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The Limitations of Partial Citizenship

Health Care Institutions Underpinned With Heteronormative Ideals

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Tensions between apparent rights of lesbian, gay, bisexual, transgender, or queer/questioning people and the continued prevalence of heteronormative health care practice emerged in research with older women who self-identified as lesbian. Having already faced considerable exclusionary institutional practices in their lives, these women expressed anticipatory dread of the erasure of their lives in residential or long-term care. Drawing on the framework of sexual citizenship, this article critiques the disjuncture between the legal reality and the lived reality of LGBTQ people and suggests that social or political rights of full citizenship remain tenuous or absent in residential care settings. Authors present an alternative approach to human health experience. **Key words:** *aging*, *citizenship*, *heterosexism*, *institutional structures*, *LGBTQ*, *residential care*

IN THIS ARTICLE, the authors address and critique the disjuncture between the legal rights and the lived reality of people who identify as lesbian, gay, bisexual, transgender, or queer/questioning (LGBTQ) as they encounter health care institutions. We begin with a short discussion of how we came to the topic of institutional health care experiences for older LGBTQ people, followed by an exploration of the idea of sexual citizenship. The article closes with proposed recommendations for institutional policy and practice beyond a normative conceptualization of sex and sexuality. Although the initiative for this article was a research study, the intention here is not to provide a report of the research per se. Rather, the purpose of this article is to discuss the topic of heterosexism in the health care system, particularly in long-term care institutions.

As a prologue to further discussion, we outline terms that may be unfamiliar to some readers. Drawing on the work of Eliason et al,[1] we note, "There is no universal language that includes all people who vary from sexual and sex norms. We use the initials LGBTQ, recognizing the limitations of the term and the fact that many people use other labels or no labels at all."[1(p237)] For the purpose of this article, the initials *LGBTQ* will stand for people who identify as lesbian, gay, bisexual, transgender, or queer/questioning. Sex itself can be understood as the experience of oneself as feminine, masculine, or both, whereas transgender is representative of sex that is beyond the historical binary categories of man or woman. For some, transgender "represents people whose sense of their sex (woman or man) is not congruent with the sexual characteristics of their physical body (female or

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male) . . . While some transgendered people are interested in aligning their physical bodies or presentation more closely with their sense of their sex through surgical, endocrine, or cosmetic actions, other people live in the sex flux, avoiding reinstatement or compliance to the historical sex dualism."[2(p390)] Similarly, the term *queer* has been reclaimed in the LGBTQ community as an umbrella term, standing for people who identify outside the normative categories of sex, sexuality, or both. This term has particular salience for people who understand the categories of lesbian and gay as reliant on particular sex categories (woman and man), as it frees them from this gender-specific association. Another important term is *questioning*, where a person is not aligned with any category of sex or sexuality, including heterosexuality.

The terms lesbian, gay, and bisexual are commonly understood as indicators of sexuality, that is, indicative of the sex of the person one is sexually attracted to (object of desire). Sexual identity is also, however, intertwined with other important aspects of a person, such as political, social, and cultural contexts. "Experiences of sexuality cannot be thought of as the same for all people who name themselves heterosexual, lesbian, bisexual, or gay . . . However, in the face of these multiple expressions and experiences of sexuality, the overwhelmingly dominant interpretation of sexuality in Canada (and elsewhere) is heterosexuality, signifying the sexual and intimate relationships between women and men."[2(pp388-389)] It is the dominance of heterosexuality that fuels the idea of heteronormativity, the assumption that all people either are or wish to be in sexual and intimate relationships with a person of the opposite gender. As a taken-for-granted structure, heteronormativity has come to underpin many societal arrangements, far beyond the confines of sexuality. In collaboration with a rigid understanding of binary sex categories of woman and man, heteronormativity provides the basis for many unquestioned social relations in our world; for example, the assumptions that boys and girls will couple to dance; that women of a particular age would always be addressed as Mrs; or that all people would relate to music, movies, or other entertainment in which romance equals a heterosexual relationship.

The term that describes social arrangements that assume heterosexuality is *heterosexism*. This can be understood as "oppressive action that privileges heterosexual people and positions non-heterosexual people in the position of 'other.'"[2(p389)] *Homophobia*, which sometimes underlies heterosexism, is an irrational fear of, aversion to, or hatred toward LGBTQ people. Although not all heterosexism is generated by homophobia, heterosexist discrimination, even when underpinned by taken-for-granted assumptions or ignorance, results in oppression of LGBTQ people.

THE IMPETUS FOR THIS ARTICLE

The tension between the legal rights conferred for LGBTQ people in Canada and elsewhere, and the continued prevalence of heteronormative policy and practice emerged for us as an issue during a qualitative research study exploring older lesbians' experience of self-disclosure. This research, funded through the Social Sciences and Health Research Council in Canada, underwent ethics review at the University of Victoria in western Canada. During research interviews, women who self-identified as lesbian, aged 60 to 84 years expressed anticipatory dread over the possibility of future personal involvement with residential care. Participants recounted situations with partners and friends living in residential facilities where heterosexism and heteronormativity were prevalent in the day-to-day delivery of care. In these circumstances, care is based on the ideology of heteronormativity, which includes the taken-for-granted assumption that a heterosexual orientation is the normative one.[3] Heteronormative decisions or actions become heterosexist when implicit assumptions result in discrimination. The encounters witnessed in residential

settings echoed the all too familiar heterosexist treatment these women faced earlier in life in other societal institutions such as family, schools, universities, and religious groupings.

HETEROSEXISM IN HEALTH CARE LITERATURE

A review of Canadian and international literature indicates that nonheterosexual people's fears of experiencing heterosexist discrimination in health care institutions are well founded. Themes of heterosexism, heteronormativity, and homophobia are prominent in research addressing particular health care experiences such as diabetes[4] and cancer care,[5] and targeting particular life stages, such as adolescence.[6] Research uncovering heterosexist health care practice has been conducted in North America[7] and abroad.[8] In addition, literature points to heterosexism within professional health care communities of nurses,[9] physicians,[10] and nursing academics.[11] Perhaps most importantly, health services research has established that "Lesbian, gay, transgender, and bisexual (LGTB) Canadians experience poorer health outcomes than their heterosexual and nontransgender counterparts because of heterosexism and homophobia in our society."[12(p8)] Given the disciplinary and geographic diversity of this literature, one can assume that the conclusions of Canadian health services research directly linking heterosexism to poor health outcomes is relevant and applicable to other health care settings.

PERVASIVE EXPERIENCES OF INSTITUTIONAL EXCLUSIONARY PRACTICES

Although it is undoubtedly true that any aging adult considers the possibility of a future in residential care with trepidation, the intensity of the concerns raised in the research conversations with older lesbians gave us reason to pause. We heard what seemed to be a particular vulnerability from women who had negotiated disclosure and nondisclosure of sexual orientation in times of widespread homophobia of lives lived for years attuned to assessing the safety of every setting, attending to language, the use of pronouns, and innuendo. From our previous research of lesbian disclosure,[13-15] we know that the need for repeated disclosure of sexual orientation or by default to accept the assumption that one is heterosexual is a central issue facing women who do not identify as heterosexual in their everyday life. Women talk about the distress generated by this need to repeatedly correct the assumption of heterosexuality but also concede that it can be even more stressful to stay silent, negating realities of their lives and who they believe themselves to be.

In addition, these older women belong to a cohort that experienced a history within which protection and rights for LGBTQ people did not exist and queer sexualities and genders were pathologized and criminalized. It is particularly the case that women talked of—the pervasive heterosexism and homophobia that they faced through exclusionary institutional practices in the family, church, workplace, and academia. These institutional practices, underpinned with heteronormative ideals, shaped nearly every aspect of the women's lives and resulted in excommunication from families, the denial of same-sex relationships, and the shame of living double lives. People were not only *not* protected from experiences of discrimination the central public institutions of one's life were also complicit in promoting heteronormative compliance.[15]

HUMAN RIGHTS AND HETERONORMATIVITY

Although we concede that the experiences of many of these older lesbians took place before the era of civil rights advancement for LGBTQ people—which has included, in varying geographic locations, reforms of family, labor, and tax laws—we suggest that the advancements of rights that have taken place

for LGBTQ people in North America in recent decades do not go nearly far enough to ensure what Judith Butler might refer to as a "liveable life." Although the increased occurrence of the legalization of same-sex marriage and mainstream television gives the impression of political and social advancement for LGBTQ people in North America, a closer reading reveals a reality in which the heteronormative ideals continue to dominate. In the remainder of this article, we explore the limitations of human rights underpinned by heteronormativity and suggest instead, as Butler articulates, "It is not a matter of the simple entry of the excluded into an established ontology, but an insurrection at the level of ontology, a critical opening up of the questions, What is real? Whose lives are real? How might reality be remade?"[16(p33)]

When we speak here of the "advancement of rights" that continue to be underpinned by heteronormativity, we refer, as an exemplar, to the Civil Marriage Act (Bill C-38) of 2005, the legislation that legalized same-sex marriage across Canada. Although there is no doubt that the Civil Marriage Act has changed the position of many same-sex couples in Canadian society, and that subsequent changes in family law have consequences in the health care system, the influence of the legal realm on the day-to-day life for LGBTQ people is nominal. And perhaps more troubling than the insignificance of the impact of the law is the effect of this *one* law in sidelining continued efforts for more meaningful changes in society. In particular, we point to the heteronormative assumptions; that is, the assumption that heterosexuality is the normative orientation that dominates the very structures of social and health care institutions. Furthermore, we argue that some approaches to *rights*, including the legalization of same-sex marriage, actually reify rather than disrupt heteronormative structures.

Framework of sexual citizenship

To further this discussion, we draw on the idea of sexual citizenship, used and critiqued by academics and researchers in social work, law, and sociology including Dayley[7,17] and Cossman[18,19] from Canada, Phelan[20] and Ingram et al[21] from the United States, and Richardson[22,23] from the United Kingdom. Sexual citizenship is about "the extent to which a person's sexual orientation restricts access to citizenship in terms of social, civic, and political rights."[7(p798)] The strength of this framework is that it allows us to tease apart legal rights from other aspects of citizenship—such as the social realm. A central premise to citizenship is that it is conferred on multiple levels, including the legal, political, and social realms and that advances in one area, for example, the legal citizenship provided through the civil marriage act, do not necessarily equate to changes in the social realm. In other words, even laws preventing discrimination do not significantly affect heteronormative practices in the social realm. Thus, the term *partial* citizenship—a situation where there are limitations about the kinds of rights on offer to a particular group that restricts their membership in *full* citizenship.

Partial citizenship

Within the politics involving LGBTQ people, the case is made that legal wins such as the 2005 recognition of same-sex marriage advance the movement of people who identify as other than heterosexual toward full sexual citizenship. Although it is undoubtedly true that these advancements mediate the ease with which *some* people move in the world, there are many compromises that accompany this change and it is clearly not without its critics. Some would suggest that the legalization of same-sex marriage, on the basis of the heterosexual model of marriage, advances the heteronormative ideal. From our perspective, perhaps the most important critique of this sexual politics lies with the discourses of "equality as sameness" used in the process to secure such rights; in this case, highlighting the notion of LGBTQ people as ordinary, normal, and respectable citizens, virtually "the same" as heterosexuals. We view this discourse as a practice of assimilation and

normalization that confers acceptability on some LGBTQ people, but leaves many behind. Notably, those LGBTQ people who "pass" as ostensibly responsible, monogamous, and "heterosexual-like couples" are accepted to citizenship through marriage, whereas people who fall outside this quasi-heterosexual norm are excluded. Although some LGBTQ people are happy to partner in long-term monogamous partnerships, others live their lives and have the right to live their lives in different arrangements, less reflective of heteronormative values. Not incidentally, this politics of assimilation obscures the significant differences between and among LGBTQ people including the intersection of sexuality with gender, class, race, age, and ability. Although it is beyond the scope of this article to provide the depth of analysis that each of these differences could generate, it remains important to acknowledge that differences between and among LGBTQ people derive from the complex influences of these various social, material, and political positions.

Relegation to the "private realm"

It is clear that this normative construction of LGBTQ couples as responsible and respectable married citizens has advantages for those of particular class, sex conformity, and leanings. Alongside the recognition, legally and in some sense socially, that marriage brings, critics point out the desexualizing of LGBTQ people that accompanies this acceptance. In other words, it is all right to be queer, but not to act queer in public. Although it has become increasingly acceptable for LGBTQ people to disclose their sexual orientation verbally, the demonstration of sexuality other than heterosexuality continues to be relegated to the private realm. This would be the case where an institution does not restrict LGBTQ people from admission, but at the same time is intolerant of the expression of same-sex intimacy or desire.

In the research with older people who self-identified as lesbian, participants gave endless examples of ways in which their sexuality was relegated to the private realm, where their orientation or partnerships were never disclosed in public.[15] Although we may be tempted to construct an "absence of public disclosure" as merely "not coming out at public events or occasions," in reality, this private life sometimes meant always living separately from their partners and living double lives of social isolation. In some sense, the progress in terms of sexual expression has been measured. The difference between saying one is LGBTQ and fully living one's sexuality, with the taken-for-granted comfort of expressing one's sexuality that heterosexual people assume, is enormous. This juncture between legal rights and the lived reality of LGBTQ people brings into focus the disparity of citizenship in the social realm. Perhaps nowhere is this disparity more articulated than in institutions such as residential care settings. The laws, even those directly regulating discrimination, are yet to influence health care institutions to provide a welcoming, comfortable, or safe environment if one's orientation is other than the heterosexual norm.

Hannah Arendt[24(p205)] explains how a life that is relegated to the private sphere "means above all to be deprived of things essential to a truly human life: to be deprived of the reality that comes from being seen and heard by others." For LGBTQ people, individual disclosure is currently the process through which "being seen and heard" emerges. The lack of sociopolitical structures to create LBGTQ realities in a public domain, however, means that the individual alone still carries the burden to negotiate safe social community. Although being "seen and heard" is essential for resisting the ontological erasure that LGBTQ people face in heteronormative contexts, placing the burden for public disclosure with the individual is problematic for a number of reasons.

First, the burden of the individualized transition of knowledge from private to public is significant for the aging and elder LGBTQ people who live a "cycle of invisibility" in which the fear of potential heterosexism and reluctance to disclose sexual orientation is reinforced by their previous experiences of

institutional exclusionary practices. Second, although the transition from private to public may offer some form of emancipation, it risks essentializing one's identity: erasing all of the particularities that make one's life worth living to create a single descriptor such as lesbian, gay, bisexual, transgender, queer, or questioning. These identity descriptors tend to conceal the diverse realties of any life and, in particular, constrain understandings of the real-life fluidity of sex and sexualities.

PROBLEMATIZING CITIZENSHIP IN HUMAN HEALTH INSTITUTIONS

The effects of partial citizenship, particularly the exclusion of full social citizenship, are especially poignant when recognizing the dominance of the public domain in residential health care settings. In these settings, the place of home as the private domain is replaced with an "intimate public space" rife with heteronormative assumptions. In other words, in residential settings, people lose the safety of their homes, which for some LGBTQ elders is the only place in which to be at ease with partners and the social networks that they have created across a lifetime.[25] In many residential settings, day-to-day activities and institutional decisions regarding everything from social activity to personal care are underpinned with the assumptions of binary genders and heterosexual structures. This might include everything from the language used in assessment forms and assumptions in the way people are addressed to the films that are shown, the books in the library, and the music that is played, all with heterosexual themes. In personal experiences with institutional settings, notions of sex are exaggerated to construct highly feminized women and masculinized men, a troubling experience, particularly, we would suggest, for people living a sex or identity outside the binary norms. Women are expected to readily engage in typically feminine pursuits such as hairdressing appointments, manicures, crafts, and shopping outings, whereas men are relegated to the workshop, barbershop, and watching sports broadcasts. Stereotypically gendered activities such as these become even more troubling when inflicted on elder LGBTQ people not able to express their preferences because of cognitive changes or other disability. These assumptions indeed drive the heteronormative exclusionary practices in institutions, and nowhere more so than in long-term care and residential institutions.

Disrupting institutional structures

If we accept the argument that assimilation of LGBTQ people into the dominant heteronormative culture compromises the human health experience, we are ethically compelled to challenge the processes and policies that underpin health care delivery. It seems reasonable to suggest that although disclosure of difference by individuals increases awareness of LGBTQ-identified people, change in the social milieu requires the disruption of institutional structures. Facing what is surely a controversial and daunting task, we suggest that this is an opportunity for institutional leadership to bring needed change to social organization. Although it is beyond the realm of this article to detail the needed disruption and reconstruction of a fully inclusive model of sexual citizenship that would unseat the dominance of heteronormative assumptions, we do have a vision of how things might be otherwise.

RECOMENDATIONS

A great deal of focus has been on normalizing LGBTQ people to construct them as acceptable to mainstream culture; however, what is repeatedly overlooked is an approach that actually accommodates diversity in sex and sexuality. This proposed approach to care calls for the deconstruction of the hetero-homo dualities and the current narrow interpretation of dual-gender categories. We might note that the long-time divisions of gender (female/male) used to assign patients to

rooms in hospitals has been collapsed—motivated not by ideological advancements but by so called austerity measures. Rather than the previous practice of rooming women in one room and men in another, patients are now admitted to an available bed in any room in hospital, regardless of gender.

Beyond heteronormativity

In the proposed approach to care, normative assumptions of sexuality and sex would be replaced with those of ethical care, respect, and space for diverse expressions of sex and sexuality. It seems reasonable that leaders in health care institutions should be able to review, revise, and implement policies and practices with these ideals in mind. The Canadian Nurses Association,[26] provides a useful template for policy that opposes heterosexist oppression among other forms of discrimination. "When providing care, nurses do not discriminate on the basis of a person's race, ethnicity, culture, political and spiritual beliefs, social and marital status, *gender, sexual orientation*, age, health status, place of origin, lifestyle, mental or physical ability, or socioeconomic status or any other attribute"[26] (emphasis added). Along with policy development goes the need for education of staff, care providers, residents, and other people frequenting the facility, including visitors. In-service education for care providers and all facility staff should be compulsory and can be organized through some LGBTQ organizations. Educational content is also available through reputable online sources such as the GenSilent Project.[25] In addition, a newly released LGBT Field Guide, titled *Advancing Effective Communication, Cultural Competence and Patient-and Family-Centered Care for the Lesbian, Gay, Bisexual and Transgender Community*, is available online through the Gay and Lesbian Medical Association[27] in the United States. It is through education that staff and care providers will not only become familiar with GLBTQ differences but also recognize their own heterosexist attitudes. The creation of a living environment that is safe for people of all genders and sexualities includes not only policy and education of care providers, but active enforcement of policy as well as education of residents, family, and visitors to the facility. In much the same way that posters in health care settings reflect intolerance for violence, posted policies can both declare that people of all genders and sexualities are welcome and that oppressive language or behavior is not tolerated. Health care institutions might look to universities across North America and abroad where grass roots organizations of students, staff, and faculty work together to make their institutions safer and more inclusive spaces for people of all genders and sexualities. These groups, frequently referred to as positive space networks, provide a number of services in academic settings, such as workshops for staff, faculty, and students that could conceivably serve as a model in health care settings.[28] As in academic settings, such programs thrive with the energy of identified resource people. In long-term care settings, staff, care providers, residents, and their friends or family members could serve as resource people to the residential setting.

Bringing conscious attention to the heteronormative assumptions that underpin the social structures of institutional settings is the first significant step. Once people who live and work in residential settings become aware of the dominance of heteronormativity, and accept the need for creation of a more inclusive setting, the changes that are required will in some sense be self-identifiable. In other words, when we come to see the heterosexist implications of the language used in assessment and admissions forms, staff orientations, policy and practice manuals, brochures, and guidelines for family and visitors, the areas for change become apparent. In addition, photographs and images in institutions should reflect multiple realities of genders and sexual/familial partnerships. Social and recreational opportunities in particular should be reviewed for assumptions of sex and sexual normativity and broadened to include the celebration of social events such as gay pride.

Returning to the discussion in this article of human rights and the expectation of full

citizenship for people of all sexualities and genders, because of the impact of heterosexism on the health of LGBTQ people, nurses have the obligation and the opportunity to create social and relational space for the realities of LGBTQ people. Furthermore, nurses and others in positions of authority have the obligation to initiate policy reform including guiding the use of language in signage and forms.

Unless health care leaders mobilize with deliberate intention to create inclusive spaces, the default context is heteronormative. To prevent past discourses from repeating, and close the gap between formal and actual equality, it is up to the health care providers, leaders, and educators to find the means for overcoming institutionalized heteronormativity. This can be achieved by working together to stop the cycle of invisibility—not by including LGBTQ people *into* heteronormative spaces, but by facilitating an approach to care in which each person can express herself/himself fully, in which no one is "deprived of things essential to a truly human life."[24(p205)]

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