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## **Discomfort, judgment, and health care for queers**

### **Abstract**

This paper draws on findings from qualitative interviews with queer and trans patients and physicians providing care to queer and trans patients in Halifax, Nova Scotia, Canada to explore how routine practices of health care can perpetuate or challenge the marginalization of queers. One of the most common ‘measures’ of improved cultural competence in health care practice is self-reported increases in confidence and comfort, though it seems unlikely that an increase in physician comfort levels with queer and trans patients will necessarily mean better health care for queers. More attention to current felt discomfort in patient-provider encounters is required. Policies and practices that avoid discomfort at all costs are not always helpful for care and experiences of shared discomfort in queer health contexts are not always harmful.

### **Keywords**

queer health, transgender health, discomfort, family physicians, cultural competence

## **Discomfort, judgment, and health care for queers**

I'm always of the idea I have to be comfortable and that will come out if I'm not comfortable and will probably add to their discomfort or create discomfort...I try to avoid it...If [physicians] are uncomfortable and they don't know how to approach [queer patients], let them be able to say that out loud without worrying about getting in trouble...to say maybe where that comes from and then how can they address it. I think that's the best thing that can happen rather than just throwing information at people.

Physician Gina

Cultural competence training is widely employed in Canadian medical schools and in ongoing professional training for physicians with the intention of educating health practitioners about the possible difficulties that may arise when working with diverse patient populations (Reitmanova, 2011). Current frameworks primarily aim to integrate context-based, experiential learning about diversity (e.g., on axes of gender, race, class, age, sexuality, and ability) into medical education, seemingly motivated by the sense that exposing practitioners to simulations or descriptions of experience with diverse patients will result in less discrimination against marginalized groups in practice. Yet it remains unclear how to understand the mechanisms by which exposure in educational settings could change the practices of care providers, or how best to chart improvements cultural competence programs provide (Chamapneria et al 2004). One of the most common 'measures' of improved cultural competence in health care practice is physician or student self-reported increases in confidence and comfort (Kumas-Tan et al 2007) — but

this metric seems inherently limited, as it fails to address how unconscious assumptions and biases about queer and trans patients may persist.

This paper draws on findings from qualitative interviews with queer (self-identified as lesbian, gay, bisexual or queer) and transgendered women and physicians providing care to queer and trans patients in Halifax, Nova Scotia, Canada to explore how routine practices of health care can perpetuate or challenge the marginalization of queers. Using feminist and queer phenomenological analyses, we focus on the lived experience of queer women and their health care providers. Taken-for-granted assumptions that bodies in the health care system are heterosexual and gender-normative until shown otherwise diminish quality of care for all persons and regularly harm queer women, and such harms are matters of serious bioethical concern. How heteronormative practices of care might be ameliorated is complex, though it seems unlikely that an increase in physician comfort levels with queer and trans patients will necessarily produce better health care for queers. We argue that an ethical approach to care would in fact require attending closely to instances of discomfort, which may signal for both patients and physicians moments where heteronormative and gender normative assumptions may be challenged, or may challenge good care. If discomfort is inevitable when queerness enters the health care context, patient and physician focus on avoiding discomfort may in fact negate the possibility of disorienting assumptions of hetero- and gender normativity. We call upon both physicians and patients to critically reflect upon instances of discomfort as potential opportunities for disrupting oppressive norms.

### **Theoretical Approach: Feminist Bioethics, Cultural Competence, and Queer Contexts**

This analysis begins at the intersection of bioethicists' perspectives on care for marginalized groups in North America, feminist, queer, and phenomenological accounts of experience in health care contexts, and critical perspectives on medical neutrality. Especially in the last three decades, bioethicists have argued for the ethical imperative to attend to the health care needs of groups marginalized because of gender, race, class, age, and disability. They have shown how membership in oppressed groups can make it more

likely both that individuals will experience serious health problems, and that they will go unrecognized in current systems where access to care can be more limited the more marginalized patients are (Baylis et al 2008; Betancourt 2006; Fowler et al 2007; Joseph et al 2007; McNair 2003; Sherwin 1992; Shildrick et al 2005; Tong 1996). Attending particularly to queer and transgender individuals' experiences, researchers in contexts of care have shown that heteronormativity positions heterosexuality as the assumed sexual identity of patients, while a persistently assumed gender binary insists patients are necessarily either men or women. Heteronormativity and gender-normativity function together to make queer, transgender, and gender queer lives invisible and make the particular needs of queer and trans patients less likely to be met (Barbara et al 2001; Fryer 2008; Goldberg 2009; Goldberg et al 2011; Ryan-Flood 2009; Salamon 2009; Steele et al 2006; Sullivan 2008; Valanis et al 2000; also the Queer Bioethics Consortium <http://www.queerbioethics.org/>). Feminist scholars have increasingly attended to the experiences of marginalized groups (Ahmed 2006; Diprose 1994, 2002; Grosz 1994; Heyes 2007; Weiss 1999; Young 2005), in many cases arguing for the need to recognize the subtle and drastic harms of social oppression against members of marginalized groups, including damage to the ways individuals experience themselves as agents and healthy bodies.

At the same time, sociologists and others have challenged the assumption that a stance of professional neutrality is an adequate response to diverse patient populations (Beagan & Kumas-Tan 2009), while also challenging the adequacy of cultural competence education which encourages health care professionals to learn about the beliefs, values and practices of cultural groups, enhance cross-cultural communication skills, and develop tolerance and appreciation for others (Dogra et al 2010; Gustafson and Reitmanova 2010; Kumas-Tan et al 2007; Reitmanova 2011; Turner 2005; Wear 2003). Despite its ongoing use in current institutions, dominant models of cultural competence training fail to address power relations, systemic sources of social inequities, and connections between social inequities and normative assumptions. Moreover, the measure of successful learning, the hallmark of 'cultural competence,' tends to be increased comfort and confidence among learners, rather than skills in critical reflexivity

(Kumas-Tan et al 2007; Reitmanova 2011). The result is that health care needs of individuals in marginalized groups may be reduced to static, homogenizing stereotypes, increasing the likelihood that practitioners will act on over-generalized or misguided assumptions about all members of that group.

Attending to experiences of comfort and discomfort in health care interactions between physicians and queer/trans patients is particularly illuminating in that it is not a matter of inequitable access to material resources affecting health care. Nor are such interactions usually complicated by overt hostility or intolerance. Rather, we argue that generally well-intentioned physicians and patients setting out to maximize comfort – their own and the other’s – in a care interaction, nonetheless unwittingly reproduce normative assumptions that marginalize and unfairly burden queer and trans patients. We explore here how an emphasis on comfort in health care interactions may in fact hinder the critical reflexivity needed to improve ethical and equitable care.

## **Methods**

This paper examines our data in relation to the theme of comfort: how both queer women’s and physicians’ expressions of felt comfort and discomfort may indicate important, and sometimes fruitful, relational developments or disruptions in the context of their interactions during care. Semi-structured qualitative interviews were conducted with both community-recruited women who identified as queer, and family physicians who identified as working with queer patients. The research was guided by feminist and queer phenomenology (Young 2005; Ahmed 2006) in attending to embodied exploration of lived experience and particularly to the way taken-for-granted aspects of providers’ and patients’ everyday lived practices and experiences can reinforce gender binaries and heteronormativity. Queer phenomenology (Ahmed 2006) is particularly suited to the examination of how taken-for-granted practices may sustain health inequities. It takes seriously the notion of orientation, implying that the body has a position or starting point from which it proceeds. That starting point constructs a sense of the familiar, the taken-for-granted aspects of everyday life that become unconscious because they are no longer

attended to. That starting point also determines what is relegated to background, what aspects of the social world or lived experience are unconscious because they are deemed irrelevant, impossible, or have never been noticed. Feminist and queer phenomenology allowed us to attend to the ways gender binaries and heteronormativity may be reinforced through unintentional, everyday, taken-for-granted practices and relations – and how those practices are understood and experienced by both patients and health care providers.

Nineteen women who self-identified as queer were recruited through posters, flyers, and word of mouth. Each one participated in a face-to-face interview about 90 minutes long, about their health and their experiences of health care. Similarly, ten family physicians in the Halifax area were recruited through advertisements, letters and word of mouth. Each one self-identified as working with LGBTQ patients in at least some portion of his or her practice. Each physician participated in a semi-structured face-to-face interview about 60 minutes long, asking about their experiences and where they felt most and least confident in their practice.

Interviews were recorded, transcribed verbatim, and analyzed inductively. Each transcript was read repeatedly by members of the team, discussing the narratives it contained and creating memos to distill each participant's story. After several transcripts were examined, the team collectively generated themes and subthemes to 'code' the data for ease of retrieving passages concerning similar themes across interviews. While coding of transcripts was being conducted, some team members continued to conduct a more narrative form of analysis, reading each person's story as a whole, as a potential corrective to the potential for reductionism or segmentation that can be introduced through coding. At regular team meetings, we discussed both processes to ensure the 'stories' were being adequately reflected in coding processes. Atlas/ti software was used for managing data.

The analysis for this paper incorporated several of the codes from the project as a whole, such as 'safety/comfort,' 'awkwardness/confusion/uncertainty,' and 'good

care/bad care.’ The first author conducted further analyses, returning to full transcripts and comparing across participants. The preliminary analysis that resulted was critiqued by the other two authors, and other team members, and then refined.

## **Participants**

The final sample included nineteen women. Ten of these identified as lesbian, five as bisexual, one as queer, two as transgender, and two as something else.<sup>1</sup> They ranged in age from 23 to 73, with nine in their 20s and 30s, five in their 40s, three in their 50s, and two in their 60s or 70s. Reflecting the Halifax population, most identified as White, middle class and able-bodied; two identified as non-White, four as working class or underclass, and four had chronic health conditions. The final sample of physicians included eight who identified as women and one who identified as a man; they had practiced mostly in family medicine clinics for between five and thirty years; one identified as lesbian, none as transgender. To the best of our knowledge, there are currently no transgendered physicians in Halifax. Though we recruited through a wide range of venues, undoubtedly our connections in particular circles influenced who felt inclined to volunteer.

## **Avoiding discomfort**

Patients and physicians in our study regularly noted the importance of feeling comfortable in their interactions. Some providers worked from an awareness of homophobia and heteronormativity, and had commitment to caring for queer patients as individuals with distinct needs that stem not only from their sexual practice or gender-identity, but also more generally from their position as systematically harmed in a heteronormative, gender-binary world. Working from such a perspective, and from an

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<sup>1</sup> Numbers total more than nineteen, since some participants identified both a gender identity and a sexual orientation.

understanding of the patient-provider relationship as one that requires some openness and trust in order to function well, means that physicians would have good reasons to strive to create safe, comfortable environments for queer patients. Queers also have good reason to seek health care providers who are comfortable with their queerness both because it seems obvious that individual interactions will be less strenuous, and because such practitioners may be more motivated to provide them with good care. *Prima facie*, as much comfort as possible within health care interaction seems desirable. Although it is clear that health care encounters are uncomfortable for many women much of the time for many reasons, we can see in queer patients' descriptions that the discomfort surrounding queerness, or of being further marginalized within the health care system, is something distinct, adding layers of discomfort.

#### Causes of discomfort

Experiences of discomfort are asymmetrically distributed among queer women and their physicians – the queer women we interviewed described more discomfort than their physicians did, and bore such discomfort in a way compounded by fear that they will be denied safe and good health care as a result of being queer. Such fear has been found in other studies of queer patients, as in the narratives of lesbians who expressed fear and low expectations in birthing contexts (Goldberg et al 2011).

Queer patients expressed discomfort in nearly every decision about whether or when to 'come out' to a health care provider. Una described multiple levels of fear regarding coming out:

I want to say something but I'm scared and I don't know how to say it and I keep thinking, how am I going to say it, so it's something that I try, I look at the pros and cons. If I tell her, what will she say? If I tell her, will she still be my doctor? If I tell her, who will I go see, who is she going to refer me to?

Fear about consequences may be construed as an extreme form of discomfort.



Queer women also expressed discomfort in moments of registering queer relationships. Women described being questioned about the name they recorded as partner for next of kin or emergency contacts. In one incident Heather was told that she must have spelled her (female) partner's name incorrectly. In another incident, queer participant Kim described a refusal to accept her definition of family:

So I'm sitting there – I think this is probably the most uncomfortable I've ever felt – with this sick baby and feeling vulnerable and afraid, and not sure what's going on and nobody can tell me why she's coughing till she's blue in the face, and she can't tell me, and ah, the [woman doing the intake] was just so insensitive and she said, well what's the relationship, and I said mother, and she says aren't you the mother? I said yes, she has two mothers. Well how can that be? And I said well she does... And then I had to dig through my bag to find this piece of paper that I carry around that confirms this Legal Guardian in Health Care, so she looks at it and the whole time she's looking at me like I've got six heads and she's saying all of this loudly enough that the people behind me are hearing and I noticed people looking at me, and then she's looking at my document and then she goes well that's not going to fit in my slot.

Here Kim's discomfort seemed to lead to anger and even outrage. Though such encounters were with staff rather than physicians, for the study participants these became part of their experiences of routine health care.

Participants regularly described discomfort around health care providers' insistence about the need for pregnancy tests or contraception. For one trans woman we interviewed (Jackie), discomfort accompanied moments of identification as simple as getting a prescription in her current name while the pharmacy needed it written in her pre-transition name in order to access payment through her medical plan. Women also expressed discomfort around descriptions of sexual practice, ranging from identifying as queer yet not sexually active, to women having sex with women and others, to queer women who had bondage and domination as part of their sexual practice. Some women described discomfort around being queer and unpartnered, noting that not having the option of coming out by means of partner gender (e.g., 'my partner Mary') meant that

their queerness could be more easily contested or treated as irrelevant in health care contexts.

Health care providers' experiences of discomfort around queerness sometimes co-occur with patients' experiences, but are rarely spurred by the same things. Physicians often noted that they feel discomfort when they mistake a patient's sexuality, or when they can't tell if the person with a patient is a queer partner. Many expressed feeling discomfort when they did not know how to provide care but felt that professionalism requires that they not disclose uncertainty (c.f. Fox 1980). Many physicians claimed that, other than requiring different approaches to sexual health, queer women's needs were the same as any other woman's. Some, like Helen, acknowledged their lack of knowledge about queer women's reproductive health and access to pregnancy, or queer rights in health contexts (e.g., to visitation, or in cases of medical emergency): "Some of our reactions come from pure ignorance and being caught flat footed to say 'Oh my god, I have no idea.' More so that, than perhaps judging." As Debbie, a physician participant, noted, responding to patients' dynamic rather than static sexual identities and practices could also be confusing:

[There are] those 'are you sure' questions. It's knowing them well enough to question, to wonder that out loud, is this a phase? I've had probably two or three women who have labeled themselves as lesbians who 10 years later are having relationships with males and males exclusively and so you look back and you think well were they testing the water?

Discomfort in the face of lacking knowledge was amplified in cases of trans care. Discomfort about providing care to trans patients was something that almost all physicians readily admitted, even those who said they felt comfortable with all queer patients. Some physicians' expressions of discomfort were also confused expressions of concern about the power they have to decide on courses of treatment in cases where they feel underprepared and ultimately responsible for trans patients' health. As Richard noted:

It's the transgender that makes me uncomfortable... If it's psychological, I have a hard time sending him to get [genitals] cut off. 'Cause it's permanent... You can't change your mind on this one. So that's my big concern... It worries me a lot and I haven't got to that point where now I need the referral to the urologist to cut it off. I don't know what I'll do.

Uncertainty about how to care for queer and trans patients' lives in the face of major decisions (e.g., about whether or when to transition) or long term identification seemed to raise significant concerns and experiences of discomfort for the physicians in our study. Rightly recognizing the power they have in some interactions with queer and trans patients, some physicians made explicit the discomfort they felt in not knowing how best to care for them.

#### Strategies for avoiding discomfort

In the face of prevalent experiences of discomfort, both health care providers and their queer and trans patients expressed various strategies for avoiding discomfort, which we group in the following ways: Avoid discomfort by avoiding each other; avoid discomfort by putting like with like; avoid discomfort by not discussing anything uncomfortable; avoid discomfort by not expressing it; avoid discomfort by denying difference; and avoid discomfort by becoming 'happy in your skin.' Below we discuss each in turn.

*Strategy 1: Avoid discomfort by avoiding each other.* On this strategy, if a queer woman is uncomfortable with her physician, she should find a different physician. If a physician is uncomfortable with queer patients, she should refer them to someone else. One physician, Mona, noted that if queer patients feel uncomfortable, it would likely be with their own identities:

I don't feel awkward or uncomfortable or nervous... If people were really uncomfortable I mean here I'd probably have them see [the gay medical director]... or just tell them that they can go to psychological services and that people over there should be very comfortable and capable of helping them 'cause they would all have the training... if they were uncomfortable with how they saw themselves and they needed more information... If you're really homophobic it's

probably better you refer those people on, you know if you're very uncomfortable with that kind of thing.

By positioning queer patients' discomfort as the source of the problem in such cases, and ending uncomfortable physician-patient relationships early, the discomfort of any particular physician does not get challenged.

*Strategy 2: Avoid discomfort by putting like with like.* On this strategy, if a queer woman is seeking care, she should seek queer providers. Straight providers should help match queer patients with queer providers. Queer providers should make themselves especially available to queer patients. As noted above, physician Mona thought referring her queer patients to her gay colleagues was appropriate. Corrie noted that, as a patient, seeing a like-minded practitioner can facilitate openness and provide comfort: "I can be pretty intimidated by practitioners...[but] the more I seek out people who are like-minded to me, the more that breaks it down like people who I just feel comfortable around."

Interacting with a physician who does not share a patient's background or understanding can be uncomfortable, but like-mindedness or the knowledge that physician and patient share features of their identities can be comforting. Goldberg and colleagues (2011) describe the regular practice of assigning lesbian nurses to lesbian couples in birthing units: such practices seem based on an assumption that shared (queer) identities will mean similar experiences, such that fewer attempts to bridge understanding across difference will be required.

*Strategy 3: Avoid discomfort by not discussing anything uncomfortable.* Queer patients should only come out to health care providers when directly necessary. Providers should ask about patients' sexual orientation or gender identity only when directly necessary. Helen said that she would not ask about sexual orientation or partners until a patient brings it up, even if it takes years, saying that to do otherwise would show disrespect:

I don't assume that just because they've come to see their physician that they're just going to tell me everything about them. The rapport building is fundamental to the practice of family practice...it's important for the person to feel empowered in that relationship...As long as they're being informed about their health risks in

a way that is more about a human being than about a sexual orientation or a gender identification, I think it's ultimately respectful.

This approach means that patients and physicians are responsible for determining in advance the health care circumstances in which queerness is directly necessary. It also hints that queer sexual orientation or gender identity is something to keep secret unless it becomes medically necessary to disclose. Similarly, when physicians treat this aspect of patients' lives as private, the message appears to be that this aspect of patient lives is too private or shameful to discuss.

Strategy 4: *Avoid discomfort by not expressing it.* Both patients and providers noted the felt need to never express discomfort. We see an example of this in the epigraph passage from Gina, a physician participant: expressed how discomfort, like an illness, might intensify or be more easily spread to others, and should therefore be avoided.

I have to be comfortable and that will come out if I'm not comfortable and will probably add to their discomfort or create discomfort so I don't want to do that if at all possible. I try to avoid it.

Strategy 5: *Avoid discomfort by denying difference.* Providers and patients who are uncomfortable should characterize all patients as the same. Retreating to the sense that everyone needs just the same kind of treatment can create ease and suggest that queerness is irrelevant, thus not the cause of discomfort, whether giving or receiving treatment. When asked how her practice might change when a patient discloses queerness, Debbie responded: "Not at all. They would have the same needs." Liza, another physician, echoed the point: "Do I go through a different cascade in my thinking, when someone discloses queerness? You know, I'm doing many of the same things with everybody regardless of orientation or gender."

Strategy 6: *Avoid discomfort by becoming 'happy in your skin'.* This approach was aimed at queers, though the sentiment was expressed by both patients and providers. On this strategy, queer women are encouraged to cultivate more comfort in health care encounters for themselves and their providers by simply being less ill-at-ease, and more

open and happy with their queer identities. For Joan, a physician participant, the easiest queer patient is “somebody who’s happy in their skin”:

This is the way I am, okay...Clear about what their needs are. I think if they’re happy, if they are happy with their choice...happy maybe isn’t the word, ah, content maybe, or at one with their choice, ah, that’s easier to handle than someone who doesn’t know themselves.

Queer participant Kim echoed the point:

People take their lead from what you say and how you are. And if you’re just matter of fact and okay with it, then they are too...People’s discomfort often comes from not knowing how to respond, they’re afraid they’re going to offend you or say the incorrect words or something that’s not political or you know, so I think if you’re just upfront and give people the language to use then they’re generally fine...Every time, the heart pounds, you know, there’s that anxiety, but generally it’s been okay.

Here, queer patients are seen by both provider and patient as bearing most of the responsibility for maintaining a comfortable atmosphere in a healthcare interaction. The belief seems to be that it’s not a patient’s queerness that makes a provider-patient interaction uncomfortable so much as her discomfort with her queerness. If a patient is happy in her skin, her provider will be supportive, and the care she receives will be as good as it should be.

Discomfort is seen as a serious enough problem in health contexts that patients and providers both suggested that patients leave if they are uncomfortable. Participant Ella highlighted explicitly the worry that a practitioner’s discomfort would signal not just personal judgment but also professional misinformation: “If they’re uncomfortable, they’re probably not informed and so you’re probably not getting the true level of health care that you need and deserve so if you can, move on.” Sarah, a physician, echoed the sentiment: “I would hope that most patients if they’re uncomfortable will be brave enough to leave that practice and find a practice where they feel welcome and they get better treatment they deserve.” Both patients and physicians articulated this in a city

where, like many Canadian cities, virtually no general practitioners are accepting new patients.

### Strategies for restoring comfort

When faced with the discomfort of not knowing how to work with queer patients, some physicians offered alternatives to avoidance strategies. They noted attempts to protect their authority while being at the same time aware that providing good care may require openness about their own incomplete knowledge. Such negotiations often concerned exercising care around conversations with queer patients.

[We] have to find that balance so that we're very open and welcoming to whatever people want to tell us but, and we do have to ask questions...I think we also have to be quite sensitive about the kinds of questions we ask and when a person is ready to tell us about something. (Beth, physician)

Care around the kind of questions asked may mean increased sensitivity to the needs of queer patients, but when over-exercised, it may also develop into such caution that queer patients are burdened with the need to raise health concerns and issues of identity themselves.

Challenging the demand to always display certainty, some providers suggested that openness about their own lack of knowledge may lead to good care. Helen explained:

I'll say to them, "You know, I've practiced for this many years. I've not come across this until now. So you'll have to be patient with me. This will be the first time this has happened." Or, "I don't know the answer [to that]. Can you tell me a little bit more about what your experience has been?" So I will learn as much as I can during that encounter. And I'd like to think that my own interest and curiosity and motivation to help them has currency for them... I think traditionally what I find is people in positions of authority, don't do well when they don't have the answers.

Although this is a case where a health care provider acknowledges her own incomplete knowledge, she is careful to engage in a way that maintains control of the situation and seems to feel comfortable with that mode of interacting.

In addition to conversational practices, some physicians noted the importance of non-verbal cues, both in terms of signaling care in non-verbal ways, and in terms of their ability to respond to the bodily cues of queer patients. Debbie described looking for ‘comfort zones’ with her patients before any discussions about queerness:

You read people after a while, just like you know people’s eyes and people’s facial, and body language, you know...Like people will come in and they’ll sit in that [closer] chair or that chair [further away], so that the people who sit in that chair tells me a whole lot about their sort of comfort zone...they’ll sit there and whether they cross their legs towards me or their body is facing that way, tells a whole lot about their comfort zone.

Following her statement above, Helen described non-verbal cues as an important alternative to traditional efforts to preserve authority,:

Let’s say if there was someone else who was a more traditional practitioner, I think sometimes [their response to a queer or trans patient] would be (gasp) “Uh, oh.”...[The] non-verbal piece sets the stage and the tone for that person ever coming back to continue that conversation.

Although the importance of physicians’ non-verbal cues was recognized, physicians were largely unable to articulate what kind of practices could help, what would make them helpful, or how such practices might come to be learned.

### Critically evaluating comfort

Physicians’ discomfort around providing care to queer patients expresses the ways health care practices remain heteronormative and gender-normative, inadequately attentive to the social harms queers may face in all realms of life, including in ways which affect their physical and emotional health. One important question from the perspective of developing care which better meets the needs of queer, trans, and other patients is



therefore how to challenge and change the taken-for-granted practices of health care which fail to attend to queers' needs, and which sometimes (often unintentionally) reinforce heteronormativity and gender-normativity in patients' lives.

From a feminist perspective, the first five strategies for avoiding discomfort—avoiding each other, putting like with like, not discussing anything uncomfortable, not expressing discomfort, and denying difference—are troubling in their own ways, if the goal is health care which takes into account rather than denies the position of queers in heteronormative and gender-normative contexts. The sixth strategy is particularly disconcerting insofar as it seems to charge queer patients alone with the task of ensuring comfort in health care interactions, and it wholly eclipses all that is involved in being the kind of person who can be 'happy in your skin'.

It may be true that if a patient enters an appointment displaying comfort with her queerness, the interaction could go smoothly and not unearth her physician's discomfort with her queerness. But it is not likely that seeming at home in her skin will ensure her physician *feels no* discomfort about her queerness. The following questions arise: Who is it serving for queer women patients to not be able to express struggles with their identifications to their physicians? How is discomfort something inherent when queerness enters a heteronormative health care context, and how do physicians and patients give insight into who gets shouldered with that discomfort? We could re-read the series of quotes about discomfort so far noting who is described as the uncomfortable one – sometimes the physician, sometimes the patient, sometimes both – but in this case, the discomfort becomes a problem for which the queer patient is responsible. The problem is that *she* is uncomfortable and this is a problem *she* should fix. Rendered invisible is what makes it difficult or possible for queers to become happy in their skins.

Providers and queer patients address the importance of comfort, the health care situations that make them uncomfortable, strategies for avoiding discomfort, and strategies for responding in uncomfortable situations in ways that restore ease for all. However, they rarely address what would happen if they were to acknowledge discomfort

with each other, or to allow for moments of discomfort around each other. The epigraph from the beginning of the paper is instructive. Gina suggests that it may be important to express rather than avoid discomfort, and that her and other physicians' worries about introducing more discomfort for patients may prevent more open expressions which could be useful. Addressing the question of how to structure anti-heteronormative education for practitioners, Gina goes on to say the following:

Having lectures about queer health and stuff like that is important, just as we get lectures about everything...Of course the patient interaction is invaluable 'cause as you just meet more people, you'll meet more different kinds of people than you've ever met before, so that's important. But I think that self-reflection piece is important.

She suggested above that uncomfortable physicians should "be able to say that out loud without worrying about getting in trouble," where opportunities for more open expression might facilitate their ability "to say maybe where that comes from and then how can they address it." In *Queer Phenomenology*, Sara Ahmed characterizes disorientation as "a bodily feeling [that] can shatter one's sense of confidence in the ground or one's belief that the ground on which we reside can support the actions that make a life feel liveable" (Ahmed 2006, 157). Building on Sara Ahmed's descriptions of disorientation in *Queer Phenomenology*, Harbin (2012) has argued for the ubiquity and potential promise of experiences of disorientation in contexts where moral agents need to develop sensitivity to the vulnerability of others, and where unquestioned habits perpetuate oppression:

Disorientations help me recognize interdependence and act relationally when my actions become more noticeable, when I become compelled to talk more explicitly about my needs, when I depend on others to help me act, and when I am pushed to rely on my community's support...Given that we enact moral agency often through habits of attention and action, coming to recognize our bodies as habitual and dynamic can be morally productive by allowing us to see troubling habits as changeable. (Harbin 2012, page forthcoming)

As we see in Harbin's fleshed out examples of illness and trauma, it may be that some degree of openness about discomfort may allow patients and physicians to highlight the

vulnerabilities of both parties, challenge oppressive habits, and bring understandings and resources which draw on rather than deny their personal experience.

The suggestion that physicians become more able to experience and express rather than avoid discomfort in caring for queers is not an unqualified endorsement of physicians unreservedly expressing discomfort with queerness to their queer patients. Expressions of discomfort can simply harm queer and trans patients, signaling lack of understanding of their needs, antipathy, or perceptions of queerness as illness or deviance rather than a legitimate way of life. Queer patients can be understandably unwilling to engage with health care providers who behave in such ways.

Emphasizing the potential use of experiences and expressions of discomfort in health care settings also does not mean a focus on the discomfort of practitioners alone. Queer patients too might experience and express rather than avoid discomfort. Because queer patients are more burdened by experiences of discomfort in heteronormative and gender-normative health care settings than are their physicians, whatever model of interaction in situations of discomfort might be established, it cannot be one that positions physicians as the main victims of discomfort. But it must be a model which presents practitioners' habits of judgment as dynamic rather than static, and which recognizes queer patients as having some degree of structural power in the interactions.

Anti-heteronormative education might be reshaped to allow for some expressions of discomfort with queerness apart from patient interaction, but it is also possible that moments of uncomfortable interaction between patients and providers may reshape norms of clinical interaction. Under Gina's explanation of the promise of expressions of discomfort, we hear a general will to improve, to challenge her own heteronormative and gender-normative practices, and thereby to provide better care for queers. Given the often unconscious character of oppression and the perpetuation of micro-inequalities, physicians may benefit more from training in critical reflexivity than standard cultural competence training. Critical reflexivity moves beyond self-reflection to connect with the social practices that shape and are shaped by everyday interactions (Beagan &

Kumas-Tan 2009). Critically reflective practitioners ask themselves not only questions about how they felt and what assumptions they may have been making, but also questions about where their assumptions came from, and how assumptions and actions/inactions may reinforce or contradict existing social and power relations.

### Discomfort and judgment

For many of the queer women in our study, feelings of comfort indicated that their health care provider was not judging them. As Arlene, one of the women in the study explained,

In a meeting with a health provider, they're busy so they don't have a lot of time, but it is important to me that they get to know me a little bit...that they, you know, are easy to talk to. By no means should I ever feel judged for anything that I have to talk to them about.

Feelings of comfort were often associated by both patients and providers with respect and with success in not judging a queer patient for being queer. Feelings and especially expressions of discomfort were associated with a failure, with a provider having communicated judgment of a patient (e.g., 'I am not comfortable with you, you should not be as you are'), more commonly conveyed through non-verbal expressions (e.g., facial expressions, sighs, looks, body positioning, tone, silences) than verbal ones.

If discomfort is often associated with judgment, with both patients and physicians understanding the best clinical encounter as one where no one expresses judgment or feels judged, and where all parties are therefore more likely to feel comfortable, then efforts to avoid discomfort are partly efforts to avoid judgment. Although the queer patient's experience of judgment is more centrally at issue, physicians could also feel judged by queer patients. Practices of diagnosis overlap complexly with practices of moral or social judgment in medical contexts—what a patient needs to do or stop doing in order to be healthier overlaps with what they ought to do as responsible adults. At the same time judgments and discernments in both directions may incorporate ideas of what 'people do' as 'normal,' socialized adults, or as 'progressive, non-bigoted liberal-minded

professionals.’ That is, judgment and disapproval may be complexly experienced by providers and queer patients, in a context where diagnostic judgment is inherent, such that both groups develop heightened sensitivity to what physicians are allowed to say in response to patients’ queerness. When physicians are uncertain about the particular needs of their queer patients and uncertain about how fully their own feelings about queerness align with neutrality and ‘cultural competence’, they may have little sense of which questions are appropriate to ask their patients and which will reveal unprofessional or biased judgments of queerness that should be kept to themselves (see Beagan et al 2009). Even so, persistent societal heteronormativity makes it likely that practitioners *are* forming judgments of their patients’ sexualities, whether or not they express them in ways their patients perceive.

Because of how regularly discomfort comes up in the context of judgment in our interviews—the discomfort queer women might feel indicates judgment, the lack of expressed judgment should make queer women feel comfortable, or practitioners who are comfortable with queers don’t judge them—bioethicists need to consider questions about the overlap of discomfort and judgment here: women would rather feel comfortable than judged and physicians do not want to make women feel uncomfortable by judging them. Physicians could still regularly judge (i.e., discriminate against) women behind postures of comfort and acceptance. When providers achieve comfort in their interactions with queer patients by not encouraging patients to express much about their sexuality, by treating all patients the same, or by hiding the discomfort they feel about not being well informed about holistic queer or trans care, comfort is not a sure sign of freedom from judgment. Beyond judgments of unnaturalness, physicians might wrongly judge that queerness is an immature phase in sexuality, that queers’ needs for care are no different than non-queers’ needs, that queer sexual practice is inherently unhealthy, and so on. It can be that some uncomfortable moments allow physicians’ judgments and insecurities, and patients’ realities to be expressed and worked through, actually improving the kind of care accessible to queer patients.

## **Conclusion**

Comfort is clearly important in health care interactions between queers and their providers. Even so, one path toward less heteronormative and gender-normative health care interactions might involve experiences of discomfort that come from uncomfortable providers and uncomfortable queer patients interacting with each other. This is particularly relevant given that possibilities for selecting ideal health care providers and for choosing to not go back to homophobic or transphobic providers are not realistically available for all queer and trans women we interviewed, some of whom for matters related to economic status, class, age, ability, health status, etc., were still without access to a family physician, and without adequate health care.

Policies and practices which avoid discomfort at all costs are not always helpful for care and experiences of shared discomfort in queer health contexts are not always harmful. These findings support bioethical concerns about the need to motivate physicians to better recognize and attend to the health care needs of diverse marginalized groups, including those needs for care which stem partly from the strains of living with systemic oppression. Bioethicists concerned about health care practices which reflect rather than further compromise the needs of marginalized individuals should pay further attention to the complex promise of uncomfortable health care encounters: in the case of health care for queers, oppressed patients stand to receive better care as a result of uncomfortable physician-patient interactions than they do if moments of discomfort are figured as uniformly bad practice.

Less harmful practitioner-patient relations may come in part from sharing responsibility for resolving discomfort rather than asymmetrically assigning this responsibility to patients, and from being open about discomfort, rather than fearing it or feigning comfort. The way shared moments of discomfort are handled may transform underlying heteronormativity and gender-normativity in the physician-patient relationship (e.g., with open expressions of frustration, vulnerability, or humor). When asked about what providers should do to care well for queer women, one participant, Corrie, said,

I wouldn't say don't ever show your surprise but be honest about it and inquisitive... Be aware when you're afraid of who you're talking to because that's really I think what ignorance is about. It's about being threatened by who you're talking to or their experience.

It might be that discomfort can produce joint efforts to recognize what causes discomfort and joint efforts to challenge underlying judgments—efforts that may not happen otherwise.

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