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TR Misener

RL Sowell

Kenneth D. Phillips

University of South Carolina, kphill22@utk.edu

C.M. Harris

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Sexual Orientation: A Cultural Diversity Issue for Nursing

Terry R. Misener, RN, CS, PhD, FAAN
Richard L. Sowell, PhD, RN, FAAN
Kenneth D. Phillips, PhD, RN
Charlotte Harris, BSN, RN

Traditional approaches to cultural diversity and the development of a culturally aware workforce have consistently ignored the importance of gender role orientation and sexual orientation as sources of potential conflict in the work environment. To maintain its integrity as a caring profession, nursing must take steps to end personal and professional discrimination on the basis of sexual orientation.

As we approach the end of the millennium, political correctness, along with legal and moral imperatives, have placed cultural diversity, affirmative action, and equal opportunity on the front burners of corporate human resources departments and university curriculum committees. Addressing issues of cultural diversity in the health care delivery workplace is particularly challenging because efforts to achieve cultural competence must focus on both health care providers and consumers.

The process of developing cultural competence is the object of many seminars and in-service educational offerings. However, true development of cultural competence must begin with the examination of personal values and stereotypes.¹ Unless health care providers are aware of their own bias they will not be available to another's point of view. This challenge has arisen

frequently over the years, with issues of discrimination relating to race, ethnicity, religious beliefs, disabilities, nationality, and/or geographic heritage being well documented.²⁻⁶ Discrimination on these grounds is unacceptable and is not only unlawful from an organizational perspective, but can result in punitive actions against the person perpetrating the discrimination. However, the issue of gender has been ignored until recently even though it crosses all age and ethnic groups.

Although the concept of "glass ceilings" has brought to light the need for gender to be addressed in the workplace, little recognition has been given to sexual orientation as a core issue in the workplace, and civil rights based on sexual orientation have not reached parity with civil rights stemming from other discriminatory practices.⁷⁻⁸ Several industries are voluntarily implementing policies and procedures to prevent employees from being discriminated against on the basis of their sexual orientation. In contrast, nursing, which prides itself on being a caring profession, has not dealt effectively with the issue of

sexual orientation as brought to light by the HIV/AIDS epidemic. Consequently, the effects of discrimination in the workplace based on sexual orientation have been completely ignored. A recent review of the nursing literature revealed no published works dealing with the issue of homosexuality in the nursing workforce.

Traditional approaches to cultural diversity and the development of a culturally aware workforce have consistently ignored the importance of gender role orientation and sexual orientation as sources of potential conflict in the work environment. The subject of reverse gender discrimination in nursing has received some media attention; however, even though the view that nurs-

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ing has no place for men may not often be overtly expressed, it lingers covertly in nursing education and practice. Attempts to attract men to the profession of nursing are undercut by sex bias expressed by the issue of homosexuality.⁹⁻¹¹

Sexual orientations that differ from the prevailing norm are not new. Throughout history homosexuals have been ridiculed, harassed, and treated differently from those who were perceived to be "normal." Men in nursing report that they are often assumed to have a problem with their sex-role identity and are frequently ques-

tioned about being homosexual. As in any other profession, thousands of gay and lesbian health care workers and nurses in particular do not reveal their sexual orientation and preferences to avoid discriminatory practices that would preclude them from being hired or advancing in the nursing profession.¹² Gay and lesbian persons fear for their personal safety and fear professional sanctions. These professional sanctions occur despite passage of American Nurses' Association Resolution #51, which supports civil rights legislation at the local, state, and federal level—support that would ensure equal protection to all persons regardless of sexual orientation and preferences.¹³ Nurses' homophobic fears do not begin with their entry into the profession but are reflections of their past experiences, even as teenagers.

Knowledge by health care workers about sexual orientation is skewed to nonexistent.

How prevalent is homosexuality among health care workers and among nurses specifically? The answer is unknown because the subject is taboo and because of its sensitive nature. Most estimates are deemed low because of an unwillingness by gays and lesbians to disclose their sexual orientation. However, a recent report by the Department of Health Policy and Management of the Harvard School of Public Health can be used to extrapolate the figures.¹⁴ Sells et al.¹⁴ used the Project HOPE International Survey of AIDS-Risk Behaviors to make estimates for the United States, the United Kingdom, and France. These investigators used both homosexual contact plus sexual attraction to a member of the same sex to derive their figures. They report that within the 5 years before data collection, 6.2%, 4.5%, and 10.7% of men and 3.6%, 2.1%, and 3.3% of women in the United States, the United Kingdom, and France, respectively, reported having sexual contact with a member of the same sex. When the investigators expanded their definition of homosexual orientation to include sexual attraction toward a member of the same sex since the age of 15 years in addition to sexual contact with a member of

the same sex, the percentages rose to 20.8%, 16.3%, and 18.5% for men and 17.8%, 18.6%, and 18.5% for women in the United States, the United Kingdom, and France, respectively. We assume that nurses are a cross-section of the culture and representative of the national statistics. The registered nurse population in the United States is estimated to be between 1.8 and 2.2 million, with 4% of this population being men.¹⁵ Therefore, assuming the number of registered nurses in the United States to be 2 million, more than 77,500 have had sexual contact with a member of the same sex within the past 5 years (72,000 women and 5500 men) and 374,000 nurses (356,000 women and 18,400 men) could be estimated to have had a sexual attraction to a member of the same sex since the age of 15 years. Stated another way, one of every six nurses has had a same-sex attraction since the age of 15 years. Although the majority of gay and lesbian nurses may not disclose their sexual orientation, if these extrapolations are correct, they represent an impressive minority in the profession and therefore require the attention of workplace antidiscrimination policies.

Gay bashing is at an all-time high.¹⁶ D'Augelli,¹⁷ in a study of 125 lesbians and gay men in a university community, found that 26% had been threatened with violence and 17% reported damage of personal property, with roommates most often implicated as those responsible. Remafedi,¹⁸ in a study of U.S. teenagers, found that 30% had been the recipient of physical abuse, whereas 55% reported verbal abuse from peers and 37% admitted being discriminated against because of their sexual orientation.

Knowledge by health care workers about sexual orientation is skewed to nonexistent. Textbooks and curricula in nursing have little or no content regarding sexual orientation. Attitudes of health care providers toward both homosexual colleagues and patients are listed in the literature.¹⁹⁻²⁰ Schwanberg²⁰ performed a comprehensive review of attitudes toward homosexuality in the health care literature. In 59 articles on the subject, 61% of the studies reviewed by Schwanberg showed negative attitudes toward AIDS and toward gays and lesbians. More importantly, Schwanberg noted that a shift from neutral to negative attitudes had occurred and warned of the im-

plications of this shift for patient care. Similarly, Smith²¹ reports that stereotyping of homosexual behaviors may negatively affect the care of the homosexual patient and states that nurses must be comfortable with their own attitudes toward sexuality and homosexuality to provide quality care for patients with sexual orientations different from their own.

Gays and lesbians have historically been treated with insensitivity, antagonism, and discrimination in their health care encounters.

Gays and lesbians have historically been treated with insensitivity, antagonism, and discrimination in their health care encounters.²²⁻²³ Several studies in the literature indicate that many nurses fear dealing with homosexual clients.²⁴⁻²⁶ In 1985 Douglas et al.²⁷ studied homophobia among physicians and nurses. Of the 114 respondents, six were either bisexual or homosexual. All respondents indicated that they had personally cared for a male homosexual with AIDS. The majority of all respondents reported working with a homosexual colleague and had a close friend or relative who is homosexual. Whereas both groups had a low-grade homophobic score on the Index of Homophobia Scale, the results revealed that nurses were significantly more homophobic than physicians. Questions dealing with AIDS and homosexuality produced unacceptable findings. An equal number of physicians and nurses (32%) agreed with the statement, "In the hospital, patients with AIDS receive inferior care compared to patients with other illnesses." Physicians (32%) and nurses (30%) agreed with the statement that they "feel more negatively about homosexuality since the emergence of the AIDS crisis." While admitting the limitations of the study, the investigators remained confident about several conclusions. Men in the study had lower homophobic scores than women. Having a close friend or relative who is gay produced significantly lower homophobic scores. In contrast to nurses, physicians' personal anxiety was not reduced if they worked closely with a gay colleague. Nega-

tive behaviors toward homosexuals have been documented to include poor care,²⁸ avoidance,²⁹⁻³⁰ and violence by caregivers.³¹ Several studies have further documented that fear, ignorance, and homophobia influence nurses' ambivalent feelings and decisions to refuse to provide care particularly for persons with HIV/AIDS, both in the United States and in other countries.³²⁻³⁷

In another study of 160 registered nurses in one London hospital, Lewis and Bor³⁸ reported that 54% of nurses feel embarrassed when discussing sexuality with patients, yet more than 78% of the nurses felt adequately educated regarding sexual matters. Male nurses were more likely to discuss sexuality with patients than were female nurses. The authors concluded that although knowledge is increased in educational programs, a strong affective component may still exist. They posit that educational programs for nurses should deal more effectively with bias and nonjudgmental approaches to sexuality. The areas of concerns and problems reported by Lewis and Bor³⁸ were the same as those found by earlier investigators, who reported a belief that an overemphasis had been placed on cognitive elements and that the affective and behavioral elements surrounding homosexuality were neglected.³⁹⁻⁴⁰

Persons who have "come out" state that it is easier when their colleagues have known and respected them as professionals before learning of their sexual orientation.

With this in mind, the reasons why nurses are unwilling to reveal their sexual orientation to their colleagues are understandable. Nurses have heard the uncaring comments made by fellow workers about gay and lesbian patients. Even though jokes about homosexuality, race, and religion are grounds for punitive actions against the person perpetrating the discrimination,⁴¹ why should homosexual nurses believe they would be treated any differently or thought of more highly than the patients talked about by their colleagues? Few if any persons in the workplace are sensitive to the

rights and feelings of colleagues who are gay and lesbian.

Persons who have "come out" state that it is easier when their colleagues have known and respected them as professionals before learning of their sexual orientation.⁴¹ However, in the same report, some persons recount "being passed over for promotion" because they were lesbian. Likewise, one nurse reported being denied compassionate leave when her long-term companion became ill and died. The stress placed on lesbian respondents was evident, with almost three quarters admitting that they consistently censored themselves when discussing social activities with colleagues. This stress has implications both personally and professionally for lesbian nurses, because personal stress associated with discrimination surely must affect the effectiveness of these nurses in interacting with colleagues and rendering the highest levels of care. Attitudes toward lesbian colleagues can easily be transferred to lesbian clients. Obviously a wide gap exists between the policy espoused by nurses and the attitudes and behaviors they manifest.

Although nursing prides itself on the central theme of caring in the conceptual paradigm of the profession, the literature abounds with reports of intolerance and insensitivity in nursing. When persons spend more waking hours in the workplace than in their own homes, the workplace should provide a safe environment for diversity, including diversity related to sexual orientation. Not only is it ethical to provide a culturally sensitive work environment, but the development of a culturally competent workforce can have positive effects on health care delivery. Agencies that develop such workforces may find that they can reduce their costs by developing more efficient care delivery teams, decreasing staff turnover and absenteeism, and reducing potential litigation based on perceived discrimination.

Cognitively, education can assist the health care professional in the process of gaining cultural competence. However, education alone cannot minimize the highly affective component of an issue like sexual orientation. To apply cognitive learning, staff must be given the opportunity to explore the affective components of this issue within in-service and seminar training sessions. According to O'Connor,⁴² exercises to encourage cultural growth for staff

can be accomplished in several ways. In addition to the more standard tactics of guest speakers and role-play scenarios, she suggests interactive theater group performances in which a facilitator manages the audience and assists them in working through issues. This technique allows feelings that emerge to be dealt with in a safe, nonjudgmental environment. As opposed to isolated in-service training, O'Connor⁴² suggests that staff be given ample opportunity to increase their cultural sensitivity through regular discussions or conferences that are built into the schedule. An important distinction to be made in this educational process is the difference in fictional scenarios and actual cases. O'Connor⁴² asserts that it may be helpful to use actual examples of cases that did not go well or to invite patients or family members to participate in discussions, because these are the situations that staff remember most.

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Just as continuing nursing education is required, cultural education is a task that is also ongoing because culture is dynamic. Nursing must emphasize that antidiscrimination regarding differences in sexual orientation is just as important as antidiscrimination regarding race, religion, and ethnic heritage. Nurses must ensure that policies are established to prevent personal and professional discrimination toward a person merely because of sexual orientation. Failure to design and implement these policies will erode the philosophical basis of the profession and severely hamper the potential human resources brought to the profession by both men and women.

Values that are central to the philosophy of nursing include autonomy, the right to

self-determination, and acceptance of the characteristics that make each person unique. A disparity exists between the philosophy put forth by nursing and the individual philosophy of many nurses in regard to sexual orientation. The disparity between nursing's philosophy and the nurse's philosophy regarding the diversity related to sexual orientation can and must be corrected.

Acceptance of a colleague or a client with a homosexual orientation does not mean that nurses must sacrifice their beliefs, morals, or values regarding the morality of homosexuality. Acceptance simply supports the individual's right to choose his or her own paths and to respect the talents and abilities he or she brings to the work setting. Acceptance of diversity requires heightened awareness, and this may be accomplished either formally through education or informally by a nurse's reaction to unkind remarks that are made by others about an individual's sexual orientation. ■

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TERRY R. MISENER is a professor at The University of South Carolina College of Nursing, Columbia.

RICHARD L. SOWELL is an associate professor at The University of South Carolina College of Nursing, Columbia.

KENNETH D. PHILLIPS is an assistant professor at The University of South Carolina College of Nursing, Columbia.

CHARLOTTE HARRIS is a graduate research assistant at The University of South Carolina College of Nursing, Columbia.