

Nurses' work with LGBTQ patients: "They're just like everybody else, so what's the difference?"

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Abstract

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

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

Introduction

Women who identify as lesbian, gay, bisexual, transgender or 'queer' (LGBTQ) face social exclusion that can translate into significant health inequities (Fish, 2010). They are less likely to get regular Pap tests and mammograms, more likely to use alcohol, tobacco and other substances, and more likely to develop breast cancer (Steele, Tinmouth & Lu, 2006). Lesbian and bisexual teens are more likely to become pregnant, to abuse alcohol and drugs, and to consider suicide (Saewyc et al., 2007). Transgendered women, those whose bodies and socially assigned gender do not match their internal sense of gender, face considerable marginalization and mistreatment in health care, as well as unique health challenges (Bauer et al., 2009). Trans persons have elevated rates of depression, substance abuse, other mental health conditions, suicidal ideation and attempts, HIV infection, and experiences of violence (Clements-Nolle et al., 2001; Kenagy, 2005, Shaffer, 2005). Stigma, homophobia and transphobia (discriminatory prejudice which may manifest as avoidance, intolerance, fear, hatred and violence) have been identified as major contributors to such health inequities (Banks, 2003; Weisz, 2009).

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

inequities for LGBTQ women. At the same time we interrogate how nurses may at times challenge those patterns to optimize care.

Literature review

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

LGBTQ experiences of health care

LGBTQ persons are twice as likely as other Canadians to *not* have a family doctor, and are significantly less likely to seek out health care, often delaying until a condition is acute (Kenagy, 2005; Newfield et al., 2006). Part of the reason for delays may be fear of ill-treatment. A study with 98 lesbian and bisexual women in Nova Scotia (Mathieson, 1998) found many avoided routine and preventive care due to care providers’ assumptions. In the face of heterosexism in forms and documentation, as well as in discussions such as those surrounding sexual history and birth control, participants often felt forced to disclose their sexual orientation. Having done so, many providers were clearly uncomfortable, not knowing what to do with that information. More recently, a survey of 2269 lesbian, gay and bisexual persons in New Zealand found 83% of the women reported that their health care providers usually or always presumed

they were heterosexual (Neville and Hendrickson, 2006). Most also reported, however, that providers were comfortable with their disclosures and their health care was not negatively affected by provider attitudes.

Many trans persons experience their treatment by health care providers as ignorant, insensitive, humiliating, and discriminatory (Newfield et al., 2006). Health professionals tend to lack knowledge and may express moral judgments about patients, sometimes even refusing treatment (JSI, 2000; Shaffer, 2005). A transgender needs assessment in Philadelphia (N=182) found 26% of respondents had been denied medical care at least once (Kenagy, 2005). One transgender participant in a Boston study reported that her physician refused her treatment, saying she “should ‘see a veterinarian’ as a medical doctor was ‘a doctor for people’” (JSI, 2000: 22).

Heteronormative and gender normative care

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

Though minority sexual orientation and/or gender identity can evoke poor (homophobic and transphobic) treatment, a far more pervasive problem seems to be heteronormativity and normative assumptions about gender. As a recent literature review concludes, “Within the clinic, heterosexuality appears to be the expected ‘default’ norm” (Dysart-Gale, 2010: 24).

Heteronormativity refers to the powerful interlocking set of assumptions and institutional practices that construct everyone as heterosexual unless shown to be otherwise. Heterosexuality is descriptively normative – statistically ‘normal’ – as well as prescriptively normative – one *should* be heterosexual and if not, one is cast as deviant, abnormal, lesser. At the very least, aberrations to the norm of heterosexuality require explanation. The pervasive assumption of heterosexuality renders other sexual orientations (and people) invisible or marginal in health care settings.

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

Recent research suggests that heteronormativity and gender normativity are pervasive in health care settings, negatively affecting care for LGBTQ patients. In Canada, McDonald concludes that lesbians are rendered invisible in health care, as “the norm of heterosexuality is

reflected in sexual and reproductive health-care practices, in demographic forms and interviews, and in the posters and pamphlets found on the walls and on the desks of health services” (McDonald, 2009: 264). In two studies of lesbian prenatal and birthing experiences, heteronormativity was found to be ubiquitous, from the forms and language used to continual references to the father (Goldberg, Harbin & Campbell, 2011; Røndahl, Bruhner & Lindhe, 2009). Similarly, in a study of lesbian cancer care, Sinding, Barnoff and Grassau (2004) noted that even the cancer support groups for lesbians or their partners were experienced as marginalizing, as they assumed participants were heterosexual.

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

Individualizing difference to overcome discomfort

In the context of pervasive heteronormativity and gender normativity, LGBTQ patients clearly believe they may be subjected to ill-treatment if they disclose their sexual orientation or gender identity. In a recent Canadian study of lesbian birthing experiences (Goldberg, Harbin & Campbell, 2011), the fears and vulnerability to possible negative treatment in health care settings were illuminated particularly by the gratitude lesbians expressed when they received quality care. Participants were surprised and exceedingly grateful when they were treated well by nursing staff – when partners were acknowledged as partners, when nurses seemed comfortable

with them as lesbians. The same finding arose in Sinding and colleagues' study of lesbian cancer care, where again simply being treated like other patients occasioned grateful praise:

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

Similarly, in Bauer and colleagues' (2009) study of trans care in Ontario, many trans participants felt grateful if they happened to encounter a care provider who was tolerant of their gender identity – let alone knowledgeable about their health needs (Bauer et al, 2009: 355)

In heteronormative and gender normative contexts, LGBTQ realities disrupt everyday assumptions, which may leave nurses and other staff uncomfortable. LGBTQ patients reporting on their health care experiences have stated that their sexual orientation or gender identity seemed to make nurses and other staff feel insecure, embarrassed, and anxious about the possibility of saying or doing something 'incorrect' and being interpreted as prejudiced (Goldberg, Harbin & Campbell, 2011; Røndahl, 2009; Røndahl, Bruhner & Lindhe, 2009). This fear of saying something wrong is sensed by patients, who then may bear the burden of easing communication. When nursing staff are afraid to discuss issues, or are insecure about how to address LGBTQ patients (Røndahl, Innala and Carlsson, 2006), patients may fear the nurses' discomfort could be accompanied by ill-treatment. Communication then breaks down:

“Insecurity, on the part of either personnel or relatives, could bring further interaction to a halt. ... Nursing staff experience a great sense of insecurity concerning how they should behave in interactions with gay families” (Røndahl 2009, p 150). Røndahl (2009) notes that this is in spite of nurses generally holding positive or neutral attitudes toward LGBTQ people, and having good

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

One way of resolving uncertainty around potentially saying or doing something ‘wrong’ is for nurses to focus on the individual. Goldberg and colleagues found nurses often engaged in “care practices blind to difference” (Goldberg, Harbin & Campbell, 2011: 184), arguing that sexual orientation was irrelevant. They identify a “pervasive, problematic tendency to understand the requirements of acknowledging diversity as best met by sustained focus on the individual” (Goldberg, Harbin & Campbell, 2011: 184-5). While the desire to see all patients as individuals, and thereby perhaps avoid stereotyping LGBTQ patients, arises from the intent not to cause harm, it simultaneously precludes any opportunity to recognize and take into account how social factors – such as heteronormativity and gender normativity – may shape patients’ (and nurses’) life experiences, health, and health care interactions (Beagan & Kumaş-Tan, 2009). Yet as noted in the study cited earlier of LGB women’s health care in Nova Scotia, participants stated that the most important attribute in a care provider was that they be gay-positive, able to grasp what it means to patients to be LGB and how societal responses to sexual orientation may affect health (Mathieson, 1998: 1637). Awareness of such social processes is precluded by narrow focus on individualized differences.

Methods

This paper is based on a subsample from a larger qualitative study of health care for LGBTQ women, in which we sought to examine how taken-for-granted practices perpetuate or transform the marginalization of LGBTQ women within the health care system. The larger study included in-depth, face-to-face interviews with women, physicians, and nurses from two Canadian cities. The research team included LGBTQ researchers and members of several

disciplines and professions, including nursing. In this paper, we draw on the data from registered nurses in Halifax, Nova Scotia. This sample included eleven nurses who identified as women and one who identified as a man; they had Bachelors or Masters training, all practiced in various settings for 10-30 years, and all self-identified as working to some extent with LGBTQ patients. The sample was self-selected, thus participants might be anticipated to have an unusually high level of experience and familiarity in working with LGBTQ patients.

Following research ethics approval, recruitment was conducted through advertisements, posters, letters sent by the College of Registered Nurses, word of mouth and snowball sampling. After receiving informed consent, a qualitative in-depth, semi-structured interview was conducted with each participant. Interview questions asked participants to describe how they experienced primary health care practice with LGBTQ women. Interviews were recorded, transcribed verbatim, and analyzed inductively generating themes and subthemes which were coded using AtlasTi software. Informed by critical, feminist and queer studies approaches, coding was conducted by a team of researchers in constant communication to reach consensus on codes and the use of codes. Transcripts were read and re-read, and 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 explore the range of ways nurses understood and approached difference.

Results

In the interviews, nurses described a range of approaches to working with diverse sexual orientations and gender identities. A common approach was the idea that difference does not matter, in other words the denial of difference. An overwhelming message was the desirability of treating patients as individuals. In part this seemed to be an attempt to avoid discriminating or

stereotyping by avoiding making any assumptions. When difference was taken into account, the focus was often restricted to sexuality and sexual health. Yet some participants showed complex understandings of societal oppression and marginalization, and potential impact on health and health care.

Denying difference by treating everyone as an individual

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

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

Some participants acknowledged that difference in terms of sexual orientation and gender identity did matter, but they seemed to struggle with according it any significance in their practice. For example, Abigail recognized that LGBTQ patients could face "things that could

stem from the fact that they're part of that community," yet she went on to diminish the significance of that difference:

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

One of the nurses' most common rationales for not practicing differently with LGBTQ patients was that they treated everyone as a unique individual. This approach was seen as avoiding discrimination or stereotyping, and ensuring equitable treatment. Phyllis clarified that she attempted to treat every patient the same, but according to their unique needs: "Same and unique, same and individually as opposed to different. Yeah, because everyone has their own individual needs." Others said they focused on the individual health needs, "the medical issue," since sexual orientation or gender identity was not usually why a patient sought care. Shelley was most explicit about treating LGBTQ patients as individuals. She and a colleague had been talking with other nurses about practice with LGBTQ patients:

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

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

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

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

Acknowledging difference as discrimination

The emphasis that a patient is more than their ethnicity, or in this case their sexual orientation or gender identity, was a strong theme in the interviews. There was an overwhelming sense that the nurses interviewed did not want to harm any patient by stereotyping, making assumptions or discriminating against them. Lia said explicitly, “I want them [LGBTQ patients] to know that I’m not homophobic or, you know, I’m accepting of everybody.” She went on to say, “I’m always so worried about offending people and sort of making that assumption that everybody is heterosexual.”

This desire not to discriminate, or to be seen as discriminatory, may have been underpinning the pervasive denial of difference, the notion that sexual orientation and gender identity did not matter. In this context, the suggestion that LGBTQ patients might receive different care was taken to mean their care would be worse than the care others received. Clara, for example, when asked how she might work differently with LGBTQ patients, said, “I don’t think I would. I, I want to believe that. I think I would give same care, you know, as, you know, people who are straight. I think I can honestly say that I would.” Phyllis similarly rebutted any suggestion that she might treat LGBTQ patients any differently, saying, “No. I’d never even consider that that would be, that they would get less of anything.” This fear of discriminating deterred some participants from discussing the role of assumptions in their practice.

In one of the few discussions of how care might be different for LGBTQ patients, some participants emphasized that it was important to know patients’ sexual orientation or gender identity in order not to offend them by saying the wrong thing. This suggests that normative language and assumptions were prevalent. Some nurses did acknowledge the inevitability of making assumptions and struggled to contain or overcome them. Shelley said that especially in

her work with trans patients, “You always are trying to be aware of what you say, and what you’re doing. But, you’re not always a hundred percent.” Abigail noted that, “You kind of get in a habit of ... assuming that everybody’s the same ... even though I know it’s not true, you do kind of fall into that trap.” Yet she clearly struggled against discriminating against any patients, even in the everyday interactions that go beyond medical care: “You joke with all of them, when it’s appropriate ... you try not to single out or exclude anyone from the type of care that you like to give to your patients.”

Similarly, while Shelley stressed the importance of attending to diversity, she was very concerned that she not stereotype by reducing anyone to their sexual orientation or gender identity:

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

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

Focus on sexuality/ focus on oppression and marginalization

The idea that people are individuals was sometimes accompanied by the idea that the only difference that mattered concerned sexuality and sexual practices. In other words, LGBTQ was reduced to and equated with sex. For example, when asked what difference it might make if a patient were LGBTQ, Anna said:

I don’t really care. If it’s a sore throat we’re talking about, ah, [pause] it has really nothing to do with that ‘cause I mean it’s still a person, it’s just, who they want to have sex with, you know what I mean? That’s the only thing that’s different, but

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

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

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

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

In contrast to the tendency to reduce sexual orientation and gender identity to sex and sexual practices, some of the nurse interviews showed complex understandings of the ways LGBTQ individuals face societal oppression and marginalization, which may affect their health,

their health care needs, and their health care experiences. Abigail spoke about transgendered youth struggling with growing up feeling different. She said, “I think that it’s important that everybody become more aware of the fact that there are people in our greater community who may feel vulnerable, and they have different issues than the norm, because they’re part of the queer community.” When asked if she thought being LGBTQ might affect someone’s needs in health care, Shelley said she did, and described a gay family friend who was raised in a conservative religious family, and who had “to struggle for his identity all the time.” Jeanette worried about aging LGBTQ people who face placement in nursing homes where family and institutions do not respect or recognize their long-term same-sex relationships. All of these examples show nurses taking into account the ways in which sexual orientation and gender identity may affect everyday life for LGBTQ persons, shaping health and relationships to health care.

Some participants addressed the complexity of striking a balance between recognizing someone’s sexual orientation or gender identity, and the potential ways it may have affected their health and health care needs, without reducing the person to that category and failing to see them as a whole person. This centered on recognition of oppression and marginalization, rather than identities, practices or ‘lifestyles’. For example, Jeanette said she gave women the same information about sexual health regardless of sexual orientation, then went on to say she took into account barriers in previous health care experiences:

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

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

Some participants learn about these barriers and harms by interacting with their patients. Jeanette, for example, had learned from conversations with lesbian mothers some of what it might be like for non-biological mothers to face misunderstandings about their role in relation to their children. Kate specifically described having learned a great deal from trans patients concerning the everyday aspects of seeking health care, and day-to-day living as transgendered:

I hear a lot more from them about fears... fear of identification in going to the lab and they call out their name and when they walk up to the desk they go, ‘No, I called out a woman’s name, you’re not–’ because their transition isn’t as complete, okay so they’re still presenting as the opposite sex. And they fear that someone in that room has just heard that and they also shouted out their address and they know now where they live... And suicide, like talk about how hard the transition has been and the really bad points they’ve been at in their lives before having the courage to make that move, right? So a lot of listening I think. (Kate)

Learning more about the context of LGBTQ patients’ lives is hindered when sexual orientation and gender identity are equated with sex, because nurses may fear invading someone’s privacy. Describing her work with a teen girl who was very troubled, and not knowing whether she might be lesbian, Clara said to provide good care, “maybe we need to know a little more about their background, so we can help them better. Not to stick our noses in their business, but to give them better care.”

Phyllis used broad understanding of LGBTQ lives and marginalization to convey to families of LGBTQ patients that their sexual orientation or gender identity was welcome. She did this through very intentionally showing respect for the relationships:

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

Here Phyllis displayed awareness of the ways everyday interactions in health care can unintentionally marginalize LGBTQ relationships.

Finally, a few nurses used their understanding of oppression to directly advocate for LGBTQ patients in health care settings. Jeanette described homophobia being prevalent in hospital settings, and deliberately trying to ease the experiences of LGBTQ patients:

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

This kind of direct advocacy was unusual in our sample, but clearly a very immediate way to mobilize understandings about oppression and marginalization to enhance good health care provision.

Discussion

The nurses in our sample displayed a range of ways of thinking about, understanding, and approaching their work with LGBTQ patients. Different approaches have different implications for equitable health care. Most commonly, participants suggested that differences such as sexual orientation and gender identity do not matter: everybody should be treated the same. Simon expressed this dismissal of diversity with a classic insistence that "we're all pink and squishy inside." There was pervasive concern that noticing social differences – as opposed to individual differences – is paramount to discriminating. Most nurses were very concerned about not reducing patients to their sexual orientation or gender identity, not reducing them to a set of stereotypes or assumptions. This was coupled with fear of offending or stereotyping, by saying

or assuming the ‘wrong thing’. This may leave nurses paralyzed by the insecurity noted in previous studies (Goldberg, Harbin & Campbell, 2011; Røndahl, 2009; Røndahl, Bruhner & Lindhe, 2009; Røndahl, Innala & Carlsson, 2006); communication then becomes problematic.

One of the ways participants found LGBTQ identity mattered was that it helped them to be careful about their language, and to avoid making incorrect assumptions about patients. To be clear, the intentions of these nurses were positive. They tried in multiple ways to avoid inadvertently causing harm to the LGBTQ patients in their care. Yet the focus on individualized difference (undeniably important) is not accompanied by equivalent attention to social differences. The fear of making unwarranted assumptions is valid; it is challenging to recognize, let alone avoid, the normative assumptions attached to categories and labels such as lesbian, bisexual or transgendered (McDonald, 2009: 271). If knowing a patient is lesbian leads a nurse to think she knows how that patient lives her life, who she shares it with, what her health concerns are, and what risk activities she is engaging in, that nurse is definitely relying on stereotypes, which coupled with the power of the health care context contributes to stigma (Weber, 2010: 383-4). In her study of lesbian experiences of disclosure, McDonald (2009) urges nurses to avoid complicity in the maintenance of restrictive categories such as ‘lesbian’, instead focusing on individual practices: “Health-care practices directed towards women should move beyond unexamined categories of identity to consider the particular behaviours that influence the health of each woman” (265).

This approach was apparent in our sample, with nurses arguing that *who* someone is (their social identity) does not matter, what matters is their sexual practices: “Do you have sex with men, women, or both?” However, in attempting not to discriminate, or reduce patients to categories, nurses restrict their ability to see the potential impact of social differences. This

approach fails to acknowledge that there *are* generalized social patterns in experiences, life chances, and influences on health (Beagan & Kumaş-Tan, 2009). Colour-blind practice, for example, is unhelpful when skin colour causes people to experience racism on a regular basis and when racism may contribute to stress-related health effects (Quintero, Lillioff & Willging, 2007).

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

For example, Jeanette used her understanding of homophobia to advocate for and protect LGBTQ patients on hospital wards. More simply, Kira said of an LGBTQ patient, “I’m cognizant of what she’s been through and that there’s more barriers and challenges.” Phyllis, without ever needing to ask about a patient’s sexual orientation (with attendant fear of prying or ‘getting it wrong’), found ways to convey respect for same-sex relationships by simply saying, “You know them best. What do you think they would like?” She used her understanding of heteronormativity to challenge the business-as-usual marginalization of LGBTQ realities.

If we consider that taking difference into account means acknowledging the context of heteronormativity and gender normativity, this means acknowledging that many LGBTQ

patients fear (justifiably) that they will be treated poorly in a vulnerable situation. Yet, fearful of offending, nurses employ a ‘don’t ask, don’t tell’ approach, trusting that quality care can be provided without acknowledging LGBTQ identities and the ways in which marginalization and oppression shape LGBTQ patients’ health and health care. While the nurses in our study said they were comfortable with disclosures of LGBTQ identities and experiences of marginalization, few seemed to see it as their responsibility to facilitate these discussions. The assumptions of heteronormativity and gender normativity remain unquestioned. Nurses enact a certain privilege when they decide it is too risky to address relevant social differences because doing so may evoke the discomfort of getting it wrong or having offended.

Conclusion

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

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