

## **L'élaboration d'une résolution de principe en matière de recherche sur la diversité sexuelle : le rôle moral des infirmières**

**Judith A. MacDonnell**

Cette étude de cas menée en Ontario, une province canadienne, examine la pertinence des relations de pouvoir en matière d'éthique de la recherche en sciences infirmières. Des infirmières de santé publique ont entrepris une réflexion critique sur le rôle qu'elles jouent pour dénoncer les inégalités sociales au moment de recueillir des données destinées à éclairer leur exercice. Ce faisant, elles ont préparé une résolution qui expose les valeurs et les principes sur lesquels devrait reposer la recherche infirmière menée auprès des différentes minorités sexuelles. L'auteure se fonde ici sur une étude de cas qualitative et un cadre féministe en matière de bioéthique pour analyser le document en question et le milieu d'exercice dans lequel il s'inscrit. Ses conclusions indiquent que les dynamiques de pouvoir, incluant celles qui relèvent du genre, influent sur la capacité des infirmières à défendre les droits des minorités sexuelles par le biais de la recherche, ce qui aura suscité l'élaboration d'une déclaration publique sur la production des connaissances. Elles comportent certaines implications pour l'éthique en matière de recherche, dont la nécessité d'explorer en quoi les discours dominants et les contre-discours, de même que les multiples dimensions du pouvoir, façonnent le rôle moral des infirmières face au besoin de remettre en cause le statu quo.

Mots clés : minorités, genre

# **Articulating a Policy Resolution for Sexual Diversity Research: Nurses as Moral Agents**

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This case study of community nurses in the Canadian province of Ontario explores the relevance of power relations to nursing ethical inquiry. Public health nurses critically reflected on their role in challenging social inequities as they generated evidence to inform practice. In the process, they developed a policy resolution articulating values and principles for ethical nursing research with diversely situated sexual minorities. The author uses a qualitative case study design and applies a feminist bioethics framework using critical literature to analyze this document and the practice context. The findings suggest that dynamics of power, including gender, influence nurses' ability to advocate for sexual minorities through research, prompting the development of a public statement on knowledge production. There are implications for undertaking nursing ethical inquiries that explore how dominant and counter-discourses and multiple dimensions of power shape nurses' moral agency in challenging the status quo.

**Keywords:** Nursing ethics, sexual orientation, research methodology, public health nursing, feminism, minority, gender

The practice of Canadian public health nurses is shaped by the ethical and professional requirement that nurses promote the health and well-being of individuals, families, and groups as well as vulnerable populations and communities (Canadian Nurses Association [CNA], 2002; Community Health Nurses Association of Canada [CHNAC], 2003). Although the nursing profession emphasizes the diversity of individual clients and communities with whom nurses interact, there is a paucity of nursing research addressing sexual diversity, especially in the Canadian context (Giddings, 2005; Gray et al., 1996; MacDonnell, 2007; MacDonnell & Andrews, 2006; McDonald, 2006b; Stephany, 1992; Stevens, 1992; Walpin, 1997). This despite the well-documented health inequities shaping the lives of sexual minorities across age, ethnoracial status, gender, geography, and other social locations (Dean et al., 2000; Jackson et al., 2006; MacDonnell & Andrews). Sexual minorities encompass lesbians, gay men, and bisexuals for whom same-sex orientation (i.e., attraction to the same sex) is relevant and transgender people for whom gender identity (one's sense of being male or female) is a defining component of their health and well-being.

This qualitative case study employs a critical feminist lens (Peter, Sweatman, & Carlin, 2005) to explore the ethical dynamics shaping the practice of a group of public health nurses in the Canadian province of Ontario. These nurses were members of a coalition devoted to improving the health and well-being of sexual minorities. After reflecting critically on the values and methodological principles driving their practice, they developed a policy resolution, *Ethical Research and Evidence-Based Practice for Lesbians and Gay Men* (Public Health Alliance [PHA], 2002), a public and professional statement linking ethics and research.

When this policy resolution was reached in 2002, the nurses involved in the discussion were affiliated with a workgroup of the Ontario Public Health Association (OPHA) focused on challenging health inequities and enhancing care for sexual minorities — communities whose health and well-being encompass their same-sex orientation and gender identity (Dean et al., 2000). This coalition is now known as the Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual, Transgender, Two-Spirit, Intersex, Queer and Questioning [LGBTTTIQQ] Equity, or PHA. In their discussion of ethical and legal issues in community nursing, Peter et al. (2005) briefly address the coalition's work to enhance social justice for sexually diverse communities, linking their contributions to the CHNAC Standard of Practice (2003) for facilitating equitable access to high-quality care. For the most part, the holistic needs of sexually diverse groups are invisible in nursing ethics research (MacDonnell, 2001, 2005). This has implications for our understanding of the relevance of ethical inquiry for this area of nursing practice.

In this article I explore the relevance of a feminist analysis and ethical dynamics for the involvement of public health nurses in the production of the knowledge that informs their practice related to sexual minority health. I apply concepts from feminist bioethics (Peter et al., 2005), a nursing framework that foregrounds ethical inquiry with a focus on gender and other relations of power, in a case study of the PHA (2002) policy resolution. The analysis is contextualized by critical literature and documentary data from other policy initiatives taken by the PHA to improve the access of sexual minorities to quality public health care.

The article begins with a description of the methodology, a critical feminist approach, the characteristics and activities of the workgroup, and the documents used. Key points in the policy resolution are noted. Through an analysis of this case focused on sexual minority health, I identify findings related to gender and other relations of power that shape nurses' ability to practise in ways that are consistent with the goals of social justice. The discussion situates these findings and the contributions of the policy resolution in the local and larger contexts of nursing practice, research, ethics, and policy. Implications for nursing are discussed.

## **Methodology**

### ***Research Design***

A qualitative case study design (Stake, 2003) focused on one workgroup, the PHA, was chosen, with the goal of a deeper understanding of the dynamics that shape nurses' involvement in the production of knowledge with sexual minorities. Nurses identified as belonging to a sexual minority or as heterosexual allies have consistently made up a high proportion of PHA members. Since the workgroup has undertaken several policy initiatives over the past 10 years to foster the access of sexual minorities to public health services, purposive sampling of this single case was used (Cresswell, 1998). In the critical feminist approach, the location of the researcher is relevant to the inquiry. I have been a member of the PHA, working as an ally on research, education, and policy initiatives, and have had insight into workgroup processes over the same 10-year period (MacDonnell & Andrews, 2006).

### ***Data Collection***

Given the retrospective nature of the study, the data include four policy documents on projects drawn up by various PHA members between 1999 and 2003. Since documents in the public domain, rather than participant interviews, were used, research ethics board approval was not required. Documents included the policy resolution *Ethical Research and Evidence-Based Practice for Lesbians and Gay Men* (PHA, 2002) and three position papers addressing access and quality of public health services for, respectively, lesbians and gay men (Duncan et al., 2000), bisexuals (Dobinson, MacDonnell, Hampson, Clipsham, & Chow, 2005), and transsexual/transgender people (Gapka et al., 2003). The latter two papers resulted from province-wide community consultations using community-based participatory action research (CBPAR). The bisexual project was completed in 2003 and published in a journal in 2005.

Literature reviews informing each PHA policy document included searches of databases such as CINAHL for health literature and contact with key informants to identify relevant policy or unpublished literature. At least two participants were involved in thematic analyses. PHA listserv members and representatives of the OPHA Board of Directors reviewed these policy submissions, which summarized existing research and gaps, implications for public health practice, resolutions, and implementation strategies for the OPHA. The submissions were approved by interdisciplinary professionals and policy analysts who make up the OPHA general membership and can be accessed online ([www.opha.on.ca/advocacy/ppres.html](http://www.opha.on.ca/advocacy/ppres.html)).

For workgroup activities, critical literature on nursing practice and research with minorities situate the analysis in the sociopolitical context. Since it is a goal of case study research to examine the particularity of the case, rather than aim for generalization, I used multiple data sources to explore the dimensions of the case, providing thick description of the workgroup and its participants (Stake, 2003). Triangulation of data over time and source enhance verification or validity (Cresswell, 1998).

### ***The Feminist Bioethics Analytic Framework***

According to Peter et al. (2005), a feminist bioethics framework offers a perspective that extends and challenges the dominant view of bioethics, which is based in biomedical tradition. As a result, nurses' understanding of what constitutes legitimate ethical concerns is affected by a prevailing discourse in health ethics equated with "highly charged medical situations... [E]veryday...ethical tensions and issues [are often overlooked]" (Varcoe et al., 2004, p. 317). In addition to a focus on ethics, defined as "values, norms, moral principles, virtues, and traditions that guide human conduct" (Peter et al., p. 39), this framework considers relations of power as both a potentially negative force (e.g., "power-over" as in oppression) and a positive force in terms of the human ability to act. As Peter et al. indicate, "power is itself ethically neutral. How it is used, is...however, ethically significant" (p. 40). An ethical inquiry focuses on processes and impacts of the structuring and exercise of power. The larger, structured dynamics of power are relevant: They are the historical, sociocultural, political, and economic contexts and the ethical challenges that nurses encounter in their everyday practice.

A focus on the relational nature of social and human relationships highlights the interconnectedness of social relationships, nurses' interpersonal connections, and nurses' relationship to the world. It also shows how relations of difference and social privilege (including gender), social disparities, and vulnerability related to social disadvantage are pertinent to ethical inquiry, as are actions that enhance care and social justice (Sherwin, 1993; Tong, 2001). A feminist bioethical analysis in this case study could reveal social structures that have an oppressive effect on nurses and their communities. Use of a lens of gender that acknowledges the intersections of gender with race, class, and sexuality offers insight into "the ways in which femininity and masculinity are reflected in lived life" (McDonald, 2006a, p. 336). Social worlds often privilege knowledges and values that are constructed from an implicit white, middle-class, heterosexual male reference point (Giddings, 2005; MacDonnell, 2007).

This analytical lens can identify complex social processes and relationships at the micro and macro levels that influence nurses' ability to practise in ways that are consistent with professional values that exhort

them to challenge health inequities and strive for social justice. The findings foreground processes in the workgroup activities and policy resolution that normalize, marginalize, or privilege certain practices and actors, in order to point out barriers to nurses' ultimate ability to provide high-quality care to sexual minorities. As Sherwin (1993) writes, "to speak meaningfully about justice, it is necessary to examine the actual forces that undermine it, as well as those that support it" (p. 21). Such an analysis can highlight nurses' concrete challenges with respect to social processes that perpetuate domination and oppression, in order to demonstrate how nurses act as moral agents in challenging the status quo in their everyday work. A critical gender analysis through this case study can reveal the transformative potential of their relationships and practices (Cresswell, 1998; Gangness & Yurkovich, 2006).

### ***Description of the Case: Public Health Alliance***

The PHA comprises both sexual minorities (i.e., those identified as LGBTTTTIQQ) and their allies. Emerging as a forum for support in the late 1990s, the coalition has, over the past decade, encompassed a diversity of age, sexual orientation, gender identity, ethnoracial, and professional status. At any given time it has approximately 10 to 35 members, mostly females of high social privilege. Since participation has shifted over time, a variety of members have been involved in activities aimed at raising awareness about sexual diversity and enhancing the ability of public health practitioners to provide equitable access to high-quality care.

In the year 2000 the PHA collectively wrote a position paper focused on two groups of sexual minorities. *Improving the Quality of and Access to Public Health Services for Lesbians and Gay Men* (Duncan et al., 2000) documents the gap in Canadian research evidence related to the health of lesbians and gay men. The authors offer resolutions with regard to making sexual minority health visible and advocating for public health education and programs, services, and other resources. In addition, they stress the diversity, such as that in socio-economic status, that exists within these communities and that influences the experiences and perceptions of sexual minorities with regard to their health. Since the issues encountered by bisexual and transsexual/transgender (trans) communities are often unique to those communities, the PHA advocated for research strategies along with education and policy strategies. Community members as well as professionals became involved in the PHA with the launching of the bisexual and trans health projects.

Over the succeeding year, as the authors of that first position paper (Duncan et al., 2000) engaged in dissemination strategies with practitioners, funding agencies, and sexually diverse communities, questions were raised about the role of professionals in enhancing the access of

sexual minorities to high-quality health care. Based on discussions with a dozen or so other nurses and colleagues and on critical reflection on their own advocacy experiences, a small group of nurses affiliated with the PHA considered implications for their practice. By engaging with the literature, as described earlier, they identified issues relevant to the content and process of sexual diversity research (e.g., health promotion discourses, partnerships with marginalized groups) and formulated a policy resolution. This resolution (PHA, 2002) set out five principles for ethical research linking specific values to the production of knowledge and policy actors involved in research. “The production of knowledge or evidence cannot be seen as separate from the socio-political structure of power in society” (PHA, 2002, p. 2). The five principles are:

1. Research on the health of lesbians and gay men must include the input and equitable participation of diverse members of the lesbian and gay communities.
2. The utilization of evidence to guide programs/services and resource allocation must include (a) members of lesbian/gay communities, and (b) published and unpublished literature and proceedings from community consultations.
3. Research funding policies and guidelines must ensure adequate input and equitable participation by stakeholders in/members of lesbian/gay communities.
4. Research capacity must be expanded beyond the academic sector and be integrated at the grassroots level, in order to ensure meaningful participation and empowerment for communities.
5. Education in cultural/diversity competency for public health practitioners, researchers, and policy-makers must address issues that are relevant to the research inquiry. (Issues around the undertaking of research on/with/about these communities must be part of higher education.)

The development of this resolution prompted the PHA to undertake two CBPAR projects with bisexual and transsexual/transgender people (Dobinson et al., 2005; Gapka et al., 2003).

### **Findings**

According to Peter et al. (2005), nurses who are involved in improving access to and equity in health care can be described in terms of their moral agency: their ability to act on values that are consistent with caring and social justice. Doane and Varcoe (2007) assert that use of a relational inquiry lens to frame nurses’ development of trusting, respectful relationships with patients supports a complex view of nurses’ obligation to

address suffering and injustice. In their view, such actions to enhance health and healing take place at the interpersonal, intrapersonal, and organizational levels simultaneously, since they inform each other and hence nurses' ability to care. This application of a feminist bioethics lens reveals interrelationships among the workgroup's actions to challenge the status quo at the individual, organizational, and macro levels.

By explicitly articulating principles that underpin action in relation to moral issues such as the structures that render sexual minority research invisible in health contexts, nurses as moral agents identified taken-for-granted dominant discourses shaping their practice. A key aspect of critical questioning represented through the policy resolution was an examination of social norms, ideologies, and dominant discourses framing practice (e.g., Doane & Varcoe, 2007; Peter, 2000). Having identified these often invisible dynamics of power that have oppressive or normalizing effects, the nurses could potentially question or challenge them, thus offering counter-discourses to normative assumptions (MacDonnell, 2001). Several examples of ideologies, social norms, and dominant discourses are addressed, as well as counter-discourses or strategies to challenge these norms and ideologies.

### ***Dominant and Counter-Discourses***

One example of a dominant ideology that influenced sexual minority health and nurses' practice dynamics, heterosexism, is the implicit normality and privileging of heterosexual relationships that underpin all social institutions. Heterosexism represents deeply embedded oppressive relations, and it interacts with racism, ageism, and other social relations to influence how individuals across social locations experience and understand their health (Ryan, Brotman, & Rowe, 2000). Until recently, sexual diversity was virtually invisible in Canadian health care except in the context of mental health, sexuality, and HIV/AIDS (Dean et al., 2000; Jackson et al., 2006). Over the last decade, sexual minority concerns have garnered media attention and significant progress has been made with respect to social and legal rights. However, diversely situated sexual minorities across ethnoracial status, gender, and religion have historically been pathologized and have met with exclusion, marginalization, stigmatization, and discrimination by practitioners and institutions. Well-documented negative health impacts include increased mortality, morbidity, and inaccessibility of relevant and high-quality care (e.g., Dean et al., Dobinson et al., 2005; Duncan et al., 2000; Gapka et al., 2003). Although there are benefits to identifying health risks linked to sexual diversity, given the neoliberal focus on individual responsibility for health (Browne, 2002), such dynamics can serve to limit support for the system-level



changes needed to improve the equitability of care for the historically disadvantaged (Jackson et al.).

Nurses involved with the PHA explicitly named heterosexism and its effects, and collectively strategized with communities and with their interdisciplinary colleagues to challenge heterosexism through education, policy-making, and research. The PHA (2002) policy resolution extended the conventional discussion of heterosexist effects to include barriers to the production of knowledge in academic and publication contexts. According to Kitson (2002) and Ray (1999), authoritative health bodies act as gatekeepers, controlling knowledge production through academic means. Jackson et al. (2006) point out that we need both large-scale population-based and small-scale community-based studies in order to inform high-quality care. As counter-discourses — actions that challenge the prevailing social relations — PHA strategies advocate for the altering of social structures that legitimize the production of research evidence and for consistent education of health researchers with regard to sexual minority health.

The PHA (2002) policy resolution also problematized dominant evidence-based discourses shaping the production of knowledge in health-care environments. Although the evidence-based discourse offers a research base to frame health care, experts who use positivist approaches and quantitative measures of health and health outcomes often dominate discussions of health priorities, excluding or marginalizing other approaches such as CBPAR (e.g., Browne, 2002; Bryant, 2002; Kirkham, Baumbusch, Schultz, & Anderson, 2007; Kitson, 2002). Underlying androcentric epistemological norms serve to privilege positivist research and expert knowledges (MacDonnell, 2005; McQueen & Anderson, 2001). Research used as evidence for health-care policy or practice is constructed within particular epistemological and historical, social, and political contexts and is embedded in social relations and discursive practices that shift across time and place (Browne).

The ways in which same-sex issues are taken up in research often reflect social and political dynamics that are dominated by positivism, heterosexism, and rational policy processes (Jackson et al., 2006; MacDonnell, 2005, 2007; Varcoe et al., 2004). The holistic health issues of sexual minorities are often invisible or inconsistently addressed in the education of health professionals (Dunn, Wilson, & Tarko, 2007). Therefore, researchers may have a limited understanding of the unique issues to be considered in studies with sexually diverse communities. Disclosure, identity issues, and barriers to undertaking randomized control trials influence how and whether sexual minority health is studied (Dean et al., 2000; Dobinson et al., 2005; Duncan et al., 2000). Dynamics of authority play into what research questions are addressed

and what methodologies are legitimized, how studies are funded and published, and how — or whether — this evidence is disseminated (Ray, 1999). These macro dynamics inform public health capacity and the likelihood of nurses and their organizations having the knowledge they need to care for sexual minorities at the individual or community level.

### ***Reflexivity***

According to Peter (2000), reflexivity “refers to the capacity to reveal the political nature of knowledge through the questioning of every step of the research process” (p. 109). As Doane and Varcoe (2007) stress, “reflexive inquiry moves nurses to look at both what they are doing and how they are doing it” (p. 200). The PHA’s (2002) resolution challenging the assumptions behind evidence-based discourse is consistent with the literature that critiques medicalization and advocates for the decentring of epistemic privilege (Kirkham et al., 2007; Peter et al., 2005). In a research context, the PHA advocated for participatory action approaches with their potential for meaningful community engagement in the creation and production of knowledge, especially for those who have historically been excluded (Smith & Davies, 2006; Varcoe, 2006). The PHA’s critique of knowledge production addressed the visibility of both content (e.g., research undertaken and published) and process, with a view to foregrounding which participants had voice and authority throughout the process. It advocated for engaging participants in reciprocal knowledge production through the exchange of ideas, so that the communities concerned might benefit from the process by acquiring skills, confidence, and competence (community capacity), as well as through community mobilization around particular issues (Naidoo & Willis, 2000).

Some of the nurses who contributed to the policy resolution (PHA, 2002) were not publicly affiliated with the workgroup, because of workplace constraints, concerns about stigmatization, or anticipated negative workplace dynamics related to disclosure as a member of a sexual minority (Giddings, 2005; MacDonnell, 2007). It was decided not to make visible only those participants, especially allies, who faced fewer risks in being named as author. Collective authorship served both to validate the contributions of sexual minorities and allies on the issue of knowledge production and to protect identities. As a counter-discourse, the resolution challenged notions about who controls and participates in knowledge production. Advocating for sexual minorities’ acquisition of material gains and active engagement in academic research such as CBPAR also served to challenge heterosexist and homophobic processes that render minorities invisible and docile. The actions supported the resilience of sexual minorities, which, along with a range of other strate-

gies, challenges systems to be more responsive to their needs (Duncan et al., 2000; MacDonnell & Andrews, 2006; Ryan et al., 2000; Sawicki, 1991).

A feminist bioethics approach also considers the importance of context and relationships in the research process. The implementation of PAR in professional contexts can vary considerably (e.g., Holkup, Tripp-Reimer, Salois, & Weinert, 2004; Varcoe, 2006). The PHA (2002) resolution explicitly named the goals of enhancing community capacity and building on community knowledges and strengths as consistent with ethical goals. However, Hagey (1997) cautions that communities are alert to how research is used to manage them, given their experiences of institutions “gathering data ‘on’ oppressed people...[and] phrases such as ‘hit and run’ and ‘fly in fly out’ research” (p. 1). In the case of the PHA, trusting, respectful, and inclusive relationships between the community and professionals begun with the PAR projects (Dobinson et al., 2005; Gapka et al., 2003) have since been enhanced by joint participation in education and policy initiatives. However, as Varcoe (2006) points out, “being inclusive must be seen as complex and the influence of diverse agendas and perspectives acknowledged” (p. 525).

In order to challenge health and social inequities, nurses must challenge their own knowledges, assumptions, and practices, considering that complex relations of power influence their nursing actions in ways that help to emancipate and empower their clients. The sociopolitical environment shaped by dominant neoliberal discourses is a significant force in informing the practice setting. All social institutions in this neoliberal era are marked by the use of efficiency and outcome measures of accountability and quality of care that primarily reflect economic interests (Browne, 2002; Gustafson, 2000; McQueen & Anderson, 2001). Policies and programs associated with the health professions are affected by business paradigms in which quality of care is equated with efficiency, standardization, and cost-effectiveness. Some recent health-care reforms, for instance, privilege dominant groups at the expense of those marginalized by race and gender (Gustafson). Particular conceptualizations of deservedness create exclusionary visions of care that direct health policies and organizational practices (Duncan et al., 2000; Raphael, Bryant, & Curry-Stevens, 2004). Such dynamics require an awareness of the structural underpinnings of health and solutions that may require sustained creative and collective action (Doane & Varcoe, 2007; MacDonnell & Andrews, 2006).

In the community context, practice settings are informed by demands for short-term measurable outcomes and discourses of health promotion based on behavioural and biomedical models. Nurses' coalition work with communities has been discounted or invisible in organizational

accounts of their practice (MacDonnell, 2005). Such policies and practices shape nurses' working conditions that implicitly discount the importance of continuity of care. Yet nurses require protected time to facilitate care based on in-depth understanding of the particular issues of the client base, as well as to develop trusting, sustainable partnerships between communities and institutions. There are implications for fostering nurses' ability to meet the needs of their communities, as well as to find meaning in their work (Falk Rafael, 1999; Gustafson, 2000; MacDonnell, 2007; Stevens & Hall, 1992).

Yet, along with neoliberal influences, emancipatory discourses, such as social equity, that align with health promotion initiatives consistent with social justice shape the public health environment. Such strategies can ultimately change the conditions that foster and sustain health and enhance communities' control over their living conditions (Stevens & Hall, 1992). The *Action Statement for Health Promotion in Canada* (Canadian Public Health Association, 1996) cites two key factors that support effective action: "enhancing our knowledge base and building stronger [community-institutional] alliances" (p. 9). In this vein, nurses' priorities include facilitating processes and outcomes that reflect community agency, meaningful participation, and empowerment (in ways that move beyond tokenism). Long-term organizational investment in community coalitions is consistent with this political work, as is investment in nurses' ability to create/co-create knowledge with communities (Hagey, 1997; Kirkham et al., 2007).

The PHA originated as a forum for personal support and the sharing of sexual diversity information among interdisciplinary public health practitioners, including nurses and health promoters, across regions. Although many of the practitioners worked in sexual health programs, they often felt isolated in their work related to sexual diversity. Most professional resources in their organizations and networks addressed the important but limited context of sexual health and HIV/AIDS (MacDonnell & Andrews, 2006). The PHA serves as a safe space for sexual minorities and their allies, communities, and professionals to connect across difference to address sexual diversity. Rodney, Doane, Storch, and Varcoe (2006), in a study of nursing ethics, advocate for nursing workplaces that provide a safe moral climate. Stevens and Hall (1992) demonstrate the relevance of critical and liberation theories for public health nursing practice, stressing that these incorporate reflection and action to engender empowerment, hope, and dialogue with vulnerable groups, including lesbians and gays, and that they "originate in historical contexts through oppressed groups' reflections on their own experiences" (p. 4). The PHA and the policy resolution process are examples of support systems that validate sexual minority identities and

knowledges and that foster the development of meaningful relationships (Peter et al., 2005). These spaces for identifying practice challenges and strategies for promoting self-determination are consistent with Doane and Varcoe's (2007) "active, accessible, moral-reflective spaces [for] ongoing inquiry and deliberation...on the contexts of practice" (p. 203).

### ***Gender Dynamics and Social Difference***

As members of a female-dominated profession, nurses in North America have had variable responses to their political and policy initiatives. Nurses are often well situated to advocate on behalf of vulnerable groups. However, given the gendered and historical context of nursing in professional hierarchies, their caring work can be devalued and rendered invisible, just as their knowledge frequently is in the policy and research arenas (MacDonnell & Andrews, 2006; McDonald, 2006a; Peter et al., 2005). Hierarchies within the profession, and the invisibility of sexual minority issues in nursing research, education, and the media, also contribute to the legitimacy accorded to this political work. The lack of attention to sexual diversity in nursing education, organizational training in cultural competency, and nursing research marginalizes the impact of nurses' practice with sexual minorities (MacDonnell, 2007).

Nurses can use their credentials and their association with policy bodies to garner the support necessary to challenge these deeply embedded gender dynamics. Public health nurses affiliated with the PHA use a variety of roles, such as that of educator or clinician, to press for change when working with individuals or agencies (MacDonnell, 2007). The OPHA's explicit support for the position papers and resolution on ethical research promotes knowledge translation at the macro level, given its leadership on public health issues among policy-makers, practitioners, and communities on behalf of diverse communities and public health professionals.

However, nurses are not neutral entities. They are marked by gender, race, class, sexuality, and other dimensions that influence their ability to act and to shape the legitimacy accorded to their voices (MacDonnell, 2005). Political allies work across differences in the PHA, using their heterosexuality and other locations of social privilege to draw attention to heterosexism, biphobia, and transphobia. Nevertheless, professionals — both those identified as members of sexual minorities and their political allies — who participate in same-sex activism can encounter obstacles, including discrimination or hostility based on claimed or assumed same-sex identity (Giddings, 2005; MacDonnell, 2007). Doane and Varcoe (2007) propose that such practices be seen not as negative but as a "window into meaningful relationships...and responsive care [consistent with]...health promoting ways" (p. 202).

Advocacy for sexual diversity is often construed as “special interest” and relevant for only a small number of Canadians (Jackson et al., 2006; Ryan et al., 2000). Such a discourse not only discounts the legitimacy of sexual diversity health issues (and pathologizes or otherwise invalidates the lives of those who identify as members of sexual minorities), but has particular significance in policy-making: Who is bestowed with the authority and legitimacy to participate in policy processes? Policy-makers are assumed to possess an objectivity that enables a separation of their knowledge-production activities from self-interest. Citizen activists, on the other hand, “tend to address issues that affect them personally and may be perceived by the public as self-interested” (Bryant, 2002, p. 93). This assumption is relevant for nurses who appear to have a personal and vested interest in such professional work. As Bryant states, “Citizen activists may have a genuine concern about homelessness, but not be homeless or at risk of becoming homeless” (p. 93). In fact, since addressing social oppression benefits the whole of society, professionals who — as citizen activists or in some other capacity — undertake sexual diversity work do have a “special” or vested interest. However, as Browne (2002) points out, the liberal ideologies embedded in nursing knowledges and practices can limit nurses’ awareness of the interconnectedness of social and human relationships, of how they participate in heterosexual processes, and of the role they could play in shifting heteronormative dynamics (Doane & Varcoe, 2007; MacDonnell, 2005; Peter et al., 2005).

### **Summary and Discussion**

As this analysis demonstrates, an ethical inquiry that considers the multiple power dynamics that influence nurses’ advocacy practices offers insight into the tensions that structure nurses’ ability to engage in caring that is consistent with the emancipatory goals of social justice. Although heterosexism, biphobia, and transphobia certainly shape the public health focus on sexual minority health, attention to the social and political context broadens our understanding of factors that influence nurses’ work to enhance access to relevant and high-quality care. Neoliberal, social justice, and empowerment discourses, authority relationships, evidence-building, and policy processes, as well as professional dynamics and situated privilege, are woven throughout the discussion. Reflexive and participatory action processes are described in light of professionals’ critical reflection on their research practices.

As this is a qualitative study focused on public health nurses at a particular historical time and place, its findings are not generalizable to other nursing contexts. The study offers insight, however, into concepts and relationships that inform nursing work across practice domains.

It resonates with and builds on nursing ethics research and scholarship using critical feminist and postcolonial feminist perspectives to critique nursing practice and health-care dynamics, as well as to foster transformative practices that challenge health and social inequities (e.g., Browne, 2002; Doane & Varcoe, 2007; Kirkham et al., 2007; Racine, 2003; Varcoe, 2006). By foregrounding sexual minorities, it extends the discussion of diversity and epistemic privilege in a context of CBPAR research and inclusive knowledge-translation strategies that focus on racial or ethnic difference (Holkup et al., 2004; Kirkham et al.; Varcoe). This case study extends the recent scholarship explicitly linking nursing ethics and public health practice, especially with its focus on social justice discourses (CNA, 2006; Davison, Edwards, Webber, & Robinson, 2006; Racher, 2007).

The PHA (2002) policy resolution has contributed to the development of ethical knowledge and nursing practices locally and provincially through PHA activities and OPHA policy initiatives. It provided impetus for the initiation of two PAR projects addressing the access of bisexual and transsexual/transgender communities to public health services (Dobinson et al., 2005; Gapka et al., 2003). These projects culminated in two widely disseminated position papers affirming the value of the CBPAR process in creating knowledge for their communities and advocating for its further use.

Although Canadian research bodies have developed processes for addressing research ethics with Aboriginal communities, there has been little ethics research with sexual minorities. In August 2003 a submission based on the PHA policy resolution was presented to the PRE Consultation Evolving the Tri-Council Policy Statement: Ethical Conduct Involving Research on Humans (TCPS) to Better Meet the Needs of Canada's Social Science and Humanities Communities, and was included in the report that followed. The policy resolution has also helped to shift knowledge-production processes through national research bodies.

Much work has yet to be done to challenge structures that limit nurses' understanding of sexual minority health and their supportive practices. A position statement by the Registered Nurses of Ontario (2007), *Respecting Sexual Orientation and Gender Diversity*, calls for nurses to critically reflect on the knowledge, values, and assumptions that shape their practice. It supports advocacy, education, and policy change across organizations to challenge health inequities related to sexual diversity. The three PHA position papers inform that document.

This focus on concepts relevant to a feminist bioethics framework (Peter et al., 2005) contributes to our theoretical understanding of factors that enable, constrain, or complicate nurses' ability to pursue lofty ethical goals such as social justice. It demonstrates the benefits of facilitating

critical reflection and dialogue among nurses and their communities in order to examine the complex dynamics that structure their practice and their care options. There are implications for affirming the challenges that nurses face in their everyday work. We need more nursing ethical inquiries that address the complexities of power dynamics, the positive, negative, and contradictory dimensions that shape public health and community practice, as well as those that focus on sexual minorities and other vulnerable groups.

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