LGBTQ2 Health in Hospital:
A brief directed to the House of Commons Standing Committee on Health,
Study on LGBTQ2 Health in Canada

Prepared by Alyssa M. Knox, RN, MSc(A)

Motivation

Lesbian, gay, bisexual, transgender, queer and two-spirit (LGBTQ2) communities have historically experienced structural inequity and pathologization of our identities. As a group, queer and trans people therefore approach public institutions from positions of vulnerability and mistrust[1, 2]. I am motivated to prepare and submit this brief based on my personal experience as both a queer person and a healthcare professional. As a registered nurse and a nursing student in acute care settings, my observations and experiences lead me to be concerned that most hospital nursing care providers, even in large Canadian cities, have inadequate preparation to assess and respond to the unique psychosocial needs of LGBTQ2 people. My personal experiences and the research literature suggest that some nurses exhibit unexamined biases, ignorance, and even overt discriminatory behaviour.

I am writing this brief from my perspective as an individual, and therefore wish to situate my personal experiences and perspective by identifying myself as a queer/lesbian cisgender woman. I feel it is important to note that since I pass as straight (i.e. am not visibly identifiable as queer), I often overhear discriminatory remarks made about other people (including patients and other professionals), but rarely face homophobia directed towards myself. My perspective is that of a white person with a middle-class background and access to graduate education.

Barriers to Care

Queer and trans[1] people seeking healthcare anticipate encountering heteronormative, cissexist environments[2-8]. Qualitative studies report that queer and trans people fear being unable to obtain respectful and appropriate healthcare, often based on past healthcare encounters in which providers reacted poorly to disclosure or presentation of queer and trans identities[4, 8-12]. In particular, trans people report being denied care (including for concerns that are not gender-related) based on their identity and primary care providers' stated lack of knowledge about trans health[3, 10, 11, 13]. Queer and trans experiences of invisibility, erasure, exclusion, and discrimination in healthcare contexts remain pervasive in Canada[2, 4, 6, 7, 9, 14-17] and around the world[8, 11, 18-25]

Barriers to care faced by queer and trans people have been found to reduce access to primary and preventative care[17, 26-29]. This lack of access could potentially result in increased incidence of acute illness, or acute episodes in chronic courses of illness, although research has yet to explore this question explicitly.

Is the Hospital Safe for LGBTQ2 Patients?

Acute care hospitalization is a time of stress and increased vulnerability[30]. Patient and family-centred care is increasingly recognized as improving hospitalization experiences, and as having a measurable, positive impact on hospitalization and health outcomes, such as decreased length of stay[31-33]. Nurses must understand the identities, culture, and health needs of LGBTQ2 patients and their families to provide patient-centred care to these populations.

A review of research addressing LGB patients in critical care published in 1998 found only

---

[1] The phrase "queer and trans people" refers to LGBTQ2 people. "Queer" in this context is an umbrella term referring to lesbian, gay, and bisexual people; and to others with minority sexual orientations, such as pansexual people. Trans, likewise, refers to transgender, agender, bigender, and non-binary people. Two-spirit people may identify within either, both, or neither category but my intention is to include them in this phrase.

two studies[34]. Over the past 20 years, LGBTQ2 patients' experiences and needs have been increasingly explored in several clinical fields (particularly primary care, mental health, and sexual health). However, there have been very few studies addressing their needs or experiences in the acute care setting. Some oncology studies touch on both inpatient and outpatient settings, and have identified gaps in care for LGBTQ2 people with cancer and their support people[12, 35, 36] and gaps in healthcare professional knowledge[37]. A single study conducted in the United States by Carabez et al assessed the LGBT health knowledge of 268 RNs, 77% of whom worked in hospital settings[38-40]; this study's results indicated that nurses had significant knowledge gaps and witnessed discrimination against LGBTQ2 patients, consistent with my personal experience. I will discuss its findings in more detail below. Significantly, no Canadian studies have focused on either patient experiences or healthcare professional skill or knowledge about LGBTQ2 health needs in the acute care setting.

Healthcare Professionals Inadequately Prepared

Numerous studies have addressed the inadequacy of LGBTQ2 content in nursing curricula over the past 10 years[38, 41-48]. Recent surveys of nursing faculty in both Canada and the United States found that LGBTQ2 identities and health needs were inadequately addressed in undergraduate nursing programs, and that some nursing faculty felt underprepared to teach these topics[43, 47]. A systematic review of LGBTQ+ education in nursing programs suggested that such education effectively increased nursing students' comfort discussing LGBTQ2 health topics[44]; another review covering medical education more broadly had similar conclusions[46].

Why, then, does this gap in nursing education remain unfilled? In recent faculty surveys, some nursing professors continue to report that they do not consider the topic important to cover[43, 47]. Median hours of education reported range from just 2.1 to 5 across the course of an entire nursing program, with some programs reporting 0 hours, or no content at all[43, 47]. This lack of education is a probable explanation for some of the omnipresent assumption of heterosexuality in the hospital environment[45, 49, 50]. One nurse interviewed about LGBT health knowledge in a mixed methods study reported that in the absence of LGBTQ2 content provided in her courses, she became the "token lesbian who taught queer health to peers in nursing school"[38] ...an experience anecdotally shared by myself and nurses and nursing students of my acquaintance.

While the lack of LGBTQ2 content in nursing curricula must be addressed at the level of entry to practice curricula, working professionals also exhibit important gaps in their knowledge[38-40]. In a 2018 quality improvement project which involved providing trans cultural competence in-services to hospital nursing staff, Shankel et al[51] demonstrated increased patient satisfaction after their intervention. Nurses' lack of LGBTQ2 knowledge is a problem that can be solved through continuing education.

Trans and Gender Non-Conforming Patients

Patient Experiences and HCP Attitudes

Both trans patients and healthcare professionals themselves report that trans people experience potentially harmful treatment while receiving healthcare[11, 40], and LGBQ patients are

also aware of this unique vulnerability[5]. Trans and gender non-conforming patients report inappropriate questioning, denial of care, misunderstanding of their health needs, lack of information or advice appropriate to their health situation, provider discomfort, and public questioning of their gender (e.g. in waiting areas)[3, 10, 11, 13].

Carabez et al's interviews with 268 nurses, 77% of whom worked in the hospital, included one question about trans health[40]. Nurses reported witnessing their colleagues refusing to provide care for trans people, and displayed a lack of knowledge about trans identities and healthcare needs. They reported taking part in stigmatizing actions including gossiping about trans patients and asking intrusive questions[40]. These actions demonstrate a lack of knowledge of appropriate care for—and, indeed, dignified treatment of—their trans patients. Some interviewees even described occasions when nursing staff abused their hospitalized patient's position of vulnerability. For example, one nurse reported that they and their colleagues "took turns" helping a trans patient use the bedpan in order "to see" [her genitals][40].

Potential Impact in the Acute Care Setting

Bedside nurses in the acute care setting are necessarily in intimate contact with their patients' bodies. If nurses are not prepared to understand, and respect, those bodies, the potential for harm to trans patients is enormous. Trans patients report experiencing considerable distress related to mistreatment by healthcare professionals in outpatient settings[10, 11]. How much more distressing must these experiences be when rather than leaving the doctor's office after a terrible appointment, the patient must remain in their hospital bed, powerless to escape future mistreatment and not knowing how the next nurse on shift will behave? Patients report self-protective behaviours such as not returning to the clinic where they were mistreated, or leaving the clinic with their physical health complaint unaddressed to protect their psychological wellbeing[11]. Might some trans patients feel the need to leave hospital against medical advice if they are experiencing what amounts to emotional abuse by healthcare professionals? More research about trans patients' hospitalization experiences is urgently needed[52].

Lesbian, Gay, Bisexual and Queer Patients

Patient Experiences and HCP Attitudes

Queer patients report feeling invisible when seeking healthcare, and heteronormative healthcare environments pose a barrier to disclosing sexual orientation[4-8, 12, 24, 53, 54]. Studies demonstrate that disclosing improves care experiences and health outcomes[36, 53, 55-59]. However, when LGBQ people do disclose their orientation, they report facing discrimination, misunderstanding, lack of competency to address their unique care needs[4-7, 12, 55, 60], and in some cases even denial of care[4, 54] and pathologization of sexual orientation[53]. While experiences of outright discrimination are relatively rare, the majority of queer people approaching healthcare contexts report feeling invisible[6, 8, 53]—or, worse, feeling impossible[20] when healthcare professionals completely fail to understand patients' sexual orientation, for example by requiring LBQ women with no exposure to sperm to take pregnancy tests or by documenting that women with same-gender sexual partners are "not sexually active"[53]. Bisexual people are both less likely to disclose than LGQ people, and at higher risk for a variety of negative health outcomes[53, 55, 59].

At the same time, research on nurses' attitudes towards LGBQ patients demonstrates that while few nurses report direct bias, many minimize the importance of difference[15, 61-63], reporting that they treat queer patients "the same"[15] as anyone else. While this attitude at first seems positive, it is ultimately not productive—since healthcare environments are overwhelmingly heteronormative[1, 2, 4, 8, 9, 20], when queer patients are treated "the same" as heterosexual patients, important parts of their lives, identities, and communities are denied. Structural inequalities LGBQ people experience and health disparities they are vulnerable to go unacknowledged[1, 2, 8, 26]. When healthcare professionals do understand LGBQ identities and health needs, patients often experience it as a "bonus"[53]. Nurses in Carabez et al's study (77% of whom worked in hospital contexts) reported feeling comfortable with LGBQ patients but lacked knowledge about their health risks and needs, and felt colleagues were not always comfortable[38].

Potential Impact in the Acute Care Setting

There is little research examining the impact this may have on hospitalized LGBQ patients. One study found that during serious illness, LGBQ2 patients' partners faced discrimination in healthcare settings[64]. Given that partners report discrimination, it seems likely that LGBQ patients also have these experiences.

Partners' experiences of discrimination are also problematic in and of themselves. This finding is supported by a study of LGBTQ oncology patients' experiences, which found that partners may not be acknowledged as the patient's spouse/caregiver, limiting access to resources available to heterosexual partners[12]. At the same time, LGBTQ2 patients' support people may in fact be close friends. Caregivers may not necessarily be those in romantic/sexual relationships, and the role played by families of origin in heterosexual culture may instead be played by a community of close friends in trans and queer patients' circles of support[12].

When hospitalized patients' networks of support are misunderstood or unacknowledged, there may be real consequences. Support people may feel uncomfortable at the bedside[12, 64], leaving LGBQ patients without support. Or they may be present but not reveal their roles in the patient's life, potentially leading to poor discharge planning. There is a need for research to examine both rates of disclosure of sexual orientation in hospital, and the potential impact of non-disclosure on both health outcomes and hospitalization indicators such as length of stay.

Two-Spirit Patients

As Indigenous people who identify with minority gender and sexual orientations, two-spirit people face intersecting oppressions and are more vulnerable to negative health impacts than LGBTQ people of other cultural backgrounds[65]. However, very little research has directly addressed two-spirit people's experiences with healthcare services, and their experiences in the acute care setting have not been studied[65-68]. Two-spirit people's reports of their experiences accessing outpatient care suggest that they may have some experiences similar to those of queer and trans people, but that these experiences are exacerbated by co-occurring racism[65, 68]. Two-spirit people's experiences and needs when accessing health care represent one of the most significant gaps in the health research literature in this area.

Recommendations

- ***Education***
  - Encourage regulatory bodies to require the systematic inclusion of ample LGBTQ2 health content in all Canadian nursing programs.
    - Inclusion of LGBTQ2 identities and health needs in nursing school curricula is an essential first step towards provision of safe care to LGBTQ2 people in hospitals.
  - Urge provincial health authorities to provide continuing education about LGBTQ2 identities, cultures, and health needs to nurses working in acute care settings.
- ***Research***
  - In an online search of studies funded by CIHR over the past 10 years, none of the 50 LGBTQ2-related projects funded addressed the needs or experiences of patients in the acute care context.
  - Recognizing that hospital experiences and associated unique needs of LGBTQ2 people are under-researched:
    - Encourage funding of relevant work via federal funding agencies.
    - Encourage research specifically focusing on the experiences of two-spirit people.
- ***Policy***
  - Acknowledge the presence and importance of gender and sexual minority groups not included in the acronym "LGBTQ2"; for example, intersex and asexual people. (Often included in versions of this acronym, i.e. LGBTQ2IA.)
    - Your committee should consider conducting a future study or studies to address the health needs of Intersex and Asexual populations.

References

1. Knox S. Exploring heterosexual hegemony in health and social services: critical que(e)ries. Variegations. 2006;3:1-8.

2. Searle J. Queer Phenomenology, the Disruption of Heteronormativity, and Structurally Responsive Care. ANS Advances in nursing science. 2019.

3. Bauer GR, Hammond R, Travers R, Kaay M, Hohenadel KM, Boyce M. "I Don't Think This Is Theoretical; This Is Our Lives": How Erasure Impacts Health Care for Transgender People. Journal of the Association of Nurses in AIDS Care. 2009;20(5):348-61.

4. Colpitts E, Gahagan J. "I feel like I am surviving the health care system": understanding LGBTQ health in Nova Scotia, Canada. BMC Public Health. 2016;16(1):1005.

5. Rounds KE, McGrath BB, Walsh E. Perspectives on provider behaviors: a qualitative study of sexual and gender minorities regarding quality of care. Contemp Nurse. 2013;44(1):99-110.

6. Fredericks E, Harbin A, Baker K. Being (in) visible in the clinic: a qualitative study of queer, lesbian, and bisexual women's health care experiences in Eastern Canada. Health care for women international. 2017;38(4):394-408.

7. Heyes C, Dean M, Goldberg L. Queer phenomenology, sexual orientation, and health care spaces: learning from the narratives of queer women and nurses in primary health care. Journal of homosexuality. 2016;63(2):141-55.

8. Meer T, Müller A. "They treat us like we're not there": Queer bodies and the social production of healthcare spaces. Health & place. 2017;45:92-8.

9. Harbin A, Beagan B, Goldberg L. Discomfort, Judgment, and Health Care for Queers. Journal of Bioethical Inquiry. 2012;9(2):149-60.

10. Kosenko K, Rintamaki L, Raney S, Maness K. Transgender patient perceptions of stigma in health care contexts. Medical care. 2013;51(9):819-22.

11. Paine EA. Embodied disruption:"Sorting out" gender and nonconformity in the doctor's office. Social Science & Medicine. 2018;211:352-8.

12. Kamen CS, Alpert A, Margolies L, Griggs JJ, Darbes L, Smith-Stoner M, et al. "Treat us with dignity": a qualitative study of the experiences and recommendations of lesbian, gay, bisexual, transgender, and queer (LGBTQ) patients with cancer. Supportive Care in Cancer. 2018:1-8.

13. Poteat T, German D, Kerrigan D. Managing uncertainty: a grounded theory of stigma in transgender health care encounters. Soc Sci Med. 2013;84:22-9.

14. Macdonnell JA, Fern R. Advocacy for Gender Diversity in the Contemporary Canadian Nursing Context: A Focus on Ontario. In: Irving D, Raj R, editors. Trans Activism in Canada: A Reader. Toronto: Canadian Scholars' Press, Inc; 2014. p. 269-85.

15. Beagan BL, Fredericks E, Goldberg L. Nurses' work with LGBTQ patients: "they're just like everybody else, so what's the difference"? The Canadian journal of nursing research = Revue canadienne de recherche en sciences infirmieres. 2012;44(3):44-63.

16. Daley A, MacDonnell JA. 'That would have been beneficial': LGBTQ education for home-care service providers. Health & Social Care in the Community. 2015;23(3):282-91.

17. Kortes-Miller K, Wilson K, Stinchcombe A. Care and LGBT Aging in Canada: A Focus Group Study on the Educational Gaps among Care Workers. Clinical gerontologist. 2019;42(2):192-7.

18. Alzate-Urrea S, Agudelo-Suárez AA, Monsalve-Orrego JY, Londoño-Candanoza FE, Chinome-Flórez GdC, Julio-Pérez AL, et al. Self-Perceived Discrimination in LGBT Population in Oral Health Services. Medellín, Colombia: A Qualitative Approach. Global Journal of Health Science. 2016;8(12).

19. Aslan F, Şahin NE, Emiroğlu ON. Turkish nurse educators knowledge regarding LGBT health and their level of homophobia: A descriptive–cross sectional study. Nurse Education Today. 2019;76:216-21.

20. Müller A. Beyond 'invisibility': queer intelligibility and symbolic annihilation in healthcare. Culture, health & sexuality. 2018;20(1):14-27.

21. Rondahl G. Lesbians' and gay men's narratives about attitudes in nursing. Scandinavian journal of caring sciences. 2009;23(1):146-52.

22. Human Rights Campaign. Health Equality Index: Promoting Equitable and Inclusive Care for Lesbian, Gay, Bisexual and Transgender Patients and Their Families. 2016.

23. Institute of Medicine. The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding. . Washington (DC): Institute of Medicine 2011.

24. Lambda Legal. When health care isn't caring: Lambda Legal's survey of discrimination against LGBT people and people with HIV. New York: Lambda Legal; 2010.

25. Duffy M. Lesbian Women's Experience of Coming Out in an Irish Hospital Setting: A Heremeutic Phenomenological Approach. Sexuality Research and Social Policy. 2011;8(4):335.

26. Blondeel K, Say L, Chou D, Toskin I, Khosla R, Scolaro E, et al. Evidence and knowledge gaps on the disease burden in sexual and gender minorities: a review of systematic reviews. International journal for equity in health. 2016;15(1):16.

27. Seelman KL, Colón-Diaz MJ, LeCroix RH, Xavier-Brier M, Kattari L. Transgender noninclusive healthcare and delaying care because of fear: connections to general health and mental health among transgender adults. Transgender health. 2017;2(1):17-28.

28. Tjepkema M. Health care use among gay, lesbian and bisexual Canadians. Health Reports. 2008;19(1):53.

29. Wight Hughto JM, Reisner SL, Pachankis JE. Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. Social science & medicine (1982). 2015;147:222-31.

30. Karademas EC, Tsagaraki A, Lambrou N. Illness acceptance, hospitalization stress and subjective health in a sample of chronic patients admitted to hospital. Journal of Health Psychology. 2009;14(8):1243-50.

31. Feinberg LF. Moving toward person-and family-centered care. Public Policy & Aging

Report. 2014;24(3):97-101.

32. Goldfarb MJ, Bibas L, Bartlett V, Jones H, Khan N. Outcomes of patient-and family-centered care interventions in the ICU: a systematic review and meta-analysis. Critical care medicine. 2017;45(10):1751-61.

33. Johnson B, Abraham M, Conway J, Simmons L, Edgman-Levitan S, Sodomka P, et al. Partnering with Patients and Families to Design a Patientand Family-Centered Health Care System: Recommendations and Promising Practices. Cambridge, MA: Institute for Patient and Family-Centered Care; 2008.

34. Albarran JW, Salmon D. Lesbian, gay and bisexual experiences within critical care nursing, 1988–1998: a survey of the literature. International Journal of Nursing Studies. 2000;37(5):445-55.

35. Eliason MJ, Dibble SL. Provider-patient issues for the LGBT cancer patient. Cancer and the LGBT community: Springer; 2015. p. 187-202.

36. Quinn GP, Schabath MB, Sanchez JA, Sutton SK, Green BL. The importance of disclosure: lesbian, gay, bisexual, transgender/transsexual, queer/questioning, and intersex individuals and the cancer continuum. Cancer. 2015;121(8):1160-3.

37. Banerjee SC, Walters CB, Staley JM, Alexander K, Parker PA. Knowledge, beliefs, and communication behavior of oncology health-care providers (HCPs) regarding lesbian, gay, bisexual, and transgender (LGBT) patient health care. Journal of health communication. 2018;23(4):329-39.

38. Carabez R, Pellegrini M, Mankovitz A, Eliason M, Ciano M, Scott M. "Never in All My Years…": Nurses' Education About LGBT Health. Journal of Professional Nursing. 2015;31(4):323-9.

39. Carabez R, Pellegrini M, Mankovitz A, Eliason M, Scott M. Does your organization use gender inclusive forms? Nurses' confusion about trans* terminology. Journal of Clinical Nursing. 2015;24(21/22):3306-17 12p.

40. Carabez RM, Eliason MJ, Martinson M. Nurses' Knowledge About Transgender Patient Care. Advances in Nursing Science. 2016;39(3):257-71.

41. Cornelius JB, Carrick J. A survey of nursing students' knowledge of and attitudes toward LGBT health care concerns. Nursing Education Perspectives. 2015;36(3):176-8.

42. De Guzman FLM, Moukoulou LNN, Scott LD, Zerwic JJ. LGBT inclusivity in health assessment textbooks. Journal of Professional Nursing. 2018;34(6):483-7.

43. Lim F, Johnson M, Eliason M. A National Survey of Faculty Knowledge, Experience, and Readiness for Teaching Lesbian, Gay, Bisexual, and Transgender Health in Baccalaureate Nursing Programs. Nursing Education Perspectives. 2015;36(3):144-52.

44. McCann E, Brown M. The inclusion of LGBT+ health issues within undergraduate healthcare education and professional training programmes: A systematic review. Nurse Educ Today. 2018;64:204-14.

45. Röndahl G. Heteronormativity in health care education programs. YNEDT Nurse

Education Today. 2011;31(4):345-9.

46. Sekoni AO, Gale NK, Manga-Atangana B, Bhadhuri A, Jolly K. The effects of educational curricula and training on LGBT-specific health issues for healthcare students and professionals: a mixed-method systematic review. Journal of the International AIDS Society. 2017;20(1):21624.

47. Shortall C. Teaching and Evaluation/Assessment Requirements for LGBTQI2S+ Health and Wellness: A Call to Include LGBTQI2S+ Content in Canadian English Baccalaureate Nursing Curricula/Exigences en matière d'enseignement et d'évaluation pour la santé et le bien-être des personnes LGBTQI2S+: un appel pour inclure du contenu dans les programmes de baccalauréat en sciences infirmières de langue anglaise au Canada. Quality Advancement in Nursing Education-Avancées en formation infirmière. 2019;5(1):7.

48. Walsh D, Hendrickson SG. Focusing on the 'T' in LGBT: an online survey of related content in Texas nursing programs. Journal of Nursing Education. 2015;54(6):347-51 5p.

49. Enson S. Causes and consequences of heteronormativity in healthcare and education. British Journal of School Nursing. 2015;10(2):73-8 6p.

50. Parameshwaran V, Cockbain BC, Hillyard M, Price JR. Is the lack of specific lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) health care education in medical school a cause for concern? Evidence from a survey of knowledge and practice among UK medical students. Journal of homosexuality. 2017;64(3):367-81.

51. Shankel K. Improving Knowledge and Attitude of Primary Healthcare Givers towards Vulnerable Populations: A Quality Improvement Project. 2018.

52. Merryfeather L, Bruce A. The invisibility of gender diversity: understanding transgender and transsexuality in nursing literature. Nursing forum. 2014;49(2):110-23.

53. Baldwin A, Dodge B, Schick V, Herbenick D, Sanders SA, Dhoot R, et al. Health and identity-related interactions between lesbian, bisexual, queer and pansexual women and their healthcare providers. Culture, health & sexuality. 2017;19(11):1181-96.

54. Hayman B, Wilkes L, Halcomb E, Jackson D. Marginalised mothers: Lesbian women negotiating heteronormative healthcare services. Contemporary nurse. 2013;44(1):120-7.

55. Mosack KE, Brouwer AM, Petroll AE. Sexual identity, identity disclosure, and health care experiences: is there evidence for differential homophobia in primary care practice? Women's Health Issues. 2013;23(6):e341-e6.

56. Neville S, Henrickson M. Perceptions of lesbian, gay and bisexual people of primary healthcare services. Journal of advanced nursing. 2006;55(4):407-15.

57. St Pierre M. Coming out in primary healthcare: An empirical investigation of a model of predictors and health outcomes of lesbian disclosure. 2013.

58. Daley AE. Being recognized, accepted, and affirmed: self-disclosure of lesbian/queer sexuality within psychiatric and mental health service settings. Social Work in Mental Health. 2010;8(4):336-55 20p.

59. Durso LE, Meyer IH. Patterns and predictors of disclosure of sexual orientation to

healthcare providers among lesbians, gay men, and bisexuals. Sexuality Research and Social Policy. 2013;10(1):35-42.

60. Burrow S, Goldberg L, Searle J, Aston M. Vulnerability, harm, and compromised ethics revealed by the experiences of queer birthing women in rural healthcare. Journal of bioethical inquiry. 2018;15(4):511-24.

61. Chapman R, Watkins R, Zappia T, Combs S, Shields L. Second-level hospital health professionals' attitudes to lesbian, gay, bisexual and transgender parents seeking health for their children. Journal of clinical nursing. 2012;21(5-6):880-7.

62. Dorsen C. An integrative review of nurse attitudes towards lesbian, gay, bisexual, and transgender patients. The Canadian journal of nursing research = Revue canadienne de recherche en sciences infirmières. 2012;44(3):18-43.

63. Rondahl G, Innala S, Carlsson M. Heterosexual assumptions in verbal and non-verbal communication in nursing. Journal of advanced nursing. 2006;56(4):373-81.

64. Dotolo D. “It's Always in the Back of your Mind”: LGBTQ Partners’ Experiences of Discrimination in Health Care for Serious Illnesses 2017.

65. Brotman S, Ryan B, Jalbert Y, Rowe B. Reclaiming space-regaining health: The health care experiences of two-spirit people in Canada. Journal of Gay & Lesbian Social Services. 2002;14(1):67-87.

66. Lyons T, Krüsi A, Pierre L, Smith A, Small W, Shannon K. Experiences of trans women and two-spirit persons accessing women-specific health and housing services in a downtown neighborhood of Vancouver, Canada. LGBT health. 2016;3(5):373-8.

67. Barnes J, Breckon MR, Houle K, Morgan R, Paquette M, Taylor C. Nowhere near enough: A needs assessment of health and safety services for transgender and two spirit people in Manitoba and Northwestern Ontario. Final Report to the Crime Prevention Branch of Public Safety and Emergency;2006.

68. Grills S. A postcolonial queer analysis of aboriginal queer clients' experiences of health care services in St. John's, Newfoundland: Memorial University of Newfoundland; 2015.