

This is not the final version. For the published version see: Baker K, Beagan BL. Making assumptions, making space: An anthropological critique of cultural competency and its relevance for queer patients. *Medical Anthropology Quarterly*. Early online. doi: 10.1111/maq.12129

## **Abstract**

**Background:** Despite increased attention to ‘culturally competent’ practice with diverse populations, lesbian, gay, bisexual, transgender and queer (LGBTQ) people remain relatively invisible within medicine and other health professions. Health care providers (HCPs) frequently dismiss sexual and gender identity as irrelevant to care. **Methods:** This study uses interviews with 24 physicians and 38 LGBTQ women to explore how routine practices in health care can perpetuate or challenge the marginalization of queer women. **Results:** While physicians avoid making assumptions to reduce judgment, a ‘neutral’ stance reinforces the hetero- and gender normative *status quo*. Assuming patients may be LGBTQ may open space for visibility and acknowledgment. In hetero- and gender normative health care contexts, women expect poor knowledge of LGBTQ health, and evaluate HCPs on ‘authenticity’ rather than expertise. **Conclusion:** Cultural competence with LGBTQ patients requires learning with, rather than learning about, and explicit attention to pervasive power relations and normative contexts.

**Key words:** cultural competence, physicians, sexual orientation, gender identity, health care

## **Introduction: Cultural Competency and the Queer Patient**

As a response to health disparities faced by minority communities, medicine and the health professions have begun to implement training in cultural competency (Beagan 2009; Carpenter-Song et al. 2007; Harbin et al. 2012; Turner 2005; Wilkerson et al. 2011). Geared towards developing a greater sensitivity to ‘culture’ in general and a deeper understanding of particular cultural groups and their values, norms, social practices, health beliefs and health practices (Beagan 2009; Turner 2005), cultural competence training is intended to help prepare health practitioners for working with culturally-diverse and minority patient populations, mitigating possible issues that might otherwise arise (Harbin et al. 2012). The goal of ensuring that health care practitioners deliver the highest-quality care to all patients regardless of race, ethnicity, gender, sexual orientation, or language proficiency, is an explicit acknowledgement that the predominant “one-size-fits-all healthcare” model is incapable of adequately meeting the needs of an increasingly diverse North American population (Carpenter-Song et al. 2007:1363). Reflected at both the institutional level in terms of policies, available services, and overall vision, and the clinical level in terms of patient-provider interaction, patient assessment, and clinic environment, cultural competency seeks inclusive healthcare tailored to “meet patients’ social, cultural, and linguistic needs” (N.S. Department of Health 2005:1).

Yet despite the best of intentions, gaps remain in the medical community’s understanding of how to define and implement culturally competent health care for the lesbian, gay, bisexual, transgender and queer (LGBTQ) community. A relatively invisible patient population, LGBTQ people have unique healthcare needs and associated risks that remain under-acknowledged among health care providers (HCPs) and patients alike. The purpose of this paper is to explore

how routine practices within health care serve to perpetuate or challenge the marginalization of LGBTQ women.

### ***LGBTQ health care***

Women who identify as queer (we use this as a term that encompasses LGBTQ self-identification) 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 mammography (Steele et al. 2006:1). 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 overweight or obese (Polonijo & 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 prevents them from obtaining decent employment (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 & 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 absent from the Canadian lexicon of ‘visible minorities’ (Mulé et al. 2009), queers’ primary care is, however, compromised by deficiencies in LGBTQ-specific knowledge and skills among health care professionals; a sometimes inhospitable clinical environment that stigmatizes queer patients; and a lack of standard policies and standards of best practice (McNair & 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 & 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 & Gurevich 2002). When they do, they frequently experience difficulty revealing their sexual or gender identity to their HCPs (Polonijo & Hollister 2011:167). Queer youth and trans-people are least likely to disclose to HCPs, almost always having to raise the topic themselves (Bockting et al. 2005; Meckler et al. 2006,). In general, HCPs do not invite discussions of gender identity with patients (Kitts 2010). This helps to construct health care settings as heteronormative environments, environments 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 might be called gender normativity (Beagan, Fredericks & Goldberg 2012).

Most health care providers receive little or no education concerning LGBTQ health (APA Task Force 2008; Corliss, Shankle & Moyer 2007; Hellquist 2006). Among medical students, competence in working with LGBTQ patients appears to rely more on personal experience than educational training (Sanchez et al. 2006). At the same time, HCPs often perceive sexual orientation as being irrelevant to the patient’s physical health, which both obscures LGBTQ

patients' particular needs and serves as a "major barrier" to patient disclosure during the clinical encounter (McNair & Hegarty 2010:534).

The negotiation of self-disclosure/non-disclosure of their sexuality is a key factor that not only distinguishes how queer patients experience and interact with health care service providers compared to their heterosexual counterparts (Daley 2010:336), but also determines the quality of care. Failure to disclose can result in the patient receiving inappropriate health care, including misdiagnosis, under-diagnosis, and delays in seeking medical intervention (Polonijo & Hollister 2011:167). Queer patients who disclose their sexual orientation to their provider report increased comfort and satisfaction, better communication with their HCP, and have a greater likelihood of seeking necessary health services (Steele et al. 2006:1). However, even after having disclosed, queer women's care remains compromised by HCP's false beliefs about and lack of acknowledgement of lesbians' unique healthcare needs and risks (Beagan et al. 2012). Often relying on popular and preconceived notions of lesbian sexuality, many doctors, for instance, perpetuate the misguided assumption that queer women are unlikely to contract STIs, resulting in a lack of proper protection, screening, and treatment (Polonijo & Hollister 2011:168). In short, despite the proliferation of cultural competency training and practices in medicine, the quality of healthcare for the LGBTQ community in general, and queer women in particular, remains inadequate.

### ***Critiquing "Culture"***

Although the term 'cultural competence' has been expanded beyond its initial definition to include gender, social class, and sexual orientation, in practice, existing measures continue to treat culture as being synonymous with ethnicity and race (Kleinman & Benson 2006; Kumas-Tan et al. 2007). Indeed, a major problem with the notion and application of cultural competence

lies in its definition of and approach to culture, which contrasts deeply with its current use in the field in which it originated, anthropology (Kleinman & Benson 2006). Certainly, the concept of ‘culture’ can play an important role in medical education and clinical practice; simply acknowledging how cultural differences are always present in healthcare interactions offers a crucial reminder that ‘obvious’ or ‘common’ knowledge will not necessarily be shared by patient and physician (Turner 2005). While it is crucial for patients to understand the medical opinions and recommendations of their HCPs, so too physicians need to recognize their patients’ understandings of “health, illness, injury, suffering, treatments, and risks” (Turner 2005:478), and how they may contradict biomedical cultural understandings of health and illness.

Medical anthropologists have, however, heavily critiqued the notion of cultural competency for its rendering of culture as a static entity in which medical professionals can be trained to develop expertise (Kleinman & Benson 2006). Misunderstood within cultural competence approaches as a “fixed, knowable entity that guides individuals’ behavior in linear ways” (Gregg & Saha 2006:543), ‘culture,’ anthropologists argue, cannot be perceived as a clearly delineated, separable entity that can be simplified enough for ‘competence’ (Gregg & Saha 2006). Rather, they understand culture as the “shared symbols and meanings that people create in the process of social interaction” (Carpenter-Song et al. 2007:1362) – an ongoing process that influences how people understand and engage in their world. And not only do individuals belong to multiple cultures, but those cultures are neither coherent, nor static, nor do they always join together seamlessly (Gregg & Saha 2006). The rendering of culture within cultural competence nevertheless equates the term with an unchanging ethnic and racialized ‘Other,’ which paints whiteness as somehow ‘outside’ of culture and reinforces it as the norm (Kumas-Tan et al. 2007).

Indeed, the danger of narrow and simplistic conceptualizations of culture is that they may actually reinforce generalized cultural stereotypes and thus contribute to, rather than reduce, cross-cultural misunderstanding (Beagan 2009; Gregg & Saha 2006; Turner 2005). Such understandings may also inadvertently place blame on a patient's culture, rendering it "both a source of problematic behavior and the solution to all the difficulties encountered" (Carpenter-Song et al. 2007:1364) with minority populations. As such, most cultural competency measures fail to address power imbalances borne out of ethnocentrism, racism, sexism, and homophobia, which obscures the interwoven social, cultural, political, and economic factors that shape patients' understandings of and access to healthcare (Carpenter-Song et al. 2007; Gregg & Saha 2006; Kumas-Tan et al. 2007). So while narrow definitions of 'culture' are problematic in their failure to recognize the complexity of people's cultural identities (Turner 2005), so too is the expansion of the term to include non-ethnic or racial minorities in that it places nearly all disparities, such as those faced by the LGBTQ community, in the realm of 'culture', eliding attention to power relations. The focus on culture may in actuality "dangerously distract us from disturbing issues" (Gregg & Saha 2006:544) of racial, gendered, classed, and sexual discrimination in the health care system. And 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.

Reflective of broader norms and values expressed in institutions such as hospitals, clinics, and medical schools, the culture of biomedicine itself must be recognized as playing a key role in

the transmission and institutionalization of stigma, discrimination and the resultant health disparities faced by minority groups (Beagan 2009; Carpenter-Song et al. 2007; Kleinman & Benson 2006). For LGBTQ people, heterosexism pervades every stage of the clinical encounter. Understood as “the ideological system that denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship, or community” (Polonijo & Hollister 2011:167), heterosexism is embedded within the systemic environment of health care through mission statements and intake forms; the physical environment through gender-specific washrooms and displays of posters and pamphlets in the clinic; and through patient flow, which encompasses all inter-personal interactions the patient has during a visit, including with receptionists, other patients, nurses, other HCPs, and physicians. In their study of LGBTQ patients’ healthcare experiences, Wilkerson and colleagues (2011) found that patient flow is considered by queer patients to be the most important factor in determining the perceived safety of the clinical environment. An increased sense of safety in turn fosters greater trust between patients and HCPs, and increases the likelihood that patients will disclose their sexual or gender identity and any related concerns (Wilkerson 2011:383).

This article explores how routine practices within health care can perpetuate or challenge the marginalization of queer women. It draws on qualitative interviews with 38 women who self-identified as lesbian, gay, bisexual, queer, or transgender in Halifax, Nova Scotia, and Vancouver, British Columbia, Canada, as well as interviews with 24 physicians who self-identified as working with LGBTQ patients in those cities. We start by exploring the taken-for-granted assumptions within the health care system that bodies are heterosexual and gender-normative until shown otherwise, and how those assumptions may affect quality of care for queer women. We challenge the notion that culturally competent healthcare ought to be ‘neutral’



in that it should not put forth any assumptions or judgments about a patient's culture or beliefs, asking if, in fact, particular kinds of assumptions might operate as acknowledgements of difference that are necessary to render the queer patient visible. We explore the ways hetero- and gender normativity establish low expectations for quality LGBTQ health care, leaving patients to evaluate care based on other factors. Exploring gender normativity and heterosexism within healthcare is a "crucial dimension" (Carpenter-Song et al. 2007:1364) for developing patient-centered and culturally-relevant practices for LGBTQ communities.

### **Research 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 and 24 physicians. Following university research ethics approval, recruitment was conducted through advertisements in local clinics, letters sent through physician mailing lists, 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. Women were asked about their experiences of health and health care, physicians were asked how they experienced and understood primary health care practice with LGBTQ women.

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. Coding was conducted by a team of researchers who sought consensus on codes and interpretations. 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. 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 the themes of assumptions and judgment, expertise and authenticity. 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 physicians almost all identified as heterosexual women, with five heterosexual men and one gay man, plus two women who identified as lesbian or queer. None of the physicians identified as transgender. They worked in clinics and private practice, and had practiced 10-40 years, and all self-identified as working to some extent with LGBTQ patients. 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, 7 as bisexual, 7 as queer, and 7 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, and physician participants are indicated as such.

### **Making Assumptions/Making Space: Acknowledging the Queer Patient**

"I think it's a difficult one... you don't want to assume that somebody wants to be addressed a certain way.... Don't assume anything." (Shelley, Halifax)

"Don't assume anything. Ask questions." (Ivy, Vancouver)

As suggested here, culturally competent healthcare is thought by many to require not "making assumptions or stereotypical remarks" and "practicing politically correct

communication at all times” (Coe, n.d). Understood by patients and providers as a form of bias, assumptions are often avoided as a way to remain non-judgmental (Harbin et al. 2012). It is preferred by many HCPs, as well as many patients, that clinical encounters be devoid of expressions and perceptions of judgment. In order to avoid making assumptions and appearing judgmental, many HCPs attempt to “retreat into professionalism” (Beagan 2009:e27) and “remain neutral” (McNair & Hegarty 2010:534). For the medical community, neutrality is seen as both valuable and achievable. As Richard, a physician participant in Halifax, noted: “You’re taught to be very formal and distant.” He went on to say about providing LGBTQ health care, “It’s about judgment... the trick is to be nonjudgmental.” This was echoed by Camille, a participant in Halifax: “It’s important for me to know that my doctor really doesn’t care, has no judgment.”

Many physicians feel that expectations of professionalism prevent them from disclosing uncertainty (Haas & Shaffir 1991; Harbin et al. 2012). Afraid not only of making assumptions-as-judgments, but also of being incorrect and/or appearing uncertain, HCPs often retreat into a demeanor of detached professionalism as a sort of coping strategy and defense against feeling uncomfortable (Benner 1984; Haas & Shaffir 1991; Harbin et al. 2012). Unfortunately, this may be perceived by patients as defensiveness, which can exacerbate tensions in HCP-patient encounters. In Halifax, Heather described provider discomfort when her female partner joins her for health care appointments:

The defensiveness that I sometimes see in health care providers, leads to that, like, “Who’s this? Why is there another person in your appointment? Why is there somebody else here? Is somebody testing me?”.... And when that defensiveness comes out, I think there’s a greater opportunity to lead into the “oh this must

be...” which can really take you on the wrong path. (Heather, Halifax)

In this scenario, the discomfort a physician may feel when faced with two women at an appointment may lead them to retreat into professionalism and making assumptions to cover uncertainty, a tactic described by Benner (1984) as a defense against the anxiety of being uncertain or fear of discriminating (c.f. Beagan, Fredericks & Goldberg 2012).

The tension between maintaining neutrality and practicing cultural competency may leave physicians at a loss concerning how to approach diversity. Concerned that acknowledging patients’ ethnic, racial, or sociocultural backgrounds is a form of stereotyping, many HCPs try to mitigate possible judgment and discomfort by attempting to suspend personal beliefs and biases. Striving to be ‘blind’ to race, gender, ethnicity, and such, they seek to treat everyone the same (Beagan & Kumas-Tan 2009; Goldberg et al. 2011; Harbin et al. 2012).

Liza, a Halifax physician, found it best to exclude patient sociocultural differences from her approach to practice: “I’m doing many of the same things with everybody regardless of orientation or gender.” Helen, also a physician in Halifax, similarly reflected: “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.” Thus, in their attempts to not discriminate, many HCPs strive to avoid making any generalizations based on a patient’s social, cultural, or racial differences, and in fact to not even see these differences at all (Beagan & Kumas-Tan 2009; Harbin et al. 2012; McNair & Hegarty 2010).

### ***Professional neutrality in heteronormative and gender normative contexts***

The risk, however, is that they may fail to acknowledge the impact of generalized social patterns on patients’ health, and deny the effects of shared experiences that arise from historical and contemporary power relations. Indeed, some physicians in our study opted to avoid

assumptions and suspend judgment by avoiding labeling queer identities and instead focusing on individual behaviors. For instance, Helen, a Halifax physician, spoke of ‘choices’ rather than ‘identities’ as a way to remain neutral and avoid assumptions: “That’s one thing that is important to me, is not to label people. They’re people. I know people have choices... And so generally my language is very neutral. And I ask it of everyone... I never assume.”

This attempted neutrality can unfortunately “contribute further to homophobia” (Goldberg 2011:174), as it not only veils the heteronormativity and gender normativity embedded within the healthcare system in general and clinical environment in particular, but also obscures the presence of LGBTQ patients, as well as any unique healthcare needs (McNair & Hegarty 2010:534). Indeed, if we understand North American society in general, and the healthcare system in particular, as built upon normative notions of sex, sexuality, and gender, it becomes apparent that neutrality is impossible; in actuality, “neutral” means heterosexual and gender normative, reinforcing the *status quo*. As Sireena, a participant in Vancouver, noted: “It’s just assumed that everybody that walks through your [clinic] door is going to be straight and married. It’s just kind of assumed.”

Sireena points out the heteronormative assumption underlying many clinical encounters. Prior to any interaction, the automatic assumption is that the patient is heterosexual. Reflected in HCP–patient interactions, or what Wilkerson and colleagues (2011:381) call “patient flow”, this assumption is embedded within the systemic environment as well. Kim, in Halifax, remembered a particular instance of homophobia in a clinical encounter:

I had to dig through my bag to find this piece of paper that I carry around that confirms [I am my child’s] legal guardian in health care, so she [the nurse] looks

at it and the whole time she's looking at me like I've got six heads and... then she goes, "Well that's not going to fit in my slot!"

Kim's experience highlights how heteronormativity is experienced not only through HCP–patient interactions but also within the system itself through formal documentation and intake forms. With her status as a second mom unable to fit in the “slot,” she was, as a lesbian mother, made literally invisible.

Dominant presumptions of heterosexuality and gender normativity mean that queer patients are often left responsible for initiating discussions about sexuality and/or gender identity, choosing whether and when to disclose during clinical encounters (Daley 2010:337; Harbin et al. 2012:155-6). As previously discussed, disclosure is important to achieving optimal LGBTQ patient health. Nonetheless, in their systematic review of guidelines for primary care with LGB people in six countries, McNair and Hegarty (2010) note that a serious weakness is the limited guidance provided for clinicians on how to facilitate disclosure of sexual orientation. Others have found that HCP behavior, including displays of gay-positivity and direct inquiry about sexual orientation, have a greater influence on patients' willingness to disclose their sexual identity than the patient's own level of personal comfort and “outness” (Steele et al. 2006:2).

The latter findings contradict the view held by a number of the physicians interviewed in our study, for whom initiating patient disclosure was perceived as making an assumption. While a number of women in our study thought doctors could avoid making assumptions by asking questions (illustrated in the quote from Ivy, above), interviews with HCPs revealed that fear of making assumptions limits the kinds of questions they may feel comfortable asking. For instance, Beth, a Halifax physician, noted, “I mean, [with] people who might have very short hair or might dress a certain way, you might make some assumptions, but that's pretty risky.”

Debbie, another Halifax physician went further to suggest, “You have to not ask directly, you have to ask indirectly. Because some people, if I asked you, you might be offended because you would think that I thought you were [gay].” There is a hint here that assuming someone might be LGBTQ is an inherently negative assumption.

Contrary to these perceptions, however, the studies cited above suggest that the responsibility for instigating patient disclosure lies with the HCP, who must cue the patient that it is safe to disclose (Steele et al. 2006:2; Wilkerson et al. 2011:385). This was echoed by our non-physician study participants: “I think as a queer person, you’re kind of always looking for signals... that other people are queer or queer friendly.... It just kind of gives me a different feeling around the, like regarding that whole office” (Jacquie, Halifax). As a queer person, when Jacquie notices cues or “signals” of comfort with queerness, from people that communicate to her their level of comfort with queerness, this transforms how she experiences the “whole office.” Her description illustrates a kind of hyper-awareness during clinical encounters, that we heard about from most of the women.

### ***Assumptions as acknowledgment***

It is important to note that such ‘cues’ can often operate in the form of particular kinds of assumptions. While both patients and physicians believed that making assumptions meant bias and (negative) judgment, thus something to be avoided, patients’ reflections indicated that assumptions can sometimes operate as ‘cues’ that may lead to acknowledgement and visibility. Because the norm in the healthcare system and elsewhere is heterosexuality and gender normativity, and because queer women patients are relatively invisible compared to other minorities included in the ‘cultural competency’ rubric, an assumption that the patient *may not* be heterosexual sometimes needs to be made to approach equitable care. As Bonita, a Vancouver

participant, noted:

If it's not acknowledged that we have this relationship, then there's an assumption going on somewhere. And I need to know what that is. What I want is that you will always make sure that you acknowledge. It's not enough to know in your own head and say, "Oh, I'm okay with it." You've got to indicate that to me. Because I've been through so much homophobia that I am not going to take it for granted that you're okay with me... I still don't assume that people are okay with me, or with us.

For Bonita, and many other participants, when her LGBTQ reality was not explicitly acknowledged, this signaled that an assumption likely was being made, the assumption that she is heterosexual and gender normative, until proven otherwise. Bonita thought ideal care would involve outright acknowledgement – or cues – communicating that the doctor is aware of her lesbian self and “okay with it”. The prevalence of homophobia means she herself will not assume the doctor is “okay” with her; she requires the doctor’s cues.

Similarly, Mabel, in Halifax, pointed out that only by acknowledging LGBTQ sexual or gender identity can particular aspects of healthcare be addressed:

One piece of advice that I would use for any professional providing any professional service to lesbians is to not be afraid to acknowledge their relationships or their sexual orientation... That is inclusive. And maybe they don't have to do that with straight couples because straight couples are the norm... [For lesbians] there are stressors that come from being a hated and despised minority.

Both Bonita and Mabel are suggesting here that an assumption – that the patient *may not be heterosexual* – has to be made, and appropriate cues given, in order for LGBTQ patients to feel



acknowledged and free to disclose, free to bring their entire self to the clinical encounter. Failing to acknowledge or take into account the patient's difference, or attempting to "remain neutral", emerges as a potential silencing of the patient's queerness.

When asked to recall a positive experience of healthcare, Bonita referred to an experience she had with an ambulance attendant:

I liked how the first ambulance attendants were, where they said, "We take family with us." They indicated that they knew there was a relationship. They asked [Partner] how she wanted to be addressed. They didn't assume she was Mrs. anybody.

Here, although she expected assumptions of heterosexuality, the attendant's assumption that Bonita might not be heterosexual pleased her and made space for her to be out as a lesbian. They acknowledged the possibility of a lesbian relationship. Similarly, Marilyn, a participant from Vancouver, recalled an instance where a physician's assumptions about her preferences as a lesbian helped deal with a male stranger in her hospital room:

Like the surgeon who thought it was wrong that a man was in my room because he knew I was a lesbian. I didn't have to say that to him. And it wasn't actually that big of a deal to me. But he used his brain and thought that would be somebody I might not feel comfortable with. You know? And, dealt with it. And I didn't have to do anything. That's the kind of treatment we need.

In Marilyn's view, the surgeon's assumption operated not as a judgment of her sexuality but as an acknowledgement of it. Such gestures can ease the burden often placed on queer patients to both disclose their sexuality and determine their own healthcare needs.

While notions of cultural competency are typically interpreted as requiring require to

remain neutral and not make any assumptions or judgments about patients, our findings suggest that for some queer women, assumptions can serve as acknowledgements, whereby their sexual/gender identities and relationships are both made visible and validated. While ‘remaining neutral’ is often understood by HCPs as the way to avoid assumptions-as-judgments, in a heteronormative and gender normative context, ‘neutrality’ reinforces the *status quo*. When providers face discomfort and make an assumption – that their patient *may not* be straight – there is potential to make space for queer women and their healthcare needs. As one physician emphasized, however, identifying potential group membership must not be the end of the engagement, it should lead to exploration of what that means for the individual patient: ”There’s that tension, I guess, between learning about different groups of people, and finding ways to use that as a starting off point for exploration of differences *versus* assuming that someone falls into a group” (Mary, Vancouver).

### **Evaluating Expertise *versus* Authenticity**

In the context of routine heteronormativity and gender normativity, it is not surprising that the expectations of LGBTQ patients upon entering health care contexts may be decidedly low (Polonijo & Hollister 2011). Fears of ill-treatment appear to underlie the gratitude expressed by LGBTQ patients when they experience decent, quality health care (Goldberg et al. 2011). 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 & Grassau, 2004:182).

The lack of HCP training for working with LGBTQ patients discussed earlier is evidenced in Polonijo and Hollister’s (2011) study of online lesbian health queries, where they

conclude that physicians' continued lack of knowledge with regard to lesbian health issues remains a primary source of heterosexism in clinical encounters. This is reflected in our study, where interviews revealed strikingly low expectations among queer women patients of HCPs' knowledge about their healthcare needs. Women simply didn't expect their HCPs to know much about queer health. For example, Halifax participant Bea stated, "I seriously doubt that my GP could instruct me on how to use a dental dam ... I would really like to see him [laughs]." Reflecting on her experiences of discussing non-heteronormative sexuality with HCPs, Bea stated, "Any time I've had to bring up some sort of taboo sexual subject, and it's been affirmed or it's been... not an issue, that's been like a mini victory."

In Vancouver, Shelley also experienced HCPs as lacking knowledge specific to LGBTQ health concerns. She had very low expectations of their knowledge, which she connected to lesbian invisibility:

I just think that lesbians are not really looked at. I think we're an invisible minority... We're kind of somewhat ignored... Don't assume that the doctor or the medical practitioners are going to be there to assist you, if you can't assist yourself.

In Halifax, Kim also experienced invisibility in health care contexts, through the ubiquitous assumption of heterosexuality. Reflecting on her expectation of discomfort in a hospital situation, she noted: "There were some uncomfortable questions... you know, 'Does your husband...?' I mean, that's not uncommon... And I always correct it right up front, but there's always that moment, like, 'Oh bugger, here we go again.'"

These women entered the clinical encounter not expecting to be understood; aware of the hetero- and gender normativity (and in some cases outright homophobia and transphobia)

embedded in the healthcare system, they tended to evaluate their physicians less on medical expertise, and more on perceived authenticity and open-mindedness as a person. For instance, as Ursula, a participant in Halifax, explained:

I like my current GP a lot because she's really approachable and more like a person than a on-a-pedestal-doctor kind of thing... Not that fake politeness or anything... She really injects that human element into her practice.

Ursula values her GP's approachability and authenticity as a person more than medical expertise.

When asked what characteristics an ideal GP would have, Bea, in Halifax, responded: "Open-minded, good, non-judgmental, genuine. If I feel like if somebody's not being authentic, if I feel like they're 'putting on' in some way, that really, really makes me feel uncomfortable." Here, Bea equates open-mindedness with being genuine. "Putting on," performing acceptance, does not enhance her perception of safety; rather, it makes her feel uncomfortable. Speaking about safety in the clinical environment, Sireena, a participant in Vancouver, similarly noted: "We need to feel safe... When we seek healthcare expertise, we're putting our trust in somebody's— not just their medical knowledge, but also how they're, what the whole experience is going to be like." For Sireena, perceived safety in the clinical encounter is less related to healthcare knowledge or expertise, than to the overall experience of the physician as a person, who may or may not be trustworthy.

For many of the LGBTQ participants, a sense of trust need not involve the HCP's being an 'expert' in queer health issues. Casey, a trans-identified participant in Vancouver, was most satisfied when it was evident that a HCP was trying to challenge heteronormative perspectives, even though they might not know exactly what to do:

I was really looking for intent, rather than the words, so I could see where her intent was... When people do slip, because people will slip, [it's a matter of] acknowledging it, and saying, "I'm sorry. You know, I'm going to keep on trying. I'm not perfect. I will make mistakes." ... It's not coming from a place of disrespect... demonstrating the effort is something that's important.

In Halifax, Camille emphasized that trying is not enough if the trying is inauthentic: "I think sometimes [they are] trying to be too protective and too, 'I feel for you and I'm really open to you.' It kind of almost feels fake." For Casey, there was a distinction between "intent" and "words." Saying the right words means nothing if not rooted in positive intentions and respect. This participant acknowledged that HCPs are human and make mistakes. For Camille, getting it 'right' accompanied by patronizingly artificial connection was offensive. Both women valued openness, honesty, and effort toward genuine respect.

With low expectations of their physicians' LGBTQ health-related knowledge, participants instead placed higher value on a willingness to admit uncertainty and seek out relevant information. Explaining her preference for her current HCP, one participant noted:

She has certainly that base of knowledge that I would associate with a health care provider but on a couple of occasions, I've also seen her take her book down, which actually sits well for me. I appreciate that and that she's willing to say when she's unclear or doesn't know. (Heather, Halifax)

The GP's willingness to admit uncertainty and look things up was valued and appreciated by Heather. This was echoed by Fran in Halifax, who stated:

All that matters when it comes right down to it, is like, "Are you well informed and do you strive to know more?".... So it's like "Oh I've never heard about that

before, let me find out; let's arrange an appointment," right? That's what I'd want to hear.

These women fully expect that their HCPs will be relatively ignorant about their unique healthcare needs. As such, the image or "cloak" of certainty most health professionals are encouraged to don is not particularly valued by these patients. Rather, they value quite the opposite: honesty, genuineness, and a willingness to openly seek out information when faced with uncertainty. This was recognized by a handful of physicians in our study. For instance, Helen, a physician participant in Halifax, reflected:

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.

As a medical professional, Helen recognized the pressure to assert authority through having "the answers," but at the same time acknowledged the "currency" that her curiosity and willingness to learn may have for LGBTQ patients.

Some women in our study cited worse experiences with 'experts' in LGBTQ health than with HCPs who have no claims to LGBTQ-specific health knowledge. As Kumas-Tan and colleagues (2007) point out, HCPs who have higher levels of confidence and comfort with diverse patient populations may demonstrate lower levels of actual insight and awareness. A number of participants echoed this sentiment, particularly transgender participants. Bea, in Halifax, explained:

I've actually had more problems with the so-called trans experts, the medical professionals who are supposedly expert in trans issues. I've had more problems

from them than the medical professionals who know nothing about trans issues because... All of my medical professionals that I have seen who don't know much about trans issues, they make an effort to understand it... The experts are all kind of like "Well I have this way of doing this and you need to follow it."

Bea's experience suggests that experts who are already knowledgeable and well-versed with trans health-related issues may lack the openness and willingness to listen and understand that others, less well-versed in trans issues but eager to learn, possess. This was echoed by Casey in Vancouver, who similarly reflected:

The first person I saw at the old Gender Clinic... after three sessions, said "You're clearly transsexual, we'll get you on the wait list for the endocrine clinic" ... I didn't go back to see her. She labeled me... She decided who I was... I needed somebody who could listen to me and not tell me who I was or where I was going.

This participant was not looking to be given a label or forced into taking a particular path, but wanted someone to listen and provide a safe space in which to explore options and health concerns. As Carpenter-Song and colleagues (2007:1365) argue, "Two systems of knowledge collide in clinical encounters. Clinicians are experts in biomedicine, patients are experts in their own experience." This may be especially true for queer patients, about whose healthcare needs physicians possess either limited knowledge or an inflated sense of expertise. Clinical encounters might better be seen as "two-way learning encounters" where patient and HCP collaborate in determining the needs and best interests of the individual patient, based on solid medical knowledge (Carpenter-Song et al. 2007:1365).

Mary, a physician in Vancouver, described a productive tension between being an expert on medical issues, and being open to learning about individual and socio-cultural aspects of health from her patients:

I used to think... ‘Shouldn’t I make my goal just to be really, really open and meet every individual person on their own terms?’ And, at the end of the day, I still think that that’s really important. ... [But] if you don’t know about some of those potential issues that people may bring in with them, then it’s really hard to actually be sensitive and imaginative enough to ask them everything that you need to ask them.

The importance of this two-way learning was strongly supported by the participants who emphasized the value of listening. For instance, Rhonda, a participant in Vancouver, stated:

I really think it should just be a matter of listening to you and assuming that you are an informed agent, and that you are the expert in your own life... I feel as though they want to help, but on their terms... [as] trained experts.

She noted that for women in particular deference to expertise is culturally instilled:

I think as young women, we’re taught to always defer, defer to expertise.... defer to the elder; defer to the expert; defer to the man; defer to, you know, the person who seems confident.... So, if I were to give young lesbians advice, it would just be you know, stop thinking that other people know better than you. If you think you know what’s right for you, then you do.

Rhonda directly contrasts medical expertise with what she feels is a more legitimate expertise – knowledge of one’s own body. For her, HCPs’ attempts to help “on their terms” as “confident” and “trained experts” invalidates lesbians’ knowledge of their own healthcare needs. Rather than



deferring to medical expertise, she suggests that lesbian patients need to ensure they are listened to and their knowledge of their own bodies taken seriously.

The extent to which LGBTQ participants held low expectations of health care providers, and were willing to accept lack of LGBTQ-specific health care knowledge, is slightly alarming. While it is extremely important that physicians and others be willing to admit uncertainty, willing to learn from patients, and willing to look things up, the notion that ‘authenticity’ holds primacy over actual health care expertise hints of gratefully accepting whatever quality of care one is offered. As Sinding and colleagues (2004:182) discovered in their study of lesbian cancer care experiences, “What is normal treatment for heterosexual women was something that the lesbians remarked on and even praised.” Similarly, in Ontario, Bauer and colleagues (2009) found many of the transgender participants in their study felt grateful if they happened to encounter a care provider who was tolerant of their gender identity – let alone knowledgeable about their health needs (Bauer et al. 2009:355)

## **Conclusions**

A major weakness of dominant approaches to cultural competency is the failure to recognize the dynamics of power, privilege, and marginalization that contribute to the very healthcare disparities they seek to resolve. Understood as an ongoing process rather than a fixed set of beliefs, ‘culture’ is not a term that adequately captures or represents the LGBTQ population. An invisible minority whose identities are also inflected by race, class, gender, and ethnicity, LGBTQ patients are often marginalized from rudimentary healthcare forms and practices. Culturally competent healthcare for queer patients must be geared not towards developing a queer-focused expertise and bounded set of knowledge, but towards making space for queers’ identities and experiences to be acknowledged and reflected in all levels of the

healthcare system.

While HCPs strive to make no assumptions, to avoid prejudice when working with patients, there is no magical state of neutrality, no view from nowhere. Physicians and others cannot step outside of heteronormativity and gender normativity through force of will. When they refuse to assume a patient might be LGBTQ, they are, in effect, assuming she is not – that she is heterosexual and distinctly a man or woman. Our LGBTQ patients suggest there may be something quite freeing, affirming, when HCPs assume that they may be other than heterosexual and gender normative. Patients may read such an assumption as a cue concerning safety. Given the prevalence of non-disclosure, and the importance of disclosure to achieve optimal health care, making such assumptions may be valuable.

If cultural competence is the framework to address diversity within health care, it is critical to note that for social scientists and anthropologists, culture refers to a continuously developing and complex process that interacts with a multitude of factors to influence people's collective and individual understandings of and approaches to their world. A 'competent' approach to 'culture,' then, must be founded not on learning *about*, but learning *with* – through collaborating with queer patients and asking the right questions. Speaking particularly about ethnicity, Kleinman and Benson (2010:1674) suggest an alternative approach to cultural competency, which begins with the HCP determining what exactly ethnic identity means to the patient's sense of self. Ethnicity, they argue, is "not an abstract identity" but rather "a vital aspect of how life is lived"; it "defines how people see themselves and their place within family, work, and social networks," and so its importance varies between individuals and contexts. The authors suggest "simply asking the patient about ethnicity and its salience" as the best way to begin the clinical encounter. This approach necessarily employs the tension between recognition that

socio-cultural group membership influences health and health care, while each individual's experiences of that socio-cultural groups, (and of health and health care) will be unique. This may work well for queer patients, whose healthcare is often compromised by misguided notions and false stereotypes of what gay, lesbian, bisexual, transgender or queer lives actually look like.

The notion of “two-way learning” (Carpenter-Song et al. 2007) may fit even better with a framework of cultural humility, than with cultural competence. Whereas the latter implies one can attain competence, suggesting an end-point to learning about the Other, cultural humility emphasizes a life-long relational learning process (Tervalon & Murray-Garcia 1988). The emphasis is on understanding power-charged (yet taken for granted) social relations, rather than learning the cultural attributes of the Other. Cultural humility emphasizes understanding ones own beliefs and assumptions, examining where they come from, and how they contribute to maintaining systems of inequality. This would necessitate recognition of heteronormativity and gender normativity, and consciously working to counter the accompanying assumptions, making space to acknowledge and make visible LGBTQ presence in health care.

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