian and queer women and their partners, which identified navigation of disclosure and characteristics of affirmative cancer care as central themes across the reviewed literature, emphasizing that affirmative care requires the removal of heteronormative assumptions and the full integration of partners into the care process rather than the mere presence of inclusive intentions. This convergence across oncology and primary care suggests that the mechanisms underlying inclusive versus exclusionary experiences for lesbian and queer patients may operate similarly regardless of clinical context.

Interaction Between GPs and Lesbian Patients

Studies on GPs' interactions with lesbian patients reveal uncertainties and a lack of knowledge about lesbian patients and their health care needs (27, 28). Our findings reflect this from the patient perspective and highlight a need for comprehensive training for both aspiring GPs and practice staff, in line with suggestions by Medina-Martínez et al. (3) on how medical staff, such as nurses, could be further trained. German medical students continue to report that the health care approaches of lesbian patients are inadequately covered in their curriculum, whereas a Swiss study demonstrated that even one hour of instruction can improve subjective care competence (32, 46). Currently, no measures in the form of training concepts are included in the licensing regulations for postgraduates (Approbationsordnung für Ärzte), and there is a corresponding gap in the care of lesbian patients within national care guidelines (Nationale Versorgungsleitlinie, NVL); only scientific recommendations for the psychotherapeutic and palliative care of lesbian patients exist (47–49). These evidence-based recommendations, and international guidelines, could also be considered for the field of primary care (44). Given the importance participants attributed to interpersonal competence, openness, and respectful communication, such recommendations should address not only lesbian-specific health knowledge but also the relational competencies required to create a safe and inclusive primary care environment.

Our findings also extend those of Hirsch et al. (25), who found that only 40% of lesbian women in their German survey had disclosed their sexual orientation to their GP, with no significant association between

discrimination experience and depressive symptoms. Our qualitative findings offer one possible explanation for this null finding: the psychological burden we identified, particularly within the protective concealment orientation, often stemmed from the anticipation of discrimination rather than its enactment. Whereas Hirsch et al. identified demographic predictors of disclosure (age, education), our two-pole model offers a complementary, mechanism-based account centered on identity integration, anticipated discrimination, and available resources. Our findings therefore suggest that binary measures of enacted discrimination may not fully capture the forms of minority stress relevant to disclosure and health care avoidance, and that structural interventions may be insufficient unless accompanied by corresponding changes in everyday GP–patient communication.

In this context, actively inquiring about sexual orientation, a positive attitude towards homosexual orientation, and even small communicative changes on the part of GPs can positively impact the health care of lesbian patients, as demonstrated by Steele et al. (50). Our research supports this finding, with the affirmed identity orientation demonstrating that a positive relationship with the GP arises precisely from patients' ability to verbalize sexual orientation as an influencing factor on their health, without fear of rejection or an anticipated negative reaction, implying that social resources shape the ability to share vulnerable information. GPs should therefore be made aware of their own potentially homophobic attitudes and actively work towards nonprejudiced and inclusive communication.

Taken together, our findings suggest that improving primary care for lesbian patients requires both structural and relational changes. While specific knowledge about lesbian health remains relevant, participants particularly emphasized the importance of how this knowledge is communicated and embedded within the patient–GP relationship. The two analytical poles should therefore not be understood as distinct patient groups, but as boundaries of a broader spectrum shaped by the dynamic interplay of identity integration, anticipated discrimination, personal and social resources, and provider-related factors. This perspective highlights that disclosure and trust are not solely individual patient characteristics but are negotiated within the relational context of primary care.

Strengths and Limitations

This study used a methodological approach that allows for deep insight into the target group and their experiences, thus providing access to complex societal phenomena. Additionally, this is the first qualitative analysis of data from lesbian patients in Germany, making this work novel both methodologically and content wise.

Selection bias can be presumed, as is common in qualitative research, which is due to self-registration, which is linked to self-reflection and the will to share private and intimate experiences with an unknown researcher. Additionally, almost all of the interviewees were highly educated, limiting generalizability. No religious background other than Christian belief was reported during the interviews. Thus, diverse cultural experiences that might differ from what Christian interviewees report are lacking. However, it is worth noting that a wide range of ages was covered.

Conclusion

The mentioned experiences with GPs reflect the spectrum of societal attitudes of health care staff towards lesbian patients, ranging from actively rejecting and discriminatory to supportive behaviour. A negative attitude and expression of rejection can have a direct effect on lesbians, causing them to avoid going to the doctor and potentially delaying diagnosis and therapy. Lesbians experience the same societal phenomena at the doctor's office as they do in society in general.

Lesbian patients want to be able to trust their GPs so they can disclose their sexual orientation safely and voluntarily. Self-disclosure can be an inherent desire that can have implications for health and health care. Within the context of the biopsychosocial model, sexual orientation appears to be a central and relevant identity factor in an individual's life and should receive adequate consideration.

In one respect, the research highlights that substantial societal shifts are required to foster a more inclusive culture and society that is mindful of discrimination. In another respect, the need for concrete action at the primary care level is also evident. In particular, in general practice, a space should be made available in which lesbian patients can open up and thus receive appropriate health care.

However, translating this understanding into practice requires more than conceptual recommendations: concrete intervention studies conducted in real-world primary care settings are needed to develop, implement, and evaluate approaches that operationalize inclusive and respectful care for lesbian patients, and to determine which structural and communicative changes are feasible and effective within the constraints of routine general practice.

Ultimately, the primary care setting itself can become either a relational resource that mitigates minority stress and fosters trust and resilience, or an additional stressor that reinforces vigilance, concealment, and anticipated rejection.

Abbreviations

GP
General Practitioner
STI
Sexually Transmitted Infection
LGBTQ+
Lesbian, Gay, Bisexual, Trans, Queer
NVL
Nationale Versorgungsleitlinie

Declarations

Ethics approval and consent to participate

Ethical approval was obtained from the Charité Universitätsmedizin ethical committee, EA1/053/22. All participants provided written and oral informed consent to participate prior to the interviews. Additionally, the study design was developed in alignment with the data protection regulations of the Charité Universitätsmedizin Data Protection Office.

Consent for publication

Not applicable. The manuscript contains anonymised interview excerpts but no individually identifiable data, images, or case reports. Participants provided informed consent for the anonymised use of their interview data for research and publication purposes as part of the general study consent process described under "Ethics approval and consent to participate".

Availability of data and materials

The interview transcripts generated and/or analysed during the current study are not publicly available due to the sensitive nature of the data and the assurance of confidentiality given to participants, but anonymised excerpts are available from the corresponding author on reasonable request, subject to approval by the Charité Universitätsmedizin ethical committee.

Competing interests

The author(s) declare(s) that they have no competing interests.

Funding

This research received no specific funding from any funding agency, and none of the authors received funding for this work.

Authors' contributions

ASW conceptualised the study, conducted the investigation and formal analysis, curated the data, administered the project, and drafted the original manuscript. JS contributed to conceptualisation, supervised the work, and critically reviewed and edited the manuscript. EB and MR critically reviewed and edited the manuscript. SM administered the project and critically reviewed and edited the manuscript. WJH contributed to conceptualisation, curated the data, supervised the work, administered the project, and critically reviewed and edited the manuscript. All authors read and approved the final manuscript.

Acknowledgements

The authors would like to thank all participants for sharing their experiences.

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