LESBIAN HEALTH AND THE ASSUMPTION OF HETEROSEXUALITY: AN ORGANIZATIONAL PERSPECTIVE

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ABSTRACT

This study used a qualitative research design to explore hospital policies and practices and the assumption of female heterosexuality. The assumption of heterosexuality is a product of discursive practices that normalize heterosexuality and individualize lesbian sexual identities. Literature indicates that the assumption of female heterosexuality is implicated in both the invisibility and marked visibility of lesbians as service users. This research adds to existing literature by shifting the focus of study from individual to organizational practices and, in so doing, seeks to uncover hidden truths, explore the functional power of language, and allow for the discovery of what we know and—equally as important—how we know.

INTRODUCTION

Health care providers and lesbians have documented heterosexism within the health care system—specifically the assumed heterosexuality of service users—as a serious concern (Mathieson, Bailey, & Gurevich, 2002). Institutional practices that assume all women are, or should be, heterosexual exclude the life experiences of lesbians and render them invisible as service users. The assumption of heterosexuality affects access to health care services and medical decision making for lesbian service users.

The assumption of heterosexuality is often so insistent that practices within health care settings don't provide the opportunity for any expression of diversity or difference. In some respects, it is a difficult issue to address in that what is not being said is loud enough to enforce silence. A failure to acknowledge the assumption of heterosexuality fosters the invisibility of lesbians (Mathieson et al., 2002). It is not enough to passively accept lesbianism—that is, to recognize that some clients may be lesbian and, therefore, to incorporate neutral words (such as partner) into our language. Instead, an active analysis of how language and practice enforce a constructed reality (heterosexuality) is needed.

Various discourses on lesbianism (i.e., liberal, heterosexual feminist, and medical) function through the process of objectification to produce the assumption of heterosexuality (Gatens, 1992). Objectification includes normalization and individualization. Normalization clearly defines what is expected and accepted (normal) and what is abnormal. For example, the binary terms of heterosexuality/homosexuality designate the category in which everyone is to belong (heterosexuality) as well as the category in which belong only persons who can be differentiated from normal (read homosexual) (Halperin, 1995). The process of indvidualization places lesbianism within the private world of women. Kitzinger (1987) refers to this as "personalization

of the political through an insistent focus on the individual and internal as opposed to the institutional and sociopolitical" (p. 34). Individualization relies on the liberal tradition of person blaming and, in so doing, silences individuals while ignoring the responsibilities of social institutions for social problems (Kitzinger, 1987).

Normalization and individualization overwrite lesbians' own voices, and delegitimate the "claim to be able to speak knowledgeably about one's life" (Halperin, 1995, p. 42). For example, medical, liberal, and heterosexual feminist discourses that construct homosexuality as a condition, and lesbian identity as either healthy or unhealthy, divide and exclude lesbians as others (abnormal) and construct female heterosexuality as *the* norm. These discourses exert power in that, as speakers of truth, they constitute a subjective stance which defines lesbianism as "marked and problematized" (Featherstone & Fawcett, 1994). Lesbians often rely on discourse for self-formation and self-identity that define us as faulty and our lives as private. In this way, our invisibility and marked visibility as lesbians lies within the success of discursive practices to perpetuate the assumption of heterosexuality.

The assumption of heterosexuality by health care providers is a powerful force which shapes the experiences of lesbians and functions to limit the quality of their health care interactions. A focus on the accessibility of services is no doubt essential to provide visibility to lesbians and their health care needs (Mathieson et al., 2002). However, this focus reflects a "distributive paradigm" that conceives justice only "in terms of the allocation of resources and the distribution of access to health care" (Wilkerson, 1994, p. 331). A focus on services can too easily ignore the experience of oppression and marginalization that results directly from the institutionalized assumption of heterosexuality, and often persists despite access to service. Iris Young suggests that a distributive paradigm of justice helps to "obscure significant and widespread harms experienced by some disadvantaged groups in society, such as homophobia, which is particularly difficult to address within the constraints of the distributive paradigm" (Wilkerson, 1994, p. 331). Analysis must, therefore, extend beyond distributive terms to "include aspects of oppression such as cultural imperialism, exploitation, marginalization, violence, and powerlessness" (Wilkerson, 1994, p.33l). Patricia Steven's (1995) article on the structural impact of heterosexual assumptions echoes this view and argues that a focus on interpersonal impact alone is insufficient to explain the barriers which lesbians face in health care settings. Research also must explore heterosexist health care structures—including health care policy and practice.

This study, which draws largely upon an earlier work (Daley, 1998a) seeks to accomplish this goal by extending the analysis of institutional homophobia to include an exploration of the polices and practices that are revealed through interviews with key individuals in front-line and policy positions in health care delivery. From this perspective, policies and practices are not understood as "objective accounts" (Smith, 1984, p. 60) but rather as "subjective processes" (Smith, 1984, p. 62) by which the voice of the speaker (research participant) makes visible that which is hidden within fixed texts. In this way, this research process includes: (a) the uncovering of hidden truths and assumptions, (b) the exploration of the functional power of language, and (c) the discovery of what we know and—equally as important—how we know.

METHOD

Setting

The original thesis research work upon which this article is based included the participation of and findings from two hospital organizations (see Daley, 1998b). However, the findings from only one hospital organization are presented here in order to provide a concise discussion of the themes, which surfaced in the analysis of both settings.

The selection of the participating hospital organization was determined by its close proximity to an area that is comprised of a large lesbian and gay population and many lesbian and gay commercial businesses. Consequently, the hospital was selected because of its likelihood of providing services to lesbian clients.

The hospital organization recognizes the unique health needs of several diverse populations, including: (a) the homeless; (b) mental health consumers/survivors; (c) the poor; (d) refugees and immigrants; and (e) lesbians, bisexuals, transgendered persons, and gay men. Various in-patient services, outreach programs, and initiatives address issues specific to these communities—including culturally specific services, treatment for sexual and physical assault, mobile treatment units, and crisis teams. The organization has a broad mission statement that pledges to respond to the diverse needs of their patient communities.

The physical cues and symbols that signal the inclusiveness of lesbians, bisexuals, transgendered persons, and gay men in the hospital organizations were fairly minimal. The hospital organization provided limited informational pamphlets and flyers about gay-positive support services and groups (i.e., counselling groups for lesbian women with addictions and services related to HIV/AIDS). The hospital organization "flew" the rainbow flag (hung in the Emergency Department only), a symbol of recognition and acceptance within lesbian and gay communities.

Participants

Formal institutional channels were used to locate participants at the organizational level within the hospital, including contact with the Public Relations Department. Initially, I provided Public Relations with information about the research topic, my academic affiliation, and the criteria for potential research participants. I then submitted a written request and résumé. The organization responded with a request for a protocol summary for review by the hospital ethics committee. Upon approval by the ethics review committee, Public Relations provided me with the contact names of the research participants. I was not told (either by Public Relations or by the participants) whether research participants volunteered or whether their participation was considered an institutional obligation based on their selection.

I requested that four staff members of the hospital organization participate in the interview process. The number of participants was limited to four in an effort to facilitate the completion of the research process within a restricted time period. The participants were chosen from the organizational (administrative/managerial) level and from the practitioner (social worker) level. The subgroups were selected in an effort to explore the issue of assumed female heterosexuality at varying organizational levels, ranging from those who have direct contact with clients (social workers) to those who may have more direct input into policy development. Greater emphasis was placed on interviewing participants at the administrative/managerial level (three

of the four participants were at this level) in an effort to capture similarities and/or differences across various departments within the hospital organization.

I gave consideration to the difficulties that may have been experienced with respect to accessing participants who hold elite positions within the hospital organization, and the power imbalance that may exist between me, as researcher, and them. Particularly, I anticipated barriers with respect to accessing administrators as compared to administrative assistants or public relations personnel. This held true in that I was unable to access, for example, the Vice-President of Patient Care Services but rather was referred to an employee/committee member within that area. Thus, the participants selected by the Public Relations contact were employed as: (a) a clinical nurse educator in the area of cultural diversity; (b) a manager of Emergency Services; (c) a community liaison worker; and (d) a social worker in an outpatient clinic specializing in sexual health. In this way, research participants were involved in activities such as equity and equality, the issues of HIV/AIDS, a gay-bashing reporting program, patient diversity, hiring, and hospital-wide sensitivity training.

All of the research participants interviewed were women and represented diverse racial/ethnic communities, including Trinidadian (one), South Asian (one), and European and Anglo-Saxon (two). One participant self-identified as non-lesbian (did not identify herself as heterosexual but stated, "I guess it's becoming obvious that I'm not, uhm, lesbian"). One participant clearly identified herself as lesbian.

Data Collection

This study employed semi-structured in-depth interviews. Face-to-face interviews were directed in one of two ways. First, an interview schedule consisting of a detailed set of open-ended questions was developed for interviewing participants at the administrative/managerial level. The interview schedule was developed as a means of collecting parallel data from each administrator/managerial participant. Open-ended questions were employed to explore: (a) whether policies existed that addressed diversity and difference; (b) the extent to which community representation had been involved in the development of those policies; and, (c) whether the issue of diversity or difference had ever been raised as a concern by patients or staff. A second set of questions explored whether the concerns of lesbian patients had ever been raised among patients or staff and, if so, how this concern was addressed. In this way, I attempted to situate institutional homophobia within the context of diversity and difference to allow for the exploration of exclusion as well as the presence of an assumption (of heterosexuality).

Second, an interview guide was used during interviews with the social worker. This approach was chosen as a means to elicit from the participant what was perceived as important within broad boundaries of interview topics. For example, open-ended questions were used to explore both the participant's experiences and understandings of client diversity and difference and her general knowledge of existing policies that addressed those issues.

Special effort was made to avoid an elite interviewee from turning the interview around and thereby taking charge of it (Marshall & Rossman, 1995). Although none of the research participants took charge, one participant in a managerial position did make it clear, through body language and tone, that the focus of inquiry (line of questioning) should be redirected. Questions exploring organizational knowledge about the concerns of lesbian service users were asked on three different occasions throughout the one-hour interview. The interviewee responded to each inquiry by

redirecting the question; during her final response the participant shifted her body away from the interviewer (turned sideways in her chair) and changed her voice tone while continuing to redirect the focus of the inquiry. I interpreted these actions as a clear signal to discontinue the focus of inquiry.

Initial contact occurred by telephone. I introduced myself by stating my position and university affiliation and then provided a brief overview of the study. A letter that explained in more detail the purpose of the study followed each telephone call. In a second telephone call, I arranged for an interview meeting time and place (each participant had been provided an advance copy of the protocol summary).

Each interview began with a personal introduction and a presentation of a statement of purpose which indicated potential uses of the study. A consent/confidentiality form was explained and presented for both interviewer and interviewee signatures. A copy of the form was given to each research participant. The participants were interviewed for approximately one hour each, and they were interviewed on one occasion only. Verbal consent had been received for a second interview to pursue subsequent interview topics that emerged from preliminary data analysis; however, these interviews were not required. The interviews occurred within the hospital environment, either in the participants' office or in a place mutually agreeable to participant and interviewer. Interviewees were reminded of the voluntary nature of their participation and their right to discontinue participation at any time during the interview.

Data Analysis

Interviews were audiotape recorded and immediately transcribed into typed form using a transcriber and word processor. Audiotapes were replayed in an effort to capture the subtlety of language – intonation, pauses, and emphasis—of participant responses. Research field notes of each interview recorded my subjective experience of the interview as well as relevant observations (i.e., the body language of participants). Each transcript and policy-document page was coded for identification purposes. The data from each transcript and policy document were unified. Once the unifyng of data was complete, themes were identified to establish outcomes of the study (see Maykut & Moorehouse, 1994). Second-level analysis made use of discourse analysis.

FINDINGS

For the purposes of this analysis, the research participants are identified as follows: Cheryl, a clinical educator in the area of cultural diversity; Frances, a manager of Emergency Services; Ellen, a community liaison worker; and Liz, a social worker in the Outpatient Clinic. The materials gathered from interviews with these women can be organized into five categories: (a) organizational knowledge as fragmented, (b) recognition of the gap between organizational knowledge and individual knowledge, (c) gay men as a vocal community, (d) an organizational philosophy of patient-focused care, and (e) education and staffing as means of change.

Organizational Knowledge as Fragmented

Fragmentation is represented by the range of participant responses that included a self-identified lack of organizational knowledge to an identification of local (departmental) knowledge about lesbian health concerns. Prior to this discussion, it is

important to note that the analysis represents the distribution of knowledge within the organization as opposed to individual knowledge.

As a clinical educator in the role of cultural diversity, Cheryl's role within the organization includes, among other things, addressing client diversity and accessibility. Her response—openly and comfortably declaring herself "the wrong person to ask" about lesbian health concerns—is, therefore, particularly revealing. Cheryl did not identify her lack of organizational knowledge as problematic nor did she acknowledge a sense of needing to know. Instead, she referred me to other participants involved with organizational initiatives that address HIV/AIDS and/or are related to lesbian and gay community(s). Cheryl's openness and the general ease by which she made the referral to "those in the know" suggest an acceptance of fragmented knowledge within the organization.

Although Cheryl was unable to discuss organizational knowledge specific to the health concerns of lesbian service users, she did provide insight into organizational knowledge production and its relationship to the notion of fragmentation. She explained that the organizational concept of clients' needs exists within the context of specific programs:

> what we had hoped was that systematically we might be able to set up some sort of consultation, key people to say, you know, to programs, o.k. we are developing this new initiative have you thought about this community, that community, that community, how is it going to play out, how is it going to be different.

In this way, organizational knowledge is the outcome of a consultation process in which new initiatives are explored in relation to specific communities of service users. This process highlights the need for community representation during the program-development stage. Cheryl's description of knowledge production as program driven supports the notion that knowledge could vary from program to program, depending on the identified relevance of the initiative to each community. This identification could be determined by: (a) who represents those groups which are subcultures of communities that have been identified, (b) who defines relevancy, and (c) how relevancy is defined (i.e., within the traditional heterosexist and sexist structure). A lesbian sexual orientation, for example, may be identified as relevant to stereotypical health issues related to women, such as gynecology, but identified as irrelevant to health concerns related to cardiology and renal function. In this way, the realities and experiences of lesbian service users become compartmentalized, and the visibility of lesbian service users becomes fleeting. Conceivably, the wholeness of one's experience as a lesbian could depend largely on the diagnosis/event/program.

Further support for the theme of organizational knowledge as fragmented exists, for example, when discussing general lesbian concerns such as inappropriate history taking. Frances (the manager of Emergency Services) delimited her response to this query by stating, "I couldn't speak for other areas of the hospital." This analysis suggests that, although concerns may be experienced universally by lesbian service users, knowledge exists at a local (departmental) level within the hospital organization.

Recognition of the Gap Between Organizational Knowledge and Individual Knowledge

Participant responses suggest an informal way of knowing that exists as bits and pieces, as opposed to being integrated into the overall framework of organizational knowledge. Participants recognized informal knowledge from a more personal, indiv-

idual perspective and, in so doing, appeared to experience discord. Ellen (a community liaison worker), for example, cautiously responded to a question about whether there had been discussion about lesbian health concerns by stating:

> It's been discussed but not to a large degree. No. It's, it's certainly been discussed at, at, at some of the (committees) and how like, in the (clinic), and same-sex couples, uhm and, and, how do you, you know, make sure that, that, you know, you ask if someone wants somebody with them you don't assume that they'll have a husband or a wife, uhm, that's a different gender, and so, there's been conversation at, at staff meetings around those uhm, but nothing, uhm, no. Nothing in a formalized way at all. No.

Ellen described discussions of the concerns in the context of staff meetings and acknowledged a lack of formalized organizational knowledge. This analysis suggests that Ellen's response conveyed recognition of organizational knowledge as informal. Ellen's cautiousness suggests a degree of uneasiness with this recognition. Moreover, data analysis revealed discord as a result of a recognized gap between organizational (formalized) knowledge and individual (informal) knowledge. Ellen, for example, previously suggested that lesbian health concerns have not been discussed in a formalized way. She revealed instead a more personal, individual way of knowing:

> Well, I don't know, like, I certainly wouldn't pretend that there aren't probably issues 'cause I can't imagine that they're not given what happens when you go to a doctor sometimes, uhm, but, the issues haven't come forward very strongly so, uhm, it's hard to kind of push it.

In a similar vein, Frances identified some of the concerns and/or issues for lesbian service users by stating that:

> Gay bashing, assaults, uh, fear of stigma has been very strong, uhm, to a lesser degree the, uhm, concern has been raised around just the fact that women, how lesbian women are treated, they're asked all of the same kinds of questions, for example, when sexual history is proposed or asked for, uh, when you're a gay woman there's no understanding of the fact that maybe this person isn't having sex with men, so, the questions aren't tailored to reflect that.

Frances negated this as organizational knowledge by classifying these concerns as "general scuttlebutt" that have not been a "strenuous concern" to this "particular area" of the hospital organization. From this perspective, she suggests that knowledge exists as an informal knowing at an individual (personal) level rather than as that which has been formally integrated at the organizational level.

Finally, Liz (an Outpatient Clinic social worker) conceded that, despite having an "openly lesbian" clinical co-ordinator, lesbian health concerns are not "getting talked about in quite the same way" as the health needs of gay men—again suggesting that what is known by particular individuals at an informal level is not necessarily knowledge that has been consistently integrated within the organization.

Gay Men as a Vocal Community

All respondents identified community input as an integral part of the process of change by which the hospital organization became more responsive to and welcoming of diverse communities. Community consultation and direction was established and maintained through the development of several advisory committees through which space for members of diverse communities was provided and by which their voices could be heard.

The vocality of gay men as a community of service users was raised by three of the four research participants when asked questions which specifically focused on

organizational knowledge about the health concerns of lesbian service users. Participant responses suggest that, in terms of organizational and general knowledge, a differential exists between that which is held about gay men as a community and that which is held about gay women as a community. The vocal presence of gay men and the knowledge differential was discussed in relation to both the HIV/AIDS crisis and the existing hierarchy of power based on gender, class, and race.

Frances clearly identified the impact of the HIV/AIDS crisis on organizational knowledge when submitting that "men have really with AIDS taken their sort of, the really forefront . . . of, really pushed for . . . been really vocal and really organized and so on and so forth." Frances elaborated on the gap between an organizational awareness of gay men as compared to lesbian women to include the larger socio-political context by commenting that:

> Like, men usually grab the headlines, grab the attention, women are always second kind of thing and I think it's been that way. My sense in the gay community, you know, again men are always up there front row centre and women are always sort of second to everything and that might be part of the reason why gay men's health has taken more of a front seat.

Frances clearly implicated gender inequalities when explaining why more is known about the health concerns of gay men than about the health concerns of lesbians. Ellen enthusiastically reiterated this notion when identifying some of the barriers confronted by a group of women that unsuccessfully attempted to get the "hospital to address the needs of women who are lesbian:"

> Uhm, women (laugh), and the lack of the health profession to look at women as, you know, when you think of it just generically how all the, all the drugs are tested on men and, and, the, the, the amount, you know, the fact that more women die of breast cancer than men die of AIDS and yet, and I'm not saying, don't get me wrong, that there shouldn't be money for AIDS testing, and, and, but, uh (laugh) it's pretty, ah, it's pretty obvious that, as women we're not as important in the medical profession and we're not particularly important as members of society.

Ellen also stated that, when you add being a lesbian on top of being a woman, "you'll just get knocked farther down."

Similarly, Liz identified both the HIV/AIDS crisis and the larger socio-political context as factors implicated in the vocal presence of gay men. Initially, Liz defined the "gay community" as a motivating factor for change in that it "challenged the hospital" to be more welcoming. However, Liz elaborated more directly and specifically by stating:

> I don't know that some ethnic groups are as powerful a voice or as organized and the poor certainly don't, and the homeless don't so, that's probably the most organized and vocal and powerful group in this community. Maybe not lesbians so much as, as, as gay men, and AIDS certainly activated, that, that, uhm, advocacy.

Finally, when describing the history of the hospital organization with respect to developing an awareness of homophobia, particularly in response to community input, Ellen clearly identified the "very strong advocacy from, I would say, at that time the gay, gay men" as an influential factor in the change process.

An Organizational Philosophy of Patient-Focused Care

The importance of a patient-focused approach for meeting the needs of diverse client populations is emphasized by three of the four respondents as a general

philosophy towards providing appropriate and sensitive care. A patient-focused approach is understood as useful for recognizing individual needs based on diverse elements—including culture, class, and sexual orientation—as well as needs related to specific physical and medical conditions. Participants discussed this philosophy in response to a broad range of topics, such as initiatives addressing homophobia, the invisibility of lesbianism as a culture, and health concerns as identified by the lesbian community.

While discussing organizational initiatives that address homophobia, Ellen described an organizational "paradigm shift" in which care providers looked beyond the medical diagnosis in order to meet the unique needs of clients. Ellen submitted that "most people are trained to look at people as a disease or, or an illness or whatever, you, you know, rather and, and who they are as an individual kind of gets lost in the context."

Cheryl discussed the notion of patient-focused care when asked about the potential for failing to identify lesbian service users in light of the fact that, unlike visible minorities, they are often non-identifiable. She responded by describing an organizational concept of culture as invisible, and therefore, something that is not to be assumed based on that which can be observed (such as skin colour and dress). Cheryl confidently identified patient-focused care as a strategy by which health care providers can avoid assuming to know client needs based on visible cues. From this perspective, a lesbian sexual orientation is viewed as an invisible culture, thereby suggesting that (hetero) sexuality is not assumed. Cheryl emphasized that avoiding assumptions about the concerns and/or needs of people means going back to "that one concept of patient-focused, patient-sensitive care—each person's a unique individual."

Creating Change: Education and Staffing

All respondents identify education and staffing as necessary for knowledge production and change. The participants discussed educational and staffing measures in response to questions that explored existing barriers for lesbian service users—initiatives that looked beyond HIV/AIDS in relation to lesbian service users—and policies that addressed diverse communities. Two important sub-themes emerged from the data: (a) educational initiatives as existing policies, and (b) hiring practices as existing policies

Educational Initiatives as Existing Policies. Educational initiatives were developed in response to both community feedback citing staff homophobia and a recognition by hospital administration that "hospital staff were very homophobic" and "needed homophobia training." Participants described educational initiatives as necessary for the change process. Liz, for example, highlighted a formalized and "compulsory" organizational initiative that provided "anti-homophobic training" for all staff. Educational initiatives appeared to represent existing organizational and departmental policies as related to the broad goals of meeting the needs of diverse communities. Frances, for example, did not identify a policy when responding to my inquiry about existing departmental policies but rather stated "I think more than policies we had to develop some understanding so we did a lot of self education."

When asked specifically about whether a policy and/or mission statement exists to address the health needs of lesbians, Cheryl answered directly, "not that I know of." She went on to make reference to the hospital mission statement as one that is "very broad" and that includes "access and diversity." Cheryl then discussed

educational initiatives, including a strategy by which education is provided at the program level in relation to specific health concerns. Cheryl's uncertainty about the existence of organizational policies contrasted with her knowledge about educational initiatives. This analysis suggests that it is the latter that plays a more prominent role in guiding organizational practices.

Ellen's response to an inquiry about specific initiatives that address homophobia provided a richer and more explicit description of the relationship between education (as policy) and organizational practice. Ellen discussed the role of a community worker to provide one-on-one education within a departmental setting in an effort to raise staff consciousness about homophobia and discrimination:

> in the [area of the hospital], specifically, it was a lot of, of one-on-one talking or challenging, uhm, when, uhm, there were incidences either reported or, or . . . a . . . in the role, one of the roles was to hang around the [area of the hospital] 'cause some of this stuff is often hidden, so if you're around and kind of chatting with people informally, uhm, you get to hear things and you get to go to someone and say well, you know, that isn't the best, you know, in, in a diplomatic way (laugh) we're often challenging in a way to not engender someone's anger 'cause sometimes it wasn't deliberate.

From this perspective, education served the necessary function of uncovering assumptions that exist within organizational practices. Conceivably, educational initiatives represent the implementation of broad organizational policies such as the mission statement.

Hiring Practices as Existing Policies. It became evident from participant responses that strategies other than education were required. More specifically, the analysis of participant responses suggested that the hiring of staff from diverse groups, including lesbian and gay communities, was integral to knowledge production and change. For example, within the context of discussing barriers that exist for lesbian service users, Liz identified the hiring of "a very assertive, aggressive bunch of people" as responsible for challenging assumptions around sexuality. Liz did not identify members of this group as lesbian (or gay); however, one could conclude from the context of the question that lesbians or gay men constitute some portion of the group. At another point, while discussing the process of change, Liz overtly identified the hiring of lesbians and gay men:

> So, staff expanded and uhm, as a result of that the kind of staff that they were hiring, the staff became less homogeneous, they began to hire people who were, uhm, I, I don't think I knew anybody in the hospital who was really out, uhm, in terms of gender orientation, but it wasn't in to be out so, uhm, this changed, uhm, people got hired, people became blatantly out.

Cheryl identified the prevalence of "gay staff" by stating:

> there's a lot of people here that are openly gay, you know, both men and women, so, gay and lesbian, uh, and it's not something that they feel they have to hide or they have to *flaunt*, it's just the way it is.

DISCUSSION

Organizational Knowledge

An important finding that emerged from the analysis is that lesbians are not visible and, consequently, are not invited to participate in the processes which result in the production of what we know and how we know (knowledge). The speakers conveyed the notion that lesbian voices are pushed aside. Ellen, for example, stated

that "issues haven't come forward very strongly, so uhm it's kind of hard to push it," and Liz acknowledged the difficulty of having concerns heard, even in the context of an "openly lesbian" co-ordinator. Finally, Frances' excerpt most clearly demonstrates this notion. When asked the source of the concerns raised, Frances stated: "from outside sources, in talking to, ah, women that are lesbians either who work here, who are co-workers of mine, that is information that they've given to me." When lesbian experiences and realities are expressed, they do not become a part of knowledge production but rather are relegated to "scuttlebutt." Conceivably, the speakers may not be experiencing discord; they may instead be expressing the space which exists because of the marginalized voices of lesbians.

The selection of language in Frances' excerpt is of particular importance to this analysis, specifically the term "scuttlebutt," which functions to minimize and make invisible the trauma of violence and oppression which results from having one's subjectivity incorrectly constructed. Frances narrowly constructed lesbian sexual orientations in the context of "absence" by submitting, "when you're a gay woman there's no understanding of the fact that maybe this person isn't having sex with men." In this way, Frances saw lesbians in relation to the absence of men rather than in relation to the presence of women and, in so doing, constructed lesbian subjectivities as lacking. This demonstrates that the heterosexual framework by which all women are understood is firmly rooted within organizational ideology. From this perspective, one could argue that, even when organizational knowledge exists informally, organizational programs that continue to locate lesbian subjecttivities within heterosexist practices might not address lesbian service users.

An alternative and important conceptualization would consider how the themes of fragmentation of organizational knowledge and recognition of the gap between organizational knowledge and individual knowledge reflect the dynamics of organizational life. More specifically, these themes may provide hints to the organization's culture. In reference to organizational life, Heracleous (2001) suggests:

> although culture is a potent force, it cannot fully dominate thought and action because of the capacity of human agents to comment critically on their situation and to choose to abstain or not act otherwise than the dominant culture would dictate (p 427).

In this way, the "assumptions, beliefs, and values" (Hatch & Shultz, 2002) that constitute organizational culture and that guide organizational life would differ from department to department, and from health care professional to health care professional, thereby suggesting the existence of subcultures that compete with the dominant organizational culture.

Conceivably, the self-identified lack of organizational knowledge, the identification of local (departmental) knowledge, and the identification of individual knowledge may, in fact, represent differing subcultures within the organization. Moreover, it is the very existence of competing subcultures that could account for variations in definitions of client needs, and who is chosen to represent communities in the community-consultation process. Given this conceptualization, participant responses that describe knowledge as an informal way of knowing or "general scuttlebutt" may represent the silent discourse of subcultures within the hospital organization.

Gay Men as a Vocal Community

The vocal presence of gay men is not understood as being responsible for the voicelessness of lesbians as a community of service users; it does, however, help to explain why the organization has more knowledge about the concerns of gay men as a community than it does about the concerns of lesbians as a community. An analysis of participant responses indicated that speakers were more likely to relay organizational experiences and knowledge as related to gay men than as related to lesbians. This trend reflects, in part, the fact that, within a health care context, knowledge and inclusion will most directly be related to a health crisis—and gay men were those primarily (and initially) affected by HIV/AIDS. What is so deafening within this theme is the absence of information/knowledge/stories that relate specifically to lesbian service users and their health needs. It is not the vocality of gay men that is so alarming; rather, it is the apparent fact that a community must exist within the context of a health crisis in order to be heard and included. Frances illustrated this understanding in her response to my query about whether lesbian service users have raised concerns: "Nope, there hasn't. I think, uhm, that maybe sometimes the squeaky wheel gets the grease and women haven't been as vocal." Conceivably, the squeaky wheel was greased within the context of the HIV/AIDS crisis.

The participants' indirect references to problems that are necessarily linked to the problem of assumed female heterosexuality—sexism, racism, and classism—are equally important to this discussion. Acker (2000) argues that organizational change must necessarily consider all factors that are central to the change strategy. By failing to address the linked problems of sexism, racism, and classism, attempts to facilitate inclusivity are compartmentalized and those from diverse communities are construed as "other." In this way, the hospital organization constructs itself as fundamentally heterosexual, white, and male. Consequently, the organizational practices of inclusion (read exclusion) recognize diverse communities through a process of separation and (hierarchical) order rather than through an examination of how organizational structures of domination foster broad exclusionary practices (Zajicek, 2002).

Patient-Focused Care

The philosophy of patient-focused care is an important theme in light of the previous discussion, which highlighted both the fragmentation of organizational knowledge and the lack of recognition for lesbians as a community of service users. Within this context, a patient-focused approach could be problematic in that health care providers may be "forced" to see lesbian service users as individual due to the lack of community context by which to understand concerns and/or needs. From this perspective, an individual patient-focused approach could reinforce lesbian invisibility and, in so doing, act to obscure rather than to explicate the health concerns of lesbians as a community of service users.

Some participants extended the general philosophy of patient-focused care to include the actual medical and physical needs of clients. Frances, for example, described the organization's "real push" as making:

> gay and lesbian patients feel that they can be themselves, that they can be open about their sexuality. *If it's related*. Maybe it doesn't relate to you, you know, if you've got a splinter in your foot it doesn't relate but, ah, if you had a gynecological problem if you're a women or if you are, you know, have pneumonia if you're a gay man and you're concerned that you might have HIV.

Cheryl reiterated the need for a focus on the individual as related to the client's

physical and medical status by stating that:

> you couldn't do it on a corporate, you can't say all lesbians have these needs, lesbians coming in to have a baby have certain other needs than lesbians coming in to Emerg for something else and, you know, that kind of approach.

The concept of clients' needs as existing at an individual level addresses distribution of access rather than the experience of oppression. Cheryl's excerpt is indicative of such a notion; by focusing on lesbians as clients with different needs and utilizing different services, Cheryl fails to address the socio-political context of the organization and its effect on lesbian service users regardless of need. One implication of focusing on the distribution of access is that, in an attempt to meet the needs of lesbian clients, the relevance of their experience based on their sexuality (diversity) or lesbian sexual orientation (uniqueness) is either minimized or over specified. From this perspective, inclusivity/exclusivity is determined by diagnosis and is measured by the degree of accessibility to services and/or programs which are deemed relevant (a perspective which begs the question of when a lesbian sexual orientation is identified as related and who decides that it is). Frances clearly demonstrated a relational notion between lesbian inclusivity/exclusivity and diagnosis by submitting that gay and lesbian patients can be open about their sexuality "if it's related" (which she emphasized with her raised voice). She then went on to discuss stereotypical concerns of women (gynecological problems) and gay men (HIV/AIDS).

Education and Staffing

The language of the respondents suggest that, despite an organizational recognition of the value of hiring staff belonging to diverse groups, specifically lesbians and gay men, underlying assumptions about the overt expression of sexuality persist. Liz and Cheryl each use language that constructs the expression of gay and lesbian sexual orientations as "unnatural." Liz, for example, referred to people as "blatantly out," whereas, Cheryl used the word "flaunt" while trying to express a notion that lesbians and gay men are comfortable with their sexuality. Each of these terms suggests that there is a particular way that lesbians and gay men should express their sexuality—conceivably like the "natural" way that heterosexuality is expressed.

Ellen discussed the hiring of lesbian and gay staff within a particular clinic that provides service to a large client population living with HIV/AIDS. Ellen submitted that:

> there's some staff that were hired specifically because of their skills, uhm, and uhm, the fact that they were gay and lesbian. Uhm, I wouldn't say it was deliberately factored in but it was kind of like a, a plus (laugh) in their hiring.

It appeared that Ellen was saying that being lesbian or gay is, indeed, a specific skill for which people were hired; however, she retracted this with her second statement in an attempt to undo what might be considered an organizational "unspoken." The speaker appeared hesitant to identify the purposive hiring of lesbians and gay men, although it is implied that this is viewed as a successful strategy for change.

Heracleous (2001) argues that "efforts to change cognitive aspects of culture directly are likely to fail" (p.440), and that "focusing on behavioural change" (p.440) may be a more viable option. In this way, educational initiatives (cognitive) in combination with hiring (behavioural) may prove more favourable to organizational change. Humphrey (1999) states that "lesbian and gay employees have been ideally placed to recognize and in some cases remedy the sexual inequalities ingrained within their workplaces" and describes a "consciousness-raising process" whereby col-

leagues and managers seek out the expertise of lesbians and gay men in "training and policy-making functions" (p.142).

Conversely, an organizational reliance on the hiring of diverse staff for knowledge production and change may be problematic in two ways. First, it presumes fixed identities and suggests that a truth exists about categories of people. Second, it avoids the issue that staff and policies should meet the needs of all people, and that self-education is the responsibility of staff and the organization. From this perspective, the safety of lesbians during their health care interactions, for example, would not depend solely on receiving service from *the* lesbian nurse.

The language used by Liz and Cheryl, and the hesitancy of Ellen to openly and comfortably identify the purposive hiring of lesbians and gay men: (a) suggest a possible cautiousness on the part of the organization when (homo) sexuality is perceived as being overtly expressed or intentionally recognized, and (b) conceivably reflect the difficulty of revealing and changing the hidden values and assumptions that are embedded in and guide organizational policies and practices. These excerpts also highlight the simultaneous existence of official organizational practices (i.e., not hiring based on sexual orientation) and unofficial organizational practices (i.e., the hiring of "out" gay and lesbian staff).

Limitations of this Analysis

Fook (2002) argues that qualitative research functions to "maximize the depth and amount of learning about a phenomenon" (p. 118) which has been little investigated. Baer (2002) emphasis the usefulness of qualitative research for exploring questions that require tolerance for both ambiguous and complex answers. To this end, a qualitative research design was considered the most appropriate way to explore and describe hospital discourses, policies, and practices related to diversity and difference. Given this choice, the issues of sample size, generalizability, and representation must be considered.

Fook (2002) questions whether the notion of generalizability is even appropriate in reference to qualitative research, and suggests the use of "transferability" in its place. Transferability refers to the process of developing an understanding of a phenomenon, which might be transferable to other situations. In this way, theories developed in one context would be used to "explicate experiences in another context" as opposed to being imposed on them (i.e., generalizability) (Fook, 2002, p.126). Croteau (1996) further supports the usefulness of qualitative research for the discovery of new concepts and models that "will differ from the existing concepts and theories that often reflect the values and concerns of the majority or dominant social group" (p.208).

The findings of this study are based on a fairly small sample size and, therefore, should be seen as applicable only to the organization studied. However, it is important to state that generalizing to other hospital organizations was not the purpose of this study. Instead, the purpose of the qualitative research in this area was to discover information about one organization's response to diversity, difference, and the assumption of female heterosexuality. Conceivable, the findings of this study could function as broad areas of inquiry (concepts) to be pursued in an attempt to gain greater knowledge and understanding of the assumption of female heterosexuality and lesbian exclusion in other hospital organizations.

CONCLUSIONS

The data from this analysis reveal four key findings:

1. Organizational knowledge of the health concerns of lesbians as a community of service users is fragmented, and informal knowledge is not formally integrated into the organizational structure.

2. Lesbians are not represented as a community of service users and, as a result, knowledge production occurs in the absence such recognition—and therefore, without community input. From this perspective, the experience (collective voice) of lesbians as a community of service users remains silent, or is marginalized, within the organizational discourse.

3. Sexuality is defined as relevant in relation to specific diagnosis/medical concerns and as irrelevant to others.

4. Lesbian sexual orientations are conceptualized at an individual level (or, rather, as a private experience). The visibility of gay women is dependent on a "relevant" medical concern (i.e., pregnancy, physical injury due to gay bashing). From this perspective, the visibility of lesbian subjectivities is fleeting, and knowledge production functions to address the allocation and distribution of access. This perspective ignores the socio-political environment of knowledge production and obscures significant harms to lesbian service users as a result of the (mis)construction of subjectivities.

These findings reveal the normalizing and individualizing practices that help to ensure that the experiences of lesbians are not recognized and that lesbian communities are not formally afforded the space to engage in knowledge production. From this perspective, heterosexuality is maintained as the norm and lesbian subjectivities are constructed as existing within the private world of women—and, thereby, are marginalized and individualized. A focus on "lesbian needs" rather than on the socio-political structure functions to privatize and individualize the experiences and reality of lesbian service users.

Based on such a construction, the implications for lesbian service users are that: (a) female heterosexuality continues to be assumed; (b) the onus remains with lesbians to disclose their orientation or to "out" themselves; (c) health issues related specifically to lesbian sexuality (such as the transmission of sexually transmitted diseases between women) is not addressed/researched; (d) expectations or standards of inclusivity/visibility vary within this health care setting; and, (e) lesbian service users are still required to guess, or investigate, which areas of health care are inclusive and, therefore, must continually negotiate their safety.

Gay women face risks due to organizational discourses that maintain lesbian invisibility and that construct lesbians as "other." The assumption of heterosexuality evident in the policies and practices within the hospital organization studied here symbolizes the reproduction of assumed heterosexuality as experienced by lesbians within the broader social context. Health care institutions must effect change by looking beyond that of individual health care providers. Rather, change must include an analysis of how knowledge production reproduces or perpetuates an assumption of heterosexuality within local hospital organizations. Such an analysis would include exploring and understanding who is included in the process of knowledge production and how knowledge is dispersed and assigned within health care settings.

RÉSUMÉ

Cette recherche qualitative explore la présomption de l'hétérosexualité féminine en ce qui a trait aux politiques et aux pratiques des hôpitaux. La présomption de l'hétérosexualité est une conséquence des discours qui normalisent l'heterosexualitie et limitent l'identité sexuelle lesbienne à sa dimension individuelle. La littérature indique que la présomption de l'hétérosexualité féminine est impliquée tant dans l'invisibilité que dans la visibilité marquée des lesbiennes en tant que consommatrices de services. Cette étude fait un pas en avant en vertu de son optique qui met en relief les pratiques organisationnelles plutôt que les pratiques individuelles. Ce changement d'optique vise à découvrir les verités cachees, à explorer le pouvoir fonctionnel du langage et à permettre de découvrir ce que l`on sait et, tout aussi important, comment on le sait.

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