

Homophobia: Does it Affect Quality of Care?

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### Introduction

Imagine you are working in an acute care setting in a hospital. Your co-worker, Nurse A, is taking care of a newly admitted patient. During the assessment Nurse A discovers that the patient is a homosexual. The nurse finds herself morally disturbed by this. Confronting her supervisor, the nurse asks that she not be obligated to take care of this patient on the grounds that she is against the lifestyle of homosexuals. Upon further discussion, the nurse admits that she is afraid that the patient will make sexual advances towards her. The supervisor does not see this as a fit reason to relieve Nurse A of her duty owed to the patient, deciding that nurse must continue the assignment. Nurse A ceases to engage in caring conversation with the patient, no longer uses therapeutic touch, and avoids the patient at all costs aside from delivering medications as prescribed. She also makes derogatory statements about the patient's partner and speaks negatively with other co-workers regarding care for this type of patient. Knowing that Nurse A normally has great rapport with her patients and prides herself on establishing positive nurse-patient relationships, do you think that she has committed unethical acts as a nurse?

Homophobia does exist in the hospital and health care settings among nurses and other health care providers, therefore this issue must be addressed. The purpose of this paper is to educate others on the issue of homophobia in the health care field and show that negative attitudes towards lesbians, gays, and bisexuals (LGB) affect the quality of care they receive, by infringing on the rights of the patient and breaching the American Nurses' Association (ANA) Code of Ethics For Nurses (2001).

### Literature Review

According to Merriam-Webster's Dictionary, homophobia refers to an, "irrational fear of,

aversion to, or discrimination against homosexuality or homosexuals (para. 1)". Up until 1973, homosexuality was considered an emotional disorder. The American Psychology Association removed homosexuality from the emotional disorder list in 1975 claiming that homophobia was a prejudice based on stereotypes (Tate & Longo, 2004). Richmond and McKenna (1998) argue that the concept and interpretation of homophobia is shaped by individual experience, cultural and religious beliefs, and social and past experiences.

Society, culture and religion influence attitudes toward lesbian, gay, and bisexual people. Since nurses play an active role in these arenas it can be expected that nurses may be negatively persuaded by the social belief of homophobic prejudice. According to Dean et al. (2000), the negative attitudes that physicians and health care workers have towards lesbian, gay, and bisexual individuals can leave these patients prone to discrimination by the health care team. Christensen (2005) defines two attributes that pertain to homophobia in the nursing context. Nurses must have an internalized feeling of anti-homosexuality, and second, they must portray those feelings toward homosexuals in practice. Christensen posed a theoretical definition from the above attributes, which stated "homophobia in nursing is the inherent unconscious fear of homosexuality that leads to the corresponding failure to provide quality holistic care to this group of individuals based on these fears" (p. 65). Christensen (2005) also noted that homophobia can be observed in individuals who avoid, who are hesitant to provide care for, and who speak in a negative manner about homosexual patients.

In an attempt to support lesbian, gay, and bisexual communities in New Zealand, Neville and Henrickson (2006) conducted a study that researched the perceptions of disclosure of one's lesbian, gay, and bisexual identity to their health care providers. The study found that health care barriers toward homosexual patients existed in the way assessment data was gathered. Patients

complained that assessment formats were generally geared toward heterosexual responses. Dean et al. (2005) stated “medical forms and the format of medical history and intake are often insensitive to the experience of lesbian, gay, and bisexual patients and likely to discourage disclosure of sexual orientation and behavior” (p. 103). Dean et al. (2005) goes on to explain that these forms ask heterosexually biased questions such as, “Are you married, single, widowed, or divorced?” or “What kind of birth control do you use?” (p. 107)? Questions are rarely asked in such a manner where homosexuals feel comfortable disclosing their sexuality or are comforted knowing that their health care providers are culturally sensitive to their unique needs. Hindering disclosure thwarts accurate assessment of health risks in this community. Incorrectly addressing the needs of a patient compromises the level of care required.

Rondahl, Innala, & Carlsson (2004) surveyed nurses from Sweden on this issue. They found that nursing staff who believed that homosexuality is congenital showed positive attitudes toward homosexual patients and those who believed that homosexuality is acquired demonstrated negative attitudes toward those patients. According to Dean et al. (2005), even though homosexuality has been taken off the emotional disorder list, a correlation continues to exist between homosexuality and illness in the minds of nurses. Providers with a sympathetic attitude toward homosexuals may not understand the need for specific questions regarding lifestyle and sexual history, and therefore do not incorporate those types of questions in the assessment. This circumstance may be due to the lack of education for physicians and health care personnel on specific health related issues focused on the lesbian, gay, and bisexual population.

According to the American Nurses’ Association (ANA) (2001), nurses have a history of working with vulnerable populations and fighting for social justice. Providing substandard care

to lesbian, gay, and bisexual populations is negating that history. High standards of ethics are expected so that all populations and clients receive the same level of care. If nurses counteract the rights of the patient by letting their attitudes toward homosexuality influence the type of care the patient receives, then the negative influence leads to an ethical issue.

The first Provision of the ANA Code of Ethics for Nurses (2001) indicated that foremost, the patient should be treated with respect and dignity for human life. The nurse must show compassion and deliver health care in a non-judgmental manner, regardless of individual lifestyle and religious beliefs. Caring for a patient as a person with unique needs and differences should be upheld in every patient-nurse relationship. Refusing to treat a patient on behalf of difference in religious thought or lifestyle, and incorporating prejudice statements is unacceptable ethical behavior in the eyes of the ANA Code of Ethics for Nurses

Provision three of the ANA Code of Ethics for Nurses (2001) takes into account patient confidentiality, maintaining patient's rights, and advocating for the patient. Information shared between the nurse and the patient that need not be reported by law, should be kept confidential and not shared with individuals that are outside of the patient's care. This is necessary to build a trust in the nurse/patient relationship. As an advocate, the nurse fights to defend the patient's rights. Impaired practice and unethical care need to be addressed in order for the patient to receive the best care. When confidential information is spread to others, and if the nurse is part of the unethical care of the patient, then trust is diminished and advocacy becomes non-existent. According to the ANA Code of Ethics for Nurses, these acts are considered unethical to the nature of nursing.

Provision seven of the ANA Code of Ethics for Nurses (2001) addresses the idea that nursing, as a profession, needs to refine and advance the scope of nursing through continuing

education. In order to advance in the field of nursing, nurses need to didactically embrace new knowledge, evaluate the knowledge, publicize the information, and put the new knowledge into clinical practice. Without furthering education, the field of nursing becomes stagnant in the ethical treatment of patients. Society is dynamic, therefore, nursing must change in order to progress with the social changes of the patients. If further education is impeded, it is considered unethical practice, according to the ANA Code of Ethics for Nurses.

### Conclusion

Christensen (2005) stated, “homophobia in nursing may undoubtedly be an extreme violation of the individual’s right to receive adequate, professional, and compassionate care” (p. 70). Even though at times we as nurses may not agree with patients’ lifestyles, religious beliefs, or cultural upbringings, every patient deserves the most competent and compassionate care we can provide. By avoiding the patient, limiting therapeutic touch and communication, speaking unkindly of the patient’s sexuality with others, and not furthering education and understanding of cultural diversity the nurse has breached provisions one, three and seven of the ANA Code of Ethics for Nurses (2001). There is a lack of research in the U.S. on the topic of homophobia in health care. More education on the topic of non-judgmental care relating to lesbian, gay and bisexual patients is necessary. Nurses should be held responsible for actions that are not in compliance with the ANA Code of Ethics for Nurses (2001) particularly where patient care is sacrificed due to disagreement of lifestyle and sexual preferences. Homophobia is real. Judgmental comments occur and do affect quality of care. Realizing that the health care needs of to lesbian, gay and bisexual patients are unique must be addressed through education and cultural diversity training.

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