

***Out in the Cold: Barriers to health care for lesbians*** was a participatory research project undertaken through the Northern Secretariat by a group of women based in both the community and the university. A report from this project is expected soon. As a background to the project, Research Associates provided the following critical discussions. The first deals with health care issues faced by lesbians generally, while the second sketches the social context for lesbians in the north, specifically in Prince George.

### **Critical Interventions: Medicalizing the lesbian body**

By Maria Hudspith (UBC) and Amber Perry (UNBC)

Historically, the medical establishment has played a key role in defining normality, in constructing culturally acceptable behaviours and identities (Findlay, 1993). According to Todd (1989), "Medical dominance in a hierarchical system...is sustained by a scientific world view that corresponds to the interests of those in power" (p. 123). Stevens (1996) asserts that "all health care providers [are] in positions of authority

relative to clients by virtue of their diagnostic knowledge, clinical expertise, licensure and title, institutional position, and societal esteem" (p. 28). So, for example, societal reverence of institutional medicine and professional health care providers contributes to and maintains the hierarchical dominance of established medicine. Some theorists construe institutional medicine as monopolizing health care (Simkin, 1991; Adams, 1989). Hugman (1991) remarks on the internal and external organization of caring along class and gender lines in the construction of hierarchical power, while other research also includes race, sexual orientation, age, able-bodiedness and location as determinants of stratifications. This

*"homosexuality was until a few years ago considered a mental illness."*

*Ideology is a constellation of beliefs and values, often held unreflectively by individuals, embedded in a particular social and historical context. Sexual ideology is more than the observance of certain sexual mores or the expression of certain sexual beliefs: sexual ideology reflects the hegemonic power that dominant social groups have to control the body politic... (Sears, 1992, p.15)*

framework that privileges "doctors...as the knowers, [and] patients [as] the knowables" (Todd, 1989, p.121) predisposes health care interactions as potential sites of institutional violence, which may take the forms of silencing and/or psychological and physical abuse.

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Homosexuality was defined throughout the early twentieth century as a disease, and lesbians particularly, by virtue of their sex, were “ensnared in an ideological netherworld between immorality and madness” (Stevens and Hall, 1991, p. 294). Homosexuality was a disease thought to be the result of genetic anomalies. It was a “congenital constitutional weakness”, an “inborn predisposition to perversion”, or “hereditary taint” (Stevens and Hall, 1991, p. 295). This perversity was thought to be dangerous and contagious, and many lesbians and gay men were confined in insane asylums to protect the virtuous from contamination.

Throughout the late nineteenth and twentieth centuries, the medical establishment theorized about the exact nature and cause of the perversion of homosexuality. Lesbians and gay men were studied and *treated* by doctors and psychiatrists who aimed to identify and to cure. Shifts in medical and psychiatric thinking on homosexuality began to occur in the mid 1900s. Freud’s psychoanalytic model, which came to dominate medicine in the mid-twentieth century, moved homosexuality further from the realm of sickness and disease. Instead, Freud’s theories described same sex attraction and behaviour as pre-Oedipal, a stage that would be outgrown by healthy individuals in favour of the “moral imperative” of heterosexuality (Carlson, 1992, p. 46).

*“...I was the only person who was giving her any information about what this culture [lesbian] and everything is about. And I don’t feel I know enough really to be saying...”*

The cross-fertilization between popular and medical discourses worked to create vivid images of lesbians. Many *scientific* studies were based on *data* from pulp novels, tabloids, and from interviews with prison inmates and sex trade workers.

Physicians developed lists of physical characteristics that could be used to detect lesbian patients (i.e., wide shoulders, taller, firmer muscles). Behaviours that could be considered unconventional or gender-inappropriate (i.e.: involvement in skilled labour, dedication to career, involvement with social movements) were also considered part of the diagnostic criteria for lesbianism (Stevens and Hall, 1991). These apparently unbiased, scientific definitions of lesbianism worked in concert with social stereotyping and prejudice to create *the lesbian* in the medical imagination. This construction has shaped the policies and practices of health care and continues to influence lesbians’ experiences with the health care system today.

### The lesbian and gay rights movement

*"I think one of the biggest fears that I have had in my life has been that if I ever got to a point...where I needed help...I would automatically be labeled ...sick, because you are lesbian. Be labeled as depressed, because you are a lesbian. To be labeled as anxious, because you are a lesbian."*

In the 1960's, in much of the Western world, the emerging lesbian and gay rights movement began to make itself more visible and to promote lesbians and gays as *normal*, respectable members of society. The cultural upheaval and the work of other anti-oppression movements facilitated the development of a lesbian and gay liberation movement. The feminist movement in particular shared many concerns: sexual freedom, human rights, and oppression at the hands of the medical establishment among them. In the 1960's, lesbian

and gay activists turned their attention to the medical stigmatization of homosexuality, recognizing this as fundamental to societal discrimination. The target was the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders II (DSM II), the publication that defines and categorizes mental illnesses. Homosexuality had been listed in the DSM II as a pathology, placed alongside psychiatric disorders and psychoses. In 1973, after several years of lobbying, the APA removed homosexuality from the DSM II (Stevens and Hall, 1991). Although this was seen as a victory by some activists, the history of institutionalized homophobia in the medical system continued to pervade the practices of health care settings and the education of medical personnel. Despite the official declassification of homosexuality from the DSM manual in 1973, lesbianism has continued to be seen as an illness by many health care professionals, at least as recently as 1992 (Gentry, 1992; Eliason, Donelan and Randall, 1992; Mathews, 1986).<sup>1 2</sup>

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<sup>1</sup>Gender Dysphoria is currently the category that addresses individuals who are diagnosed as being unhappy with their sexual orientation. Remarkably, the WHO (World Health Organization) only removed homosexuality from the International Classification of Diseases in 1988.

<sup>2</sup> To briefly summarize here the relationship between mental health and lesbians would trivialize the atrocities that have been committed, and are currently still being committed. For this reason, lesbian mental health research warrants its own distinction as a research subject, and should not be subsumed under *lesbian health*.

### The legacy of homophobia in health care

*“Anything a Lesbian does she has to stem with caution...”*

Given this historical context, one would expect considerable barriers for lesbians attempting to access the health care system. Indeed, qualitative research on lesbian experiences with health care providers demonstrate the unique struggles that lesbians face (Denenberg, 1995; Stevens, 1995; Rosser, 1993). Most fundamental is the question of being out, or disclosing one’s lesbian identity. While it is assumed that honesty, respect and confidentiality are the cornerstones of the patient-health care provider relationship, this is not often the case for lesbians, for whom the disclosure of a lesbian identity may have negative consequences. A study of nurse educators in the United States found that 25 percent of participants saw lesbianism as immoral and wrong and 52 percent believed that lesbians should undergo treatment to become heterosexual (Rankow, 1995). A recent survey of American Association of Physicians for Human Rights found that 67 percent reported knowing of instances where lesbian, bisexual or gay patients had been refused care or had received substandard care because of their sexual orientation (Rankow, 1995). These attitudes are not left at the doors of operating rooms or clinics, but affect the quality of care that lesbians receive, impacting every aspect of medical interactions from diagnosis to treatment.

*“...I saw her [the receptionist] laugh and smile with other clients, patients,. It was like ‘Oh! She has teeth.’” [receptionist was always very cool and reserved with interviewee]*

The overt and subtle power conferred on nurses and physicians to control the experiences of health care interactions in a positive or negative manner is consistently addressed in the literature (Stevens, 1993; Bain, 1992; Gentry, 1992; Robertson, 1992; Jones, 1988; White, 1979). This power operates in an asymmetrical and pessimistic way in encounters between socially marginalized populations (including visible and invisible populations) and the health care system, maintaining and aggravating the relationship of empowered and disempowered. The definition of health, who counts as health experts, what constitutes legitimate health needs and/or sicknesses, and who may qualify as a deserving client are meanings that are rarely constituted by the (lesbian) patient: “caring professions regularly involve the separation of decision-making from contact with individual clients/patients” (Hugman, 1991, p. 67).

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The western construction of the “sick role” as dependent and incapacitated and the “need for caring” as an admission of one’s inability to “exercise a full adult social role,” infuses physicians with tremendous power to define “who is and who is not ‘really’ sick...”(Hugman, 1991, p. 121-122). This power to define fundamentally contributes to institutional medicine’s monopoly of health care, for clients are subjected to institutional values and prejudices that remain resistant to scrutiny that may construe them as anything other than objective and disinterested.

For lesbians, the assumption of heterosexuality determines the experience of dealing with the health care system, as it does in society in general. The presumption that all women partner with men guides the policies and practices of health care and renders lesbians invisible, an invisibility that directly affects the care that they receive. Invisible instances of abuse and violence occur, for instance, when advice, support, information and treatment are withheld at the discretion of the health care provider, or when unnecessary or arbitrary restrictions are placed on individuals that limit their daily lives. Some studies demonstrate that physicians ignore and/or trivialize women’s health concerns, or even withhold treatment to female clients whose lifestyles they may not support (Fisher & Roth in Stevens, 1990).

*“I think there is an assumption, well, first when you are having your initial visit with any health care provider, there is an assumption that you are heterosexual. Even on in-take forms....”*

Considering the historical controversy over lesbianism within institutional medicine, it is hardly difficult to recognize the potential for abuse by health care practitioners who hold negative opinions of homosexuality.

In this context, to ensure that adequate care is provided, lesbians must often make a declaration of their sexual identity or sexual practices. This disclosure is often met with disgust, fear, hostility, or misunderstanding and the anticipation of such a reaction may discourage a woman from being out (Rosser, 1993). The fear of identifying as a lesbian means that some lesbians must pass as heterosexual in health care settings, providing incomplete or inaccurate information about themselves in an effort to camouflage their lesbianism and ensure appropriate treatment. This carefully constructed charade often results in misdiagnosis and improper treatment, as well as discomfort and anxiety for the patient (Rankow, 1995; Denenberg, 1992; Stevens, 1992). The irony of disclosure is great: *If I allow the presumption of heterosexuality to go unchallenged, I risk receiving inappropriate care due to misinformation. Yet if I am out about my lesbian*

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*identity, I fear antagonism, disgust or sub/conscious medical mistreatment.* In an effort to avoid this negotiation of identity, many lesbians simply go without medical care.

*“If you go in [to the doctor] there’s an assumption that you’re a heterosexual woman. And, if indeed you are a heterosexual woman then you don’t need to do anything about that assumption. It’s true. But if you you’re a lesbian woman then the assumption is not true, yet the doctor is operating with those assumptions as though they were true. In that sense, you almost need to come out. And if you do, there’s a risk you may not get the best health care you need and want.”*

Lesbians are also silenced by the systemic preoccupation with women’s reproductive issues. The medical system has focused very little attention on women’s health, the only area of study to look exclusively at women’s health issues being obstetrics and gynecology. Given that this discipline deals primarily with issues of procreation and heterosexual sexual activity, it becomes apparent that the one component of health care to focus solely on women does so only in terms of their relations with men (Rosser, 1992). The most highly funded areas of

interest in women’s health take reproduction as their focus: contraceptives, in vitro fertilization, genetic testing and analysis. Conversely, those aspects of women’s health not related to the production of children (i.e.: nutrition, stress, menstrual pain) are considered low priority (Lefebvre, 1996). Given the medical system’s focus on the regulation of reproduction, it is not surprising that lesbian health is understudied. What is surprising is the invisibility of lesbian health on the agenda of the women’s health movement. Despite feminist organizing around women’s health issues for more than two decades, lesbian health, as a subject of struggle, has remained marginal.

### Social Context

*Smith states that “Comprehensive health care depends in part on the quality of the physician-patient relationship...” (1985, p. 1085).*

Most studies to date that focus on lesbians’ experiences of health care diagnose homophobia and heterosexism as the origins of most if not all of the barriers to care specific to lesbians (Roberts, 1995; Stevens, 1994; Gentry, 1992; Robertson, 1992; Trippet & Bain, 1992; Reagan, 1981). In particular, the relevance of wellness to the quality of the physician-client relationship (and how this is

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compromised by fears of coming out as a lesbian, issues of confidentiality, lesbian stereotypes and invisibility) is considered in much of the literature on lesbian health care experiences (Trippet & Bain, 1992; Adams, 1989; Edelman, 1986; Smith, Johnson & Guenther, 1985.) More recent (and perhaps a consequence of the impact of the popularization of alternative care on institutional care) is the recognition that health care that aims to address the needs of lesbian clients must be committed to understanding the social realities of being a lesbian, and that concepts of illness and wellness may be tied to particular lesbian subcultures (Stevens, 1988).<sup>3</sup> Trippet and Bain (1993 & 1992), Gentry (1992), Eliason (1991), Adams (1989) and Stevens (1988) are some researchers who emphasize the responsibility of health care providers to familiarize themselves with the social context of lesbian lives in order to provide sensitive care. The high probability of caring for some lesbians means “it is critical for health care providers to understand the lesbian life-style...to increase [their] sensitivity, knowledge, and awareness of the concerns of lesbians in a homophobic society” (Gentry, 1992, p. 173). For instance, ambiguity concerning lesbian sexual practices could mean that some physicians may not inform lesbian clients about specific preventative steps to ensure safe sex. Though lesbians have low rates of sexually transmitted diseases, susceptibility to STDs differs from heterosexual behavioural risks in that the spread of STDs in the lesbian population has more to do with modes of transmission than number of partners (Shaw, 1989). Often, inaccurate information or ignorance of this difference occurs (Gentry, 1992), posing an unnecessary health risk for the lesbians who depend upon and trust institutional health to assess and prescribe for their (or their partners’) health concerns and needs.

*“You are treated different because you are a minority.”*

Acknowledging the social context of lesbian health may also affect the kinds of support health care workers can offer to lesbian clients. For example, recognizing lesbian partners as spouses and/or family who are entitled to decision-making regarding care (for example, life-support systems), children, visitation rights and counselling, would constitute health care policy that both validates and is sensitive to lesbian lives. Adams (1989) notes the positive impact of one informed and caring doctor who “wrote a medical certificate for a woman who was working in an incredibly homophobic

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<sup>3</sup> Research on lesbian folk theories of wellness/illness is lacking; such projects would constitute an innovative, challenging and intriguing look at lesbian health from lesbian cultural perspectives.

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environment so that she was able to quit her job and remain eligible for unemployment insurance” (p. 57). Although statistics of homophobia among physicians, nurses and BSN students are disturbing, they cannot measure the impact homophobic behaviour

*“I feel that alternative forms of medicine, or people practicing more alternative forms of medicine have a tendency to be more open.”*

can have on health care clients who are already vulnerable both inside and outside medical institutions, and who cannot always access or relate to support groups that are based on heterosexual models. Eliason (1991) summarizes the literature

on this growing topic when she states simply that “nurses [in effect all health care providers] need to be aware of lesbian cultures in order to provide quality care to lesbians” (p. 364).

Though many marginalized populations experience health care as disempowering and intimidating, the doubly stigmatized position of lesbians in social and medical contexts means that quality, non-threatening care for lesbians will have to be free of homophobia and heterosexism, and take into account the particular cultures, lifestyles and sexual practices of lesbian populations. The literature on lesbian health suggests that many lesbians choose self care and/or what is deemed *alternative health* or *nontraditional health care*.<sup>4</sup> Seeking alternative health care may be construed as a deliberate choice of some lesbians who want to avoid negative encounters with traditional health care (Trippet & Bain, 1993 & 1992; Johnson, 1985).

One study found that 35% of lesbians chose nontraditional or alternative care (Johnson & Palermo in Robertson, 1992). Holistic concepts of wellness and care, non-hierarchical relationships and client autonomy are some attractive components of alternative

*“I think access in the north, whether to traditional or alternative practitioners is more difficult.”*

health care that counter factors in traditional health care largely responsible for the negative experiences of many lesbians, although the National Lesbian Health Care Survey listed financial reasons as the second most common explanation for not seeking traditional care (Bradford & Ryan, 1987). Alternative health care settings may also validate lesbian lives, for instance, by recognizing

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<sup>4</sup> We use *alternative* health care to designate the rise of homeopathic care since the 60s, which may include massage therapy, reflexology, herbal therapies, healing touch, acupuncture etc. Payment for such care may be negotiated via barter/trade, money, or it may be offered freely.



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lesbian relationships, involving lesbian partners in decisions of care, and/or by being knowledgeable and responsive to common lesbian health issues (for example, artificial insemination and lesbian sexuality issues). However, not all lesbians use alternative health care as a solution to barriers within institutional care.

Some lesbians may pursue holistic wellness for reasons other than those related to their sexual orientation (for example, superior care), while other lesbians receive both institutional and alternative care. Which lesbians seek alternative health care, why they do so, and other accessibility issues need to be considered in further research. It would be naive to assume that all lesbians can pursue alternative health care, or that alternative health care is essentially immune to homophobia, sexism and/or heterosexism.

*“He was very attentive and real talkative before I told him that [that interviewee was a lesbian]. And then the room became silent, and he wouldn't ... his whole attitude changed, you could tell. And he stared at me, like stare at me, you know. And it's like, What's the matter with you! I don't know, it just kinda...”*

For the lesbians who do interact with institutional health care, heterosexism, sexism and homophobia are barriers that are often manifest in health care encounters. Lesbians have always had (and continue) to endure, negotiate, outsmart, and at times confront the sorts of barriers listed above in their pursuit of medical attention. Many lesbians have survived institutional violence in forms such as silencing; overt hostility; withholding of information, care, treatment and support; denial of status to partners; and otherwise the enforcement of heterosexual frameworks onto our lives and health concerns. However, sometimes the tactics lesbians employ when negotiating heterosexism, sexism and homophobia within institutional health care are represented as “protective strategies” (Stevens, 1994, p. 217), which emphasizes lesbian resiliency to barriers as opposed to victimization by and subordination to these barriers. Not only do protective strategies serve as a wealth of knowledge for marginalized populations on how to navigate health

*“He'd already had a lesbian patient and she'd already broken him in, real good.”*

care, but particular strategies also reflect the specific needs and barriers of marginalized populations within the lesbian population along the lines of age, race, class and region. The predominant barriers to care - and how to strategize around them - for white, middle-class

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lesbians may be similar but not the same as those for working-class disabled lesbians or lesbians in rural communities.<sup>5</sup>

*"I don't go to the doctor very often, but I really find, like, it's really hard. I gotta push myself to go., I really got to push myself."*

However, some commonality exists within the standing literature with respect to protective strategies that many lesbians utilize in their negotiations of institutional health care. Some of these are summarized in Steven's article "Protective Strategies of Lesbian Clients in Health Care Environments" (1994) as follows: rallying support, screening providers, seeking mirrors of one's experiences, maintaining vigilance, controlling information, bringing witnesses, challenging mistreatment (registering complaints and striking daring poses), and escaping danger.

Unfortunately, delaying or refusing care except in emergency situations is a strategy consistently cited throughout the literature, although risks of increased susceptibility to cancer cautiously associated with irregular care hardly characterize this strategy as protective.<sup>6</sup> As in all areas of lesbian health, more research is necessary to accurately detail the protective strategies - and hence the specific needs and barriers - of lesbian populations.

When asked, lesbians readily make suggestions on how their health care experiences could be improved, and these recommendations are both consistent and well noted throughout the literature. There is a pronounced desire to restore self-knowledge and beliefs about personal health in the analyses of wellness. Open communication, confidentiality, access to information, informed health care providers and a commitment to deconstructing the assumed power differential in health care encounters are just a few changes lesbians believe would contribute to the success of this goal. Education for health care workers on lesbian health issues and lifestyles could be accommodated via lesbian health workshops. Elaine Wilson (1988) documents the positive impact that workshops can have on homophobic attitudes among nurses.

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<sup>5</sup> For example, accessing alternative health care is perhaps more readily an option for white, middle-class lesbians than it is for working-class lesbians or First Nations lesbians.

<sup>6</sup> It is important to note that sexual orientation has not been a variable in any study done on breast cancer (up to 1995), so actual rates of breast cancer among lesbians compared to bisexual and straight women until that time is not currently known (Roberts, 1995).

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Educating those who are currently employed in health care positions on the social realities and health issues of lesbians, as well as incorporating this education into the BSN curriculum, could effect a positive change, since several studies indicate that BSN students model their behaviours and attitudes after their instructors. Considering that 34% of nurses in one study found lesbian behaviour disgusting (Randall, 1989), there is reason to believe that educating medical practitioners about their homophobia could have a significant positive impact on the delivery of care now and in the future.

It is probable that a broader and more sensitive lesbian health research agenda will suggest other recommendations, protective strategies, and health meanings than the ones currently known, since the majority of research reflects the priorities/experiences of white, urban, middle and upper middle-class, formally educated lesbians who fall between 25-40 years of age. The difficulties in researching invisible populations are well documented, and to a certain degree may account for the demographic consistency or bias of most of the studies. What is striking is that there are very few instances in the literature where this bias is acknowledged and/or discussed in a critical, reflective way. Interestingly, one study (Roscoe in Rothblum, 1994) claims the futility of studying

*"I think we need a wellness centre here, like, an information centre, a clinic, but with more ommph to it, with a library and information and feedback, and seminars, speakers. They could do a big thing up here, there's enough people for that. Knowledge is a wonderful great thing if we could share it."*

homosexual populations in the first place, since homosexual identities are often spontaneous, discursive and unstable. It is unlikely, though, that a significant population masquerades as lesbian for sheer entertainment, or for the purpose of skewing research methods. Though it is clear that homogenizing the lesbian population will eliminate

significant differences, there must also be a continuous sense of lesbian identity initiating and sustaining the research. Aiming for sensitivity within an inclusive definition of lesbianism will result in more accurate knowledge. Qualitative research is an ideal framework that can both recognize and esteem unique findings, since it does not assume to represent large, random populations in the first place.

While there exists an academic consensus on both the status of homophobia as the original barrier to care for lesbians, and on the fact that many lesbians avoid routine care, there remains huge

gaps in the existing research (along the lines of race, age, class, ability and region) which make it difficult to summarize lesbian health in terms of *norms* or *constants*. In fact, the lack of diversity in the studies to date should be considered a considerable weakness in the existing knowledge on lesbian health needs and experiences. For example, although issues around patient confidentiality surface throughout the body of literature as a consistent barrier to care, it is not clear how the reality of living in northern, rural/remote areas impacts upon confidentiality and privacy in a way that is specific to the social and health needs of lesbians living in such locations. Other factors that make it difficult to control the meaning of lesbian health issues are developments in technology and the impact of social movements (Shaw, 1989). Recognizing the intricacy of these relationships, and how they impact determinants of health care, will be important goals of future health-oriented research interested in destabilizing those monolithic categories that have prevented lesbians from receiving sensitive, quality health care in the past.

Language such as *heterosexism*, *homophobia* and *sexism* do little to convey the tangible experiences of violence, humiliation, hostility and fear that a disturbing number of lesbians have experienced in diverse health care settings. The existing qualitative research is a source of powerful testimony to the offensive accounts of received care by lesbians. Such testimony consistently defines and qualifies these terms “homophobia” and “heterosexism” - a process that helps to ensure these varied accounts of institutional violence towards lesbians are not attenuated and compartmentalized into tidy boxes. The health care provider-client setting is theoretically one of trust and confidentiality (Gentry, 1992). As such, these settings can have a positive influence on the wellness of lesbians, given their lives are validated through awareness and respect for their particular social contexts, and their particular health needs.

### **Dangerous Territories: A Case Study in Homophobia, Prince George, 1997**

By Kathy Buhler, M.A.

The controversy began on January 28, 1997 with a segment on CBC Prince George's "Daybreak" Host Marcus Schwabe interviewed an employee of local health food store Ave Maria. The employee, Dominic, claimed to have found several items of a homophobic nature on the bookshelves of the store. The story had been precipitated by a letter from a tourist, addressed to the mayor of the City of Prince George calling attention to the store and its material. Fuelled by subsequent newspaper editorials, public reaction was swift, though in the ensuing tumult of opinion and name-calling, no one seemed to care whether or not the allegations were a) true; b) exaggerated or c) unfounded. Both the store's supporters and detractors began intense campaigns, played out in the local media. The main issues appeared to be threefold. On one hand, the store's right to display material of a kind they saw fit was debated as a free-speech issue. Opposing that issue were those who believed that such material, homophobic in itself, is the sort of thing that propagates hatred towards homosexuals. And finally, there were those who saw the issue as fundamentally religious in nature, and debated the interpretation of the Bible's stance on homosexuality. One of the real issues, Prince George's inhospitable atmosphere for gay people, was ignored.

The "Daybreak" segment was only the beginning of an issue that seemed to expose some of Prince George citizens' core beliefs about homosexuality. It was impossible to maintain neutrality in the face of explosive rhetoric on all sides. One of the first commentaries appeared in the Prince George *Free Press*, in an editorial entitled "Straight but not narrow". Editor Shane Mills spoke out against homophobia disguised as Christian virtue. In an editorial the following week, on February 9, he attacked what he saw as a government restricting free speech by censoring unpopular opinion. In part, this column was surely an attempt to protect the newspaper from those who would claim that it was printing hateful material. From there, the letters to the editor poured in.

One of the first letters appeared in the *Free Press* on February 13, 1997. The author attacked what he saw as Ave Maria's owners' intolerance towards homosexuality, and their propagation of hate literature. (For the record, most of this debate took place in the pages of the *Free Press*; the Prince George *Citizen* and *Prince George This Week*, the city's other newspapers, were completely

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silent on the subject until much later.) The author called for Ave Maria's owners to show respect for homosexual people and emphasized that not all people share their views. He warned that "there are many different ways of understanding our world and if one refuses to acknowledge this then they should be prepared to face public oppositions." The letter was a clear indication that Ave Maria would be subject to intense scrutiny and criticism in the coming weeks.

That same day, a full-page ad appeared in the *Citizen* and the *Free Press*. Louis Matte, owner and president of Ave Maria, placed the ad in response to heavy public pressure. In small print, Mr. Matte recounted his version of the controversy, beginning with the CBC "Daybreak" segment. Mr. Matte claimed to have no prior knowledge of the pamphlets on display at his store, and insisted that Dominic, the employee who publicized the story, had misled him and falsified the information. He wrote that Dominic had, in effect, stolen the offending literature from the store, and proceeded with "his campaign to undermine our business and good reputation." The next half of the ad was filled with anti-homosexual rhetoric disguised as Christian morality. "I also stated [to a CBC reporter] that if any of our literature which accurately expresses the truth happens to offend lechers, prostitutes, pimps, homosexuals, pedophiles, thieves, abortionists, or anyone else so inclined to oppose cohesive social values, that we will not be deterred by them as long as there are good people around willing to expose the truth and to be persecuted for it." As Mr. Matte coloured homosexuals with the same brush as he did pedophiles, it was clear that from his standpoint, good Christians must stand firm on their beliefs, homophobic or not, and be ready to take the heat.

Mr. Matte intended to clear his name and that of his store. However, his ad sparked even more heated controversy, as he refused to show any tolerance towards anyone he deemed morally depraved, including homosexuals. By using the banner of "truth", Mr. Matte opened the debate further to those who would interpret the Biblical views of homosexuality, and to those who debated free speech. The issue of homophobic material in itself took second place to issues of religion, truth, and interpretation. Though many repeatedly called for open debate and honest discussion, it appeared that no one wanted to hear their opponent's "honesty".

Evangelist Allan Sadinmaa took out his own ad in the *Free Press* on February 20. Verse after biblical verse was held up as the truth that homosexual people are morally corrupt and should be condemned. Further letters to the editor attempted to expose this

and the Ave Maria material as hate literature. Some of those who supported Ave Maria's owner and managers promoted free speech and bemoaned a too-politically-correct society. In all of this, the common theme was religious interpretation. People divided along lines of religion, and while many wondered aloud how it was that a religion founded on love could show such intolerance towards homosexuals, others insisted that homosexuality was a symptom of a corrupt society, one which religion could mend.

*"...when they say gay lifestyle, well tell me what that is because, it's funny. I live next to my neighbour and my neighbour is heterosexual and I live the same lifestyle they do. I go to the same market; I do the same Friday night thing. My sexual preference is different, that's all."*

On Saturday, March 8, a group of young people protested outside of Ave Maria. At issue for them was, in part, community awareness. Ave Maria responded by placing a sign in their window that called the group a "radical gay and lesbian group" (Prince George Citizen, March 10, 1997). Ave Maria's manager defended the material on his store's shelves by

insisting that to remove it would also necessitate removal of all material with which people might take issue. He held to his defence of free speech throughout the controversy, while most of those around him continued to debate along religious lines. Further letters to the editor debated interpretations of the Bible, each letter more strident than the last. Each side claimed to have found the truth. As Cam McAlpine stated in a March 16 editorial of the *Free Press*, "But no one's really listening to anyone else. Everyone is convinced of the correctness of their side, and of the fact that the other side just needs to be shown the light. Again, it doesn't matter what side your on [sic] -- the other guy needs saving." His editorial was one of the last on the issue. Two further letters called for open public discussion and honest dialogue. Ironically, the issue faded from the spotlight from there.

At issue here was not only one store's right to sell material that some called hate literature, but also the way Prince George treats gay and lesbian people. What became clear, however, was that religion is all-too easily used as a banner of truth, whichever truth that may be. Ave Maria's owner and managers sold literature that condemned homosexuality. The citizens of Prince George reacted with deeply held convictions on all sides.

*"The term lifestyle, it's just code, code for hate."*

As the letters to the editor showed, there were no common grounds that

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would open discussion. Rhetoric and religion, used as weapons, became shields for the problem that no one wanted to address: namely that homophobia is rampant in Prince George. By holding up the Bible as the one truth, Prince George residents avoided speaking for themselves and effectively stifled open discussion. The owner of Ave Maria remained unapologetic for the material his store carries, the manager stood behind free speech ideals, and most members of the general public were outraged on all sides. The outrage in itself brought the issue of homophobia to light, where no one knew what to do with it. As long as it was hidden, as long as no one talked about it, no one had to deal with it. But suddenly there it was: one store is accused of selling hate literature, and the issue could no longer be ignored. No one even knew how to talk about it, and thus used the words of religion and free speech to address an issue that no one properly understood. In some ways the issue could have been one step in a growing process for Prince George.

However, just as quickly as the issue arose, it died down again. The fire had burned itself out and people were tired of the controversy, tired of the debate and animosity. Many people wished the issue would disappear, so that, having said their piece they would not have to listen to others. No issues were resolved as a result, and Prince George is not much further along in terms of tolerance towards gay people. Although people will not publicly debate the rights of gay people, or what may constitute hate literature, the lines in the sand are still fairly clearly drawn. Ave Maria now has a reputation as being intolerant and closed-minded though a change in ownership has taken place and the hate literature has been removed. There are many people who will still not set foot in the store because of this issue even though alternative and complementary health remedies are only available to them through the store. The city is more clearly divided along religious lines. No one will debate the issue publicly, preferring not to expose the intolerant attitudes of many Prince George residents. The attitudes are still there, but as long as they remain undiscussed, the city does not have to go through the painful process of growing up.



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### **References**

- Cassidy, Roberta and Hughes, Tonda. (1995). Lesbian Health: Barriers to Care. In *The Annual Review of Women's Health*, Volume 3. McElmurry, Beverly and Parker, Randy Spreen (eds.) National League for Nursing Press. New York, New York.
- Denenberg, Risa. (1995). Report on Lesbian Health. *Women Health International*. Vol.5, No. 2., pp. 81-91.
- Glassman, Carol. (1995). Lesbians and HIV Disease. *Journal of Gay and Lesbian Social Services*. Vol. 2, No.3\4, pp. 61-74.
- Healthy Communities Committee. (1997). *Lesbians, gays and bisexuals. In Quality of life: Report on the quality of life in Prince George*. City of Prince George, BC.
- Maguire, P. (1987). *Doing Participatory Research: A Feminist Approach*. Amherst, Mass.: The Center for International Education, University of Massachusetts.
- Reinharz, Shulamit (1992) *Feminist Methods in Social Research*. New York, Oxford: Oxford University Press.
- Rosser, Sue. (1992). Ignored, Overlooked or Subsumed: Research on Lesbian Health and Health Care. *National Women's Studies Association Journal*. Vol. 5, No. 2, pp. 183-203.
- Stevens, Patricia, E. (1996). Lesbians and Doctors: Experiences of Solidarity and Domination in Health Care Settings. *Gender and Society*. Vol. 10, No.1, pp. 24-41.
- Stevens, Patricia E. and Hall, Joanne M. (1991). A Critical Historical Analysis of the Medical Construction of Lesbianism. *International Journal of Health Services*. Vol. 21, No. 2, pp. 291-307.
- Stevens, Patricia E. and Hall, Joanne M. (1988). Stigma, Health Beliefs and Experiences with Health Care in Lesbian Women. *IMAGE: Journal of Nursing Scholarship*. Vol. 20, No. 2, pp. 69-73.
- Trippet, Susan. (1992). Reasons American Lesbians Fail to Seek Traditional Health Care. *Health Care for Women International*. Vol. 13, pp. 145-153.
- Sears, J. Dilemmas and Possibilities of Sexuality Education: Reproducing the Body Politic. In James T. Sears (ed.) *Sexuality and the Curriculum: The*

## **Out in the Cold: Barriers to health care for lesbians**

---

- Politics and Practices of Sexuality Education*. Teachers College Press. New York. 1992.
- Lucas, Vicki. An Investigation of the Health Care Preferences of the Lesbian Population. *Health Care for Women International*. Vol. 13, pp. 221-228. 1992.
- Rankow, Elizabeth. Lesbian Issues for the Primary Care Provider. *Journal of Family Practice*. Vol. 40, No. 5, pp. 486-491. 1995.
- Robertson, Ann and Minkler, Meredith. New Health Promotion Movement: A critical Examination. *Health Education Quarterly*. Vol. 21, No 3, pp. 295-312. 1994.
- Robertson, Morag. Lesbians as an Invisible Minority in the Health Services Area. *Health Care for Women International*. Vol. 13, pp.155-163. 1992.

### **Inclusive Research:**

- CRIAW (1996). *Feminist Research Ethics: A Process*. Second Edition.
- CRIAW (1996) *Research Partnerships: A Feminist Approach to Communities and Universities Working Together*.
- Kirby, S. And McKenna, K. (1989) *Experience, Research, Social Change: Methods from the Margins*. Toronto: Garamond Press.
- Lather, P. (1991) *Getting Smart: Feminist Research and Pedagogy with/in the Postmodern*. New York, London: Routledge.

### **Bibliography**

- Adams, M.L. 1989. "You're all right so long as you act nice": Lesbians' experience of the North American health care system. *Fireweed*: 53-67.
- Andrews, S. 1997. Gynecologic and obstetric care of lesbian and bisexual women. In Varney, Helen (ed.) *Varney's Midwifery*. 3<sup>rd</sup> Edition. London: Jones and Bartlett.
- BC Centre for Disease Control. 1996 Annual Report.
- Bell, D., and G. Valentine. 1995. Queer country: Rural lesbian and gay lives. *Journal of Rural Studies* 11 (2): 113-122.
- Bradford, J., and C. Ryan. 1987. *The National Lesbian Health Care Survey*. Washington, DC: National Lesbian and Gay Health Foundation.

## **Out in the Cold: Barriers to health care for lesbians**

---

- Buenting, J.A. 1992. Health life-styles of lesbian and heterosexual women. *Health Care for Women International* 13:165-171.
- Carlson, D. L. 1992. Ideological conflict and change in the sexuality curriculum. In James T. Sears (ed.) *Sexuality and the Curriculum: The Politics and Practices of Sexuality Education*. New York: Teachers College Press.
- Cassidy, R. and Hughes, T. 1995. Lesbian health: barriers to care. In *The Annual Review of Women's Health, Volume 3*. McElmurry, Beverly and Parker, Randy Spreen (eds.). New York: National League for Nursing Press.
- Cole, R., and Cooper, S. 1991. Lesbian exclusion from HIV/AIDS education: ten years of low-risk identity and high risk behaviour. *SIECUS Report*.
- Collier, H. 1982. *Counselling women: A guide for therapists*. New York: Free Press.
- Denenberg, R.1995. Report on lesbian health. *Women' Health International*. 5 (2): 81-91.
- Douglas, C.J., C.M. Kalman, and T.P. Kalman. 1985. Homophobia among physicians and nurses: An empirical study. *Hospital and Community Psychiatry* 36 (12): 1309-1311.
- Edelman, D. 1986. University health services sponsoring lesbian health workshops: Implications and accessibility. *Journal of American College Health* 35:44-45.
- Eliason, M.J., C. Donelan, and C. Randall. 1992. Lesbian stereotypes. *Health Care for Women International* 13:131-144.
- Eliason, M.J., and C.E. Randall. 1991. Lesbian phobia in Nursing students. *Western Journal of Health Research* 13 (3): 363-374.
- Findlay, D. 1993. The good, the normal and the healthy: The social construction of medical knowledge about women. *Canadian Journal of Sociology*. 18 (2): 115-135.
- Fisher, S. Lesbian Health Issues: A Guide for Gynaecologists.
- Freedman, E. 1982. Resources for lesbian history. In Margaret Cruikshank (ed.) *Lesbian Studies: Present and Future*. New York: The Feminist Press.

## **Out in the Cold: Barriers to health care for lesbians**

---

- Gentry, S.E. 1992. Caring for lesbians in a homophobic society. *Health Care for Women International* 13:173-180.
- Glassman, C. 1995. Lesbians and HIV disease. *Journal of Gay and Lesbian Social Services*. 2 (3\4): 61-74.
- Hall, J. 1992. An exploration of lesbians' images of recovery from alcohol problems. *Health Care for Women International*. 13:181-198.
- Hugman, R. 1991. *Power in caring professions*. London: MacMillan.
- Jones, R. 1988. With respect to lesbians. *Nursing Times* 84 (20): 48-49.
- Lucas, V.A. 1992. An investigation of the health care preferences of the lesbian population. *Health Care for Women International* 13:221-228.
- Mathews, C.W.M., M.W. Booth, J.D. Turner, and L. Kessler. 1986. Physicians' attitudes toward homosexuality - survey of a California County medical society. *The Western Journal of Medicine* 144 (86): 106-110.
- Nechas, E., and D. Foley. 1994. *Unequal treatment: What you don't know about how women are mistreated by the medical community*. New York: Simon & Schuster.
- Randall, C.E. 1989. Lesbian phobia among BSN educators: A survey. *Journal of Education* 28 (7): 302-306.
- Rankow, E. 1995. Lesbian issues for the primary care provider. *Journal of Family Practice*. 40 (5): 486-491.
- Reagan, P. 1981. The interaction of health professionals and their lesbian clients. *Patient Counselling and Health Education* 3:21-25.
- Renzetti, C.M. 1993. Violence in lesbian relationships. In M. Hansen and M. Naraway (Eds.), *Battering and Family Therapy: A Feminist Perspective*. Newbury Park: Sage.
- Robertson, M. 1992. Lesbians as an invisible minority in the health services area". *Health Care for Women International*. 13:155-163.
- Rosser, S. 1992. Ignored, overlooked or subsumed: research on lesbian health and health care. *National Women's Studies Association Journal*. 5 (2): 183-203.

## **Out in the Cold: Barriers to health care for lesbians**

---

- Rothblum, E.D. 1994. Introduction to the special section: Mental health of lesbians and gay men. *Journal of Consulting and Clinical Psychology* 62 (2): 211-212.
- . 1994. "I only read about myself on bathroom walls": The need for research on the mental health of lesbians and gay men. *Journal of Consulting and Clinical Psychology* 62 (2): 213-220.
- . 1990. Depression among lesbians: an invisible and unresearched phenomenon. *Journal of Gay and Lesbian Psychotherapy*. 1 (3): 67-87.
- Sears, J. 1992. Dilemmas and possibilities of sexuality education: reproducing the body politic. In James T. Sears (ed.) *Sexuality and the Curriculum: The Politics and Practices of Sexuality Education*. New York: Teachers College Press.
- Shaw, N.S. 1989. New research issues in lesbian health. *Women's Studies* 17:125-137.
- Simkin, R.J. 1991. Lesbians face unique health care problems. *Canadian Medical Association* 145 (12): 1620-1623.
- Simms, G. 1996. Aspects of women's health from a minority/diversity perspective. Paper given at the Canada-USA Women's Health Forum.
- Skinner, W. F. 1994. The prevalence and demographic predictors of illicit and licit drug use among lesbians and gay men. *American Journal of Public Health*. 84 (4): 1307-1310.
- Smith, E.M., S.R. Johnson, and S.M. Guenther. 1985. Health care attitudes and experiences during gynecological care among lesbians and bisexuals. *American Journal of Public Health* 75 (9): 1085-1087.
- Stevens, P.E. 1996. Lesbians and doctors: Experiences of solidarity and domination in health care settings. *Gender and Society* 10 (1): 24-41.
- . 1995. Structural and interpersonal impact of heterosexual assumptions on lesbian health care clients. *Nursing Research*. 44 (1): 25-30.
- . 1994. HIV prevention education for lesbians and bisexual women: a cultural analysis of a community intervention. *Social Science and Medicine*. 39 (11): 1565-578.
- . 1994. Lesbians' health-related experiences of care and non-care. *Western Journal of Nursing Research*. 16 (6): 639-659.

## **Out in the Cold: Barriers to health care for lesbians**

---

- , 1994. Protective strategies of lesbian clients in health care environments. *Research in Nursing & Health* 17 (3): 217-229.
- , 1993. Marginalized women's access to health care: A feminist narrative analysis. *Advances in Nursing Science* 16 (2): 39-56.
- Stevens, P.E., and Hall, J.M. 1991. A critical historical analysis of the medical construction of lesbianism. *International Journal of Health Services*. 21 (2): 291-307.
- , 1990. Abusive health care interactions experienced by lesbians: A case of institutional violence in the treatment of women. *Response* 13 (3): 23-27.
- , 1988. Stigma, health beliefs and experiences with health care in lesbian women. *Image: Journal of Nursing Scholarship* 20 (2): 69-73.
- Todd, A.D. 1989. *Intimate adversaries: Cultural conflict between doctors & patients*. Philadelphia: University of Pennsylvania Press.
- Trippet, S.E., and J. Bain. 1993. Physical health problems and concerns of lesbians. *Women & Health* 20 (2): 59-70.
- , 1992. Reasons American lesbians fail to seek traditional health care. *Health Care for Women International* 13:145-153.
- Vancouver-Richmond Health Board Gay, Lesbian, Bisexual, Transgender Population Health Advisory Working Group. 1997. *Proceedings from the GLBT Health Conference*.
- Vasquez, C. 1994. The myth of invulnerability: lesbians and HIV disease. *Focus: A Guide to AIDS Research and Counselling*. 8 (9): 1-6.
- White, T.A. 1979. Attitudes of psychiatric nurses toward same sex orientations. *Nursing Research* 28 (5): 276-281.
- Winnow, J. 1992. Lesbians evolving health care: Cancer and AIDS. *Feminist Review* 41 (Summer): 68 -76.
- Young, E.W. 1988. Nurses' attitudes toward homosexuality: Analysis of change in AIDS workshops. *The Journal of Continuing Education in Nursing* 19 (1): 9-12.