

Résumé

Le travail du personnel infirmier avec des patientes LGBTQ : « Elles sont comme les autres, alors quelle est la différence? »

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Se fondant sur les méthodes d'études critiques féministes et *queer*, cet article explore les perceptions qu'ont les infirmières et les infirmiers de leur pratique avec des patientes lesbiennes, gaies, bisexuelles, transgenres ou *queer* (LGBTQ). L'étude a comporté la réalisation d'entrevues en profondeur semi-structurées avec 12 membres de la profession infirmière à Halifax, en Nouvelle-Écosse. Ces entrevues ont permis de faire la lumière sur diverses approches en matière de pratique infirmière. Les participants ont le plus souvent soutenu que les différences comme l'orientation sexuelle et l'identité de genre ne font pas de différence : tout le monde devrait être traité comme une personne distincte. Les participants semblaient tenir beaucoup à éviter la discrimination ou la stéréotypisation en tentant d'éviter les suppositions. Ils étaient soucieux de ne pas offenser les patientes par leur langage ou leurs gestes. Lorsqu'il était tenu compte des différences sociales, l'accent se limitait souvent à la santé sexuelle, bien que certains participants aient montré une compréhension nuancée de l'oppression et de la marginalisation. Faire la distinction entre les généralisations et les stéréotypes peut aider le personnel infirmier dans ses efforts pour reconnaître les différences sociales sans faire de tort aux patientes LGBTQ.

Mots clés : lesbiennes, bisexuelles, transgenres, pratique infirmière, LGBTQ

Nurses' Work With LGBTQ Patients: “They're Just Like Everybody Else, So What's the Difference?”

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Informed by critical feminist and queer studies approaches, this article explores nurses' perceptions of practice with patients who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ). Qualitative in-depth, semi-structured interviews with 12 nurses in Halifax, Nova Scotia, illuminate a range of approaches to practice. Most commonly, participants argued that differences such as sexual orientation and gender identity do not matter: Everyone should be treated as a unique individual. Participants seemed anxious to avoid discriminating or stereotyping by avoiding making any assumptions. They were concerned not to offend patients through their language or actions. When social difference was taken into account, the focus was often restricted to sexual health, though some participants showed complex understandings of oppression and marginalization. Distinguishing between generalizations and stereotypes may assist nurses in their efforts to recognize social differences without harming LGBTQ patients.

Keywords: lesbian, bisexual, transgender, nursing practice, qualitative research, LGBTQ issues

Introduction

Women who identify as lesbian, gay, bisexual, transgender, or “queer” (LGBTQ) face social exclusion that can translate into significant health inequities (Fish, 2010). They are less likely than members of the general population to get regular Pap tests and mammograms, and more likely to use alcohol, tobacco, and other substances (Steele, Tinmouth, & Lu, 2006). Lesbian and bisexual teens are more likely than other teens to become pregnant, to abuse alcohol and drugs, and to consider suicide (Saewyc, Poon, Wang, Homma, & Smith, 2007). Transgender women, those whose bodies and socially assigned gender do not match their internal sense of gender, face considerable marginalization and mistreatment in health care, as well as unique health challenges (Bauer et al., 2009). Trans people have elevated rates of depression, substance abuse, other mental health conditions, suicidal ideation and attempts, HIV infection, and experiences of violence (Clements-Nolle, Marx, Guzman, & Katz, 2001; Kenagy, 2005; Shaffer, 2005). Stigma, homophobia, and transphobia (discriminatory prejudice that may manifest as avoidance, intol-

erance, fear, hatred, and violence) have been identified as major contributors to such health inequities (Banks, 2003; Weisz, 2009).

At the same time, LGBTQ women are less likely to seek out health services, in part because many experience health care as heterosexist, grounded in institutional and interpersonal assumptions that heterosexuality is the norm for relationships and any variation is considered deviant and subordinate (Sinding, Barnoff, & Grassau, 2004). For trans people, their very existence, as well as their health-care needs, is erased from attention and action at individual, organizational, and systemic levels (Bauer et al., 2009). In this study we explore how a small sample of nurses in one east coast Canadian city approached and understood their work with LGBTQ patients. We ask how everyday practices and ways of relating, as well as ways of thinking about sexual orientation and gender identity in nursing care, may unwittingly contribute to health inequities for LGBTQ women. At the same time, we ask how nurses may challenge those patterns to optimize care.

Literature Review

In 1993 Michelle Eliason (1993) wrote that “homophobia and heterosexism are not the fault of individual nurses, as they are the legacy of their socialization” (p. 18). Nonetheless, she argued, “failing to address prejudices and biases in adulthood is a breach of the nursing code of ethics” (p. 18). She argued that education and culturally congruent health care were key to bringing about change. In a systematic review of the nursing literature published 17 years later, Eliason, Dibble, and DeJoseph (2010) conclude that nursing scholarship has largely maintained an overwhelming silence with respect to LGBTQ health and health care. They call for emancipatory efforts in nursing education, research, and professional advocacy concerning LGBTQ health, to address the harms done by that silence.

LGBTQ Experiences of Health Care

LGBTQ persons are twice as likely as other Canadians to not have a family doctor, and are significantly less likely to seek out health care, often delaying until a condition is acute (Kenagy, 2005; Newfield, Hart, Dibble, & Kohler, 2006). Part of the reason for delaying may be fear of ill treatment. A study with 98 lesbian and bisexual women in Nova Scotia (Mathieson, 1998) found that many avoided routine and preventive care due to care providers’ assumptions. In the face of heterosexism in forms and documentation, as well as in discussions such as those surrounding sexual history and birth control, participants often felt forced to disclose

their sexual orientation. This left many providers feeling uncomfortable, not knowing what to do with the information. More recently, in a survey of 2,269 lesbian, gay, and bisexual persons in New Zealand, 83% of the women reported that their health-care providers usually or always presumed they were heterosexual (Neville & Hendrickson, 2006). Most also reported, however, that providers were comfortable with their disclosures and that their health care was not negatively affected by provider attitudes.

Many trans people experience their treatment by health-care providers as ignorant, insensitive, humiliating, and discriminatory (Newfield et al., 2006). Health professionals tend to lack knowledge and may express moral judgements about patients, sometimes even withholding treatment (JSI Research and Training Institute, 2000; Shaffer, 2005). In a transgender needs assessment carried out in Philadelphia ($N = 182$), 26% of respondents had been denied medical care at least once (Kenagy, 2005). A transgender participant in a Boston study reported that her physician withheld treatment, saying she "should 'see a veterinarian' as a medical doctor was 'a doctor for people'" (JSI Research and Training Institute, 2000, p. 22).

Heteronormative and Gender Normative Care

In recent studies, nurses have generally been described as having positive or neutral attitudes towards LGB patients (Goldberg, Harbin, & Campbell, 2011; Røndahl, Innala, & Carlsson, 2004; Sinding, Barnoff, & Grassau, 2004). For example, a Swedish study of perinatal care for lesbian mothers found that most had had positive experiences with nursing staff (Røndahl, Bruhner, & Lindhe, 2009). A broader study of nursing experiences with 27 lesbian and gay adults in Sweden found that most participants had found nurses to be caring and friendly, although some had experienced negative treatment (Røndahl, 2009). In a recent Canadian study, in contrast, trans persons reported constant struggles with uninformed health-care providers, with providers wanting to "pass" them off to other staff and belittling them (Bauer et al., 2009). This study found that forms, institutional procedures and policies, and health insurance requirements consistently erased the existence of transgender people.

Though minority sexual orientation and/or gender identity can evoke poor (homophobic and transphobic) treatment, a far more pervasive problem seems to be heteronormativity and normative assumptions about gender. A literature review carried out recently concludes, "Within the clinic, heterosexuality appears to be the expected 'default' norm" (Dysart-Gale, 2010, p. 24). Heteronormativity refers to the powerful interlocking set of assumptions and institutional practices that construct everyone as heterosexual unless shown to be otherwise and that view

heterosexuality as the preferred, normal — indeed only thinkable — sexual orientation. In heteronormative contexts, heterosexuality is descriptively normative (statistically “normal”) as well as prescriptively normative — unless heterosexual, one is cast as deviant, abnormal, lesser. At the very least, aberrations of the norm of heterosexuality require explanation. Heteronormativity, the pervasive assumption of heterosexuality, renders other sexual orientations (and people) invisible or marginal in health-care settings (Dysart-Gale, 2010; McDonald, 2009).

A similar set of normative assumptions contributes to the erasure of transgender existence and visibility. The normative assumptions that erase trans people are about gender binaries — that there are two distinct genders and everyone fits neatly and uncontestedly into one or the other, with no “spillage” over the edges of the categories. Normative assumptions about gender binaries erase not only trans people, but also those who experience themselves not as masculine or feminine but rather as something else, or something in the middle. Some of these individuals may identify as gender-queer. The pervasive assumptions that none of these gender-identity alternatives exist (or should exist) we refer to as gender normativity.

Recent research suggests that heteronormativity and gender normativity are pervasive in health-care settings, negatively affecting care for LGBTQ patients. In Canada, McDonald (2009) concludes, lesbians are rendered invisible in health care, as “the norm of heterosexuality is reflected in sexual and reproductive health-care practices, in demographic forms and interviews, and in the posters and pamphlets found on the walls and on the desks of health services” (p. 264). In two studies of lesbian prenatal and birthing experiences, heteronormativity was found to be ubiquitous, from the forms and language used to continual references to the father (Goldberg et al., 2011; Røndahl et al., 2009). Similarly, in a study of lesbian cancer care, Sinding and colleagues (2004) found that even the cancer support groups for lesbians or their partners were experienced as marginalizing, as they assumed that participants were heterosexual.

In Røndahl’s (2009) study with Swedish gay and lesbian adults, nearly all participants reported that nursing staff routinely assumed heterosexuality. Heteronormativity was conveyed through pamphlets and other information in waiting rooms, intake forms and documentation, routine questions about family relationships, and even routine practices such as insisting on a pregnancy test even when a patient said she was lesbian and could not be pregnant. Heteronormativity in written, verbal, and non-verbal communications marginalized and rendered invisible the lesbian and gay patients.

Fears, Discomfort, and Individualizing Difference

In the context of pervasive heteronormativity and gender normativity, LGBTQ patients clearly believe they may be subjected to ill treatment if they disclose their sexual orientation or gender identity. In a recent Canadian study of lesbian birthing experiences (Goldberg et al., 2011), the fear of and vulnerability to negative treatment in health-care settings were illuminated by the gratitude lesbians expressed when they received quality care. Participants were surprised and exceedingly grateful when they were treated well by nursing staff — when partners were acknowledged as partners, when nurses seemed comfortable with them as lesbians. The same finding is reported by Sinding and colleagues in their study of lesbian cancer care — simply being treated like other patients occasioned grateful praise:

What is normal treatment for heterosexual women was something that the lesbians remarked on and even praised. The narratives reveal that legacies of homophobia and heterosexism leave lesbians in the position of being grateful for things that heterosexual people take for granted. And if gratitude for equal treatment is a consequence of marginalization, so too are anticipation of problems and readiness to fight for care. (Sinding et al., 2004, p. 182)

Similarly, in Bauer and colleagues' more recent study of trans care in Ontario (Bauer et al., 2009), many trans participants felt grateful if they happened to encounter a care provider who was tolerant of their gender identity — let alone knowledgeable about their health needs.

In heteronormative and gender normative contexts, LGBTQ realities disrupt everyday assumptions, which may leave nurses and other staff uncomfortable. LGBTQ patients reporting on their health-care experiences have stated that their sexual orientation or gender identity seemed to make nurses and other staff feel insecure, embarrassed, and anxious about the possibility of saying or doing something “incorrect” and being seen as prejudiced (Goldberg et al., 2011; Røndahl, 2009; Røndahl et al., 2009). This fear of saying something wrong is sensed by patients, who then may bear the burden of facilitating communication. When nursing staff are afraid to discuss issues or are unsure about how to address LGBTQ patients (Røndahl et al., 2004), patients may fear that the nurses' discomfort will be accompanied by ill treatment. Communication then breaks down: “Insecurity, on the part of either personnel or relatives, could bring further interaction to a halt. . . . Nursing staff experience a great sense of insecurity concerning how they should behave in interactions with gay families” (Røndahl, 2009, p. 150). Røndahl (2009) notes that this is in spite of nurses generally holding positive or neutral attitudes towards LGBTQ people and being well-intentioned. He likens it to

cross-cultural communication struggles, when lack of knowledge coupled with good intentions can paralyze interactions.

One way that nurses can address fear of saying or doing something “wrong” is to focus on the individual. Goldberg and colleagues (2011) found that nurses often engaged in “care practices blind to difference” (p. 184), arguing that sexual orientation was irrelevant. They identify a “pervasive, problematic tendency to understand the requirements of acknowledging diversity as best met by sustained focus on the individual” (pp. 184–185). The desire to see all patients as individuals, and thereby perhaps avoid stereotyping LGBTQ patients, arises from a desire to cause no harm. However, it simultaneously precludes the opportunity to recognize and take into account how social factors — such as heteronormativity and gender normativity — shape patients’ (and nurses’) life experiences, health, and health-care interactions (Beagan & Kuma-Tan, 2009). The participants in Mathieson’s (1998) study of LGB women’s health care in Nova Scotia stated that a care provider must above all be gay-positive — able to grasp what it means to patients to be LGB and how societal responses to sexual orientation can affect health. A narrow focus on individualized differences precludes awareness of such social processes.

Summary

LGBTQ communities face particular health concerns, in part because health care typically does not take them into account. In the contexts of heteronormativity and gender normativity, LGBTQ patients challenge assumptions that may render their lives invisible and/or result in discomfort for practitioners. In this article we explore how nurses approach and understand their work with LGBTQ patients. We ask how everyday practices and ways of thinking about sexual orientation and gender identity in nursing may perpetuate or challenge inequitable health care for LGBTQ women.

Methods

This article is based on a subsample from a qualitative study of health care for LGBTQ women in which we sought to examine how taken-for-granted practices perpetuate or transform the marginalization of LGBTQ women within the health-care system. The study included in-depth face-to-face interviews with women, physicians, and nurses in two Canadian cities. The research team included LGBTQ researchers and members of several disciplines and professions, including nursing. In this article we draw on the data from registered nurses in Halifax, Nova Scotia. This sample comprised 11 nurses who identified as women and one who identified as a man; they had bachelor’s or master’s training, had practised

in various settings for between 10 and 20 years, and self-identified as working to some extent with LGBTQ patients. All of those who reported their sexual orientation self-identified as heterosexual; none identified as transgender. The sample was self-selected; thus participants might be expected to have an unusually high level of experience and familiarity in working with LGBTQ patients.

Following research ethics approval, recruitment was conducted through advertisements in local clinics, letters sent by the College of Registered Nurses, word of mouth, and snowball sampling.

After informed consent had been obtained, a qualitative in-depth, semi-structured interview was conducted with each participant. The participants were asked to describe how they experienced and understood primary health-care practice with LGBTQ women. The interviews were recorded, transcribed verbatim, and analyzed inductively, generating themes and subthemes, which were coded using ATLAS.ti software. Coding was conducted by a team of researchers in constant communication to reach consensus on codes and the use of codes. Analysis was informed by critical feminist and queer studies, which meant that we were sensitive to indications of power dynamics and to normative assumptions about gender and sexuality, and we read these as instantiations of social relations rather than as individual limitations. Transcripts were read and reread, and coded segments were interpreted both in the context of the entire interview and in comparison with the other transcripts. Drawing on the coded data, and again returning to transcripts repeatedly, the analyses described in this article explore the range of ways that nurses understood and approached difference.

Results

In the interviews, nurses described a range of approaches to working with diverse sexual orientations and gender identities. A common approach was to take the view that difference does not matter — in other words, to deny difference. An overwhelming message was the desirability of treating patients as individuals. In part this seemed to be an attempt to avoid discriminating or stereotyping by not making any assumptions. When difference was taken into account, the focus was often restricted to sexuality and sexual health. Yet some participants showed complex understandings of societal oppression and marginalization and the potential impact on health and health care. None of the nurses could be categorized into just one of the themes below; they all expressed various stances throughout their interview. Participants tended to have less experience working with transgender patients and thus had less to say about those patients than about other LGBTQ patients.

Denying Difference by Treating Everyone as an Individual

Almost every nurse interviewed expressed the idea that a patient's sexual orientation and gender identity do not matter, that the care the nurse gives to women is the same regardless of their sexual orientation and gender identity. Some participants simply did not see any differences that mattered relative to care. Others displayed a complex tension in their reasoning, clearly not wanting to reduce LGBTQ patients to their sexual orientation or gender identity by focusing on difference, yet wanting to acknowledge this difference as meaningful. For many this tension was resolved by acknowledging individual difference through treating each patient as a unique person.

When asked whether they treated or worked with patients any differently if they knew they identified as LGBTQ, most participants said they treated everyone the same. Kira asserted, "I think that I treat everybody the same, so I don't know that I would do anything different in regards to whether they've already identified that, you know, they're queer." Simon made it very explicit that sexual orientation and gender identity did not really matter because, inside, people are all the same: "It's not a great big deal, not only in terms of sexual orientation, but whatever, skin colour, whatever. I mean, in the end, we're all pink and squishy inside."

Some participants acknowledged that difference in terms of sexual orientation and gender identity did matter yet seemed to struggle with the idea of ascribing it any significance in their practice. For example, Abigail acknowledged that LGBTQ patients might face "things that could stem from the fact that they're part of that community," yet she went on to diminish the significance of that difference:

Even though I say "different," there's really so much of them that is still the same. . . . It really is only a small part of their life. There's so much more to the person than their gender identity or their sexual preference. . . . There's so much more to them that you just treat them like a regular — they are a regular person.

One of the nurses' most common rationales for not practising differently with LGBTQ patients was that they treated everyone as a unique individual. This approach was seen as avoiding discrimination or stereotyping and ensuring equitable treatment. Phyllis explained that she attempted to treat all patients the same but according to the unique needs of each: "Same and unique, same and individually as opposed to different. Yeah, because everyone has their own individual needs." Others said they focused on the individual health needs, "the medical issue," since sexual orientation or gender identity was not usually why a patient sought care.

Shelley was most explicit about treating LGBTQ patients as individuals. She and a colleague had been talking with other nurses about practice with LGBTQ patients:

One of the nurses was, like, "Oh, my gosh, how do you cope with that?" And we were saying, "Cope with them the same as you cope with anybody else." You know? They're individuals. They're patients the same as everybody else. . . . They're no different than anybody else. . . . They're individual and you treat individuals as individuals.

This focus on individualized difference served to diminish the role of social differences. Later in her interview Shelley suggested it was important to "look at both sides of it," treating people as individuals while also recognizing social diversity:

. . . making sure that each patient is an individual and that care regardless of what journey they're walking on, whether or not it's mental health, whether or not it's gay/lesbian, wherever, you're still dealing with the individual. But there's also that importance of always being mindful that you need to meet needs, and look at the diversity of those needs.

Shelley went on to compare LGBTQ to ethnicity, suggesting that a patient's ethnicity affects their needs in important ways but that a patient is always more than their ethnicity.

Acknowledging Difference as Discrimination

The idea that a patient is more than their ethnicity, or in this case more than their sexual orientation or gender identity, was a strong theme in the interviews. There was an overwhelming sense that the nurses interviewed did not want to harm any patient by stereotyping, making assumptions, or being discriminatory. Lia said explicitly, "I want them [LGBTQ patients] to know that I'm not homophobic or, you know, I'm accepting of everybody." She went on to say, "I'm always so worried about offending people and sort of making that assumption that everybody is heterosexual." Though this is to some extent about conveying a particular impression, we also interpret it as a genuine statement about not wanting to stereotype or harm.

The desire not to discriminate or to be seen as discriminatory may have been underpinning the pervasive denial of difference, the notion that sexual orientation and gender identity do not matter. In this context, the suggestion that LGBTQ patients might receive different care was taken to mean that the care would be poorer than that received by other patients. For example, when asked how she might work differently with LGBTQ patients, Clara said, "I don't think I would. I want to believe that. I think I would give the same care, you know, as [to] people who

are straight. I think I can honestly say that I would.” Phyllis similarly dismissed the suggestion that she might treat LGBTQ patients differently: “No. I’d never even consider that that would be, that they would get less of anything.”

In one of the few discussions of how care might be different for LGBTQ patients, some participants said that it was important to know patients’ sexual orientation or gender identity in order not to offend them by saying the wrong thing. This suggests that normative language and assumptions were prevalent. Some nurses did acknowledge the inevitability of making assumptions and struggled to contain or overcome them. Shelley explained that, especially in her work with trans patients, “You always are trying to be aware of what you say and what you’re doing, but you’re not always, a hundred percent.” Abigail noted, “You kind of get in a habit of . . . assuming that everybody’s the same . . . even though I know it’s not true, you do kind of fall into that trap.” Yet she clearly struggled to not discriminate against any patients, even in the everyday interactions that go beyond medical care: “You joke with all of them, when it’s appropriate . . . you try not to single out or exclude anyone from the type of care that you like to give to your patients.” Abigail’s efforts to connect helped her to avoid discriminating.

Similarly, while Shelley stressed the importance of attending to diversity, she was very concerned about stereotyping by reducing a person to their sexual orientation or gender identity:

What I guess I’m trying to say is that the diversity part, by my being able to look at the diverse person I’m better able to look at that person as an individual and a bigger individual than it’s just this. I’m not categorizing just as a gay person, but I’m looking at her as a gay person with this number of needs, this need that she brings to us as her being individual.

The tendency to associate assumptions with stereotyping undermines efforts to acknowledge social diversity and indeed encourages an individualized perspective on difference. When group differences were acknowledged, there was a tendency to reduce these to differences in sexual practices.

Focusing on Sexuality/Focusing on Oppression and Marginalization

The idea that people are individuals was sometimes accompanied by the notion that the only difference that mattered was that of sexuality and sexual practices. For example, when asked what difference it might make if a patient were LGBTQ, Anna said:

I don’t really care. If it’s a sore throat we’re talking about, [pause] it has really nothing to do with that, because, I mean, it’s still a person, it’s just

who they want to have sex with, you know what I mean? That's the only thing that's different, but they're just like everybody else, so what's the difference?

Clara said she did not care if patients were LGBTQ as long as affection was not evident: "I don't really care. As long as it's not publicly displayed, I don't, I'm just looking at the patient . . . I want to make them feel better." Later she affirmed that "it" referred to physical affection. It is not clear whether Clara was suggesting that LGBTQ people are more highly sexualized than others, or more inappropriately sexual, but she did seem to equate LGBTQ people with sex.

Similarly, when asked how she might work differently with LGBTQ patients, Shelley implicitly linked LGBTQ identity to sexuality when she connected it to having multiple sex partners: "There's a couple of our patients, there's one in particular, that I'm always aware of his health status, because of multiple partners." When the interviewer commented that this is not necessarily unique to gay men, Shelley agreed: "No. It would be the same if he was heterosexual." She went on to say that any difference would be due not to "their sexuality, but because of their, maybe lifestyle, maybe, um, of who they are." It was unclear if she meant an LGBTQ lifestyle or any lifestyle that included having multiple sex partners.

Several of the nurses said they invited disclosure of sexual orientation by inquiring broadly about sexual practices. Regardless of the patient's sexual orientation, they would ask all patients some version of "Do you have sex with men, women, or both?" Knowledge about practices could lead to another line of questioning, as indicated by Lia:

Practices might drive the discussion and the information a little bit differently. Okay, so you have sex with women. Do you use toys, do you share toys, what are you cleaning them with, do you know you can actually catch something off of those? Are you really good with safe sex practices?

In contrast to the tendency to reduce sexual orientation and gender identity to sex and sexual practices, about half of the nurses showed some insight into the complex ways that LGBTQ individuals face societal oppression and marginalization, which can affect their health, their health-care needs, and their health-care experiences. Abigail spoke about transgender youth growing up feeling different: "It's important that everybody become more aware of the fact that there are people in our greater community who may feel vulnerable, and they have different issues than the norm because they're part of the queer community." When asked if she thought being LGBTQ might affect a person's health-care needs, Shelley answered in the affirmative; she spoke of a gay family

friend who was raised in a conservative, religious family and had to “struggle for his identity all the time.” Jeanette worried about aging LGBTQ people who face placement in nursing homes and not have their long-term same-sex relationships acknowledged or respected by their families or the institution. These are all examples of nurses taking into account the ways in which sexual orientation and gender identity can affect the everyday lives of LGBTQ persons, shaping their health and their relationships to health care.

Some participants addressed the complexity of recognizing someone’s sexual orientation or gender identity and its possible effects on their health and health-care needs without reducing the person to that category and failing to see them as a whole person. This centred on recognition of oppression and marginalization, rather than on identities, practices, or “lifestyles.” For example, Jeanette said she gave women the same information about sexual health regardless of their sexual orientation, adding that she took into account barriers faced in previous health-care experiences:

I'd give the same information to a lesbian woman and a straight woman about Pap smears. But, you know, you might approach how you give information differently, especially when I think about some of the clients I've seen. Some of them have been not very well treated by their health-care practitioners, you know: nurses, doctors, dentists, social . . . it doesn't matter who. I've had a lot of people that just didn't have a good experience. So I'm probably going to tread a little bit more lightly . . . at least at first, until they get to know me and know that I'm not going to mistreat them or bad-mouth them because they've got a same-sex partner or whatever.

Similarly, Kira said that with an LGBTQ patient she drew on an understanding of possible barriers and harms experienced: “I’m cognizant of what she’s been through and that there’s more barriers and challenges. . . . I’d still go through the same assessment of what works with her, but I do see that there are a lot of barriers.”

Some participants learned about these barriers and harms by interacting with their patients. Jeanette, for example, had learned from conversations with lesbian mothers what it might be like for a non-biological mother to be misunderstood about her relationship with her child. Kate had learned a great deal from trans patients about the everyday aspects of seeking health care and day-to-day living as transgender:

I hear a lot . . . from them about fears . . . fear of identification in going to the lab and they call out their name and when they walk up to the desk they go, “No, I called out a woman’s name, you’re not —” because their

transition isn't complete . . . so they're still presenting as the opposite sex. And they fear that someone in that room has just heard that, and they also shouted out their address and they know now where they live . . . And suicide, like talk about how hard the transition has been and the really bad points they've been at in their lives before having the courage to make that move . . . So a lot of listening, I think.

Learning about the context of LGBTQ patients' lives is hindered when sexual orientation and gender identity are equated with sexual practices, because nurses may not want to invade the person's privacy. Clara had worked with a teenage girl who was very troubled, and, she believed, might have been lesbian. In order to provide good care, Clara said, "maybe we need to know a little more about their background, so we can help them better — not to stick our noses in their business, but to give them better care."

Phyllis used a broad understanding of LGBTQ lives and marginalization to let partners of LGBTQ patients know that their sexual orientation or gender identity was accepted. She did this by deliberately showing respect for the relationship:

Inviting the person to help with the bath or help with giving the medication, or we'll say, "You know them best. What do you think they would like?" And that sort of lets them know, it's like, "Okay, I know that you're the significant other here." That's probably the simplest way. I mean, that's the easiest way. . . it's sort of upfront and right there.

Here, Phyllis displays awareness of how everyday interactions in health care can unintentionally marginalize LGBTQ relationships.

Finally, a few nurses used their understanding of oppression to directly advocate for LGBTQ patients in health-care settings. Viewing homophobia as prevalent in hospital settings, Jeanette tried to make things easier for LGBTQ patients:

If I knew, I was more likely, then, to try to pave the way — like, say, if the partner wanted to come in to the ICU to visit them . . . I'd maybe go out of my way to be nearby to make sure nobody said anything to them or was mean to them. . . . I can remember a few times that nurses would be saying things about the patients behind their back. So I just knew that I would have to be on the lookout for them.

This kind of direct advocacy — challenging one's colleagues to improve care — was unusual in our sample, but clearly it was a very immediate way to affect understandings about oppression and marginalization in order to enhance the quality of care provided.

Discussion

The nurses in our sample displayed a range of ways of thinking about, understanding, and approaching their work with LGBTQ patients. To be clear, no nurse displayed only one approach — they all moved among differing understandings. This is a positive finding, since it suggests that individual nurses may hold multiple, even contradictory, understandings of LGBTQ care. That provides scope for drawing on and strengthening the understandings with optimal implications for equitable health care.

Different approaches have different implications. Most commonly, participants suggested that differences such as sexual orientation or gender identity do not matter: Everybody should be treated the same. Simon expressed this dismissal of diversity with the classic insistence that “we’re all pink and squishy inside.” There was pervasive concern that noticing social — as opposed to individual — differences is tantamount to discriminating. Most of the nurses were very concerned about reducing patients to their sexual orientation or gender identity, to a set of stereotypes or assumptions. This concern was coupled with fear of offending or stereotyping by saying or assuming the “wrong thing.” This could leave nurses paralyzed by the insecurity noted in previous studies (Goldberg et al., 2011; Røndahl, 2009; Røndahl et al., 2004, 2009; communication then becomes problematic.

One of the ways that LGBTQ identity mattered, the participants found, was that it led them to be careful with their language and to avoid making incorrect assumptions about patients. To be clear, these nurses were well-intentioned. They tried in multiple ways to avoid inadvertently causing harm to the LGBTQ patients in their care. Yet the focus on individualized difference, while undeniably important, was not accompanied by equivalent attention to social differences. The fear of making unwarranted assumptions is valid; it is challenging to recognize, let alone avoid, the normative assumptions attached to categories and labels such as lesbian, bisexual, or transgender (McDonald, 2009). If knowing a patient is lesbian leads a nurse to think they know how that patient lives her life, who she shares it with, what her health concerns are, and what risk activities she is engaging in, that nurse is definitely relying on stereotypes, which, coupled with the power of the health-care context, contributes to stigma (Weber, 2010). In her study of lesbian experiences of disclosure, McDonald (2009) urges nurses to avoid complicity in the maintenance of restrictive categories such as “lesbian” and to instead focus on individual practices: “Health-care practices directed towards women should move beyond unexamined categories of identity to consider the particular behaviours that influence the health of each woman” (p. 265).

This approach was apparent in our sample, with nurses arguing that what matters is not *who* someone is (their social identity) but their sexual practices: “Do you have sex with men, women, or both?” However, in attempting not to reduce patients to categories, nurses restrict their ability to see the potential impact of social differences. This approach fails to acknowledge that there *are* generalized social patterns in experiences, life chances, and influences on health (care) (Beagan & Kuma-Tan, 2009). “Colour-blindness,” for example, is unhelpful when skin colour causes people to experience racism on a regular basis and when racism can have stress-related health consequences (Quintero, Lilliot, & Willging, 2007).

Similarly, “care practices blind to difference” (Goldberg et al., 2011, p. 184) render sexual orientation and gender identity irrelevant, when in fact they shape people’s lives. In the context of heteronormativity and gender normativity, social power relations privilege some people (as “normal”) while marginalizing and harming others. Generalizations about the potential impacts of such contexts are not the same as stereotyping and discrimination. Generalizations allow nurses to take into account the possible effects of shared experiences that arise from historical and contemporary power relations. In other words, instead of assuming that all LGBTQ individuals share common practices or lifestyles (stereotyping), nurses could attend to potential experiences of marginalization and oppression.

To be clear, not every LGBTQ person experiences homophobia, transphobia, heteronormativity, or gender normativity in the same way. Class, race, ethnicity, citizenship, age, and other forms of social privilege can lessen the impact of LGBTQ marginalization. This does not mean that marginalization does not exist, or that it does not affect LGBTQ people as a social group. The fact that other social privilege may ameliorate the impact of oppression does not erase it. Similarly, class, gender, sexual orientation, skin colour, disability, religion, and age may all affect the ways that members of a specific ethnic group experience and relate to their cultural heritage and potential cultural identity. This does not change the fact that ethnocentrism privileges some cultural groups and systematically disadvantages others. Individual access to alternative sources of social privilege in no way nullifies the social marginalization of a group; it simply mediates the individual experience.

Generalizations look at the shared values, beliefs, tendencies, and typical experiences of the majority in a particular sociocultural group. They bring together group-specific observations and experiences. They imply difference, not deficit. Stereotypes are an end point for understanding a person, limiting rather than broadening understanding. They apply

group tendencies as if they were always true for all members of the group. In contrast, generalizations are a starting point for understanding a person. Practitioners cannot understand an individual from generalizations, but generalities can sensitize nurses to probable patterns, issues of social difference, leading them towards particular kinds of questions.

For example, Jeanette used her understanding of patterns of homophobia to advocate for and protect LGBTQ patients on hospital wards. More simply, Kira said of an LGBTQ patient, “I’m cognizant of what she’s been through and that there’s more barriers and challenges.” While not every LGBTQ individual faces more challenges than every non-LGBTQ individual, Kira is acknowledging that distinct social barriers accrue to LGBTQ status. Phyllis, without ever needing to ask about a patient’s sexual orientation (with the attendant fear of prying or “getting it wrong”), found ways to honour same-sex relationships by simply saying, “You know them best. What do you think they would like?” She used her understanding of heteronormativity to challenge the business-as-usual marginalization of LGBTQ realities.

Generalizations can only provide what might be considered “sensitizing awareness.” They cannot be a stand-in for knowledge of an individual patient. As McDonald (2009) argues, health care must “consider the particular ways that a range of oppressions and privileges influence the health and health care of each woman” (p. 265). Each patient’s story and experiences will be individual. Yet, by alerting nurses to the ways that marginalization and social exclusion can shape LGBTQ experiences of health and health care, generalizations may cause them to bring up particular issues or ask particular questions, rather than leaving it entirely to LGBTQ patients to raise concerns.

If taking difference into account means acknowledging the context of heteronormativity and gender normativity, then we must acknowledge that many LGBTQ patients fear (justifiably) that they will be treated poorly in a vulnerable situation. Yet nurses, for fear of offending, take a “don’t ask, don’t tell” approach, trusting that quality care can be provided without acknowledging LGBTQ identities and the ways in which marginalization and oppression may shape LGBTQ patients’ health and health care. While the nurses in our study said they were comfortable with disclosure of LGBTQ identities and experiences of marginalization, few apparently saw it as their responsibility to facilitate such discussions. The assumptions of heteronormativity and gender normativity remain unquestioned. Nurses enact a certain privilege when they decide that the risks of discomfort of having got it wrong or having offended are too great to address relevant social differences.

Conclusion

One of the most significant findings from this study is that the nurses were very concerned to not harm their LGBTQ patients in any way — through stereotyping, discriminating, making assumptions, using offensive language, or saying the “wrong thing.” This regard is extremely important and can be used productively. Education and training could help nurses to grasp the differences between generalizing and stereotyping, enhancing awareness of the patterned ways that heteronormativity and gender normativity shape health and health care, and potentially improving care for LGBTQ patients and their families.

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Acknowledgements

We greatly appreciate funding from the Canadian Institutes of Health Research, the participation of the nurses, and recruitment assistance from the College of Registered Nurses of Nova Scotia. We thank the Halifax research assistants Brenda Hattie and Ami Harbin as well as research team members Sue Atkinson, Cressida Heyes, and Mary Bryson.

There are no financial or other conflicts of interest to report.

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