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Fostering Nurses' Political Knowledges and Practices

Education and Political Activation in Relation to Lesbian Health

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This article describes findings from a qualitative policy study focused on female nurses' activism in relation to lesbian health. Critical feminist analysis and comparative life history methodology were applied to career histories obtained from 10 diversely situated female nurses across Ontario, Canada. The findings show that nursing activist practices are informed by advocacy experiences that foster inclusive professional and community education plus formal education processes that shape their political socialization. Implications for nursing theory include the development of political knowledges and practices that support caring science, sociopolitical knowing, and primary healthcare nursing practice in a community context. **Key words:** *Canada*, *caring science*, *critical feminist*, *diversity*, *education*, *lesbian health*, *life history*, *nursing practice*, *nursing theory*, *political action*, *policy research*, *political socialization*, *qualitative research*, *sexual orientation*

We started with nursing theory right away. I just liked what the theorists had to say about what nurses do and what nursing is . . . the whole caring piece . . . I found it really connected for me.

Nora, pseudonym[1(p83)]

To tell them in that kind of atmosphere that I was a lesbian . . . . I knew that I always had to keep my mouth shut about being a lesbian.

Maura, pseudonym[1(p83)]

SINCE the 1980s, when the World Health Organization and policy bodies in Canada indicated that professionals had a key role in health and social reform which works toward goals of social justice and equity, Canadian nurses have been encouraged to participate in primary healthcare strategies of political action and policy-making.[2–4] However, despite nurses' significant contributions on both individual and collective levels, locally and globally, to advance the holistic health of patients and clients over time, dominant spheres have not always recognized the significance of nurses' involvement in policy and politics.[5–8] Nursing research has often considered nurses' political participation as congruent with their involvement in state-level politics. In this vein, findings suggest that nurses' political participation is linked to particular practice settings and involvement with graduate studies or professional organizations and as such, the profession itself indicates that nurses lack engagement with politics.[7,9]

In fact, however, gender dynamics play a fundamental role in how we conceptualize politics and political change. As Jill Vickers[10] has pointed out, for the most part,

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conventional discussions are characterized by a focus on the legislative and electoral spheres with little attention to the historical context of how male experiences and voices have dominated this sphere. An examination of the normative features of politics and political change shows how such a discourse overlooks how and where women often engage with political action: at the local level.[11] As a consequence, in these discussions of women's political contributions, there is little recognition of the different opportunities open to men and women within political parties and ways that women and men experience and understand political life; nor is there understanding of the extent of their involvement in sites of action that include formal and informal advocacy through community-based activities and nongovernmental organizations.[10]

Nursing practice and politics have been influenced not only by the gender dynamics that inform all female-dominated health services and caring professions but also by an implicit heterosexual norm which is entrenched in all social institutions.[11,12–17] The profession has demonstrated commitments to supporting diversity, cultural competence, and universal access to healthcare. Nevertheless, although Canadian nurses' policy initiatives related to healthcare reform and support for vulnerable groups such as the homeless through union and professional associations have been highly publicized in media and professional discourses, until very recently nursing leadership and research on sexual minority health have been virtually ignored. This article examines nurses' political practice in relation to lesbian health.

As a group, sexual minorities, who include lesbians, gays, bisexuals, and transgender (LGBT) people, experience well-documented health inequities such as lack of access to relevant programs and services.[16–19] Despite an improved social climate for sexual diversity in Canada over the last decade, the historical context in which sexual minorities were denigrated and pathologized and subjected to harsh treatments and violence continues to shape their current social realities.[13,20,21] Many have learned to anticipate and continue to encounter provider discomfort, hostility, and/or overt discrimination in their interactions with individuals and social institutions. Although their holistic health concerns are complex, much of the literature focuses on their health risks related to sexuality, mental health, and substance use. Avoidance of care given the heterosexism and homophobia that mark all social institutions contributes to their increased risk for mortality and morbidity.[18–24]

Although lesbian health may be included under the umbrella of women's health, given the pervasive social context of heterosexism, diversely situated lesbians experience and understand their lives in ways that are similar to and different from women as a whole. As Mcdonald et al[22] indicate, women's health is often taken up through a biomedical lens with a focus on heterosexual reproductive health and this renders lesbian health, which is regarded as a social phenomenon, invisible in this context. Although diversely situated lesbians do share commonalities with other sexual minorities such as gay men, their lives have been shaped by their gender socialization and gendered and racialized hierarchies within North American LGBT communities in which white middle-class gay men have often been the public face of sexual diversity. Lesbian health may be subsumed under "gay" issues.[14,15,19–21,23]

Lesbians comprise all ages, religions, cultures, geographic regions, and socioeconomic groups, yet many nurses and other healthcare providers lack knowledge and understanding of their holistic health concerns across the life span. A review of the literature indicates that a significant proportion also hold negative attitudes toward lesbians and this has a direct impact on their capacity to provide high-quality care.[14–16,18,23–28] Despite ethical, legal, and professional mandates to advocate for vulnerable populations such as lesbians and the increasing evidence base that should drive nursing practice related to lesbian health, little in the nursing literature has

reflected this as a priority focus for nursing advocacy.[24–27]

My own experience as a public health nurse and educator indicated that many, those identified as sexual minorities and those working as heterosexual allies, have advocated on behalf of lesbians in the course of their everyday practice. Others shared frustration at being unable to participate publicly in such work, at times having experienced significant upheaval, which they attributed to personal, professional, and/or organizational barriers in relation to their sexual identity and other significant factors in their lives. Several years before, I had begun to examine how system-level factors as well as my own practice were implicated in the silence on lesbian health in nursing and became involved with nursing and community activists in the area.[27] I became aware of research that suggested that professionals who were politically active on these issues could encounter career and workplace repercussions.[12,14,15,24–26,28] So, given the advocacy role that nurses have to challenge heterosexism in order to foster the holistic health of lesbians and these personal and professional dynamics, I was interested in the lived experiences of nurses who advocate publicly for lesbian health.

In this article, I describe findings from a Canadian qualitative policy study[29] with female nurses that focus on nurses' education and political activation in relation to their lesbian health advocacy. I describe the methodology, participants, and their advocacy initiatives. I address how 2 factors, formal education and experiences of advocacy, influence their political development while foregrounding how gender informs their experiences and understandings of this aspect of their practice. I then contextualize the findings in relation to relevant nursing theory.

METHODOLOGY

This study examines the relationship between nurses and policy, using career histories as a way to determine how policy actors themselves experience and understand policy.[30] Critical reflection on my own nursing practice as a public health nurse working as a political ally in education, policy, and research related to lesbian health prompted this inquiry. A qualitative design was chosen to explore in-depth nurses' experiences and understandings of this area of practice, one that might potentially raise sensitive career and workplace concerns. I was aware of the challenges of limiting this study to "lesbian" health, given the potentially fluid nature of categories and contested meanings that language can signify.

I employed a critical feminist analysis[10,31] and comparative life history methodology,[32] which situates individual life stories in the broader sociocultural, political, economic, and historical contexts. I conceptualized lesbian health as a career focus—albeit one that is unlikely to be found in the nursing career literature—and collected career histories with a view to examining policy as meaningful life activities that span personal and professional lives and political action at the everyday level.[30,31,33] In addition to validating individual narratives, this comparative life history approach allows for examination of patterns across narratives, which can point to normative dynamics shaped by gender, sexuality, other social relations and their intersections. Analysis of documentary sources such as nursing policies and health promotion research contextualizes narrative data. Vickers'[10] elaboration of a feminist political science provided a template to consider diversely situated women's politics and their relationships to the "realities of existing systems and . . . the potential for transformation."(p56) Research questions explored (1) the social and material influences that shape nurses' advocacy for lesbian health and (2) the social and material impacts of their everyday work on their institutions, communities, and the nurses themselves. Ethical approval for research with human participants was obtained.

Purposeful convenience sampling was used to collect career histories with female nurses in Ontario who self-identified as advocates for lesbian health and who were publicly known for their lesbian health

advocacy. Information letters about the study were posted through professional networks. Participants contacted the researcher if they wished to learn more about the study. The sample aimed for diversity with respect to sexual orientation, geographic location, and practice setting. Sensitivity to disclosure issues and confidentiality were paramount during the study. In this article, pseudonyms for participants were used.

I obtained one or two 1- to 4-hour career histories, semistructured interviews from participants. Interview questions addressed participants' everyday activities, workplace issues, career history, political activities, motivations for their involvement in lesbian health advocacy, and supports and barriers for doing this advocacy work. Interviews were audiotaped after informed consent was obtained. I ensured rigor by using member checking and including verbatim narratives in the reporting of findings.[34] Verbatim interview transcripts were analyzed for themes and patterns along with literature informing the study, using NVivo2 qualitative research software (QSR International Pty Ltd; Cambridge, Massachusetts).

Reflexivity

The critical feminist approach foregrounds gender and other dynamics of power across the research process. The reflexive process required that I document dynamics that shaped my biases and interpretations of the data. This entailed making explicit my own location and goals for undertaking the research and being clear that my epistemological, ontological, and methodological stances merge through a lens of the political so that I address gender and other relations of power. As a heterosexually identified nurse who had been involved in lesbian health advocacy in the classroom and beyond, I was particularly tuned to thoughts, feelings, and behaviors emerging over time. I constantly grappled with how my own identities, experiences, power, and privilege shaped the direction of the inquiry as well as my authority to represent diversely positioned participants' lives.[14,31–37]

Checking in with my participants was important at various points across the process to ensure that I was interpreting and reporting findings in meaningful and respectful ways. In fact, a number of participants at various points of the study process expressed their delight that I was studying these everyday issues that they do not see addressed in nursing research. One lesbian nurse openly expressed her surprise as our interview concluded, indicating her disbelief that a heterosexually identified nurse might find such issues relevant to examining within a nursing context, while proceeding to immediately contact a colleague to encourage her participation in this study. This, along with explicit comments by almost all participants either during or at the conclusion of the interviews, or in encounters after the formal interviews, showed that, for these nurses, this interview process opened space for a legitimate naming and articulation of "talk" often quashed or subjugated in other sites of dialogue. These dynamics appeared especially relevant for the lesbian, bisexual, and questioning-identified participants given their well-documented longstanding marginalization within the profession; however, those participating as political allies also acknowledged them.

Themes within and across narratives and gendered discourses[37] were identified through a process of iterative analysis that involved use of the reflexive research journal to document observations and interpretations of events and data. I systematically coded data in phases of describing, organizing, editing, and representing the research findings.[35] Analysis occurred as I documented and reflected on the implications of the links I was making. This involved reading and rereading literature (new documents and previous research), contextualizing in the journal for my own nursing experiences in practice, and flagging transcripts for themes and discourses.[31,32,34,35]

PARTICIPANTS

Twelve nurses expressed interest in participating and 10 nurses participated. The

participants comprised a highly privileged group of nurses who had lifetime nursing experiences reflecting a variety of practice foci including public health, education, and intensive care across urban, suburban, rural, and remote regions of Canada and internationally. They represented diverse sexual orientations: 4 self-identified as lesbians, 1 as bisexual, 1 questioning her sexual orientation (LBQ), and 4 as heterosexual. This group of well-credentialed nurses encompassed those whose ages ranged from their 30s through 50s: clinical nurse specialists, nurse practitioners, and those with a range of leadership experience in education, research, clinical settings, and unions. At the time of the interviews, most were working full time in nursing with several also involved in extra part-time work. In Table 1, I have included a profile of these 10 participants using their own descriptions if possible. Several nurses wrote their own profiles. Pseudonyms are used for all participants.

ADVOCACY PRACTICES

These nurses are well situated to advocate for lesbians, having developed a strong knowledge base related to sexual diversity and having been involved with a variety of advocacy opportunities over the courses of their practice. For the most part, their work involves individuals, families, groups, and communities across health concerns and life span foci (eg, maternal-child health, immigrants, or seniors) rather than activities that are explicitly geared to sexual minorities or lesbians (eg, LGBT-focused coalitions or youth groups). The trust relationship that underpins the nurse-client/patient care is central to their advocacy practice. Whether they are working with individuals or populations, their narratives are informed by a recognition that nurses are professionally accountable for addressing conditions that contribute to injustices and health inequities experienced by vulnerable clients and communities.

These life histories show diverse ways in which nurses engage in advocacy across frontline, research, education, administration, and policy-making domains. In contrast to an implicit assumption that nurses' advocacy is mainly at the bedside in a clinical context, whereby nurses advocate to the physician on behalf of individual patients, however, these participants often describe their activities in a broader socioenvironmental context of health and policy-making. As these nurses exercise agency to effect change at the individual level, they work with interdisciplinary providers and with clients of all ages such as young mothers and immigrant families to foster culturally relevant care, programs, and services. Case managers, such as Wendy and Marnie work directly with sex workers as well as incarcerated individuals and those with developmental delays and individuals who are often underhoused and dealing with mental health concerns or substance misuse. An understanding of risk factors for these communities, the sociopolitical dynamics that shape conditions that determine their health and awareness that LGBT people are often overrepresented in these vulnerable groups, underwrites their actions. Their practice requires not only clinical judgment and knowledge of resources but also political skills to work with individuals, providers, and other stakeholders at the local, organizational, and macrolevels.

A variety of collective initiatives have shaped these nurses' politics whether their nursing practice involves community or hospital settings and participation during their workplace hours or on their own time. They describe ties to street outreach teams and woman abuse projects and affiliations with boards of community agencies, professional organizations, and political parties. Health strategies to foster the well-being of diverse population groups such as youth, Aboriginal, and immigrant communities include coalitions, research and conference development, and participation in local LGBT community celebrations. In the course of this work, they have developed important relationships with interdisciplinary health and social service workers as well as police, politicians, and

Table 1. Participant profiles

Name	Participant profile
Anne	Self-identifies as WASP: white, Anglo-Saxon and Celtic, Protestant, as a middle-class lesbian, mother, wife, daughter, and student in her early 50s. She describes herself as a nurse practitioner and teacher with extensive clinical and community experience in rural and urban centers, including the far north of Ontario. She is a nurse educator.
Marnie	Self-identifies as a middle-class, ethnic minority and lesbian in her 30s whose nursing has focused on community health, education, and administration in urban and rural settings.
Maura	Describes herself as a dyke feminist in her 50s. She has significant nursing educator, administrative, and clinical nursing experience in urban, suburban, and rural centers of Ontario, including the far North, as well as international nursing background. Her current focus is nursing education.
Meg	Self-identifies as WASP (white, Anglo-Saxon, Protestant) and as a middle-class heterosexual, married woman and mother in her 50s. She has nursing education, clinical and public health nursing experience in mostly suburban areas of Ontario and works in a sexual health program.
Nora	Self-identifies as white, Caucasian, and Canadian and as a menopausal, middle-class, straight woman with Amish roots in her 50s. She is a nurse practitioner and has significant public health nursing experience in suburban, rural, and urban Ontario. She works in sexual health.
Sara	Describes herself as a heterosexual, married, white, Anglo-Saxon, middle-class woman in her 40s with no disabilities or impairments. Her public health nursing career in rural Ontario has involved a diversity of programming. A majority of her nursing work has been spent developing and implementing sexual health programming and clinical services. She self-identifies as an advocate for nursing by being actively involved in union activities that preserve the quality of the work environment in which she and her colleagues practice community health.
Renée	Self-identifies as an upper-class, white woman who has some French-Canadian background. She is questioning her sexual orientation and identifies that her low self-esteem and high degree of internalized homophobia have disabling elements in her life. She has clinical, nursing education and public health experience in suburban and urban Ontario. She is currently employed as an educator.
Risa	Self-identifies as a middle-class, bisexual woman and mother. She has extensive public health and nursing educator experience working in urban and rural Ontario. She primarily works as a nurse educator.
Toni	Describes herself as a white, Italian Catholic, middle-class, heterosexual woman in her 30s whose main career focus has been public health nursing in rural Ontario. She currently works in sexual health.
Wendy	Describes herself as a human being and lesbian-feminist and is in her 40s. Her nursing experience has involved urban and rural Ontario and international settings. She has significant expertise in mental health nursing and does this on a part-time basis. She primarily works in a nonnursing capacity as a paid volunteer coordinator.

academics; their networks extend beyond the health sector to include education, justice, and the private sectors.[36]

As Vickers[10] has indicated, women's politics may involve both mixed gender and women-only contexts. These nurses, both those same-sex–identified and heterosexual allies, participate on coalitions and committees with colleagues who work across difference related to gender and sexuality and

represent a variety of community and professional backgrounds. A number also stress how feminist or lesbian-focused women-only spaces in academia and community play important roles in their emotional, physical, and spiritual well-being.[36]

ROLE OF NURSING EDUCATION

One factor that prompted several nurses' political activation, along with my own engagement with advocacy, was formal education. Although some participants originally completed 4-year university degrees or college diplomas with their liberal arts coursework, others began their careers through apprenticeship-style hospital training programs, which no longer operate in Ontario. Entry to practice for new registered nurses is currently a baccalaureate degree and curriculum includes a focus on political leadership and policy dynamics.

These career histories indicate that both the theoretical content and tone set by their programs played an important role in nurses' political trajectories. Nora, for instance, who had already been highly involved in political organizations in university before turning to nursing after completing her first degree, immediately found that nursing theory with its focus on caring and social justice resonated nicely with her political roots. Meg found herself making the connections to political activism toward the end of her 4-year program in the 1970s, at a time when her program's professional coursework on nursing leadership paralleled her political awakenings that were emerging through consciousness-raising in an era of second-wave feminism. In contrast to 2 other participants who graduated the following decade and who denied that their nursing studies prompted any thoughts of political engagement, Meg and Nora's involvement in professional association and union activities followed quickly after graduation. Looking back, Meg reflects that this process paved the way for her current activism. As she states, "I got very much hooked on issues in nursing and women's issues. ... It's not so far from women's issues ... to go to other minority issues."[1(p83)]

For Maura, however, who trained outside of Canada in the 60s, rigid expectations and control over both student and graduate nurses' practice and lives beyond the work setting had long-lasting effects on her capacity to claim an identity as a lesbian nurse as well as her perceived opportunities to take political action. The profession exerted highly visible gender conforming rules with strict sanctions against nurses who challenged the modest professional dress codes and regulations on their interpersonal relationships with the opposite sex. At the time, nurses gave up their career when they married. For Maura, disclosure of her lesbian identity was unthinkable given these dynamics. However, the continued professional silencing of lesbians in any but a pathological context over the next decades reinforced her understanding of "what was considered legitimate nursing work in which any reference to lesbian health was erased—a dynamic she also encountered until very recently in Canada."[1(p83)]

Participants of all sexual orientations indicated that graduate studies often offered ample opportunities to locate communities where they could engage with ideas and develop their activist capacities. Although some completed graduate studies in nursing, interestingly, even nurses who continued to practice nursing on the front lines or in education settings, were surprised to find that interdisciplinary studies fostered their appreciation for and deeper understandings of the potential for activism within the profession. Wendy, for instance, identified that women's studies which introduced her to gender analysis and an affirming women's community unexpectedly catalyzed her politicization in her 30s and was integral to her coming-out process in her personal and professional environments. As these narratives show, however, lesbian, bisexual, and questioning nurses perceived considerable variation in academia for discussions of sexual diversity; some participated in LGBT coursework with highly engaged professors

and peers, whereas others encountered invisibility and silence.

ADVOCACY THROUGH EDUCATION

These narratives illustrate the multiple contributions of nurses across practice settings in roles as students, teachers, and employees to create workplace, education, and community environments, which foster positive space. Significant time and energy are directed toward educational initiatives that can increase their colleagues' and students' understanding of lesbian health and sexual diversity in both curriculum and workplace training contexts.

Curriculum dynamics

Nurse educators work individually and collectively to develop curriculum which examines cultural competence as well as political activism and leadership in relation to sexual diversity. For instance, in a variety of nursing classroom settings, Renée points out how power dynamics including gender and its intersections with race, class, and sexual orientation are an integral part of her class discussions. However, nurse educators can encounter organizational dynamics that vary markedly from one context to the next. For several participants, supportive institutional climates have facilitated nursing involvement to develop curriculum that is inclusive of lesbian health as well as participation in collaborations to establish positive space in the larger organization. Risa, for example, notes that her institution recognizes and supports her contributions, remarking, "I can create what I need to create."[1(p84)]

Nurses teaching in the classroom stress the importance of both an explicit focus on sexual diversity and integration of issues throughout the curriculum. Anne constantly raises ethical dilemmas as she teaches enormous amounts of theoretical and clinical content. "We've discussed racism, homophobia . . . you name it, it comes up, and the content lends itself to so many issues. It's all nursing and it's all relevant. . .!" As she stresses to her students, the classroom is a potential arena for transformation: "You've come to school with the expectation of change and that's what happens in the classroom, doesn't it? But I cannot allow racist comments in the classroom, and the homophobic comments we explore." One educator challenges her students to consider the heterosexist assumptions that underpin their discussions of female youth. Another shares how showing a video about 2 lesbians' experience of the healthcare system was instrumental in shifting students' awareness.

> Basically [one] wasn't even informed that her partner was dying and I think that had a huge impact on discussion. That's when one of my students said after seeing the movie it was clear that it was not about sex. So I helped some people understand, but there were still those people who could not accept it, and that was fine.

However, educators can also face barriers in the classroom, given the limited or inconsistent inclusion of critical and antioppression pedagogy in nursing education. Community nursing, with its focus on social equity and foundations in primary healthcare philosophies, was identified as a place to illustrate how nursing and critical social theories share goals that support practices to challenge the status quo. Meg contrasted the prevailing victim-blaming approach of biomedical and behavioral health promotion models in public health, which focus on diagnosis and lifestyles with the socioenvironmental approach's attention to the social determinants of health. Yet, participants indicate that the antioppression approaches that draw attention to social structures and foreground intersections of racism and heterosexism are not consistently reflected in nursing pedagogy and this has political implications for advocates. As nurses who illuminate the invisibility and marginalization of lesbian health as they challenge dominant streams in the theory and practice of nursing education, their efforts are within the scope of ethical nursing practice, yet at the same time on the margins of nursing work.

For Maura, being openly identified as a lesbian nurse educator has been highly beneficial for developing more inclusive curriculum in her school of nursing. She states, "Nowadays when they look around the room their eyes meet mine—'Maura, I don't have any LGBT material in my course'.... And that's the kind of thing people are ... saying, 'I teach such a class. Do you have anything?' " Other participants echoed her sentiments about workplace support from heterosexual allies and administration as important for queer-positive spaces and curriculum.

Despite these positive dynamics, however, and the fact that cultural competency standards should address sexual minorities, Maura is conscious that a number of her colleagues consistently omit sexual diversity as they implement the curriculum. In doing so, these educators send a strong message to students about the legitimacy of sexual minority health as a focus of practice. In fact, nurse educators' discretionary power in the classroom and in determining key directions for future nursing practice plays an important leadership role in representing to faculty and students whether the profession is genuinely committed to being inclusive of sexual minority health in both policy and practice contexts.

Gendered assumptions about sexual minority health can influence how lesbians are represented in the classroom when LGBT health is addressed. Several participants described particular challenges working with professionals when they attempted to focus on lesbian health rather than using terms such as "gay" or "LGBT." One educator explains that the historical context of lesbian issues is relevant. In her experience, there is enormous resistance to addressing lesbians within the profession because of the "whore-Madonna" stereotypes that continue to frame nursing practice, noting that gay colleagues encounter different dynamics and benefit from male privilege. She regards the term "gay" as having more neutral connotations within nursing, although she acknowledges that gay men do encounter professional barriers. Her analysis was borne out by a nonnursing colleague's request to her that a lesbian educator lead an LGBT-focused course because of her view that gay male voices dominate in sexual minority communities.

Even today, however, both nursing educator and student disclosure remain very limited. Few nursing educators are consistently out to their colleagues and most of these same-sex–identified participants carefully weigh the benefits and risks of disclosing to their students. As noted elsewhere, educators can be at risk for negative teaching evaluations from students who espouse homophobic values.[26] According to these nurses, today's education settings may be more supportive for sexually diverse students but have not yet wholeheartedly created climates that embrace disclosure. As one participant indicates, "Particularly in nursing, it is not safe to be queer. I know there are queer students, but are they out? Not a chance."

Education in the workplace

Narrative findings related to workplace initiatives identified how education that was geared to developing nurses' and organizational cultural competence in relation to sexual diversity had a number of implications. Creating positive agency dynamics for clients prompted agency training in several organizations. As Sara indicates, "We decided that we couldn't, as a health unit, support the [LGBT] youth group fully without our own staff looking at their own backgrounds, their own level of homophobia ... so that ... people should be free to come here." Despite the increased media attention to sexual diversity, however, colleagues in both rural and urban settings may continue to question the relevance of related in-services, especially given many competing professional priorities. Meg, for instance, found her colleagues somewhat bewildered by her efforts to address lesbian childbearing when she included this topic in a team meeting, given the few same-sex–identified parents they encounter.[36] Marnie agrees, indicating that public health practitioners continue to conceptualize lesbian health as sexual health, despite its relevance to programs focused on workplace, schools, and tobacco and substance use.

With a wealth of professional experience and solid educational credentials, these nurses are often invited to share their clinical expertise with colleagues in the workplace. Their capacity to advocate for lesbian health is bolstered by their professional credibility and educational preparation. Gender, however, is implicated in the credibility of nurses' roles as educators across the health professions. Although these nurses indicated that most of their working relationships with physicians and other interdisciplinary providers were positive, one nurse cited an example of how gender shapes professional hierarchies and knowledges. Nora describes how questions were raised about her credentials as a nurse to lead a hospital workshop geared to physicians on teen sexuality. The planning committee was finally persuaded that with her graduate degree in adult education she "could actually inform physicians about something!"[1 (p84)]

In addition to creating more inviting programs and services, in-service education processes facilitated by these nurses also had impacts on professional development and working conditions. For instance, at one agency, Nora noted that a number of workshops on sexual diversity were well attended and supported by administrators. As a result of the more welcoming atmosphere within the agency, a number of nursing employees on the front lines as well as administrators became open about their same-sex orientation. She remarks that this was in addition to "school nurses [who] were having kids come up to them and that had never happened before . . . just because nurses had more information and were more comfortable."[1 (p84)] However, more commonly these sessions have been a forum to "preach to the converted," with attendees mainly care providers whose clients include a focus on youth, HIV/AIDS, or counseling, contexts which are more likely associated with sexuality.[26]

The importance of such workplace initiatives cannot be overlooked, as they provide spaces to challenge heteronormative assumptions, affirm identities, and develop an understanding of the complex dynamics of power and privilege that shape social realities for sexually diverse clients and colleagues and allies. As a social practice linked to the development of political knowledges related to lesbian health, education can create spaces for political activation and institutional communities that can foster responsive action.

Heterosexual allies indicated that workplace sessions on homophobia, heterosexism, and biphobia were pivotal in their understanding of LGBT health. Along with active and ongoing interactions with sexually diverse colleagues, clients, and their communities, learning emerging from such initiatives has prompted them to continue their LGBT advocacy, even as their job focus has moved them in other directions. Toni spoke of a panel discussion that prompted her to consider what it was like to live as a young lesbian in the rural communities she knew. This took her back to memories of her high school peers, several of whom she discovered later had been grappling with disclosure issues as young gay men. It was also a conference session that sparked Meg's passion for counseling LGBT youth. For Nora, who had been involved in civil rights and feminist activism for many years, the impact of workplace training focused explicitly on homophobia and heterosexism in the early 90s took her by surprise. Her understanding of oppression broadened to examine the complex intersectionalities implicated in the issues. As she notes, "I had my eyes opened around oppression a lot more than I had thought. . .. You always think of in terms of racism, and not so much other oppressions."[1 (p85)]

Positive and negative dynamics including critical incidents that had occurred in participants' workplaces, personal lives, and communities were linked to participants' perceived options to act politically and publicly in a specific context. As reported elsewhere,[26] the sexual orientation of these nurses was linked to their visibility as lesbian health advocates as well as the impacts of the discrimination, overt or more subtle hostility that all faced at some point. In contrast to heterosexual participants who often represented the public face of LGBT issues as public health nurses in sexual health services, diversely

situated sexual minority nurses' visibility as lesbian health advocates in professional spaces was more complicated.

Lesbian, bisexual, and questioning nurses cited concerns for career mobility and personal and professional safety. As reported elsewhere,[26] vigilance for cues in their relationships with clients, colleagues, and organizational spaces for lesbian-affirming or discriminatory dynamics marked their work lives and influenced their disclosure and career decisions. Several used disclosure and gender-conforming dress as political strategies, at times encountering incredibly supportive colleagues and workplaces. In other contexts, they advocated outside of work and avoided any affiliation with LGBT issues even in agencies with more progressive and inclusive climates. These same-sex–identified nurses, having experienced the erasure of their identities and pathologization of their lives in nursing and the larger social sphere over the course of a lifetime, described their struggles to participate as public activists for lesbian health in heterosexist and biphobic work settings despite improved public support. They anticipated and experienced more extensive professional and personal consequences of unpredictable negative work/career dynamics than those faced by heterosexual allies. However, this not only influenced their willingness to take on the challenges of education and training but also catalyzed their nursing activism and shaped their political commitments.[26]

DISCUSSION

These life histories illustrate how these participants engage in lesbian health advocacy as a career focus. Meaningful activities for nurses occur both on work and volunteer time and are carried out through individual and collective actions. As qualitative research, this study is not intended to offer findings that can be generalized; however, the findings using critical gender analysis of in-depth career histories offer insight into the complex lived experiences of nurses across settings who advocate for lesbian health and have relevance for activist professionals in other female-dominated health service professions.

Both a commitment to care and social justice inform a vision of activist practices that create and sustain holistic health in these narratives. Although not all participants were working as public health or community nurses, their advocacy activities were consistent with the 5 primary healthcare principles that inform the Canadian Community Health Nursing Standards of Practice.[38] These principles of accessibility, public participation, health promotion, appropriate technology, and intersectoral collaboration support preventive action to address health inequities by addressing the social determinants of health such as oppression. For instance, these nurses' networks and coalitions are interdisciplinary or intersectoral in nature. Consistent with an upstream strategy to address root causes of health and social inequities for marginalized groups with the collaboration of individuals and groups beyond the health sector this approach creates opportunities to sustain changes at the institutional and community levels.[38,39]

The collaborative elements of these nurses' work with sexual minority communities are apparent as the participants attend to dynamics of power and privilege with a goal of fostering conditions to increase community empowerment. Falk-Rafael[39] describes Critical Caring Theory as nursing theory that can inform public health nursing practice since it is congruent with critical feminist principles and caring science informed by Watson.[40] Although she illustrates how this theory applies to public health nursing practice, with its focus on aggregates, communities, or populations, these findings show how nurses working in settings well beyond public health or community also practiced in ways consistent with the relational focus of caring science.

With its focus on the material and social influences and impacts of policy and other factors on advocacy, this study offers insight into the cognitive and ontological dimensions of nurses' political practice. As

Doane and Varcoe[41] indicate, these embodied expressions of subjectivity are inherent in the process of taking action at any time. For these participants, developing political knowledges is not an abstract process but informed by a variety of personal, ethical, and empirical knowledges acquired in formal and informal settings. Reflections on the decision-making process and inquiry process also shape political knowledges. Material factors such as the political stakes or career/workplace costs of acting as well as social processes such as the construction of identities affect embodied knowing and thus praxis.[40,42] The ontological stance is a way of being that is oriented toward the preferred goal, ideal, or vision. These participants, with their sustained focus on social justice goals, demonstrate the authentic and therapeutic use of self in relation to individuals and their larger worlds aligned with nursing ethics.[40–42]

Also relevant to this study is what White[43] called the fifth pattern of nursing knowing "sociopolitical knowing" with its focus on ethics and a critical analysis of structures of power and domination and their effects on individuals and communities. One element involves "the socio-political context of nursing as a practice profession, including both society's understanding of nursing and nursing's understanding of society and its politics."[43(p81)] Having participated as students or faculty in formal educational, organizational, or community initiatives, these nurses had opportunities to critically reflect on professional norms that shaped leadership, politics, gender, and sexuality. Emerging political knowledges shaped their points of reference for action and evolving social practices, whether these involved self-disclosure as lesbian to nursing colleagues or membership in a professional organization.

Political knowledges are not static but often contradictory, complex, and even messy to articulate; they vary over time and are situated in particular contexts. Individual nurses acquire embodied political knowledges as they experience and understand their lives in particular ways, yet cross-case comparison of career narratives demonstrates that there are larger social, political, cultural, and economic dynamics that inform their lived experiences and interpretation of their lives. Factors such as sexual orientation, geographic location, practice focus, political socialization, and institutional dynamics shape nurses' understanding of influences that constrain and enable work decisions and advocacy strategies. Along with dominant discourses, social justice discourses that challenge social and institutional norms contribute to the development of political knowledges, which can potentially emerge from reflection on critical incidents over a lifetime or in dialogues and collective spaces which encourage emancipatory inquiry.[8,9,14,24,44,45]

As nurses critically reflect on the community and institutional dynamics that have shaped their practice over time, they consider how social relations, power, and privilege such as that related to gender, race, and ethnicity have historically been implicated in authoritative health discourses that regulate women's lives. By identifying social and professional norms they can question and potentially challenge processes and policies that inform heterosexist institutional and professional dynamics and their participation in knowledge-making through professional education as a form of political action[8,14,24,25]

The historical context is relevant. These nurses shared life histories that reflected several decades of personal and professional life. Certainly over this last decade, LGBT health and policy have been front and center in media discourses. As well, for the most part, Canada has become a more tolerant and welcoming public for sexual minorities in many places. All of the nurses had some very positive outcomes as they advocated building relationships and community, programs, and services. However, these findings, taken in conjunction with others reported on this study,[26] indicate that few female nurses, including those who have high social privilege and are living in urban centers, can consistently be out at work and in fact encounter discriminatory dynamics for their work in this area

and raise questions about how the nursing profession is implicated in maintaining the dominant heterosexist gender order in today's world.[14,24,25]

As Giddings and Smith[25] indicate, "out" lesbian nurses are needed to provide positive role models for lesbian-identified colleagues and students and to challenge the invisibility of lesbians in the profession. By virtue of being authentic and out as lesbian, same-sex–identified activists challenged the implicit norms for a North American nurse: white, middle-class, heterosexual, and "nice."[14] Participants in my study, whether they were working from an ally status or self-identified as lesbian, bisexual, or questioning, took opportunities to have political impact by challenging professional gender norms for appearance (eg, stereotypical feminine apparel) and behavior (unconventional focus of practice).[14,26] Their authenticity as a nurse activist is reflected through a political identity that bridges their locations as insiders or outsiders to sexual minority communities as they advocate in an ongoing way in public spaces.[26,36] However, in this role, they are aware of the tensions of power and privilege, ensuring that they are not assuming authority of knowledges on behalf of sexually diverse groups.

Counter-hegemonic practices that destabilize the dominant heterosexist gender order work to recreate nursing as a profession that aligns with its moral imperative to work toward caring and social justice. In fact, this advocacy focus on lesbian health is simultaneously inside and outside nursing practice. As a group, these nurses have high social privilege and solid educational credentials. Yet it is clear that both formal education and life experiences factor into their political socialization. Both positive and negative critical incidents and influences such as labeling or career costs have contextualized their own and colleagues' experiences of activism. Their capacity to advocate for lesbian health in a particular time and place is shaped by awareness that emerges from critical self-reflection on power dynamics in their own workplaces and larger social institutions that inform normative features of nursing activism.[14,25] Given the unpredictable dynamics encountered by even highly privileged nurses, these findings raise questions about the implications for nurses who are minoritized in other ways, by language, skin color, or disability, to advocate given the career concerns many encounter.[14,26]

These findings indicate that meaningful educational strategies can be very useful in creating spaces to build capacity within the nursing profession to support lesbian health. However, given the continued invisibility of lesbian health in systems of knowledge-making such as research, education, and policy, nurses' lesbian health advocacy practice and the nurses themselves may be marginalized or silenced in relation to this political practice and institutionally supported spaces to effect change such as educational sessions few and far between. There are, however, hopeful signs. These findings support recent calls for support for LGBT students, sexual diversity education, and political leadership in nursing and other health provider curriculum.[8,14,17,19,21,24–26,28,42,46–51] In fact, findings from this policy study informed the development of a policy resolution which was accepted by the provincial nursing association and from which a position statement and interest group for nurses across sexual orientations and gender identities emerged.[51]

These findings support Rafael's[9] dialectic of caring in which nurses who understand the essence of nursing practice work at the most complex level, "empowered caring," by envisioning possibilities for change and taking action accordingly. She explains, "A transformative caring practice is empowering not only for clients but also for nurses. . . . They were strengthened by their nursing legacy, understood and valued nursing and themselves, and dared to imagine transformative possibilities."[9(p41)]

The broad scope of these nurses' political activism across sectors is evident. Their work, which crosses both public and private spheres, extends understandings of nurses' advocacy practice, which typically focuses on the individual level. Collectively, their

advocacy to enhance the visibility of sexual diversity has fostered community development as well as organizational policy and curriculum directions that challenge the often unexamined heterosexism embedded in the profession. Their practices demonstrate how their activism is consistent with nursing theories that support caring science and primary healthcare with their goals of social justice. As well, their knowledges and practices, while mutually constitutive and demonstrating sociopolitical knowing, are embodied by tensions related to gender and other power relations. There are implications for nursing leadership at the everyday level to foster transformational educational spaces across institutions and communities that support nurses across orientations in actions that affirm the diverse lives of LGBT people and foster conditions for their health.

REFERENCES

1. MacDonnell JA. Fostering community health: practices and processes of women's politics. In: 6th Biannual International Institute Proceedings of the Canadian Association for the Study of Women and Education (CASWE); May 30–June 1, 2006; Toronto, Ontario, Canada.
2. World Health Organization, Health and Welfare Canada, and Canadian Public Health Association. Ottawa Charter for Health Promotion. *Can J Public Health.* 1986;77(6):425–427.
3. Rafael ARF. The politics of health promotion: influences on public health promoting nursing practice in Ontario, Canada, from Nightingale to the nineties. *ANS Adv Nurs Sci*. 1999;22(1):23–39.
4. Raphael D, Bryant T, Curry-Stevens A. Toronto charter outlines future health policy directions for Canada and elsewhere. *Health Promot Int*. 2004;19(2):269–273.
5. Mallik M. Advocacy in nursing—a review of the literature. *J Adv Nurs*. 1997;25:130–138.
6. McDonald C. Issues of gender and power: the significance attributed to nurses' work. In: McIntyre M, Thomlinson E, McDonald C, eds. *Realities of Canadian Nursing: Professional, Practice, and Power Issues.* Philadelphia, PA: Lippincott Williams & Wilkins; 2006:334–347.
7. Gott M, ed. *Nursing Practice, Policy and Change.* Abingdon, Great Britain: Radcliffe Medical Press; 2000.
8. MacDonnell JA. Articulating a policy resolution for sexual minorities: nurses as moral agents. *Can J Nurs Res.* 2007;39(4):74–92.
9. Rafael ARF. Nurses who run with the wolves: the power and caring dialectic revisited. *ANS Adv Nurs Sci*. 1998;21(1):29–42.
10. Vickers J. *Reinventing Political Science: A Feminist Approach*. Halifax, Nova Scotia, Canada: Fernwood Publishing; 1997.
11. Boston Women's Health Book Collective. *The New Our Bodies, Ourselves: A Book by and for Women.* Rev ed. New York, NY: Simon & Schuster; 1992.
12. Diane S. *Amazing Grace(s): A Qualitative Study of Lesbian Helping Professionals* [master's thesis]. Vancouver, British Columbia: University of British Columbia; 1999.
13. McPherson K. *Bedside Matters: The Transformation of Canadian Nursing, 1900–1990.* New York, NY: Oxford University Press; 1996.
14. Giddings LS. Health disparities, social injustice, and the culture of nursing. *Nurs Res.* 2005;54:304–312.
15. Stevens PE. Lesbian health care research: a review of the literature from 1970–1990. *Health Care Women Int.* 1992;13:91–120.
16. Walpin L. Combating heterosexism: implications for nursing. *Clin Nurse Spec.* 1997;11(3):126–132.
17. MacDonnell JA, Andrews GJ. Placing sexuality in health policies: feminist geographies and public health nursing. *Geojournal*. 2006;65:349–364.
18. Dean L, Meyer IH, Robinson K, et al. Lesbian, gay, bisexual, and transgender health: findings and concerns. *J Gay Lesbian Med Assoc.* 2000;4(3):101–151.
19. Jackson B. (with Daley A, Moore D, Mulé N, Ross L, Travers A.). *Whose Public Health? An Intersectional Approach to Sexual Orientation, Gender Identity and the Development of Public Health Goals for Canada* [Discussion paper]. Toronto, Ontario, Canada: Ontario Rainbow Health Partnership Project; 2006.
20. Denenburg R. A history of the lesbian health movement. In: White J, Martinez MC, eds. *The Lesbian Health Book: Caring for Ourselves.* Seattle, WA: Seal Press; 1997:3–22.
21. Duncan K, Clipsham J, Hampson E, et al. *Improving the Access to and Quality of Public Health Services for Lesbians and Gay Men* [position paper]. Toronto, Ontario, Canada: Ontario Public Health Association; 2000.
22. McDonald C, Anderson B, McIntyre M. The view from somewhere: locating lesbian experience in women's health. *Health Care Women Int.* 2003;24(8):697–711.
23. Stevens PE. The experiences of lesbians of color in health care encounters: narrative insights for

improving access and quality. In: Ponticelli C, ed. *Gateways to Improving Lesbian Health and Health Care: Opening Doors*. New York, NY: Haworth Press; 1998:77–94.
24. Randall CE. *Nurse Educators' Experiences of Including Lesbian Content in Teaching: Impact on Pedagogy* [dissertation]. Victoria, British Columbia: University of Victoria; 2005.
25. Giddings L, Smith M. Stories of lesbian in/visibility in nursing. *Nurs Outlook*. 2001;49(1):14–19.
26. MacDonnell JA. Comparative life histories of nurses who advocate for lesbian health in a Canadian context: sexual orientation as a factor in career and workplace dynamics. In: Badgett MVL, Frank J, eds. *Sexual Orientation Discrimination: An International Perspective*. London: Routledge; 2007:118–135.
27. MacDonnell JA. *Educational Issues Perceived by Expectant Lesbian Couples* [master's thesis]. St Catharines, Ontario, Canada: Brock University; 2001.
28. Gray DP, Kramer M, Minick P, McGehee L, Thomas D, Greiner D. Heterosexism in nursing education. *J Nurs Educ.* 1996;35:204–210.
29. MacDonnell JA. *Situating the Political in Nurses' Lives: The Intersection of Policy, Practice and Career for Lesbian Health Advocates* [dissertation]. Toronto, Ontario, Canada: University of Toronto; 2005.
30. Ozga J. *Policy Research in Educational Settings: Contested Terrain*. Buckingham, Great Britain: Open University Press; 2000.
31. Casey K. *I Answer With My Life: Life Histories of Women Teachers Working for Social Change*. New York: Routledge; 1993.
32. Goodson I. Scrutinizing life stories: storylines, scripts and social context. In: Thiessen D, Bascia N, Goodson I, eds. *Making a Difference About Difference: The Lives and Careers of Racial Minority Immigrant Teachers*. Toronto, Ontario, Canada: Garamond Press; 1996:123–125.
33. Marshall C. Dismantling and reconstructing policy analysis. In: Marshall C, ed. *Feminist Critical Policy Analysis: A Perspective From Primary and Secondary Schooling*. Vol 1. Philadelphia: Falmer Press; 1997:1–39.
34. Oleson V. Feminisms and qualitative research at and into the millennium. In: Denzin NK, Lincoln YS, eds. *Handbook of Qualitative Research.* 2nd ed. Thousand Oaks, CA: Sage Publications; 2000:215–255.
35. Miller W, Crabtree B. The dance of interpretation. In: Crabtree B, Miller W, eds. *Doing Qualitative Research*. Thousand Oaks, CA: Sage Publications; 1999:127–143.
36. MacDonnell JA. Exploring matrices of mothering and feminisms: life history methodology as a venue for understanding the complexities of mothering discourses for lesbian health advocates. *J Assoc Res Mothering.* 2006;1(8):298–310.
37. Weiler K. Remembering and representing life choices: a critical perspective on teachers' oral history narratives. *Qual Stud Educ.* 1992;5(1):39–50.
38. Smith D, Jacobson L, Yiu L. Primary health care. In: Stamler LL, Yiu L, eds. *Community Health Nursing: A Canadian Perspective*. Toronto, Ontario, Canada: Pearson Prentice Hall; 2008:111–124.
39. Rafael ARF. Advancing nursing theory through theory-guided practice: the emergence of a critical caring perspective. *ANS Adv Nurs Sci.* 2005;28(1): 38–49.
40. Watson J. Theory of human caring. Accessed September 3, 2008, from http://hschealth.uchsc.edu/son/faculty/jw_evolution.htm
41. Doane GH, Varcoe C. Knowledge translation in everyday nursing: from evidence-based to inquiry-based practice. *ANS Adv Nurs Sci.* 2008;31(4):283–295.
42. Walsh CMM. *Personal and Professional Choices, Tensions, and Boundaries in the Lives of Lesbian Psychiatric Mental Health Nurses* [dissertation]. Wellington, New Zealand: Victoria University of Wellington; 2007.
43. White J. Patterns of knowing: review, critique, and update. *ANS Adv Nurs Sci*. 1995;17(4):73–86.
44. Stevens PE, Hall J. Applying critical theories to nursing in communities. *Public Health Nurs.* 1992;9(1):2–9.
45. Chinn P. *Peace and Power: Creative Leadership for Building Community*. New York, NY: Jones & Bartlett; 2004.
46. Barker A, Fairley L, Carey S. Why Q.N.S.A.? Working toward visibility in instructional environments: queer nursing student alliance. Poster presented at: McMaster University Annual Nursing Research Day; 2003; Hamilton, Ontario, Canada.
47. Dunn B, Wilson S, Tarko M. The LGTB health matters project. *Can Nurse.* 2007;103(8):8–9.
48. Edmonds E. Heterosexualization and nursing education. Paper presented at: The Canadian Rainbow Health Coalition 2004 Conference; November 4–7, 2004; Gatineau, Quebec, Canada.
49. Hart C. Heterosexism in nursing education: realities and possibilities for change. Paper presented at: The Canadian Rainbow Health Coalition 2004 Conference; November 4–7, 2004; Gatineau, Quebec, Canada.
50. Stephany T. Faculty support for gay and lesbian nursing students. *Nurse Educ.* 1992;17:22–23.
51. Registered Nurses Association of Ontario. *Respecting Sexual Orientation and Gender Identity* [position statement]. Toronto, Ontario, Canada: Registered Nurses Association of Ontario; 2007.