

Homophobia and heterosexism: implications for nursing and nursing practice

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ABSTRACT

Discrimination against lesbian, gay, bisexual and transgender people (LGBT) continues to exist in contemporary society and in institutions such as health care systems despite increasing social tolerance over the past three decades. This article explores the existence of discrimination against LGBT people among nurses and the implications this has for nursing and the quality of care delivered. The evidence suggests that LGBT patients and clients experience discrimination because of the homophobic and heterosexist attitudes of some nurses and other health professionals. Furthermore, some gay and lesbian health care workers also experience prejudice, discrimination and rejection from their colleagues. These experiences have detrimental effects for LGBT patients and staff. Strategies that may enhance the wellbeing of LGBT patients and staff are suggested.

INTRODUCTION

Societal attitudes to lesbian, gay, bisexual and transgender (LGBT) people have changed significantly over the last three decades. The catalyst for these changes includes the gay and lesbian rights movement in the 1970s, and a change in attitude toward homosexuality by elements of society and the medical profession. In 1973 the American Psychiatric Society removed homosexuality from the list of disorders in the Diagnostic and Statistical Manual of Mental Disorders (AMA 2002; Rose 1994), and in 1975 the American Psychological Association followed suit (Tate and Longo 2004 p.28). Homosexuality changed from being viewed as a mental illness, or psychiatric disorder, to a form of sexual orientation or expression. The events of the 1970s and subsequent legislative changes have resulted in LGBT people becoming more visible and demanding more equal rights. However despite this increasing acceptance of sexual diversity, discrimination against lesbian, gay, bisexual and transgender people continues to persist in contemporary societies.

This article explores the existence of homophobia and heterosexism among nurses and examines its potential impact on nursing practice. In addition to considering the impact of nurses' homophobia and heterosexism on patients and clients, the article considers the potential impact on LGBT colleagues. Since it may be expected that nurses' attitudes to homosexuality will mirror those of society at large, some attention is given to the prevailing societal views.

Although the term LGBT is used through out this article it is important to note that this group, like other groups of people, is diverse. Like heterosexual people, LGBT people are present in every facet of society. They vary in socio-economic status; age; type of employment; place of residence; culture and ethnic identity, and other social differences. However, despite these differences they do share similar experiences in relation to stigma, discrimination and rejection and on occasion violence (Meyer 2001).

Homophobia and heterosexism defined

Homophobia and heterosexism can be viewed as different aspects of the same phenomena: discrimination against lesbian, gay, bisexual and transgender people. Homophobia has been variously described as 'fear and hatred of gay and lesbian people and of their sexual desires and practices' (Leonard 2002 p.9) or as an irrational fear and dislike of lesbian, gay, bisexual and transgender people which may lead to hatred and result in physical or verbal abuse (Douglas Scott et al 2004 p.31).

Heterosexism refers to the belief that everyone is, or should be, heterosexual and that alternative sexualities are unhealthy, unnatural and are a threat to society (Leonard 2002 p.9). It may involve a conscious or unconscious exclusion of the acknowledgement of LGBT people by individuals, institutions or communities through prejudice, discrimination and harassment (Blanch Consulting 2003 p.6). The outcome of such structural heterosexism is that everyone is simply presumed to be heterosexual. This presumption, or expectation, has implications for LGBT people in many settings. For example, there are legal restrictions on recognition of their relationships; in the workplace there is denial of the work-related entitlements heterosexuals enjoy, and in health care settings, partners can be excluded from important decision making and denied access by hospitals with narrowly defined next-of-kin visiting rights (Dodds et al 2005 p.2).

In Australia, attitudinal change has led to a number of legislative changes that partially protect the rights of people with different sexual orientation and other minorities. For example, anti-discrimination laws and anti-vilification laws provide limited protection against discrimination. Homosexuality has been decriminalised in all Australian states and occupational health and safety, sexual discrimination, and equal opportunity legislation obliges employers to provide safe workplace environments in relation to harassment and victimisation for all employees.

Nonetheless, despite these positive changes the Australian Human Rights and Equal Opportunity Commission notes that gay, lesbian and transgender

people face widespread discrimination because of their sexual orientation. Forms of discrimination include: lack of recognition of same-sex relationships; inconsistent laws regarding the age of consent; and refusal of health care (HREOC 2006). Furthermore, despite the fact that workplace discrimination on the basis of gender or sexuality is illegal, a recent survey found that 10.3 per cent of respondents reported being refused employment or promotion because of their sexuality (Pitts et al 2006 p.50). The recent national inquiry into discrimination against people in same-sex relationships in relation to financial and work-related entitlements and benefits, provides further evidence of the degree of discrimination lesbian and gay people experience in Australia (HREOC 2006). Such discrimination means LGBT people are denied access to the same range of entitlements and opportunities available to heterosexual people and this contributes to their sense of social exclusion and 'invisibility'.

Some governments in Australia have acknowledged the health inequalities and special needs of LGBT people. The Victorian Government for example, established Australia's first Ministerial Advisory Committee on Gay and Lesbian Health (MACGLH) in 2000 (McNair et al 2001). In late 2003 it established Gay and Lesbian Health Victoria (GLHV) to, among other things, train health care providers about lesbian, gay, bisexual, transgender and intersex (LGBTI) health and service needs; act as a research and information clearinghouse; and advise government on the development of LGBTI programs (GLHV 2006). In Tasmania the Department of Health and Human Services commissioned a health and wellbeing needs assessment project to determine the health and wellbeing needs of gay, lesbian, bisexual and transgender people, and their experiences interacting with the health and welfare service system (Blanch Consulting 2003).

The special needs of LGBT people have also been acknowledged by a number of health professional associations at an international and domestic level. In 2002 the Australian Medical Association (AMA) released a position statement titled: *Sexual Diversity*

and Gender Identity (AMA 2002). It recognises homophobia as a health issue and rejects the view that homosexuality itself poses some biological or genetic hazard for poorer health. Rather, it supports the argument that it is the discrimination that these groups experience that leads to poorer general health, reduced utilisation of health care services and decreased quality of health care services (Diamont et al 2000; Harrison 1998).

The responsibilities nurses have in ensuring the LGBT people and other minorities do not experience discrimination and prejudice is outlined in the Australian Code of Ethics for Nurses, and Code of Professional Conduct for Nurses (ANMC 2002, 2003). According to the Code of Ethics, 'nursing care for any individual or group should not be compromised because of ethnicity, culture, aboriginality, gender, spiritual values, sexuality, disability, age, economic, social or health status, or any other ground' (ANMC 2002 p.3). The Code of Professional Conduct for Nurses in Australia, a breach of which may constitute professional misconduct or unprofessional conduct, also draws attention to the need for nurses to promote and protect the interests of individuals irrespective of their 'gender, age, race, sexuality, lifestyle, or religious or cultural beliefs' (ANMC 2003 p.3). In addition, both Codes refer to the responsibilities nurses have in facilitating the participation of significant others in the care of a patient or client if that is their wish. It is instructive to note that the Code interprets significant other persons as 'persons of whatever relationship to the person receiving nursing care, who play an important role in the life of that individual' (ANMC 2003 p.1-2).

Although there is evidence to suggest that tolerance toward LGBT people has improved over the past three decades, discrimination against LGBT people continues to exist in contemporary society and institutions such as the health care system because of homophobia and heterosexism.

The effects of homophobia and heterosexism on patients and staff

Homophobia and heterosexism need not be conscious or intentional. They may affect policies

and attitudes indirectly and unintentionally by, for example, defining LGBT health issues as marginal, or less important, because they affect only a small majority of the population and are therefore, marginal to the concerns of the broader population. The influence of heterosexism in the structuring of health care delivery is evident in the images and messages that LGBT people experience when they engage with the health care system. For example, admission forms that require patients to identify themselves as married, divorced, widowed, in a de facto relationship, or single assume heterosexuality and may make lesbian and gay men feel invisible or unwelcome (Bowers et al 2006; Hitchcock and Wilson 1992). Forms that assume next of kin is either a spouse or a member of the patient or client's biological family are particularly worrying for LGBT people because this type of information determines who may be granted visiting rights; given access to important information about the health status of the patient; and be involved in the decision-making processes.

In the case of LGBT people, many are estranged from their biological families so families of their choice become very important to their wellbeing. The difficulties people of same-sex relationships face in having their relationships recognised and acknowledged is demonstrated by the need many feel to give power of attorney to their partners to ensure they are not excluded from participating in important decision making about the care of their partner.

In addition to these structural, or macro level, conditions, the individual's interactions with homophobic health care providers can reinforce their sense of isolation and alienation. Several studies have highlighted the existence of homophobia and heterosexism among health care professionals and the impact they have on the health of LGBT people, the ability of LGBT people to access health care, and the quality of care they receive.

International surveys of gay, lesbian and bisexual health consumers have reported between 31 per cent and 89 per cent of respondents experienced

negative attitudes from health professionals because of their sexuality (Harrison 1998). Byron-Smith (1993) reported that 57 per cent of their sample of psychiatric nurses exhibited moderate homophobia and 20 per cent severe homophobic attitudes. A 1994 survey of American gay, lesbian and bisexual physicians reported 52 per cent of respondents had observed colleagues providing reduced care or denying care to patients because of sexual orientation and 88 per cent reported colleagues making disparaging remarks about LGB patients (Schatz and O'Hanlan 1994). Rose (1994) has also commented on the negative attitudes of members of the medical profession toward homosexuality.

In Australia, a 2000 study by the Victorian Gay and Lesbian Rights Lobby (VGLRL) reported that at least 23 per cent of GLBT people in Victoria have experienced discrimination when seeking health care (VGLRL 2000), and it appears that some GLBT people avoid disclosing their sexuality to health care providers for fear of discrimination or negative responses (McNair and Medland 2002; Pitts et al 2006).

The participants in the recent study by Bowers et al (2006) of health service delivery in a New South Wales metropolitan area health service also reported the negative impact of nursing and medical staff making derogatory comments about LGBT patients. In addition, this research reported instances of same-sex partners of patients or clients being ignored by staff, not being kept informed of their partner's condition and progress, and being excluded from participating in decision making about their partner's care.

These types of negative experiences may explain research that shows LGBT people under-utilise health services compared to the general population. Research has shown that LGBT people avoid the health care system because of past discriminatory experiences or expectations they will experience prejudice, or indifference, when they access mainstream health services (Simkin 1998; McNair and Medland 2002). Under-utilisation of health services has an obvious negative impact on the

health care needs of GLBT people and their access to preventative measures such as screening programs for a number of health conditions.

Of equal concern is the impact of homophobia and heterosexism on lesbian and gay health care workers. In environments that assume everyone is heterosexual, or should be, lesbian and gay staff and their relationships are unlikely to be given positive acknowledgement. They must contend with lack of recognition of their relationships and living arrangements and the threat and fear of discrimination, abuse and ridicule from their colleagues. Some health care workers have chosen not to disclose their sexuality for fear of discrimination, harassment and rejection from fellow workers (Bowers et al 2006). Some have believed declaring their sexuality may impact negatively on their career and job prospects (Rose 1994; Bowers et al 2006). Others have reported instances of verbal harassment and insults from colleagues (Burke and White 2001; Bowers et al 2006), and negative and derogatory remarks being made by nursing and medical colleagues in the presence of lesbian, gay and bisexual staff (Bowers et al 2006). It does not take much imagination to understand the negative effects of such comments and behaviour from colleagues. The negative effects of such comments and behaviour from colleagues include feeling unsafe and undervalued in the workplace.

Intervening in homophobia and heterosexism in health care delivery is a complex process. Indeed, the assumption of heterosexuality by nurses and other health care workers is frequently left uncorrected or unchallenged by homosexual staff and patients for fear of discrimination, rejection and ridicule (Bowers et al 2006). Staff often do not feel safe enough to advocate for the rights of LGBT patients, or openly confront prejudice, for fear of their behaviour being discredited by colleagues, being seen as simply 'stirring up trouble', or being interpreted as evidence of themselves being gay (Bowers et al 2006). The study by Bowers et al (2006) found discrimination in the form of homophobia largely goes unchallenged, while other forms based on racism or sexism are

dealt with more seriously by managers in the health care system.

All members of staff, including LGBT staff, have a right to be protected in the workplace from harassment, victimisation and bullying. Under occupational health and safety, sexual discrimination and equal opportunity legislation employers are obliged to have written policies and protocols that reflect the requirements of legislation in relation to these matters and processes to manage such behaviours (ANF 2004). Nonetheless, although anti-discrimination legislation and policies on bullying may temper overt discrimination and bullying there remains a challenge for health services to address institutionalised homophobia and heterosexism and understand its responsibility to respect the rights of all its clients, patients and employees.

Suggestions for enhancing the wellbeing of LGBT clients and staff

Legislative frameworks and professional codes of practice require that nurses and other health care workers consider their professional obligations to minority groups such as LGBT people. To be effective they need to be sensitive to cultural differences, embrace diversity, and provide an environment that is open and respectful of the needs of minority groups such as LGBT people. From the patients' or clients' perspective the strategies that may increase their comfort with health care professionals include: ensuring confidentiality of information provided; structuring questions and comments that do not assume heterosexuality; and with the agreement of the patient or client, allowing partners to be present during consultations and allowing them to participate in decision making (Bowers et al 2006; Simkin 1998). It is important that nurses and others use inclusive language on forms and when talking to patients to ensure they do not unintentionally present same-sex relationships as less significant than heterosexual ones.

A number of commentators have pointed to the need to educate nurses and other health care professionals about sexual orientation and homophobia (Bowers et al 2006; Douglas Scott et al 2004; Tate and

Longo 2004; Burke and White 2001; Rose 1994). This includes ongoing education through workshops and in-service seminars as a routine aspect of staff training. It is equally important that students receive education related to understanding and working with LGBT people. The challenge for educators is to recognise and acknowledge their own prejudices and biases as these can be communicated directly and indirectly to students. Nurse education programs need to promote autonomous and critical thinking, encourage students to challenge prejudice and intolerance, and to question conformity and similarity in thinking (Irwin 1992). Unquestioning acceptance of heterosexism as the norm is a significant barrier to equal access and quality of access to health care.

Bowers et al (2006) found that some staff believed that the attitudes and behaviours of more 'junior' staff are influenced by that of more 'senior' members of staff such as senior clinicians and managers. In their view it is most important that senior staff set the limits or tone of what behaviour is acceptable. However, it is not always an easy task for individuals to challenge prejudice and discriminatory behaviour in the workplace. As pointed out above, advocacy for LGBT patients may be discredited by colleagues, interpreted as 'trouble making,' or a sign that the advocate is also gay or lesbian (Bowers et al 2006). Health care institutions however, have a responsibility to ensure a safe environment for staff, patients and clients. Training and policies within health care services need to counter the culture of institutionalised homophobia that makes services inaccessible and inappropriate for LGBT people and workplaces unsafe for staff. Health care workers who tease, intimidate or threaten their homosexual or bisexual colleagues need to receive firm messages that such behaviour will not be tolerated. All staff need to understand that harassing a LGBT patient or client, or colleague, is a form of abuse.

CONCLUSION

It would appear from the evidence available that LGBT people have justified concerns regarding the quality and appropriateness of their care. This suggests

that nurses and other health professionals may be shrinking away from their responsibility to this group of people. The Code of Ethics and Professional Conduct for Nurses requires nurses to recognise and respect the uniqueness of each patient or client, and provide high standards of care. Unfortunately, the evidence suggests this is not always the reality for LGBT people. LGBT patients want and deserve the same courtesy and attention that is given to heterosexual patients. Furthermore, nurses and other health professionals, who are themselves homosexual, experience homophobia from both outside and within the professions. LGBT staff members also want and deserve a safe work environment. In other words, LGBT people do not want special rights: they want equal rights.

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