

Inhospitable Healthcare Spaces: Why Diversity Training on LGBTQIA Issues Is Not Enough

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Abstract In an effort to address healthcare disparities in lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations, many hospitals and clinics institute diversity training meant to increase providers' awareness of and sensitivity to this patient population. Despite these efforts, many healthcare spaces remain inhospitable to LGBTQ patients and their loved ones. Even in the absence of overt forms of discrimination, LGBTQ patients report feeling anxious, unwelcome, ashamed, and distrustful in healthcare encounters. We argue that these negative experiences are produced by a variety of subtle, ostensibly insignificant features of healthcare spaces and interpersonal interactions called microaggressions. Healthcare spaces and providers often convey *heteronormative* microaggressions, which communicate to LGBTQ—and, we suggest, intersex and asexual (IA)—people that their identities, experiences, and relationships are abnormal, pathological, unexpected, unwelcome, or shameful. We identify heteronormative microaggressions common to healthcare settings and

specify how they negatively impact LGBTQIA patients. We argue that standard diversity training cannot sufficiently address heteronormative microaggressions. Despite these challenges, healthcare institutions and providers must take responsibility for heteronormative microaggressions and take steps to reduce their frequency and mitigate their effects on LGBTQIA care. We conclude by offering strategies for problem-solving at the level of medical education, institutional culture and policy, and individual awareness.

Keywords Microaggressions · Heteronormativity · LGBTQIA health · Diversity training · Queer bioethics

It is becoming more common for hospitals and clinics to institute diversity training about lesbian, gay, bisexual, transgender, and queer (LGBTQ) patient experiences in an effort to address healthcare disparities in these populations. While such initiatives may reduce explicit forms of discrimination, many healthcare spaces remain inhospitable to LGBTQ patients and their loved ones. Even in the absence of overt forms of homophobia, transphobia, or discrimination, LGBTQ patients report feeling anxious, unwelcome, ashamed, and distrustful in healthcare encounters. In this paper, we argue that these negative experiences are produced by a variety of subtle, apparently insignificant features of healthcare spaces and interpersonal interactions called *microaggressions*—brief, nuanced, and often unintentional slights and offenses that underlie verbal and nonverbal communication (Sue 2010). We contend that healthcare spaces and providers often convey

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heteronormative microaggressions, which communicate to LGBTQ—and, we suggest, intersex and asexual (IA)—people that their identities, experiences, and relationships are abnormal, pathological, unexpected, unwelcome, or shameful. These negative messages undermine patient–provider trust and may lead LGBTQIA individuals to avoid care. There is evidence that diversity training does little to reduce the frequency with which providers communicate such messages (Boysen and Vogel 2008); something more must be done in order to improve the healthcare experiences of LGBTQIA people and the quality of care they receive.

Our aims in this paper are twofold. First, we identify heteronormative microaggressions common to healthcare settings and specify how they negatively impact LGBTQIA patients. We begin by explaining what microaggressions are and revealing how they operate within broader patterns of social meaning called *schemas*. We draw from Kevin L. Nadal's 2013 taxonomy of microaggressions against LGBT people and bioethics literature on LGBTQ healthcare experiences to identify common heteronormative microaggressions within healthcare settings. While the experiences of intersex and asexual patients are often excluded or overlooked in the queer bioethics literature, we suspect that these individuals are also negatively affected by heteronormative microaggressions in healthcare. We therefore incorporate available data about IA patient experiences as examples of how heteronormative microaggressions marginalize LGBTQIA persons. In the next section, we argue that heteronormative microaggressions contribute to barriers to patient–provider communication and trust. When trust is undermined, LGBTQIA patients may not share relevant information about sexual or gender identity or background information, which can hinder the ability of the healthcare provider to offer the best possible care and be deleterious to the patient's mental and physical health as well as their well-being more generally. Distrust may also lead to healthcare avoidance.

Our second aim is to establish healthcare providers' responsibility to address heteronormative microaggressions and to offer practical recommendations toward this end. We argue that standard diversity training is unable to adequately address heteronormative microaggressions due to the habitual, unintentional, and often invisible nature of microaggressions and the institutional embeddedness of heteronormative messages. Despite these challenges, healthcare institutions and

providers must take responsibility for heteronormative microaggressions and take steps to reduce their frequency and mitigate their effects on LGBTQIA care. We conclude by offering strategies for problem-solving at the level of medical education, institutional culture and policy, and individual awareness.

Microaggressions

Microaggressions are “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual-orientation, and religious slights and insults to the target person or group” (Sue 2010, 5). When microaggressions operate within interpersonal communication, they are conveyed in tone of voice, body language, word choice, eye-contact patterns, and focus. They can also be conveyed environmentally, through the organization of space, display of images, and media representations. Institutionally, microaggressions can be expressed through curriculum choices, policies, and regulations. Microaggressions are often communicated unconsciously and unintentionally and may be invisible to those who communicate them (Sue 2010, 5). Nonetheless, there is a growing body of literature suggesting that microaggressions cause psychological and emotional harm to their recipients (Wong et al. 2013; Nadal 2013; Nadal et al. 2014).

Microaggressions can convey a range of negative meanings. Drawing from the work of Sally Haslanger, we contend that these meanings operate within *schemas*, which are “intersubjective patterns of perception, thought, and behavior” (Haslanger 2012, 415). Schemas can be understood as cognitive mechanisms of association that “consist in clusters of culturally shared concepts, beliefs, and other attitudes that enable us to interpret and organize information and coordinate action, thought, and affect” (Haslanger 2015, 4). Schemas are intersubjective and culturally shared because the patterns or associations that make up a schema derive from social contexts. The association between women and nurturing, for instance, is formed by media representations, art, scientific accounts, and narratives within a culture where women provide the majority of caring labour. Individuals who grow up in such a culture are likely to share this “woman-nurturing” schema.

Schemas guide perception, interpretation, emotional dispositions, and decision-making; what shows up as relevant or irrelevant, troubling or permissible, and derogatory or objectively factual will be a function of the dominant schemas in a given context. These perceptions, interpretations, and dispositions guide behaviour and provide a shared basis for successful communication (Haslanger 2012, 463). For example, Ann’s surprise at a woman’s decision not to have children is intelligible against the expectation that it is natural, normal, and usual for women to want children and unnatural and suspicious for women to choose otherwise. If you notice Ann’s surprise and understand it, you likely share this schema. Someone who grew up in a radically different context might be confused by her surprise or may not even notice it. That said, schemas often function at a non-conscious level (Haslanger 2012, 415). Ann may not be aware that she has this expectation about women and parenthood. She may even fervently believe that such an expectation is sexist and unfair. Schemas are “entrenched dispositions” (Haslanger 2012, 474), and, like habits, they do not easily respond to conscious efforts to change, so they can continue to influence perceptions and behaviours despite conscious beliefs to the contrary (Haslanger 2008, 213).

We contend that common microaggressions toward members of LGBTQIA populations express a *heteronormative* schema. This schema is constituted of a cluster of beliefs and attitudes which presuppose that human beings come in two complementary genders (man and woman), which are premised on two biological sexes (male and female). Individuals are understood to be either heterosexual or homosexual, and heterosexual love and romantic relationships are cast as the most normal, natural, or privileged sort of relationships to have (Barker 2014). Darrell’s look of disgust at two men holding hands is intelligible against the assumption that gay relationships are abnormal and wrong; Becca’s stares at a transgender woman’s face are intelligible given the belief that those whose gender does not match up with their birth sex are bizarre. Jessie asks her co-worker if he’ll be bringing a girlfriend to the work party, implying that heterosexuality is the normal orientation; Monique’s parents are relieved when she introduces them to her new boyfriend, believing that this means she is done “experimenting” with dating women—implying the expectation that bisexuality or homosexuality is just a “phase” and not a legitimate orientation. These are all ways in which a heteronormative schema informs perception, affect, and behaviour.

The influence of schemas on thought and behaviour is both pervasive and inevitable (Valian 1999, 1044). The worry, then, is not that people have internalized schemas but that they may have internalized schemas which produce false and harmful perceptions and behaviours. We argue that this is the case with heteronormative schemas in healthcare settings. Not only do such schemas involve false associations, such as the view that heterosexuality is the only natural or normal sexuality, but they produce harmful behaviours, including heteronormative microaggressions. The next two sections are dedicated to identifying examples of these microaggressions in healthcare contexts and some of their harmful effects.

Heteronormative Microaggressions in Healthcare

In *That’s So Gay: Microaggressions and the Lesbian, Gay, Bisexual and Transgender Community* (2013), Kevin L. Nadal offers a thorough taxonomy of common microaggressions directed toward lesbian, gay, bisexual, and transgender individuals. In this section, we draw from this taxonomy and from bioethics literature to identify common microaggressions against LGBTQ individuals within healthcare settings. While much of the research on differential treatment and health disparities for LGBTQ populations does not address microaggressions as such (see Eliason and Dibble 2015 for one recent exception), examples of heteronormative microaggressions are well-documented anecdotally and in accumulated research. Unfortunately, there is a lacuna in the literature pertaining to intersex and asexual (IA) patient experiences and disparate treatment (MacInnis and Hodson 2012; Ben-Asher 2006). We suspect that the effects of heteronormative microaggressions aimed at the IA populations will be similar in kind to those of LGBTQ populations, though they may be different in tone. We have divided the following discussion of microaggressions into two groups (LGBTQ and IA) to reflect this difference. Before we move on, it should be noted that heteronormative microaggressions may be enacted by people who identify as LGBTQIA themselves, not only by heterosexual cisgender individuals. Shared schemas affect everyone, and LGBTQIA individuals are not thereby immune on account of their gender or sexual identity. Thus the analysis and the recommendations that follow will be relevant for all healthcare providers regardless of their own identity.

Microaggressions Toward LGBTQ Patients

Nadal identifies nine categories of microaggressions directed at lesbian, gay, and bisexual (LGB) people and ten categories for transgender people. These microaggressions occur in a variety of contexts, including the workplace, schools, religious institutions, governmental institutions, healthcare, social settings, and the media. Common microaggressions toward LGB individuals include (1) use of heterosexist terminology, (2) endorsement of heteronormative or gender normative culture and behaviours, (3) assumption of universal LGB experience, (4) exoticization, (5) discomfort with or disapproval of LGB experience, (6) assumption of sexual pathology, deviance, or abnormality, (7) denial of the reality of heterosexism, (8) physical threat or harassment, and (9) environmental microaggressions (Nadal 2013, 54–71). Categories one through eight also apply for transgender individuals, though the focus is on transphobic terminology and transgender experience. Nadal identifies two further categories for microaggressions toward transgender people: (9) denial of bodily privacy and (10) systemic microaggressions (Nadal 2013, 85–99).

Drawing from bioethics literature on healthcare experiences reported by LGBTQ patients, common microaggressions in clinical contexts include endorsement of heteronormative or gender normative culture and behaviours, discomfort with or disapproval of LGB or transgender experience, environmental microaggressions, and systemic microaggressions. Though Nadal associates environmental microaggressions with LGB experience and systemic microaggressions with transgender experience, we find examples from both categories directed at both LGB and transgender persons. We will now discuss each of these categories in more detail and provide representative examples for each. In doing so, we are building an argument that these seemingly small, punctuated experiences structure the clinical encounter to create an unwelcoming or hostile environment for LGBTQIA persons.

Endorsement of Heteronormative or Gender Normative Culture and Behaviours

This category encompasses microaggressions that communicate the “message that heterosexuality is normal while homosexuality or bisexuality is abnormal, wrong, or unnatural” (Nadal 2013, 57) and the expectation that transgender people should “subscribe to the gender

binary, by subscribing to a gender normative culture and participating in gender normative behaviors” (Nadal 2013, 87). Examples of verbal microaggressions common in healthcare that fit this category include the use of improperly gendered pronouns for transgender individuals, heteronormative words for partners (like husband and boyfriend when speaking to female patients only), and insistent questions about birth control to women who do not have sex with cisgender men (Röndahl et al. 2009; Barbara et al. 2001).¹ One trans participant in a study by JSI reported that a provider refused to refer to her with feminine pronouns, despite repeated requests to do so (JSI Research and Training Institute 2000, 13). Röndahl, Bruhner, and Lindhe report that a pregnant lesbian couple were given a tour of a delivery ward by a midwife who “emphasized the whole time that ‘here is where the father can go and get coffee’, and ‘the father can sit there’” (Röndahl et al. 2009, 2341). A participant in Barbara, Quandt, and Anderson’s study recounted the following encounter with a physician: “They said, ‘Do you think you could be pregnant?’ I said, ‘no.’ He said, ‘Are you sure?’ It got to the point where he was very annoying. I said, ‘I am a lesbian, ok.’ He turned around very upset and left the room. Then, another doctor came back and finished the exam” (Barbara et al. 2001, 52). These behaviours convey the assumption that patients are heterosexual and cisgender, with the implication that this is the usual and normal way of being. This assumption is a recurring theme in bisexual patient narratives as well. One patient reported, “I am a bisexual woman who has been in a long-term relationship with a man, and people tend to assume I’m heterosexual”; another patient, a bisexual man, stated, “they [healthcare providers] always assume you’re heterosexual” (Guasp and Taylor 2012b, 7).

Discomfort With or Disapproval of LGB or Transgender Experience

This category includes “instances in which a heterosexual person, whether aware or unaware, shows her or his displeasure of or apprehension toward nonheterosexual

¹ These examples might also fit into the category “use of heterosexist and transphobic terminology.” However, in *That’s So Gay*, Nadal reserves this category for slurs. In an earlier article (Nadal et al. 2010), the terminology category is broader and would include the above examples. In any case, it is clear that the use of these terms and phrases are microaggressions according to Nadal’s taxonomy.

[and transgender] people” (Nadal 2013, 63). Healthcare providers’ reactions to patients’ disclosure of LGBTQ status can include microaggressions of this sort. Patients report that providers respond with surprise, shock, apparent discomfort, awkwardness, doubtfulness, disengagement, and avoidance (Buchholz 2000; Goldberg et al. 2011; Røndahl 2009; Institute of Medicine 2011; JSI Research and Training Institute 2000), as well as more explicit bias in the form of rudeness, scoldings, and moral and religious admonishments (Røndahl 2009; Wilton and Kaufmann 2001). Sinding, Barnoff, and Grassau report that a lesbian patient noticed nursing staff “pulling faces” in response to her disclosure (Sinding et al. 2004, 177). Another lesbian patient describes a physician displaying physical avoidance: while performing a breast exam, the physician “stood about as far away as a person could—you know, like she was moving a computer mouse from across the room” (Sinding et al. 2004, 177). One trans man described healthcare staff “staring, laughing, and whispering” about his appearance (JSI Research and Training Institute 2000, 17). Another trans patient described walking into a doctor’s office to be greeted with a “glazed, blank look that goes ‘Oh yeah, I’ve never seen one of you before’” (Bauer et al. 2009, 353–354). Partners of lesbian patients reported being ignored by healthcare providers despite their presence throughout medical care, which they experienced as “non-acceptance as a ‘true’ relative, exclusion and neglect” (Røndahl et al. 2006, 379). These microaggressions communicate the view that LGBTQ people are unworthy of the same level of respect and acknowledgement as would be due to other patients.

Environmental Microaggressions

Examples of environmental microaggressions—slights, insults, and invalidations communicated through the organization of space, printed materials, art, and other media, for example—are common in the bioethics literature regarding both LGB and transgender groups. Printed materials, such as intake forms and assessments, often leave no space for queer relationships (Spinks et al. 2000) nor for indicating preferred or self-identified gender rather than birth sex (Bauer et al. 2009, 354). A trans participant in the JSI study stated simply: “There is no box for me” (JSI Research and Training Institute 2000, 21). Brochures, posters, advertisements, reading material, and pictures throughout the

healthcare space often reflect exclusively heterosexual relationships, interests, and concerns (Spinks et al. 2000; Røndahl et al. 2006). In a study of gay men’s experiences with general practitioners in the United Kingdom, Cant reports that many of the study participants took the lack of “gay-friendly signs” in their providers’ offices to indicate providers’ assumption that gay men did not live in the providers’ geographical region and would not be accessing services there (Cant 2002, 128). The ubiquity of gendered washrooms also fits within this category, as well as sex-segregated wards (Bauer et al. 2009, 355). These features communicate the assumption that most or all patients are heterosexual and cisgender and that LGB and transgender individuals are unexpected or unwelcome.

Systemic Microaggressions

Systemic microaggressions manifest in institutional organization and policy (both de jure and de facto), including educational programming and curricula. The bioethics literature offers examples of systemic microaggressions against both transgender and LGB individuals, specifically in the training and education of healthcare professionals. As reported by the Institute of Medicine, “few physicians are knowledgeable about or sensitive to LGBT health risks or health needs. Medical schools teach very little about sexuality in general and little or nothing about the unique aspects of lesbian, gay, and bisexual health, and it is rare for medical students to receive any training in transgender health” (Institute of Medicine 2011, 65). Bauer and colleagues note that few healthcare providers are knowledgeable about transgender health needs and experiences, in part due to a dearth of knowledge on the topic. But even when such knowledge is available, it is not widely distributed, and healthcare providers often assume that it does not exist (Bauer et al. 2009, 352). Furthermore, when transgender health is taught, it is sometimes subsumed under LGB health, obscuring highly significant differences (Bauer et al. 2009, 353). In a similar fashion, lesbian healthcare has been largely subsumed under women’s healthcare, which ignores important sociocultural factors that impact lesbians’ health differently than heterosexual women (Goldberg et al. 2009). Women’s healthcare is often grounded in assumptions that revolve around heterosexual reproduction (McDonald et al. 2003), and the administration of pap smears has been connected to prescriptions for birth control (Stevens

1995). In addition, many providers hold misconceptions about lesbian health needs, which may lead to improper care, such as failure to screen for STIs (Hutchinson et al. 2006). Tod Chambers notes that same-sex desires are virtually absent from bioethics courses and texts, and when they are discussed, they are almost exclusively focused on young, homosexual men and the threat of AIDS (Chambers 2006, 403). These features suggest that LGBT individuals are rare and that their health needs are unimportant.

Disparate Treatment of IA Patients and Potential Microaggressions

The limited research on healthcare experiences of intersex and asexual individuals suggest that they are commonly subject to explicit forms of discrimination, pathologization, and dismissal. In addition, we find examples from two categories of microaggressions: endorsement of heterosexual or gender normative culture and behaviour, in combination with assumptions of sexual pathology, deviance, or abnormality.

Intersex adults and parents of intersex children are still frequently pressured to “normalize” genitalia from medical professionals, which comes with assumptions, advice, and microaggressions that suggest they ought to “fix” a tragic mistake of nature and find a “true sex” (Ben-Asher 2006, 81).² Surgeons who specialize in “normalizing” genitalia for intersex patients make their recommendations and decisions within a heteronormative framework; for example, surgeons traditionally have expressed more hesitancy about attempting male assignment, since achieving “proper manhood” in the genitalia is considered to be especially difficult (Ben-Asher 2006, 83; Greenberg 2012, 859).³ Given this framework, it would be expected that patients and families experience microaggressions that suggest that being intersex is shocking or undesirable. The heteronormative schema presumes a strict sex–gender

binary, which privileges a narrow conception of what it means to present as a man or woman, male or female. As shown in the research, there are resulting pressures to conform to the commonly understood binary within the dominant schema. Moreover, this schema presumes that “solid” gender identity depends on a typical biological presentation of sex. Because of the limitations of the schema, anyone with atypical genitalia would seem to be stuck without an adequate or authentic gender identity. The implication is that a strong gender identity is viewed as out of reach or alienating for intersex persons, despite evidence that they can form a strong gender identity that may or may not conform to healthcare providers’ expectations (Jones 2009). Although there are gaps in the literature on the extent to which microaggressions are targeted (even unintentionally) at this population, we suspect that they probably experience subtle insults in verbal and nonverbal communication in healthcare settings—in addition to discrimination and insinuations that the intersex condition needs to be “fixed” for the sake of their gender identity and overall welfare.

Individuals who identify with asexuality regularly confront mistaken assumptions that they have a physical or psychological disorder, such as hypoactive sexual desire disorder (Bogaert 2006). They also frequently face overt challenges to the legitimacy of asexuality as an orientation; their lack of sexual activity is instead suggested to be due to not having met “the right one” yet (The Sex Information and Education Council of Canada 2012). Having their identity understood and respected as an orientation on the sexuality spectrum without having it pathologized explicitly or implicitly is a continual struggle for this population. A 2012 study found that asexual persons were commonly subjected to sexual minority prejudice, severe dehumanization, contact avoidance, and discrimination (MacInnis and Hodson 2012). Asexuality runs contrary to the prevailing heteronormative schema, since these individuals do not share the sexual orientation or proclivities that are deemed to be normal and healthy under this limited framework. As a result of not having sexual impulses that fit this schema, asexual persons encounter disbelief and doubt when it comes to the authenticity and value attached to their identity and preferences. There is evidence of microaggressions against this population in popular culture, where “mockery and humor are being used in ways that derogate asexual or those suspected of being asexual” (MacInnis and Hodson 2012, 726). Dismissive attitudes and constant suspicion of pathology

² This is despite prolonged activist efforts and work by the Hastings Center to argue that these “normalizing” surgeries should not be performed without the individual’s consent, unless there are other medically relevant considerations. Greenberg reports: “Most doctors, however, oppose a moratorium on infant genital cosmetic surgeries and believe that surgical alteration is in the best interests of a child born with an intersex condition ... According to one comprehensive study published in 2007, most parents still choose to consent to genitoplasty on behalf of their infants” (2012, 866).

³ This trend of “feminizing” intersex patients has been critiqued heavily, and these cases are not as common as they used to be (Greenberg 2012, 860).

will likely contribute to microaggressions in clinical contexts. Asexual patients may feel uncomfortable disclosing their orientation, since their asexuality may be misconstrued as a symptom or as a medical dysfunction.

More research is needed to investigate the microaggressions experienced by intersex and asexual people in healthcare settings and their impact on care. However, we can extrapolate from extant research to say that intersex and asexual people experience environmental and systemic microaggressions similar to LGBTQ populations. Intake forms without space for queer relationships or transgender status also preclude the indication of asexuality or intersex status. Furthermore, health education which barely addresses LGBT health likely includes little to nothing about these groups (Institute of Medicine 2011, 65). These features communicate to intersex and asexual people that they are unnatural and unexpected.

Consequences of Heteronormative Microaggressions

We have identified several categories of LGBTQIA microaggressions common to healthcare settings. While this discussion is not exhaustive, it is sufficient to establish that a variety of heteronormative microaggressions are common in healthcare spaces and in patient–provider interactions. In this section, we discuss the consequences of these microaggressions. We begin with a brief discussion of the psychological, emotional, and physical consequences of heteronormative microaggressions in general. We then argue that microaggressions in healthcare contexts constitute barriers to care by engendering distrust and avoidance of healthcare providers. For the reasons given above, we draw from literature pertaining to LGBTQ patients, but we believe that many of these consequences will be relevant for IA patients as well.

While any given instance of heteronormative microaggression may seem trivial, members of marginalized groups experience microaggressions on a regular basis and in a wide variety of contexts, in addition to explicit discrimination and bias (Sue 2010, 7). Discrimination and bias contribute to poor physical and mental health outcomes for the LGBTQ community. Stress from stigma and heterosexism may contribute to higher rates of substance abuse (Banks et al. 2003; Valanis et al. 2000), mental health issues (Beals and Peplau 2005; Valanis et al. 2000; Greenberg 2012), and on a more basic level, higher than normal levels of cortisol, leading

to both physical and mental consequences (Pettinato 2012). Christopher Banks argues that homophobia contributes to substandard healthcare for gays, lesbians, and bisexuals, contributing to a decreased life expectancy compared to the heterosexual population (Banks et al. 2003). The adverse effects on mental and physical health increase within the LGBTQ aging population and extend to assisted care facilities (Metlife Mature Market Institute and The Lesbian and Gay Aging Issues Network of the American Society on Aging 2010; Fredriksen-Goldsen et al. 2011).

While research isolating the consequences of microaggressions on LGBTQ health is scarce, several studies report that LGBT individuals who experience microaggressions experience a variety of negative emotions, including anger, distress, and hopelessness (Nadal et al. 2014). Microaggressions may negatively affect mental health and be linked with conditions such as depression (Nadal et al. 2011), especially amongst LGBT persons of colour (Balsam et al. 2011, 171). While more work needs to be done in this area, it is plausible that, like more explicit forms of discrimination, microaggressions contribute to “minority stress,” which may lead to higher levels of mental illness amongst minority populations than in non-minority populations (Meyer 2003).

Barriers to Care

Some LGBTQ patients pay close attention to the mannerisms and behaviours of their providers, looking for signs of possible discrimination or bias (Barbara et al. 2001; Stevens 1998). Microaggressions can intrude on the patient–provider relationship and breed feelings of hostility even when patients are not actively looking for evidence of bias. Meyer identifies the need for vigilance against bias as itself a source of minority stress, which can lead to poor mental health outcomes (Meyer 2003, 676). LGBTQ patients report a variety of negative emotional responses to such messages, including worry, upset, offence, embarrassment, vulnerability, humiliation, anxiety, emotional pain, fear, discomfort, and invisibility (Röndahl et al. 2009; Stevens 1995; Wilton and Kaufmann 2001; Bauer et al. 2009; Barbara et al. 2001; JSI Research and Training Institute 2000).

In this context, it is unsurprising that LGBTQ people report difficulty trusting healthcare providers (Barbara et al. 2001; Dysart-Gale 2010; Hutchinson et al. 2006; JSI Research and Training Institute 2000). This lack of

trust contributes to ambivalence about “coming out” to providers, which is a recurring theme in the LGBTQ bioethics literature. Many LGBTQ people are reluctant to disclose their LGBTQ status to providers (JSI Research and Training Institute 2000; McManus et al. 2006; Wilton and Kaufmann 2001; Guasp and Taylor 2012b). By challenging the assumption of heterosexuality or cisgender status by coming out to a provider, a patient risks homophobic and transphobic reactions, and it provokes worries that a biased provider would intentionally or even unintentionally compromise care or mistreat the patient’s partners (Barbara et al. 2001; Buchholz 2000; McManus et al. 2006; Røndahl 2009; Sinding et al. 2004).⁴ While explicit discrimination against LGB individuals may be increasingly recognized as unacceptable, this is a fairly recent development. One 1994 study found that more than two-thirds of the providers surveyed believed they had seen gay or lesbian patients receive substandard care because of their sexual orientation (Schatz and O’Hanlan 1994). For transgender people, such explicit discrimination continues to be common. According to a 2012 study conducted by the National Center for Transgender Equality, 19 per cent to 27 per cent of transgender people report being turned away by providers who refused to care for them, across all types of providers (not just specialists in care related to trans status) (National Center for Transgender Equality 2012). Even when providers did not explicitly discriminate, some people worried that providers’ embarrassment or awkwardness following disclosure affected the quality of care they received. One African American lesbian patient explains: “[providers] don’t know what kinds of questions to ask or what subjects to talk about because they are so nervous. I think I lose a lot in the treatment, in the diagnosis, in the whole thing that I go in there for” (Stevens 1998, 84).

On the other hand, not disclosing relevant information about sexuality or gender identity to a provider means that patients may receive improper or inappropriate care or find themselves unable to trust medical advice, knowing that the provider did not have potentially relevant information (Barbara et al. 2001; Stevens 1995; Bauer et al. 2009; Neville and Henrickson 2006).

⁴ It should be noted that individuals who do not explicitly share their LGBTQIA status with a provider may not be withholding anything; they may simply feel that the information is irrelevant to their care at that time.

For example, there are significant differences in the health risks for bisexual women and men compared to both the general population and lesbian and gay populations. Bisexual men and women have higher instances of self-harm, attempted suicide, and eating disorders, and they have lower rates of testing for STIs compared to lesbian and gay populations (Guasp and Taylor 2012a). Yet if bisexual patients feel unable to disclose to their providers, providers may not recommend adequate testing. Some LGB people who did not disclose to their providers (some simply because the provider had assumed they were heterosexual, and the patient felt awkward or embarrassed to correct them) felt they were unable to ask important health questions because that would require outing themselves (Stevens 1995; Cant 2002). Failing to challenge the assumption that one is cisgender and/or heterosexual also risks inadvertent “outing,” or accidental or unwanted disclosure, especially for trans individuals (Bauer et al. 2009), and it can also result in the exclusion of partners from appointments and care decisions (Barbara et al. 2001; Buchholz 2000; Stevens 1995; Wilton and Kaufmann 2001).

All of this evidence points to an unacceptable dilemma for LGBTQIA patients: come out and risk discrimination or inadequate care, or do not disclose potentially relevant information about sexuality and gender identity and risk inadequate care and lack of social support. Hutchinson, Thompson, and Cederbaum describe this situation as a “double bind” (2006). A double bind occurs in “situations in which options are reduced to a very few and all of them expose one to penalty, censure or deprivation,” which is characteristic of entrenched oppressive systems and practices (Frye 1983, 2). It is clear that microaggressions contribute to this double bind, as the dilemma presents itself even in the absence of explicit and intentional forms of discrimination. LGBTQIA patients may find themselves in this double bind repeatedly, even within a single healthcare visit: each encounter with a provider or staff member may require a patient to out herself again due to the pervasiveness of heteronormative assumptions and inadequate policy about sharing patient information (Stevens 1995). The need to “come out over and over, [and] to anticipate and deal with awkward or homophobic reactions” can be emotionally draining itself (Sinding et al. 2004, 182). This too may contribute to minority stress and thereby to poor health outcomes.

Avoidance of the healthcare system is common amongst LGBTQ people (Barbara et al. 2001; Bauer

et al. 2009; Davis 2000; Mathieson et al. 2002; McNair 2003). LGBTQ individuals are less likely than heterosexual and cisgender people to seek preventative care; for example, lesbians and bisexual women are at higher risk for breast, ovarian, and colon cancer but less likely to have pap smears and mammograms (Valanis et al. 2000). Similarly, gay men are at higher risk for prostate and testicular cancer, which may be due to the ineffectiveness of preventative healthcare messages for this population (Hunt and Minsky 2012, 11). Some trans patients turn to self-treatment and illegal sources for hormones rather than access healthcare services (Bauer et al. 2009; JSI Research and Training Institute 2000). One trans person stated: “I have to be deathly sick before I go to a doctor” (JSI Research and Training Institute 2000, 23). While there are many factors contributing to healthcare avoidance, including fear of explicit discrimination, the stress and anxiety caused by microaggressions are likely contributing factors. There is evidence that heteronormative microaggressions from healthcare providers may lead patients to terminate their care, even in the face of life-threatening illnesses. One lesbian cancer patient recounted an experience which led her to consider ending cancer treatment. When the surgeon noticed that she was upset following a brief discussion about a mastectomy, the surgeon said: “If breasts are important to you and your husband we can always do implants and we can talk about reconstructive surgery after you do that.” The patient continues: “And he left. And I remember sitting there thinking, he forgot who I was, you know, and he left, and I just thought, oh my God, I’m never going back to see that guy ever again” (Sinding et al. 2004, 178). While the surgeon’s use of the word “husband” was likely inadvertent, it had a significant impact on the patient’s relationship with the surgeon, even to the point that she considered ending treatment.

In short, we have demonstrated that heteronormative microaggressions undermine patient–provider trust, which can lead to poor therapeutic communication. Poor communication can lead to misdiagnosis or improper care. Even when there is no explicit discrimination or risk of it, it is our contention that microaggressions may lead patients to perceive disclosure as risky. Providers may unintentionally convey awkwardness and discomfort that damage the therapeutic relationship. Microaggressions, or the anticipation of microaggressions and other forms of discrimination, may be so emotionally damaging that they lead LGBTQIA people to terminate or avoid care. In the

next section, we will discuss diversity training meant to improve care of LGBTQIA people and why this training is insufficient to address the harms of heteronormative microaggressions.

Why Training Is Not Enough

Given prominent disparities in LGBTQ health, more hospitals and medical schools may institute diversity training on LGBTQ patient experiences and healthcare needs. Training often aims to increase provider awareness and familiarity with the target population (Kumaş-Tan et al. 2007, 550). It can educate providers on available resources inside and outside their clinical setting and help providers identify common healthcare barriers facing these groups. Increasing providers’ awareness, knowledge, and access to resources may help mitigate the “unexpectedness” of LGBTQ patients and ensure that appropriate patient-centered care is offered. Additionally, successful training can educate providers about various dimensions of prejudice and discrimination and how such bias conflicts with healthcare providers’ professionalism and the hospital or clinic’s mission. Diversity training is therefore an important tool for addressing ongoing disparities in LGBTQ health. However, we will argue that there are several ways in which such training fails to adequately curtail heteronormative microaggressions and their harms.

Diversity training may aim to get providers to identify and challenge their own biases (Kumaş-Tan et al. 2007, 552; Dogra et al. 2009, 991), but schemas and microaggressions are often invisible to those who employ and convey them. Providers who are convinced that they have egalitarian beliefs may struggle to see that they could have any areas for improvement. This raises the possibility of backlash; providers may feel they are being targeted for something they have not done or have not done on purpose (Kaplan 2006, 62). The risk of backlash inherent to diversity training of this kind can be exacerbated when, for instance, clinicians and healthcare staff hold religious or cultural beliefs that are antithetical to the spirit of such initiatives (Kaplan 2006; Mobley and Payne 1993). Both forms of resistance must be overcome in order to address the harms of such biases, whether conscious or non-conscious.

Even when providers acknowledge the need for improvement and work to correct bias, training may have little effect on the influence of schemas. As Boysen and

Vogel found, diversity training for counsellors had no effect on implicit biases, the sorts of negative and stereotypical associations that contribute to schemas (2008). Brief training sessions cannot undo habitual patterns of perceiving, thinking, and behaving. Consider the difficulty of changing any habit, exacerbated by the fact that the problematic behaviour is often invisible to the actor. Mere awareness of a habit is not enough to change it. Moreover, heteronormative schemas are widespread and reinforced throughout various areas of life. Brief training sessions are ill-equipped to undo schemas that have formed throughout a person's life and that continue to be reinforced in- and outside of the healthcare space. Whatever work might be done within a training session to identify and critique heteronormative biases may be undermined by continued exposure to heteronormative media, education, social structures, relationships, and the like in other areas of a provider's life.⁵

Dissonance between explicit egalitarian beliefs and non-conscious heteronormative schemas is worrying; patients in a study by Penner and colleagues reported that the most negative patient–provider interactions involved providers who had low levels of explicit bias but high levels of implicit bias (Penner et al. 2010). In other words, someone who confidently views herself as egalitarian—say, because she has had diversity training—but who nonetheless conveys heteronormative microaggressions might make patients *more* uncomfortable and distrustful than those who hold explicit heteronormative beliefs. In this way, diversity training ironically exacerbates the harm of heteronormative microaggressions. Training might also make providers wary of offending LGBTQIA patients, but well-meaning providers' attempts to avoid “saying the wrong thing” or offending queer patients may present as awkwardness or lack of engagement, which in turn can make patients uncomfortable (Wilton and Kaufmann 2001; Røndahl et al. 2006).

Finally, diversity training that focuses on interpersonal interactions may not address environmental and structural microaggressions embedded in the institutional space and organization. As we have argued, intake forms, procedural steps required to receive care, posters, advertisements, informational pamphlets, and the organization of restrooms can convey

microaggressions and have discriminatory effects. Even if individual providers work to undo their own heteronormative schemas, microaggressions throughout the healthcare space can send marginalizing and stigmatizing messages to patients.

Despite these challenges, there are concrete steps that can be taken to address heteronormative microaggressions in healthcare spaces. In the final section of our paper, we discuss steps that individual and institutional actors can take to promote improved care and respect for LGBTQIA patients and their families. Our recommendations highlight the avenues open to addressing microaggressions at the level of individual awareness, institutional culture and policy, and education.

Recommendations

Diversity training on LGBTQIA issues should incorporate discussion of microaggressions and schemas, with an emphasis on their non-conscious and non-intentional aspects. This may help those with explicitly egalitarian beliefs understand that they may be nonetheless conveying harmful messages. An understanding of the social nature and ubiquity of heteronormative schemas may help to destigmatize them—that is, make people feel less defensive about how these biases can appear in their behaviour, which may be central to undermining their impact (Teal et al. 2010, S118). Because people are often unable to perceive the microaggressions that they enact, training that involves group work may help providers better identify the influence of heteronormative schemas on their own behaviour (Teal et al. 2010, S117). It should also be emphasized that the schemas underlying heteronormative microaggressions are produced socially and cannot be addressed merely at the level of individuals. Rather, a multi-level approach is needed to undermine heteronormative schemas in clinical settings. But this social aspect does not undermine the need for individual action; individuals must take responsibility for their own future behaviour and over other features under their control if the situation is to improve.

The language of *personal responsibility*, rather than blame, is another way to destigmatize heteronormative schemas and may reduce the risk of backlash. Iris Marion Young explains that blame is backward-looking; it

⁵ This point holds for providers who belong to the LGBTQIA population as well as those who are cisgender and heterosexual.

demands reparations and apologies for an act already committed. Holding responsible, on the other hand, is future-oriented. To hold someone responsible means we hold her to a commitment to do better in the future, to “submit such unconscious behavior to reflection, to work to change habits and attitudes” (Young 1990, 134). Providers should not be blamed for committing microaggressions if they did not realize they were doing so. However, once educated about microaggressions, providers should be held responsible for taking steps toward preventing the occurrence of future microaggressions and, where they persist, mitigating their harm, whether in themselves, their colleagues, or in the healthcare space.

Challenging schemas requires ongoing efforts that reach beyond diversity training and the walls of the clinic. Given the ubiquity and embeddedness of heteronormative schemas, a multifaceted and long-term approach is needed. On a personal level, providers can undermine the heteronormative schemas which they have internalized by reading literature written by those who identify as LGBTQ, watching films on their experiences, and participating in LGBTQ community events (Nadal 2013, 180; Sue 2010, 205). Another strategy is to expose oneself to examples of non-stereotypical LGBTQIA individuals (Staats 2014, 20), perhaps through reading biographies or watching films about prominent LGBTQIA community members.

In a clinical context, we recognize that many healthcare workers are overburdened and may not have the resources to devote to these activities. Within a hospital or clinic, institutional changes can go some way toward changing the climate and culture in which patient-provider exchanges occur. Clinics and hospitals could provide scripts to clinicians to structure their encounters with patients. Such scripts could include common questions the clinician might ask any patient, like asking married patients “what is the gender of your spouse?”, and could provide behavioural cues that convey respect for the patient and the patient’s loved ones, such as maintaining eye contact, paying attention to tone of voice, whether arms are crossed in front of the body, etcetera. This kind of simple tool can make it easier for people to reflect on their behaviours, notice differences in their behaviours when interacting with different patient populations, and change habits. When available, a hospital’s organizational ethics committee should consider patterns of disparate

treatment and potential sources of microaggressions against LGBTQIA patients. This committee can influence policies, practices, and overall climate while working towards institutional integrity, given the mission statement of the hospital. Although there is no set way for collecting these data, ethics consultants and committee members could keep records of what ethical challenges are reported most often when a patient presents as LGBTQIA. Details of miscommunications and patient care obstacles could be accumulated, so trends can be discovered related to sources of distrust and broken therapeutic relationships. Additionally, these committees often review and propose hospital policies, which generally do not provide adequate guidance or specificity on how to avoid overt and subtle discrimination against LGBTQIA patients. These sorts of initiatives and ethics involvement could help facilitate institutional changes that curb microaggressions.

Hospitals and clinics can address environmental microaggressions by ensuring that brochures, magazines, and posters reflect the interests and experiences of a variety of sexualities and gender identities. For example, pamphlets and posters from the Fenway Institute can be printed out for free and placed in a waiting area (The Fenway Institute 2015). Intake forms should allow for a variety of pronoun preferences and relationship types; the *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health* offers an example (Makadon et al. 2015). Additionally, gender neutral restrooms should be readily available.

Finally, structural heteronormativity needs to be addressed within clinical contexts and health education. While acknowledging that diversity training is essential, we stress that it should include education about LGBTQIA experiences and healthcare needs and introduce providers to reliable resources for LGBTQIA health information. Changing the narratives available to healthcare providers throughout their pre-professional and professional training is another way to undermine structural heteronormativity. The introduction of new narratives should aim to meet the standards put forward by Lance Wahlert and Autumn Fiester’s *Queer Bioethics Inventory* (2014, S62). In their analysis of clinical ethics textbooks, Wahlert and Fiester examine the ways in which LGBT patients are portrayed in harmful, stereotypical ways or not mentioned at all. For example, they demonstrate that the “small handful of LGBT-related cases in the large canon ... are almost

exclusively about HIV/AIDS and focused on gay men, almost never involving lesbian women or transgender patients” (Wahlert and Fiester 2014, S58). In response, Wahlert and Fiester created an inventory of questions to “[s]crutinize the efficacy, legitimacy, and impartiality of the cases we use in bioethics. While by no means exhaustive, the [inventory] helps us to better attend to the unique needs of LGBT parties in the clinic” (Wahlert and Fiester 2014, S62). The inventory includes questions such as “are both the nonqueer and queer subjects treated as equally important and valid?”; “are non-normative bodies appreciated as legitimate, appropriate, and neutral?”; and “does the case omit, exclude, or dismiss important characters—such as partners, lovers, or caregivers?” (Wahlert and Fiester 2014, S62). To the extent that clinical ethics textbooks incorporate narratives that are more inclusive of the experiences of LGBTQIA patients *and* avoid the most explicit kinds of biases, the tone of medical education will be more comprehensive and more LGBTQIA-affirming.

Concluding Thoughts

We have argued that heteronormative microaggressions contribute to persistent barriers to care for LGBTQIA people. We provided evidence that heteronormative microaggressions are ubiquitous in healthcare spaces and interactions and that these microaggressions contribute to poor patient–provider relationships and may lead to avoidance of care. Moreover, we contend that training healthcare professionals about LGBTQIA issues is unlikely to adequately address the harms of heteronormative schemas and microaggressions, and it does not ensure that all patients are given the appropriate standard of care. In response to these concerns, we have offered a variety of strategies for individual and institutional actors to promote adequate care for LGBTQIA patients and their families.

We recognize that institutions come in a variety of forms (e.g., private/public, not-for-profit/for-profit, small/large), and governance policies vary based upon location. Consequently, there may be practical limitations in addressing heteronormative microaggressions. Nonetheless, it is clear that heteronormative microaggressions have a significant impact on the health and well-being of LGBTQIA populations, and these health disparities will persist until microaggressions are appropriately addressed.

Additional research into the pervasiveness of microaggressions in healthcare spaces and the effectiveness of specific measures to disrupt problematic schemas and implicit biases is needed.

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