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Making Assumptions, Making Space: An Anthropological Critique of Cultural Competency and Its Relevance to Queer Patients

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. This study uses interviews with 24 physicians and 38 LGBTQ-identified women to explore how routine practices in health care can perpetuate or challenge the marginalization of LGBTQ women. While physicians avoid making assumptions to reduce judgment, a “neutral” stance reinforces the hetero- and gender normative status quo. Cultural competence with LGBTQ patients requires learning with, rather than learning about, LGBTQ people’s particular healthcare concerns as well as paying explicit attention to pervasive power relations and normative contexts. [LGBT health, cultural competence, physicians, gender identity, health care]

Introduction: Cultural Competence and the LGBTQ 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 and Kumas-Tan 2009; Carpenter-Song et al. 2007; Harbin et al. 2012; Turner 2005; Wilkerson et al. 2011). Geared toward 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 and Kumas-Tan 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). It is an explicit acknowledgment that the predominant “one-size-fits-all health care” model is incapable of adequately meeting needs that may vary by race, ethnicity, gender, sexual orientation, or language proficiency (Carpenter-Song et al. 2007:1363). Cultural competency efforts are reflected in both institutional policies, services, and overall vision and at the clinical level in terms of patient–provider interaction, patient assessment, and clinic environment (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 health care needs and associated risks that remain
under-acknowledged among health care providers (HCPs) and patients alike. Feminist critiques have identified how the prevalence of the prototypical male body within biomedicine has ignored many health concerns particular to women (Ruzek et al 1997), highlighting not only women’s unique health care concerns but also social dynamics that produce them (Morrow et al. 2008). Much of the health research in sexual minority communities over the past three decades has tended to focus on HIV/AIDS among men (Kapadia 2013). In this article, we explore how routine practices within health care perpetuate or challenge the marginalization of LGBTQ women.

*LGBTQ Health Care*

Women who identify as LGBTQ 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, mammograms, and pap smears (Fredriksen-Goldsen et al. 2013:1802; Steele et al. 2006:1). Lesbians also tend to have higher levels of substance use, greater likelihood of mental health or psychosocial issues, and higher body weights (Fredriksen-Goldsen et al. 2013:1802; 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 prevents them from obtaining well-paying 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 (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). Negative experiences with providers, as well as limited financial resources, also result in an increasing number of self-performed surgeries (Rotondi et al. 2013).

Generally absent from the Canadian lexicon of “visible minorities” (Mulé et al. 2009), LGBTQ people’s primary care is, however, compromised by deficiencies in LGBTQ-specific knowledge and skills among health care professionals, a sometimes inhospitable clinical environment that stigmatizes LGBTQ patients, and lack of policies and standards for best practice (McNair and Hegarty 2010; Wilkerson et al. 2011). Indeed, in Canada and the United States, lesbians report overall low satisfaction with health care services, largely as a result of heterosexist or homophobic encounters with HCPs (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 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 et al. 2002). When they do, they frequently experience difficulty revealing their sexual or gender identity to their HCPs (Polonijo and Hollister 2011:167). LGBTQ 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 construct health care settings as heteronormative environments, in which heterosexuality is presumed and privileged as the preferred, normal sexual orientation (Dysart-Gale 2010:24). Gender normative assumptions (the existence of two binary genders) similarly erase the existence of transgender and gender-variant people (Bauer et al. 2009).
Most HCPs, however, receive little or no education concerning LGBTQ women’s health (APA Task Force 2008; Corliss et al. 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 and Hegarty 2010:534).

The negotiation of self-disclosure/non-disclosure of their sexuality is a key factor that not only distinguishes how LGBTQ patients experience and interact with HCPs 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 and Hollister 2011:167). LGBTQ patients who disclose their sexual orientation to their HCP report increased comfort and satisfaction, better communication, and a greater likelihood of seeking necessary health services (Steele et al. 2006:1). However, even after disclosure, LGBTQ women’s care remains compromised by their HCPs’ false beliefs about and lack of acknowledgment of lesbians’ unique health care needs and risks (Beagan et al. 2012; Polonijo and Hollister 2011). In short, despite the proliferation of cultural competency training and practices in medicine, the quality of health care for the LGBTQ community in general, and LGBTQ 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 it tends to still be equated with ethnicity and race (Kleinman and 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 anthropology, the field in which it originated (Kleinman and 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 health care interactions offers a crucial reminder that “obvious” or “common” knowledge will not necessarily be shared by patient and physician (Turner 2005). Although 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 and Benson 2006; Willen and Carpenter-Song 2013). Misunderstood within cultural competence approaches as a “fixed, knowable entity that guides individuals’ behavior in linear ways” (Gregg and Saha 2006:543), anthropologists argue that culture cannot be perceived as a clearly delineated, separable entity that can be simplified enough for “competence” (Gregg and Saha 2006; Kirmayer 2012). 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 and 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 and Kumas-Tan 2009; Gregg and 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 health care (Carpenter-Song et al. 2007; Gregg and Saha 2006; Kumas-Tan et al. 2007).

While narrow definitions of culture are problematic in their failure to recognize the complexity of people’s cultural identities (Kirmayer 2012; 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 and Saha 2006:544) of 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 health care system itself, impede access to quality care among minority populations.

Reflective of broader norms and values, the culture of biomedicine itself must be recognized as playing a key role in the transmission and institutionalization of stigma, discrimination, and resultant health disparities (Beagan and Kumas-Tan 2009; Kleinman and Benson 2006; Willen and Carpenter-Song 2013). 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 and Hollister 2011:167), heterosexism is embedded within the health care system through mission statements and intake forms, gender-specific washrooms and displays of posters and pamphlets, and all the interactions a patient has during a visit, including those with receptionists, other patients, nurses, other HCPs, and physicians. In their study of health care experiences, Wilkerson and colleagues (2011) found these interactions are considered by LGBTQ 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 LGBTQ women. It draws on qualitative interviews with 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 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. We challenge the notion that culturally competent health care 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 acknowledgments of difference that are necessary to render the LGBTQ 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 health care is crucial to developing patient-centered and culturally relevant practices for LGBTQ communities.

Research Methods

This article reports on the results of a qualitative study of health care for LGBTQ women, which included interviews with women, physicians, and nurses. We draw on the data from the 38 women and 24 physicians. Following university research ethics approval, we recruited 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, we conducted an in-depth, semi-structured, face-to-face interview 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 that 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 done 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 repeatedly returning to transcripts, the analyses in this article 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.

All members of the research team identified on the LGBTQ continuum, as did all the research assistants except one. All researchers were academics in social sciences and health-related fields, except one HCP. All identified as women except one, who identified as genderqueer. Ages ranged widely. The research team’s identification with the LGBTQ community was crucial in building trust during the recruitment process; many participants’ involvement was contingent on our identities as LGBTQ researchers and, in some cases, on our personal involvement in and familiarity with the community. This also meant that we were able to recruit participants of varying degrees of “out-ness,” which broadened the experiences reflected in our data and results. Our experiences as LGBTQ also helped build rapport with participants throughout the interview process and meant we could ask more significantly informed questions than we would otherwise have been able to do.
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, had practiced 10–40 years, and self-identified as working to some extent with LGBTQ patients. The 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. Those who identified not as lesbian or bisexual but as queer or something else were generally younger and conceived of such identity terms as more inclusive, fluid. 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. A number of participants who identified as transgender, genderqueer, or something else also rejected the binarisms of lesbian and bisexual, identifying instead as queer, pansexual, or other more fluid sexual orientations. All participants volunteered for the study based on their own self-identifications; thus, women who are not really out and who may have very different health care experiences, likely did not volunteer.

Of the LGBTQ women participants, three identified as Jewish, two as Japanese, one as aboriginal, and one as part Mexican. The remainder of the women participants identified as white EuroCanadian, including French, British, Irish, Dutch, and Polish ancestry. Of the physician participants, three identified as of Asian heritage, one as Scottish, and the rest as white EuroCanadian. With little racial or ethnic diversity, no conclusions could be made regarding relationship with LGBTQ identities; this was a limitation of the study. Participant ages ranged from 20 to 73.

Situating Contexts

With just over two million residents, Vancouver, located on Canada’s west coast, is Canada’s third-largest city (Statistics Canada 2014). Vancouver also houses a substantial LGBTQ population, with a number of LGBTQ-focused health clinics and STI testing sites. With a population of approximately 300,000, Halifax is Canada’s 14th-largest city and the largest city in eastern Canada (Statistics Canada 2014). Although the LGBTQ population is substantial and growing, few Halifax HCPs focus on LGBTQ health. LGBTQ participants’ health care expectations were consistently low in both sites, and stories of better care elsewhere were touchstones for discussing local care experiences (Baker and Beagan Forthcoming).

Results

Neutrality, Assumption, and Acknowledgment of Difference

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, nurse participant, Halifax)

Don’t assume anything. Ask questions. (Ivy, participant, Vancouver)
For a number of patients and providers in our study, assumptions were understood as a form of bias and were often avoided as a way to remain non-judgmental (Harbin et al. 2012). Many HCPs and patients preferred that clinical encounters be devoid of expressions and perceptions of judgment, for judgments were seen as negative and as possibly leading to assumptions of heterosexuality. Richard, a Halifax physician, noted that with LGBTQ patients, “It’s about judgment … the trick is to be nonjudgmental.” This was echoed by many participants, including Camille (Halifax), who noted: “It’s important for me to know that my doctor really doesn’t care, has no judgment.”

These concerns appear to rest on the discomfort that can arise from making incorrect assumptions. For instance, Rachel, a Halifax participant who practices polyamoury, recounts a clinical encounter where her frequent STI testing led her HCP to believe she was a sex worker:

I’ve had multiple care providers assume that I’m a sex worker because I get tested regularly and that is for me really frustrating just ’cause I think it says a lot around … our perceptions around sexual activity and women. … The one that sticks out most is someone just like being really sort of obvious about it and being like “Ah, you know you can get tested through other services that support the work that you do.” And I’m like “What do you mean? I’m a researcher and a student.” … Then it kind of settled in for me that’s what the person was saying and I was like “O.k. … I’m not a sex worker, yeah,” and she’s like, “Oh sorry,” and there was like this really awkward moment.

Fear of making incorrect assumptions, or assumptions-as-judgments, however, also limits the kinds of questions physicians 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.

Fears of discrimination led many physicians to avoid acknowledging difference altogether. 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.” Nancy (Vancouver physician) said, “I understand it’s important to that patient. But to me, I guess it doesn’t impact the way I practice, because I wouldn’t do anything different. I’d feel that I would be treating everybody equally.” In their attempts to not discriminate, these physicians avoided making any generalizations based on a patient’s social, cultural, or racial differences, and attempted to ignore these differences altogether.

Some physicians in our study opted to avoid assumptions and suspend judgment by avoiding labeling LGBTQ 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.”

Participants’ experiences revealed, however, that this attempted neutrality and avoidance of labels or identities worked to reinforce the heterosexual assumption inherently embedded
within health care settings. Despite physicians’ best efforts at maintaining a neutral and non-judgmental stance, health care settings were experienced as heterosexual spaces. 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 that prior to any interaction, the automatic assumption is that the patient is heterosexual, an assumption embedded in systems and procedures. Kim (Halifax) remembered a particular instance of heteronormativity 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. The inappropriate attention drawn to her also rendered her problematically visible or out-of-place in what would be, for a heterosexual parent, a routine procedure.

The heightened visibility can be very subtle and hard to identify. Marilyn in Vancouver describes an incident in which she felt she and her partner were treated by HCPs as exotic:

I was really ill last year and they thought I probably had that flu that killed people off. I went to the hospital emergency department, with my partner. Told them she was my partner. And there was kind of busyness around the nursing station. Registration wasn’t an issue but there was a buzz around the nurses’ station. I was really, really sick. And one of the nurses came the curtained off area where my partner and I were waiting to see the doctor. And they wanted to know who she was. And I think they just were like “Well, is that her?” You know? At the time, I was just feeling dreadful. But I thought afterwards, there was like a gossipy thing going on. … Maybe I was paranoid, but why did they need to come and ask her who she was? And, you know?

Marilyn said she found it hard to even pinpoint how she knew something was happening that felt wrong, but she knew in her gut it was about being lesbian.

Dominant presumptions of heterosexuality and gender normativity, coupled with physicians’ attempts at maintaining neutrality, mean that LGBTQ 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. 2012:155–156).

As previously discussed, disclosure is important to achieving optimal LGBTQ patient health. For many participants in our study, disclosure was dependent on cues that their HCP was accepting of LGBTQ people. As Jacquie, a participant in Halifax, explains: “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.” 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” and increases the likelihood that she will disclose. Her description illustrates a kind of hyper-awareness during clinical encounters that we heard about from most of the women.

LGBTQ patients’ reliance on physicians’ cues contradicts physicians’ emphasis on remaining neutral and not making assumptions. Indeed, it is important to note that such cues can often operate in the form of particular kinds of assumptions. 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 acknowledgment—or cues—communicating that the doctor is aware of her lesbian self and is “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 (Halifax) pointed out that only by acknowledging LGBTQ or gender identity can particular aspects of health care 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, 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 non-heterosexuality or queerness.

When asked to recall a positive experience of health care, 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.”

Although she expected assumptions of heterosexuality, the attendants’ assumption that Bonita might not be heterosexual pleased her and made space for her to be out as a lesbian. The attendants had acknowledged the possibility of a lesbian relationship. Similarly, Marilyn (Vancouver) recalled an instance where a physician’s assumptions about her preferences as a
lesbian helped her 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 acknowledgment of it. Such gestures can ease the burden often placed on LGBTQ patients to both disclose their sexuality and determine their own health care needs.

**Expertise versus Authenticity**

To avoid making assumptions and appearing judgmental, many HCPs draw on notions of neutrality and professionalism (McNair and Hegarty 2010). This was the case for Richard, a Halifax physician, who noted: “You’re taught to be very formal and distant.” Many physicians feel that expectations of professionalism require them to appear as “experts” and prevent them from disclosing uncertainty (Haas and Shaffir 1991; Harbin et al. 2012).

The women, however, simply didn’t expect their HCPs to know much about LGBTQ 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 health care system, they tended to evaluate their physicians less on medical expertise and more on perceived authenticity and open-mindedness as a person. As Ursula, a Halifax participant, 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 (Vancouver) similarly noted: “We need to feel safe. … When we seek health care 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 health care knowledge or expertise than to the overall experience of the physician as a person, who may or may not be trustworthy.

For many LGBTQ participants, a sense of trust need not involve the HCP’s being an expert in LGBTQ 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.

Some women in our study, particularly transgender participants, actually cited worse experiences with experts in LGBTQ health than with HCPs who have no claims to LGBTQ-specific health knowledge. 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 concern.

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 health care needs. The image or “cloak” of certainty most health professionals are encouraged to don is not particularly valued by these patients. Rather, they value the opposite: honesty, genuineness, and a willingness to openly seek out information when faced with uncertainty. This was recognized by only a handful of physicians in our study. For instance, Helen, a Halifax physician, 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.

Mary, a physician in Vancouver, described a productive tension between being an expert on medical issues, and being open to learning about individual and sociocultural 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.

As Mary also emphasized, 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.”

The importance of this two-way learning was strongly supported by the participants, who emphasized the value of listening. For instance, Rhonda (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 health care needs. Rather than deferring to medical expertise, she suggests that lesbian patients need to ensure they are listened to and that their knowledge of their own bodies is taken seriously.

Discussion: Making Assumptions/Making Space: Acknowledging the LGBTQ Patient

Framing Expectations

In the context of routine heteronormativity and gender normativity, it is not surprising that on entering health care contexts, the expectations of LGBTQ patients may be decidedly low (Polonijo and 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 et al. 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 LGBTQ women patients of HCPs’ knowledge about their health care needs.

Cultural Competency and the Acknowledgment of Difference

Despite the critical attention paid to cultural competency techniques, little remains known about “the range of ways in which concepts like ‘cultural competence’ and ‘cultural sensitivity’ are translated into real-life” (Willen and Carpenter-Song 2013:242). For Llerena-Quinn (2013:341), “the message remains that ‘culture’ is still something ‘others’ have, ‘cultural knowledge’ is not essential to clinical excellence.” Our data suggest that culturally competent health care remains
understood by many HCPs 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. To avoid making assumptions and appearing judgmental, many HCPs attempt to retreat into professional neutrality (Beagan and Kumas-Tan 2009; McNair and Hegarty 2010). For the medical community, neutrality is seen as both valuable and achievable. 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; Harbin et al. 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 and Kumas-Tan 2009; Goldberg et al. 2011; Harbin et al. 2012). 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 and Kumas-Tan 2009; McNair and Hegarty 2010).

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 LGBTQ identities and instead focusing on individual behaviors. This attempted neutrality can unfortunately “contribute further to homophobia” (Goldberg 2011:174), and/or heterosexism, as it not only veils the heteronormativity and gender normativity embedded within the health care system in general and clinical environment in particular, but also obscures the presence of LGBTQ patients as well as any unique health care needs (McNair and Hegarty 2010). Indeed, if we understand North American society in general, and the health care system in particular, as built on 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.

While notions of cultural competency are typically interpreted as a requirement to remain neutral and not make any assumptions or judgments about patients, our findings suggest that for some LGBTQ women, assumptions can serve as acknowledgments, whereby their sexual/gender identities and relationships are both made visible and validated. 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 LGBTQ women and their health care needs.

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—in other words, not being neutral—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).
Indeed, for Kirmayer, successful clinical engagement across difference “hinges on both the person of the clinician and the clinician-patient relationship” (2012:4, cited in Willen and Carpenter-Song 2013:248).

Such 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. Although a number of women in our study thought doctors could avoid making assumptions by asking questions, interviews with HCPs revealed that fear of making assumptions limits the kinds of questions they may feel comfortable asking. 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.

Both patients and physicians believed that making assumptions meant bias and (negative) judgment, and thus something to be avoided, but patients’ reflections indicated that assumptions can sometimes operate as cues that may lead to acknowledgment and visibility. Because the norm in the health care system and elsewhere is heterosexuality and gender normativity, and because LGBTQ 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.

The extent to which LGBTQ participants held low expectations of HCPs and were willing to accept lack of LGBTQ-specific health care knowledge is 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 (2009:355) 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.

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 LGBTQ patients, about whose health care needs physicians possess either limited knowledge or an inflated sense of expertise. Indeed, 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. 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). Carpenter-Song’s 2011 chapter on positive patient/clinician relationships points to mutual engagement, continuity, flexibility, and availability of HCPs as being key characteristics that are “integral to positive clinical relationships” (p. 175).

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 health care
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 through rudimentary health care forms and practices. Culturally competent health care for LGBTQ patients must be geared not toward developing a LGBTQ-focused expertise and bounded set of knowledge, but toward making space for LGBTQ identities and experiences to be acknowledged and reflected in all levels of the health care system.

Although 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 LGBTQ 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,” 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 sociocultural group membership influences health and health care and acknowledgment that each individual’s experiences of that sociocultural group, (and of health and health care) will be unique. This may work well for LGBTQ patients, whose health care is often compromised by misguided notions and false stereotypes of gay, lesbian, bisexual, transgender, or queer lives.

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 and Murray-Garcia 1998). 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 one’s 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.
References Cited

American Psychological Association, Task Force on Gender Identity and Gender Variance

Bauer, G. R., R. Hammond, R. Travers, M. Kaay, K. M. Hohenadel, and M. Boyce
2009 “I Don’t Think This Is Theoretical; This Is Our Lives”: How Erasure Impacts Health Care for Transgender People. Journal of the Association of Nurses in AIDS Care 20:348–361.

Baker, K., and B. L. Beagan
Forthcoming “Unlike Vancouver … Here There’s Nothing”: Imagined Geographies of Idealized Health care for Queer Women. Gender, Place & Culture.

Beagan, B. L., E. Fredericks, and L. Goldberg
2012 Nurses’ Work with LGBTQ Patients: “They’re Just Like Everybody Else, So What’s The Difference?” Canadian Journal of Nursing Research 44:44–63.

Beagan, B. L., and Z. Kumas-Tan

Benner, P.

Bockting, W. O., B. E. Robinson, J. Forberg, and K. E. Scheltema

Bradford, J., S. L. Reisner, J. A. Honnold, and J. Xavier

Carpenter-Song, E. A., M. Nordquest Schwallie, and J. Longhofer

Clements-Nolle, K., R. Marx, R. Guzman, and M. Katz

Coe, S.

Corliss, H. L., M. D. Shankle, and M. B. Moyer

Daley, A.

Dewey, J. M.

Dysart-Gale, D.

Fredriksson-Goldsen, K. I., H.-J. Kim, S. E. Barkan, A. Muraco, and C. P. Hoy-Ellis

Goldberg, L., A. Harbin, and S. Campbell

Gregg, J., and S. Saha

Haas, J., and W. Shaffir

Harbin, A., B. L. Beagan, and L. Goldberg

Hellquist, G.

Kapadia, F.

Kenagy, G. P.

Kirmayer, L. J.

Kitts, R. L.

Kleinman, A., and P. Benson

Kumas-Tan, Z. O., B. Beagan, C. Loppie, A. MacLeod, and B. Frank
Llerena-Quinn, R.
Mathieson, C. M., N. Bailey, and M. Gurevich
McNair, R., and K. Hegarty
Melendez, R. M., and R. Pinto
Morrow, M., O. Hankivisky, and C. Varcoe
2008 Women’s Health in Canada: Critical Perspectives on Theory and Policy. Toronto: University of Toronto Press.
N.S. Department of Health
Polonijo, A. N., and B. A. Hollister
Rotondi, N. K., G. R. Bauer, K. Scanlon, M. Kaay, R. Travers, and A. Travers
Ruzek, S. B., V. L. Olesen, and A. E. Clarke
1997 Women’s Health: Complexities and Differences.Columbus: Ohio State University Press.
Sanchez, N. F., J. Rabatin, J. P. Sanchez, S. Hubbard, and A. Kalet
Schilder, A. J, C. Kennedy, I. L. Goldstone, R. D. Ogden, R. S. Hogg, and M. V. O’Shaughnessy
Sinding, C., L. Barnoff, and P. Grassau
2004 Homophobia and Heterosexism in Cancer Care: The Experiences of Lesbians. Canadian Journal of Nursing Research 36:170–188.
Statistics Canada

Steele, L. S., J. M. Tinmouth, and A. Lu

Tervalon, M., and J. Murray-Garcia

Turner, L.

Wilkerson, J. M., S. Rybicki, C. A. Barber, and D. J. Smolenski

Willen, S. S., and E. Carpenter-Song