INSIGHT

Learning, Welcome, Generosity and Sexual Orientations/ Gender Identities

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"This should be straightforward." I've learned to quash any immediate impulse to hold onto, let alone voice, this thought. Healthcare is inescapably complex which means my "ethics antenna" actually perk up when someone begins a consult request with the quasi-apologetic "This is kinda ordinary." Case in point: "This is kinda ordinary, but we're making minor changes to our program's intake form. Is it still okay to use 'female', 'male', and 'other' in the client demographics section?"

Clinical, health equity, and client advocacy colleagues' help has been invaluable in answering such questions and deepening my own knowledge. As a result of our discussions and shared resources, now I often ask: does your service, program or research really need people to disclose such details at this particular time in this particular way? When it is relevant to the assessment, treatment or research, however, it is not uncommon for gender identity and sexual orientation to be mixed up with each other. Moreover, if a clinic, program, or protocol's checklist includes "Sex", this can be unclear: is it asking about the individual's endocrine system, anatomy, genetics, sexual orientation, or sexual behaviours?

The ethics-related concepts of diversity and respect are familiar in healthcare settings, but they can be unintentionally too 'thin,' rigid and static. For instance, there aren't a handful of gender identities and a handful of sexual orientations. There are many (see page 6 of CAMH's online *Asking the Right Questions 2* for more information). Furthermore, distinctions can still be used to label, distance, and suffocate. Awareness of differences can be erroneously conflated with fact or truth. Socio-political contexts are contested and evolving which means healthcare organizations and workers must understand and respond to their clients' socio-politically informed and influenced health and well-being. Consider the relatively new words 'cisgender' and 'cissexual.' First used in chemistry, 'cis' means alignment of atomic bonds within a molecule. In the case of gender/sexual orientation, it means alignment or matching of physiology, genetics, gender image, and sexual interest. Many societies and groups---past and present---presume, expect or demand such alignment. The *Cisgender Privilege Checklist* (available online) helps show the depth and magnitude of cisgender/sexual normalization in our everyday interactions and activities, despite governments, organizations, and individuals' efforts to eliminate stigma, discrimination and most recently, bullying.

The health implications of inequitable attention and engagement are real. Various studies show that people of minority identities and orientations are 4-5 times more likely as adolescents and 2-3 times more likely as adults to attempt suicide. They are more likely not to have various health needs met, irrespective of our publicly funded system. Importantly, however, a 2008 Health Canada study by Tjepkema cautioned against simply grouping these minority groups together (e.g., the ubiquitous "Other" on medical and research checklists). Given marked differences in both their health needs and service access, efficiency----as a practice and organizational value---must be counterbalanced by something else.

Arthur Frank, a medical sociologist at the University of Calgary, offers ethically restorative counterweights. Based on *The Renewal of Generosity* (2004) and discussions with Dr. Frank, I consider the concepts of welcome and generosity for healthcare settings to be much like Inuit inukshuks: they are deliberate, visible markers to safety, sustenance, and community. Do people who are not cisgender/sexual feel *truly* welcome in our programs, clinics, information lines, reception areas, and treatment units? Website information, paper and electronic forms, signage, and bath/changing rooms convey a lot about the amount of our forethought, preparations, and enjoyment in being of help (i.e., hospital: inhospitable or hospitable/hospitality?).

Generosity is critical because being in a minority gender identity or sexual orientation is unsafe in most settings, public or private. It should be expected that people will choose---wisely---to evade or not answer questions, even lie, because the personal harms can be immediate (i.e., the questioner's facial or oral response), serious, transitive (e.g., unprofessional gossip), and enduring. Generosity of time means patience as well as never demanding disclosure. In closing, healthcare workers and organizations must proactively create safe interactions, practices and spaces for *needed* disclosure of gender identity and sexual orientation information, rather than rely just on complaint hotlines and static posters/brochures.

P.S., note the unplanned irony of using "straightforward" in the opening sentence…

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