'Unlike Vancouver... here there's nothing': Imagined Geographies of Idealized Healthcare for Queer Women

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This paper will explore imagined geographies of ideal healthcare among queer women in Halifax and Vancouver. In expressing the possibilities and limitations of accessing care, participants framed their own experiences through spatialized narratives of how queers are thought to be treated elsewhere. Participants' explicit connections and distinctions between Halifax and Vancouver gave insight into how their perceived difficulties in one health care context were sometimes framed by imagining more ease in accessing care in the other. In Halifax, participants frequently referred to how much better things were in larger cities, like Toronto and Vancouver. In Vancouver, participants also thought things must be better in a larger place, like Toronto. Although Halifax is a much smaller city and participants there spoke about both the benefits and challenges of small communities, participants in Vancouver also surprisingly depicted a sense of a small city or cities as they navigated a large space and population within boundaries set by access to and openness of LGBTQ-friendly health care. We explore here the implications of these imagined, idealized spaces, which may simultaneously give hope and direction for activist efforts, and set up false expectations that things are always better elsewhere.

Keywords: LGBTQ health; women's health; place; healthcare expectations; health inequality; healthcare access

Introduction

Lesbian, gay, bisexual, transgender and queer (LGBTQ) people face unique health concerns and too often face inhospitable health care environments (Bradford et al. 2012; Steele 2009). Yet despite increased attention to relationships among identity, place experience, and health by health geographers (Kearns and Collins 2010), and increased attention to health among geographers of gender and sexuality (Sothern and Dyck 2010), the spatial aspects of experiences with and access to quality LGBTQ health care remain under-explored. Attention to the impact of place is particularly intriguing in a context where the health care system claims universal accessibility, such as Canada. This paper explores imagined geographies of ideal healthcare among LGBTQ women in Halifax and Vancouver, Canada. Based on qualitative interview data, it examines how participants expressed the possibilities for and limitations to accessing care, framing their own experiences through spatialized narratives of how LGBTQ people are thought to be treated elsewhere. We explore here the implications of these imagined, idealized spaces, which may simultaneously give hope and direction for activist efforts, and set up false expectations that things are always better elsewhere.

Placing health and care – geographies of health and healthcare

Geographers' concerns with health have changed dramatically over the past decade. The 'new' geography of health described by Kearns and Moon (2002 606) demonstrated a 'distancing from concerns with disease and the interests of the medical world in favour of an increased interest in well-being and broader social models of health and health care'. At the forefront of this

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development was a deep concern with the notion of place (Andrews and Moon 2005; Macdonnell and Andrews 2006; Williams and Kitchin 2012). Traditionally understood as a mere 'point, mode or container of human activity' (MacDonnell and Andrews 2006 351), place became seen as a 'complex, symbolic, power-laden and contested cultural phenomenon' (351) that both affects and reflects human behaviour. As such, conventional arguments about the impact of access, distance and the physical and social environment on the quality and use of various healthcare services have been reworked to reflect this more relational approach to place (Cummins et al 2007 1830). Predominant measures of universally-applied 'neighbourhood exposures,' for example, are increasingly seen to 'severely underestimate the total effect of 'context', in its myriad of forms and in its multiple locations, on individuals' (Cummins et al 2007 1830-1).

Place matters with regard to health, disease and health care, just as health care provision can both positively and negatively affect the experience of place (Kearns 1993 141). Experiences of both literal physical place and perceived place-in-the-world shape health care needs and experiences (Kearns and Collins 2010 17). Research prompted in large part by feminist and disability studies has demanded attention to the voices of the people researched and their subjective realities of local places (Kearns and Collins 2010 16; Kearns and Moon 2002 610). In conjunction with a focus on place, 'new' health geographies have also emphasized a more critical, qualitative, focus (Kearns and Collins 2010 15; Kearns and Moon 2002 609). In 1997, Kearns stated that 'the challenge is now to build upon initial forays into the symbolic landscapes of healthcare and attain more interactive understandings of the construction of health(care) meaning by users themselves' (273). But in 2002 Kearns and Moon remarked that people remained 'generally absent' from narratives of health geography, with the individual often seen

not as a person but 'as an observation' (613). And in 2010, Kearns and Collins maintained that although more attention has been paid to the relationships among identity, place experience, and health, the focus of much work in health geography has remained in the areas of disease and health care services, with quantitative methods continuing to dominate (15).

In their 2004 overview of emotional geographies, Davidson and Milligan argue that 'a more explicit engagement' with the spatiality of emotions could help us better interpret and understand the relationship between people and place (524). They point to geographies of health and illness as being at the forefront of works acknowledging the important place of emotions in conceptualizing and 'faithfully re-presenting subjects' experiences' (2004 525). They also highlight urban sexual communities, as well as rural communities, as fruitful sites for examining the emotive dynamics of in- and exclusion on axes of race, class, and gender (2004 527). It is 'perhaps through an exploration of diverse senses of space', they argue, that 'we could become better placed to appreciate the emotionally dynamic spatiality of contemporary social life' (Davidson and Milligan 2004 524). Within health geography, the humanist-inspired work discussed above, as well as work dealing with the notion of 'landscape', have perhaps most closely heeded this call. Although sometimes used to refer to literally defined localities, 'landscape' has also been used as a metaphor for 'the complex layerings of history, social structure and built environment that converge in particular places' (Kearns and Moon 2002 611). Helping to uncover and analyse the multiple layers of meaning that constitute people's physical and social environments, the concept of landscape remains, for Kearns and Moon (2002 611), 'the term that most clearly embodies the tropes of place and health that were expected to be the hallmarks of a new geography of health'. A more critical focus that includes theoretical

approaches such as feminism, queer theory, and post-colonialsm has also helped to underscore the spatial inequities and exclusions prevalent with regard to experiences of and access to quality health care (Parr 2004 250; Sothern and Dyck 2010).

Geographies of gender, sexuality, and health

Health and medical geographers have, however, been slow in contributing to geographies of gender and sexual difference. Parr (2004 252) contended that much work in this area had merely 'included' voices of difference, rather than thinking differently through them. However, she did point to a few examples (Dyck, Lewis, and McLafferty 2001 251) that had begun to present women as actively negotiating and strategically managing health and illness. Such work begins to understand how 'webs of meaning about masculinity and femininity are translated into the organization of politics and economies and attendant social life and health'. But more is needed, she argued, that 'directly acknowledges the economic, social and cultural determinants of women's health across a variety of scales' as well as engages how gender, race, and class intersect 'to produce particular geographies of health for both women and men' (250). Even here, however, sexuality is absent, and heteronormative constructions of gender and sexuality remain intact.

Tracing the divergences and convergences of feminist and health geography, Dyck (2003 363) similarly points to the 'narrative turn' in health geography – 'talking *to* people, rather than *about* "dots on maps"' – as a key factor in prompting the inclusion of gender, race, sexuality and disability. Indeed, echoing the concerns long noted by feminist geographers, some health

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geographers are paying increased attention to issues of power, scale, and localized experience, alongside the more 'medically-driven categories' that have long been the primary focus (Dyck 2003 362). For Dyck, a hallmark of this shift is a heightened interest in what she calls the 'very local' scale of the body (2003 364). Although her 2003 review does not include non-heteronormative genders and sexualities under these newly explored 'deviant' or 'out of place' bodies (2003 365), her 2010 review points to a number of works that have explored how the spaces of biomedical science and the power/knowledge of medical authority work to construct and reinforce heteronormative assumptions surrounding sex, gender, and the body (Sothern and Dyck 2010 224).

Certainly LGBTQ people, and women in particular, have unique health concerns; they are not only at a greater risk of developing breast and gynecological cancers, but are also less likely to seek preventive health care, such as breast exams, pap smears and mammograms (Steele et al. 2009). Lesbians also present higher levels of drug, alcohol, and tobacco use; a greater likelihood of mental health or psychosocial issues; and are more likely to be categorized as overweight or obese (Polonijo and Hollister 2011 167). Transgender communities face disproportionately high rates of HIV, substance abuse, and mental illness (Clements-Nolle et al. 2001). Many trans-persons face the health detriments that accompany poverty, as discrimination erodes employment opportunities (Bradford et al. 2012; Schilder et al. 2001). The health effects of violence are prevalent, with high rates of sexual and physical violence, including stranger violence in response to perceived gender violation (Kenagy 2005; Melendez and Pinto 2007). When hormones are difficult to obtain legitimately, transgender persons (especially youth) may use hormones obtained from the street and may share needles (Schilder et al. 2001).

Generally invisible as a 'visible minority' (Mulé et al. 2009), LGBTQ peoples' primary care overall remains severely compromised by deficiencies in LGBTQ-specific knowledge and skills among health care professionals; a sometimes inhospitable clinical environment that stigmatizes LGBTQ patients; and a lack of standard policies and standards of best practice (McNair and Hegarty 2010; Wilkerson et al. 2011). Indeed, in Canada and the United States, lesbians report overall low satisfaction with healthcare services, namely as a result of heterosexist or homophobic encounters with health care providers (Polonijo and Hollister 2011:167). Health care encounters may be particularly challenging for trans-persons, who face hostility and open discomfort, and are frequently denied care when they present at hospitals or clinics (Bauer et al. 2009; Bradford et al. 2012; Dewey 2008; Kenagy 2005). Not surprisingly, LGBTQ persons are twice as likely as other Canadians to *not* have a family doctor (Hellquist 2006) and are significantly less likely to seek out health care (Mathieson, Bailey and Gurevich 2002). When they do, they frequently experience difficulty revealing their sexual or gender identity to their care providers (Polonijo and Hollister 2011 167). LGBTQ youth and trans-people are least likely to disclose, almost always having to raise the topic themselves (Bockting et al. 2005; Meckler et al. 2006). This helps to construct health care settings as heteronormative environments, spaces in which heterosexuality is presumed and privileged as the preferred, normal sexual orientation: 'Within the clinic, heterosexuality appears to be the expected 'default' norm' (Dysart-Gale 2010 24). Similar normative presumptions about the existence of two, and only two, binary genders erase the existence of transgender people and all those who experience gender more broadly or fluidly. This has been called gender normativity (Beagan, Fredericks and Goldberg 2012).

While increased attention has been paid to LGBTQ health inequities, little has specifically examined the geographic factors impeding LGBTQ peoples' access to quality care, particularly within universally accessible healthcare systems. Geared towards increasing cultural competency, much work in this area approaches LGBTQ people as an at-risk population, and focuses primarily on the importance of facilitating patient disclosure and mitigating personal bias and ignorance among health professionals. Though poignant issues, most cultural competency measures fail to address power imbalances borne out of sexism and homophobia, which obscures the interwoven social, cultural, political, spatial, and economic factors that shape patients' understandings of and access to healthcare (Carpenter-Song et al. 2007; Gregg and Saha 2006). As Kumas-Tan and colleagues (2007 554) argue, the implication within cultural competency training that cultural incompetence or insensitivity is a matter of individual bias and ignorance also 'denies the larger structural and systemic realities of racism, ethnocentrism, and other forms of social inequality,' such as heterosexism, that, embedded within the healthcare system itself, impede access to quality care among minority populations. In short, despite the proliferation of cultural competency training and practices in medicine, the quality of healthcare for the LGBTQ community in general, and LGBTQ women in particular, remains inadequate. Additionally, the role of space in framing expectations of LGBTQ health care remains under-explored.

Queer[1] narratives of space and place

The omission of attention to space is peculiar, given the proliferation of feminist and queer geography. Indeed, the notions of space and place have become useful lenses through which to

understand both the construction of LGBTQ identity and community, and the operationalization of heteronormative power and oppression (Brown 2000; Valentine 2002). Since the 1990s geographies of sexualities have examined how the heteronormativity embedded within everyday spaces impacts LGBTQ peoples' lives in fundamental ways (MacDonnell and Andrews 2006 351). Foucault (1990), among others, has pointed to the fundamental relationship between space, sexuality, and power. More than a representation of power, space for Foucault materializes power; it is the dimension of social relations through which power and knowledge become actualized within the world (Brown 2000 3). In this way, the production and experience of everyday space serves to reinforce heterosexual hegemony in that educational, religious, legal, and medical discourses work to erase or constrain the public presence of queerness (Berlant and Warner 1998 554). Queerness is equated with sexuality, which is then conflated with intimacy and relegated to the realm of 'personal life', segregated from the public sphere (Berlant and Warner 1998 553).

Judith Butler's notion of performativity has also been a useful lens through which to understand the heterosexing of space. For Butler, much like the gendering of bodies, the heterosexing of space is an act of performance that is naturalized through repetition and regulation (Butler 1999 25, 33). That is, the seeming naturalness of heterosexual space is maintained through subtle and repetitive performances of heteronormative sexuality and gender, including bodily displays of public affection, advertisements and window displays, gendered mannerisms and dress, and conversations and music (Somerville 2000 141; Valentine 2000). Berlant and Warner, among others, point out, however, that the heterosexuality embedded within everyday spaces is not necessarily fixed or stable (1998 555; Valentine 2000). The instability of

heteronormative space allows LGBTQ individuals to queer or restructure it; they can produce

their own spaces or 'read heterosexual space against the grain' (Valentine 2000 5), experiencing

it and producing it differently. As such, the 'queering' of urban public space has been historically

linked to the emergence of gay politics during early twentieth-century America, and the

establishment of a collective consciousness, identity, and struggle (D'Emilio 1983; Valentine

2002).

Making space for lesbian geographies of health

While geographies of health have begun to delve into the impact of material place and

individuals' 'sense of place' on health care provision and outcomes, and geographies of

sexualities have explored the myriad ways that LGBTQ identities and communities are shaped by

and have re-shaped space, the spatial dynamics of LGBTQ peoples' experiences, expectations,

and accessing of health care remain underexplored. This article explores imagined geographies of

ideal healthcare among LGBTQ women in Halifax and Vancouver, on Canada's East and West

coasts. Study participants discussed experiences and imagined possibilities for accessing care

through spatialized narratives of how LGBTQ people are thought to be treated elsewhere. Stories

of better or worse care elsewhere were touchstones for discussing local care experiences. There

was evidence of an idealized longing as Halifax residents depicted much better LGBTQ health

care in Vancouver, while Vancouver residents depicted much better care in Toronto. Participants

in both sites used an urban/rural binary as a framework for imagining their own care as being

better or worse than that of LGBTQ people in other places. Spatialized narratives of better or

worse care were also framed at the national, as well as neighbourhood scale. We explore here the

implications of these imagined, idealized spaces, in terms of hope and expectations concerning health care for LGBTQ women.

Methods

This paper reports on the results of a qualitative study of health care for LGBTQ women, which included interviews with women, physicians, and nurses. In this paper, we draw on the data from the 38 women, 19 in each of Vancouver and Halifax on the West and East coasts of Canada. Following university research ethics approval, recruitment was conducted through advertisements in local clinics, posters and ads in LGBTQ venues, word of mouth and snowball sampling. After discussing informed consent, an in-depth, semi-structured, face-to-face interview was conducted with each participant.

Interviews were recorded, transcribed verbatim, and analyzed inductively generating themes and sub-themes which were coded using AtlasTi software. Analysis was informed by critical, feminist and queer studies, which meant sensitivity to power dynamics, as well as normative assumptions about gender and sexuality. 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 sub-themes to 'code' the data. Coding was conducted by a team of researchers who sought consensus on codes and interpretations through weekly meetings. Coded segments were interpreted both in the context of the larger interview, and in comparison with the other transcripts. Drawing on the coded data, and again returning to transcripts repeatedly, the analyses

in this paper particularly drew on themes of place, space and perceptions of health care. In the interests of reflexivity, team members discussed the data and interpretations of data all the way through the process, from interviewing to writing.

Participants

The 38 LGBTQ women participants ranged in age from 22 to 73 years, and most described themselves as 'pretty healthy.' In terms of sexual orientation, 17 self-identified as lesbian, seven as bisexual, seven as queer, and seven as something else. In terms of gender, 28 identified as women, five as transgender, and five as something else. All participants are identified by pseudonyms.

Imagining worse

Research into LGBTQ women's experiences of healthcare has illuminated a devastatingly low level of patient satisfaction and expectation (Daley and MacDonnell 2011; MacDonnell and Andrews 2006; Polonijo and Hollister 2011). Given the persistence of routine heteronormativity, gender normativity, and overall ignorance, this is not surprising. Fears of ill-treatment appear to underlie the gratitude expressed by LGBTQ patients when they experience decent, quality health care (Goldberg, Harbin, and Campbell 2011). For instance, in a study of lesbian experiences with cancer care, simply being treated like other patients occasioned grateful praise: 'Legacies of homophobia and heterosexism leave lesbians in the position of being grateful for things that heterosexual people take for granted... Gratitude for equal treatment is a consequence of

marginalization' (Sinding, Barnoff and Grassau 2004 182). For the women in our study, this gratitude – a sense of 'being lucky' – was hugely prevalent. For instance, Mya, a trans-identified participant in Halifax, explains: 'I'm probably very fortunate…. They treat me as a woman; everybody treats me as a woman.' For Mya, simply being recognized as her chosen gender renders her 'fortunate'; she takes for granted that she won't be accurately recognized. For many participants, gratitude for decent care was situated against both real and imagined narratives of how other LGBTQ people are treated. As Bea, a Halifax participant, explains: 'I think I've been lucky 'cause I've had friends with stories that would like, blow my mind…. I know I've been lucky because of stories which scared the crap out of me.' Bea knows she is 'lucky' not because the care she receives is optimal, but because the care her friends received was certainly not.

As Scherzer (2000 97) points out, LGBTQ peoples' own experience of prejudice, coupled with the knowledge of others' experiences, 'accumulate in a type of collective history and consciousness' – a history that both lowers their expectations and informs their healthcare-related decision making practices. These narratives get mapped onto senses of place. For Kearns (1994 113), place can be understood as 'the consciousness that people themselves have of places that possess a particular significance to them, either personal or shared'. Similarly, 'sense of place' describes the 'interactive relationship between tangible, lived places and people's perceived "place-in-the-world"' (Kearns 1994 113). In this way, material experience of a place is shaped by imagined perceptions of self in relation to that place. At the same time, for Davidson and Milligan (2004 524), meaningful senses of place also emerge through 'movements between people and places'. This notion echoes Massey's (1994 5) notion that the particularity of place is constructed not within its boundaries, but through the 'mix of links and interconnections' to the

others that lie beyond it. As such, the relationships between places that are physically distant but emotionally connected can hugely impact people's spatial experiences of health (Cummins et al 2007 1832).

Not only do participants frame their own gratitude within the context of others' care, but in many cases, others' care is firmly placed elsewhere. Some, for instance, evaluate their own healthcare experiences in Canada by imagining it being worse for those in the United States. As Jordan, a Vancouver participant, explains:

> I would imagine that in the United States, the doctors still have pretty limited knowledge. In Canada, I think it might be better. It might be better, especially in bigger cities, like here [Vancouver].

Jordan forms her own healthcare expectations through imagining LGBTQ peoples' experience elsewhere – the United States. This was also the case for Mya, a participant in Halifax, who qualifies rising rates of suicide among transgender people by noting:

> Our [trans peoples'] suicide rate has been tremendous over the years, but I think it's a bit better now, I think we're [Canada] better off than the [United] States actually.

Imagining the situation as being worse in the United States, Mya is able to remain rather positive about the fact that, although suicide rates among trans people are 'tremendous', people elsewhere are faring worse.

Participants also form their healthcare expectations by imagining others' care at the neighbourhood scale. This is most prominent within the context of Vancouver, where the LGBTQ community of women is thought to be concentrated within a particular neighbourhood space, Commercial Drive. Jordan, a Vancouver participant, points to how both the size and spatial concentration of Vancouver's LGBTQ population informs assumptions about the quality and location of healthcare services:

> I mean, you know, we have tons of queer people living here [in Vancouver]. But it may also be an assumption that if you're a doctor on Commercial Drive and you will be in touch with a lot of queer people, you better be queer friendly. So, maybe there is just already an assumption that those clinics are queer friendly.

Brenda, a participant in Vancouver, echoes this point, noting that:

> Because of [clinic's] location [on Commercial Drive] they are almost forced to be somewhat more educated, I guess, on queer issues than if they were located somewhere else.

In this scenario, good care is attributed to place and socio-spatial location of the clinic. Care in this facility is assumed to be superior for LGBTQ people than if they were located 'somewhere else' – a vague space that could occupy the street, city, or even national scale.

The most prominent spatial imaginary that emerged, however, is the rural/urban opposition. Indeed, work on sexuality and space has revealed LGBTQ or queer culture as having a special relationship with urban space. Much of LGBTQ history has mirrored the history of the city, with major urban centers being intrinsically linked to the formation of global LGBTQ politics and the historical construction of LGBTQ identity and community (Halberstam 2005 34; Weston 1998 33). As Halberstam points out, the construction of LGBTQ subjectivity is itself embedded within a narrative of rural to urban migration, which maps the psychological journey of 'coming out' onto a physical journey to the city (Halberstam 2005 36-7; Weston 1998 39-40). In this sense, queerness is configured through a symbolic opposition between the urban and the rural, whereby the latter is positioned as a closet from which an authentic, metropolitan sexuality must emerge (Halberstam 2005 37; Weston 1998 39-40). The image of the escape from the countryside into the anonymity and diversity of urban space was in this sense embedded within the queer subject from the very start (Halberstam 2005 10; Weston 1998 40). A 'beacon of tolerance and… community' (Weston 1998 40) for LGBTQ individuals, the city has been cast as a refuge from the oppression and discipline of small-town surveillance. In short, queerness is popularly thought not only to be embedded within an urban location, it is also situated within a symbolic opposition between urban and rural life (Weston 1998 55). Within the queer imaginary, rural and urban spaces exist 'hand in hand… each making and remaking the other' (Browne 2008 25).

This rural/urban opposition threads through study participants' framing of others' and their own health care experiences. Often assumed to be much worse off, non-urban places served as a symbolic benchmark against which urban LGBTQ people could positively interpret their own healthcare experiences. For instance, Rhonda, a participant in Vancouver, ponders:

I don't know whether it's my own prejudice or just experience… I tend to think that the suburbs aren't going to be the greatest places to find medical care. And it could be because all my friends say 'Oh, well, if you can pretend that you live here, you can go to Three Bridges. Or if you pretend to live here, you can go to Ravensong.'…. But definitely I was always of the impression that if you want good medical care, you have to go to the downtown eastside…. You have to go to places where there's a big gay or trans community.

For Rhonda, friends' influences combine with her own 'prejudices' and personal experiences to form a collective expectation of suburban *versus* urban care. Diana, a Vancouver participant, similarly qualifies her own positive healthcare experiences by contrasting urban and rural space: 'But we have to remember also that we're in Vancouver. You know? We're not in Flin Flon [northern Manitoba]. And in Vancouver, There's a lot of political correctness going on.' This is echoed by Shelley, a participant in Vancouver, who states:

[Geography]'s huge, it would be a totally different situation if I lived in [rural area] and I know it would be because I know lots of stories around health issues if you're [LGBTQ], and what it would be like if you're in the [Fraser] Valley or have a doctor… that's not part of, you know, an urban centre.

For Shelley, others' 'stories' work to both frame her own healthcare experiences as well as reinforce the notion that care would be worse elsewhere, especially in a rural place. The urban/rural opposition plays a prominent symbolic function in her imagining of her own healthcare experiences and expectations. Mabel, a participant in Halifax, similarly comments:

> It's not like a rural community where you only have one of everything and you'd have to sort of put up with that. I mean in the city you can have quite separate health care providers. In a rural area, there may only be one dental practice within 100 km.

These narratives reflect Kearns' (1993 140) notion of understanding of place-as-location through exploring 'the richness of place as context'. Physical access and social access overlap in LGBTQ women's imaginings of the difficulties and discomfort associated with obtaining health care in rural space. These narratives complicate dominant ideas surrounding meaningful and desirable healthcare exchange. While for Kearns, 'residences, community clinics, and small settlements can all be regarded as home' in that people may feel geographically and psychologically 'centered' and a sense of belonging while receiving care in them, LGBTQ peoples' sometimes complicated relationships with 'home' can sometimes lead them towards the anonymity of 'large hospitals and other functionalist structures in the modern urban landscape' (1993 144) that, for Kearns, work to hinder, rather than facilitate, belonging.

In fact, some participants imagined movement away from home as being the only solution to accessing good care. Mya, a trans woman participant in Halifax, illustrates this point succinctly:

What happens is you live in Cape Breton or you live way out in the country somewhere

and then you find you've got a trans child. You can't get any help for that trans child so

what do you do? You move to Halifax.

Mya imagines the lack of resources, particularly for trans people, in rural areas as requiring a

rural to urban migration – in this case, to Halifax. This point is echoed by Jackie, a participant in

Halifax, whose concerns surrounding LGBTQ heath are framed by a rural/urban opposition

where trans people in rural places are imagined as being socially and geographically cut off from

the necessary healthcare services:

I guess my concern for the health care is just the fact that it's a bit ad lib for trans health

right now. I know there's people in places who are trying to get things organized and stuff

but … it seems very fragile …. It's not so bad if you're here in Halifax but if you're in

[rural area] or something, I'm not sure there's much to do there or places to go there at all

so I don't know. I mean that could be true even in B.C… Maybe the place is Vancouver,

like the place is Toronto, so maybe that's where you end up having to have to go …. I

don't know for sure that the people on the outskirts know that there's something

happening here.

Jackie not only qualifies her own healthcare concerns by imagining worse care for those in rural

areas, as well as similar problems of access in places outside Toronto and Vancouver, but she

also points to movement as being the only way for those who are socially and geographically

isolated to access quality care. Rural places are rendered inhospitable healthcare environments

for LGBTQ people, while cities are imagined as having the knowledge, resources, and services necessary for the delivery of satisfactory healthcare to the LGBTQ community.

While the search for and subsequent movement towards quality healthcare is not limited to LGBTQ people alone, the negotiating of space and access within urban centres requires some maneuvering rather unique to the LGBTQ community. For the women in our study, place was used as a framework for assessing one's own healthcare experiences and expectations. Imagining other places as worse – other countries, cities, and, most persistently, places more remote or rural – allowed participants to feel grateful for their own experiences, regardless of whether or not their needs were actually being met. A concern here is that by creating and reinforcing low expectations, such imaginings may stymie activist efforts towards demanding and receiving better care in local spaces. As we will demonstrate in the next section, these narratives of an imagined 'elsewhere' can also operate in the form of idealizations, whereby healthcare experiences and expectations are assessed based on the idealized notion that things are better some place else.

Imagining Better

While early geographies of sexualities mapped urban gay spaces as 'sites of political power, freedom and sexual expression' (Browne 2008 26) – a spatial symbol that to a large extent continues to prevail in the popular and academic LGBTQ imaginary – more recent work has sought to dispel the myth of the 'urban utopia' (e.g., Baker [2011]; Bell [2001]; Browne [2008 26]). Working to counter the image of rural places as ultimately repressive, as well as explore the

connections, movements, and interactions between rural and urban imaginaries, such work explores the co-constitutions of spatial imaginings and realities, exposing how notions of 'elsewhere' 'interact with the materialities of everyday lives and perceptions of the places [LGBTQ people] live in' (Browne 2008 27). LGBTQ women's experiences of seeking out, accessing, and receiving healthcare serve as a useful node for examining how material reality is experienced through imaginings of elsewhere.

For Bell (2003 187) the idyllic queer urban 'exists as an equally mythological site to its rural counterpart'; it is a place 'made in the imagination and unmatched in reality'. However, this mythical urban space is imagined not only by rural LGBTQ people, but by those in urban areas as well. Indeed, Knopp and Brown (2003) problematize the hierarchical rural/urban divide by exploring how LGBTQ subjectivities are cultivated through a maneuvering and movement between multiple spatial scales. Although the women in both cities in our study consistently imagined rural space as delivering poor healthcare for LGBTQ people, they simultaneously imagined an idealized urban elsewhere, where care was thought to be better than their own. As interviews demonstrate, the reality of this 'elsewhere' was rarely realized. While some women in Halifax bemoaned the reliance on word of mouth networks and looked to bigger cities such as Vancouver as a bastion of ideal care, those in Vancouver described the complex spatial maneuverings required for them to seek out care in such a large space.

In some instances, the women's notion of a better elsewhere was reinforced by medical practitioners themselves. Kim, a participant in Halifax, for example, recollects an exchange she

had with her daughter's paediatrician. Challenged by another doctor about her daughter having two mothers, Kim reflects on the Montreal-born paediatrician's reaction to such ill-treatment:

> She was great. She was from Montreal…. 'This place is so backwards' she said. 'I don't know why anybody is even asking you stuff like this… in Montreal this would be a non-issue.'

In this instance it was the paediatrician who forwarded the bigger city/smaller city opposition whereby the image of progressive Montreal contrasted sharply with that of backwards Halifax. This contrast, for Kim, attributed her negative experience to place, and invited her to imagine better experience elsewhere.

While a number of participants in Halifax imagined Halifax to be a sought-after locale for rural LGBTQ people in need of health care, they also spoke of Halifax's relative backwardness, perceiving their own difficulties against the imagined ease they would purportedly experience in bigger cities such as Montreal, Toronto, and Vancouver. As Jackie, a trans-identified participant in Halifax explains:

> Unlike Vancouver where they have a whole sort of clinic set up, right, here there's nothing… there's no official kind of thing…. It would be nice if they could sort of formalize it a little bit and maybe kind of have some sort of little structure to it or something and think about those type of things [such as] well what if this person retires? What if [endocrinologist A] leaves? …. It's a concern; the whole community is concerned about it.

Jackie depicts Halifax as having 'nothing' compared to Vancouver, which is imagined as being superior in that it has an official clinic solely for gender queer/trans patients. With no 'official' trans clinic, the worry in Halifax is that the community is overly dependent on the very few specialists working in trans health. However, some Vancouver participants also imagined larger cities or provinces such as Ontario as offering better care. Casey, a trans-identified participant in Vancouver, reflects:

> I understand that Ontario just actually put some new medical thing in and they've got a task force going in and there's a trans woman sitting on it and everything else, they're actually starting to move forward. I just don't feel B.C. [British Columbia] is.

For Casey, Vancouver's gains, though highly significant for those in Halifax, paled in comparison to Ontario.

Participants in Vancouver also spoke extensively about the difficulties encountered as they navigated a large space and population within the spatial boundaries set by access to and openness of LGBTQ-friendly health care. For instance, Brenda, a participant in Vancouver, recounts her experience of trying to find a LGBTQ friendly holistic doctor:

> So I'm trying to find like, find a holistic doctor but I don't know what, where to look. Again, it's like big city, you basically need to get referred by somebody to know where to go. To be like 'This place is good.' ….You're just like 'Aaahhh' Like, imagine trying to

find a doctor here, just by looking in the phone book. Holy fuck. (laugh) I'd be like,

there's probably like thousands. (laugh)

Here, Brenda contrasts the availability of services in a large urban centre with needing to access good LGBTQ-friendly services through small community networks. In a large city like Vancouver, it is a struggle to know which providers are tolerant of or even welcoming to LGBTQ patients. In contrast, mobilizing community networks was described by Halifax participants as key in accessing LGBTQ-friendly health care. Jewel, for instance, states: 'In Halifax, if you search you shall find, I think… If you'd ask around you'd find you know who to see.' This point was echoed by Jennifer, a Halifax participant, who explains:

That seems to be the way you get in to see good people, through who you know, so I would recommend that they find someone that way…. If people are unconnected from a broader community of people, how would they know about it, how would they find out about it?

Some Halifax participants also expressed frustration with manoeuvring a relatively small number of service providers, who can then act as gatekeepers. Mabel, a participant in Halifax, explains:

When I would see another doctor I would probably seek one out that's known to the community…. I would go by people's reports. I mean I always hear about [Family Doctor A] who everybody raves about, but you can never see [because her practice is full].

Although the community is perceived by Mabel as a reliable source for obtaining healthcare-related information, the small number of well-recommended doctors in this small city impedes her ability to access such care. Heather, another participant in Halifax, reflects on how the insular nature of the community actually facilitated her accessing this same doctor:

> My ex-partner knew [Family Doctor A] from various health meetings and boards and departments and things like that because the community is quite small. My ex-partner worked in health here and so knew of her and began to talk to her and so on and kind of… got me in the back door.

While the size and insular nature of Halifax and its LGBTQ community is described by some participants as easing the burden of trying to seek out reliable information about and access to LGBTQ friendly health care practitioners, the size of Vancouver and its LGBTQ community was described by some as inhibiting access to care. For instance, Emily, a transgender participant in Vancouver, recounts her difficulty in trying to access a medical clinic in Vancouver whose services were restricted to specific neighbourhoods, while Emily lived in a suburb:

> The second time I went there [clinic] I wasn't eligible to be there because they restricted it only to residents of Vancouver 'cause they were over flowing....That's my big complaint, is anybody outside of Vancouver proper, there's basically no care for them at all.

Although there are a number of services tailored specifically to LGBTQ patients, many are unable to accommodate the high demand resulting from the size and density of the LGBTQ

community. Access is also inhibited spatially in that restrictions prevent residents outside the city from using some services. As Mya, a Halifax participant pondered previously, just as 'the place' to go for rural Nova Scotians is Halifax, Vancouver is 'the place' to go for rural British Columbians. However, while Vancouver may have the knowledge, 'political correct-ness', and LGBTQ friendly services it is assumed to have, spatial restrictions may limit who can access these 'big city' benefits. Such difficulties are echoed by Rhonda, a participant in Vancouver, who expresses her frustration with the criteria that inhibit her access to care:

> In the end, I still don't know where to access the medical services that would be right for me, because the ones that I know about are based on geography, based on being Aboriginal or based on fitting into certain criteria. And ideally, you should be able to get the services you need wherever, anywhere. But you can't yet. And it's not just me, because I have these conversations with everyone, all the time.

For Rhonda, inclusion criteria, including geography, prevent her from accessing medical services that would meet her needs in her local place. While many participants in Halifax bemoan the lack of official knowledge exchange, and express both satisfaction and frustration with the reliance on word of mouth left in its place, many also imagine bigger cities such as Vancouver to possess the LGBTQ knowledge and services that would meet their healthcare needs. Evidence from Vancouver, however, points to a number of access-related difficulties that stem from both the size and density of the city. Similarly reliant on informal community networks, participants expressed varying degrees of frustration with trying to access these information networks in such a large space. Often restricted based on geography, physical access is also severely inhibited for those who live outside the urban core.

Conclusions

Health and medical geography has become more attuned to the more emotive and imaginative ways that place shapes access to and experiences of health care. Place has been reconceived by many geographers, both within and outside the field of health, as a dynamic, fluid, and cultural phenomenon that intersects with power structures of gender, race, class, and sexuality to shape peoples' health and well being in particular, and ways of being in the world in general. Slow in contributing to geographies of gender and sexual difference, health scholars in general and geographers in particular, have paid increased attention to LGBTQ health inequities. Little attention, however, has been granted specifically to the effects of geographic factors on LGBTQ peoples' access to quality care.

Often invisible as a 'visible minority', LGBTQ peoples' primary care overall remains severely compromised by deficiencies in knowledge and skills among health care professionals; as well as stigma and discrimination. Despite the proliferation of cultural competency training in healthcare, the quality of care for the LGBTQ community in general, and LGBTQ women in particular, remains inadequate (Steele et al 2009). And although the women in our study reveal geography in general and space in particular as being key factors shaping access to and experiences of care, as well as framing expectations of care, little research on LGBTQ health in general, and LGBTQ women's health in particular, specifically explores 'place' with regard to LGBTQ health.

Our study, however, shows geography, and especially imagined geographies and senses of place, as highly relevant features in LGBTQ women's accounts of experiences with and access to healthcare. Women in a big city express difficulty knowing which providers or clinics are safest, while those in a smaller city express both success and frustration with accessing good care through a small number of potential gatekeepers, in what sometimes seemed an insular community. One of the distinctions between the sites was the operation of formal and informal networks in accessing health care; while safe health spaces were formally more available for LGBTQ women in a large urban space, through standardized practices of referral, in both sites actual access to safe healthcare appeared to be navigated primarily through word of mouth. Women in both sites expressed the importance of accessible sources of knowledge, and joint practices of knowledge seeking, both with providers and in broader communities. In expressing the possibilities and limitations of the spaces and structures within which they accessed care, participants offered insight into their common experiences of thinking about how LGBTQ people are treated elsewhere, in other contexts of care. Participants in both sites echoed each other in characterizing this as an important part of their reflections on care.

In expressing the possibilities and limitations of accessing care, participants framed their own experiences through spatialized narratives of how LGBTQ people are thought to be treated elsewhere. Participants' explicit connections and distinctions between Halifax and Vancouver gave insight into how their perceived difficulties in one health care context were sometimes framed by imagining more ease in accessing care in other places. These narratives of an imagined 'elsewhere' can sometimes operate in the form of idealizations, whereby healthcare experiences and expectations are assessed based on an idealized notion that things are better

some place else. In this sense they may serve as goals for local activist efforts, something to strive toward, existing models of possibility. On the other hand, there is reason for concern here that imagining other places as worse (other countries, cities, suburbs, remote or rural places) allowed participants to feel grateful for their own local healthcare experiences, regardless of quality. By reinforcing low expectations, such imaginings may stymie activist efforts towards demanding and receiving better care in local spaces.

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Acknowledgements

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[1] We use the term 'queer' as a broad concept encompassing LGBTQ inclusively. It is used here particularly in discussing the academic literature on space and place, which tends to term itself 'queer'.

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