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Queering Know-How: Clinical Skill Acquisition as Ethical Practice

Cressida J. Heyes · Angela Thachuk

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Abstract Our study of queer women patients and their primary health care providers (HCPs) in Halifax, Nova Scotia, reveals a gap between providers' theoretical knowledge of "cultural competency" and patients' experience. Drawing on Patricia Benner's Dreyfusian model of skill acquisition in nursing, we suggest that the dissonance between the anti-heteronormative principles expressed in interviews and the relative absence of skilled anti-heteronormative clinical practice can be understood as a failure to grasp the field of practice as a whole. Moving from "knowing-that" to "knowing-how" in terms of anti-heteronormative clinical skills is not only a desirable epistemological trajectory, we argue, but also a way of understanding better and worse ethical practice.

Keywords Women's health · Sexual health · Cultural competency · Clinical skills · Clinical ethics

Introduction and Methods

It is no surprise that the existing literature on sexual minority patients and their primary health care providers indicates that there is still direct discrimination as well as widespread heteronormativity within health care systems (e.g., Bauer et al. 2009; Bjorkman and Malterud 2009;

Dorsen 2012; Dysart-Gale 2010; Hutchinson, Thompson, and Cederbaum 2006; Rounds, McGrath, and Walsh 2013; Saewyc et al. 2007). In this context, we define *heteronormativity* with our collaborators as:

the powerful interlocking set of assumptions and institutional practices that construct everyone as heterosexual unless shown to be otherwise and that view heterosexuality as the preferred, normal—indeed only thinkable—sexual orientation. In heteronormative contexts, heterosexuality is descriptively normative (statistically "normal") as well as prescriptively normative—unless heterosexual, one is cast as deviant, abnormal, lesser. At the very least, aberrations of the norm of heterosexuality require explanation. Heteronormativity, the pervasive assumption of heterosexuality, renders other sexual orientations (and people) invisible or marginal in health-care settings (Beagan, Fredericks, and Goldberg 2012, 47–48).

General practitioners (GPs) and nurses dealing directly with diverse populations still too frequently assume that everyone who is sexually active has one partner of the opposite sex and gender, followed by various concomitant assumptions about STIs, reproductive needs, parent status, family formation, and social support. The humdrum practices of the clinic (from intake forms to the pamphlets on display to conversations with a receptionist) as well as its larger institutional context (To whom can a GP refer a trans patient? How do patients access donor sperm?) create a complex network of actors, practices, and institutions within which individual instances of active discrimination or passive heteronormativity are

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nested. We already know something about how these instances play out in the clinical encounter, from the perspectives of both patients and health care providers (Beagan, Fredericks, and Goldberg 2012; Bjorkman and Malterud 2007; Dorsen 2012; Hinchcliff, Gott, and Galena 2005; Neville and Hendrickson 2006; Rounds, McGrath, and Walsh 2013). There is also plenty of existing social theoretical work that analyzes how heteronormativity functions and how homo- or trans-phobia sustain their momentum as conceptual schemes and networks of institutionalized practices (Fish 2010; Herek 2007; Norton and Herek 2013; R ndahl, Innala, and Carlsson 2004; Sedgwick 1990; Willoughby et al. 2010).

Our interview-based research with queer women patients and their primary health care providers in two very different Canadian cities contributes to both these literatures (Beagan et al. 2012, Beagan, Fredericks, and Goldberg 2012; Bryson 2012; Harbin, Beagan, and Goldberg 2012; Hattie and Beagan 2013). Describing the specific clinical interactions that constitute discriminatory health care treatment for queer patients and making recommendations for what guidelines might mitigate them are useful endeavors. In this article, however, we take a slightly different tack. We are interested in how (continuing) medical education, and especially so-called “cultural competency training” for prospective physicians, can reconceptualize itself as less concerned with imparting propositional knowledge (what philosophers sometimes call “knowing-that”) and more concerned with teaching queer-positive health care as a set of embedded practices. Underlying this inquiry is our observation that the distinction between what can be learned in the lecture hall and what is learned in the consulting room is essentially contested and poorly grasped, yet central to effective pedagogy and social change as well as to individual skill acquisition, effective health care provision, and ethical practice.

This paper draws from a qualitative study of queer women patients ($n=20$) and their primary health care providers ($n=21$) in the small maritime city of Halifax, Nova Scotia, Canada.¹ Here, the term *queer* is used inclusively to reference those who self-identify as lesbian,

bisexual, transgender or transsexual, or any of a range of neologisms now sometimes used by people with non-normative sexualities (including “polyamorous,” “pansexual,” and queer itself). Self-identification with the phrase “queer woman” was sufficient to include participants in the study, although the largest category in the Halifax sample identified solely as lesbian ($n=9$).² The study sought to examine the ways in which taken-for-granted practices can perpetuate or transform the marginalization of queer women within the health care system. It included in-depth, face-to-face interviews with nine family physicians and 12 registered nurses who self-identified as working with queer patients to any extent.³ Following research ethics approval, recruitment was conducted through advertisements, posters, letters to clinics, word of mouth, and snowball sampling. After receiving informed consent, in-depth, semi-structured interviews were conducted with participants.⁴ Interview questions asked participants to describe how they experienced primary health care practice with queer women. Interviews were recorded, transcribed verbatim, and analyzed inductively, generating themes and subthemes that were coded using Atlas.ti software by a team of researchers. Transcripts were read and re-read, and coded segments were interpreted both in the context of the larger interview and in comparison with the other transcripts.

Our analysis of the interview data reveals a gap between providers’ expressed theoretical knowledge of “cultural competency” and the lived experience of patients. All of the nurses and physicians interviewed had

² Two other women identified as primarily lesbian with a qualifier (“I see myself as just Arlene” and currently identified as lesbian “but exploring doing the bi thing”), two as trans, two as queer, four as bisexual, and one as “fluid.” Many other terms were introduced during the interviews (“polysexual,” “bent”). In addition to the complexities of their own gender/sexuality as it related to the complexities of their partners’ gender and sexuality, a few participants also construed “queer” (especially in the context of health care) as connected to polyamory or undertaking commercial sex or practicing BDSM (bondage, domination/submission, or sado-masochistic sex). The use of the term “queer women” in the way this research was conceptualized and conducted clearly raises its own methodological and epistemological questions, which are not our focus here (see Bryson 2012).

³ Some health care providers (HCPs) objected to the term “queer” and early in the project recruitment materials were changed to “LBGT” to avoid discouraging participation or encouraging participation only from those HCPs already comfortable with the term “queer.”

⁴ Ethics review and approval for the Halifax interviews were granted by Dalhousie University. All names used are pseudonyms.

¹ The larger research study drew on two sites—Halifax and Vancouver—with a roughly equal number of interviews at each. We examine here only the Halifax interviews, and some of our specific examples were clearly influenced by the context of a small, relatively conservative, culturally homogeneous city located in a large area of isolated rural communities (see Bryson 2012 for some initial comparisons between the research sites).

volunteered for the survey in response to postering or been recruited to participate by a colleague or a member of the research team. Unsurprisingly, therefore, no health care providers recounted current overtly anti-queer practices by themselves or colleagues, and each expressed a strong measure of acceptance and support for queer women. Nonetheless, *patients* commonly described routine instances of poor treatment, both psychosocial and medical—a finding that is replicated in other studies and evidenced by disparities in health outcomes for queer women.⁵ A critical literature on cultural competency training in Canada and elsewhere confirms that it tends to be individualizing, oriented toward propositional knowledge of a culturally different Other, and lacking in self-reflexivity (Gustafson and Reitmanova 2010; Beagan and Kumas-Tan 2009; Kumas-Tan et al. 2007; Reitmanova 2011).

Reinterpreting our interview data, we suggest a richer model for understanding this gap between theory and practice. Drawing on Patricia Benner's appropriation of the Dreyfus model of skill acquisition (originally published in 1984), we suggest that the dissonance between the *articulation of anti-heteronormative principles* expressed in interviews and the relative absence of *skilled anti-heteronormative clinical practice* can be understood as a failure to grasp the field of practice as a whole. Extending Benner's analysis, we also briefly show that ethical practice with queer patients could usefully be reconceptualized away from making the right considered judgments in advance of (or after) a clinical encounter toward a project of establishing conditions where more spontaneous and everyday forms of ethical coping can be successful and compassionate (Dreyfus and Dreyfus 1991; Varela 1999, esp. 4–11). Physicians in particular struggle to move from “detached observers” to “involved performers.” Indeed, we understand the tacit micromanagement of practitioners by queer women as, in part, an attempt to reconnect physicians to the possibility of involved performance. We describe how the role of detached observer may be not just a practice default for the novice provider (as Benner describes it) but also an ethical coping strategy. Thus, the paper argues that moving from knowing-that to knowing-how in terms of anti-heteronormative clinical

⁵ Note that the HCP and patient populations did not map—i.e., although all the research participants came from the same small city, the patients were not reporting directly on the HCPs we interviewed (nor vice versa).

skills is not only a desirable epistemological trajectory but also a way of understanding better and worse ethical practice.⁶

Benner's Dreyfusian Model and Nursing Practice

In her 1984 classic *From Novice to Expert: Excellence and Power in Clinical Nursing Practice*, Patricia Benner adapts the “Dreyfus model” of skill acquisition to nursing practice (Benner 2001). In their original work, Stuart and Hubert Dreyfus defend the position that “concrete experience” and “everyday familiarity” are essential and central to intelligent behavior (Dreyfus and Dreyfus 1980).⁷ Their examples derive from secondary research on chess expertise and second-language acquisition, as well as from primary research with airline pilots. They argue that attempts to understand how humans acquire skills or solve problems by abstracting from the situations in which those skills are actually practiced serve only to remove the very environment in which competence develops.

The form of skill acquisition that Benner posits is counterposed to a model based on technical understanding—that is, the assumption that all action can

⁶ The distinction between “knowing how (to)” and “knowing that” has generated a large philosophical literature. In recent years the debate has focused around the work of Timothy Williamson and Jason Stanley (Stanley and Williamson 2001; Stanley 2011), who argue that knowing-how in fact always does turn out to be dependent on knowing-that. Stanley argues against Dreyfus (and Gilbert Ryle before him) on the grounds that both presuppose a false view about what it must mean to act on propositional knowledge. According to Stanley, Dreyfus assumes that because we do not mentally *consult* our propositional knowledge prior to conducting a skilled action, knowing-how cannot be dependent on knowing-that (2011, esp. 23–24). Stanley then goes on to make a lengthy, complex argument to the conclusion that knowing how to do something is the same as knowing a fact. Although a longer consideration of our position could usefully engage parts of Stanley's analysis, we bracket it here. Our argument starts from the distinction between propositional knowledge as claims upon which an audience is invited to reflect and the complex everyday encounters practitioners have with their patients. That is, we are concerned with an epistemically and pedagogically implausible emphasis in medical education on abstracted discussion and moral guidelines as remedies for heteronormative practice. One could still, in theory, agree with Stanley and find this distinction unproductive in the situations we describe.

⁷ Benner draws on this very early work, but Dreyfus (and Dreyfus) have published a great deal since on this point, as well as extending the work more explicitly into the ethical domain. See in particular Dreyfus and Dreyfus (1991) and Dreyfus (2006, 2007).

be determined through explicitly stated theories and directives (Benner 2001). Simply expressed, one learns how to be a progressively better nurse (or airline pilot or chess player) by learning more and more formal rules of practice prior to their successful application in a professional setting. For Benner, however, like Dreyfus and Dreyfus, although technical learning in the form of rules, directives, and theories remains an important aspect of nursing practice, the development of nursing skill can only be understood through observation and analysis of the “discretionary judgment used in actual clinical situations” (Benner 2001, xxiii).

Within the Dreyfus model there are five posited levels of proficiency: novice, advanced beginner, competent, proficient, and expert. The move from one level to another reflects three general transitions in skilled performance: (1) from “reliance on abstract principles to the use of past concrete experience as paradigms”; (2) from seeing all the elements of a given situation as equally significant to being able to identify those most relevant and pressing; and (3) from “detached observer” to “involved performer” (Benner 2001, 13). In this last transition, as Benner describes it, the “performer no longer stands outside the situation but is now engaged *in the situation*” (2001, 13, *emphasis original*). Becoming a skilled practitioner thus precisely entails a move away from dependence on the rules one has learned in a classroom to understanding a field of practice as an entirety that can be grasped or immediately apprehended without self-conscious reflection.

In its most general form this implicit understanding of expertise is widespread: The expert chess player doesn't run through every possible move in her head before settling on the best but, rather, quickly intuits the best options; the experienced driver treats the vehicle as an extension of his body and defensive driving as fully internalized habits of action. Nonetheless, the beginner at chess still has to have the rules explained, and the learner driver takes a written exam and painstakingly learns how to operate a car. As Benner puts it, “the rule-governed behavior typical of the novice is extremely limited and inflexible” (2001, 21). She continues:

The heart of the difficulty lies in the fact that, since novices have no experience of the situation they face, they must be given rules to guide their performance. But following rules legislates *against*

successful performance because the rules cannot tell them the most relevant tasks to perform in an actual situation (2001, 21, *emphasis original*).

For example, a perinatal nurse who is an “advanced beginner” might move along the line of neonatal intensive care unit (NICU) incubators doggedly following her preceptor's detailed instructions, treating each as equally important for she has not yet developed the skill of identifying the most important actions; thus, if given a list of eight checks, advanced beginners will start by doing these things even if a baby down the line is visibly distressed (Benner 2001, 23–24).

In his fascinating short lectures on enactive cognition, Francisco Varela (drawing on Dreyfus and Dreyfus) makes a similar point about know-how, but relates it more specifically to ethical action. In contemporary Anglophone moral philosophy, he points out, the dominant understanding of ethical experience is represented by situations in which a central self performs deliberate, willed actions, the rightness of which is then post hoc evaluated by reference to reasoned moral judgments. By contrast, much of our everyday ethical life consists of situations in which we act spontaneously, to immediately cope with the challenge of a complex intersubjective situation. We could, argues Varela by way of a complex articulation of enactive cognition as it meets Asian wisdom traditions, understand the virtuous person as “*one who knows what is good and spontaneously does it*” (Varela 1999, 4, *emphasis original*). Later, he explains that although virtue in this sense is not indifferent to ethical rules, it uses them only as training guides, potentially to be dissolved “in the demands of responsiveness to the particularity and immediacy of lived situations” (Varela 1999, 74). In the traditions Varela is citing here, there is an interesting parallel with Benner: It is not the expert who follows rules most strictly, but rather the beginner. Further, either skilled or ethical action emerges as a spontaneous and unreflective undertaking only through certain repetitive practices that are its background conditions of possibility. For Benner, this would be something like the experience of working alongside a more skilled nurse for a period of mentorship, where the example of the other person's actions and spontaneous habits more than her verbal instruction play a developmental role; for Varela, it would be something like a meditation practice, in which an egoistic attachment to the idea of a unified self is eroded so that genuinely compassionate action can take

place. The articulation of Dreyfus, Benner, and Varela, then, links three positions: an epistemological argument (how one comes to know-how-to and its relation to knowing-that), an application of the argument to a new domain of practice (nursing), and an ethical position (moral maturity as a related kind of know-how).

Benner and Anti-Heteronormative Medical Education

A central purpose of Benner's model is, as it was for Dreyfus and Dreyfus, to point toward better forms of training that will more quickly and thoroughly advance practitioners from novice to expert. For Benner, this expertise is not only a matter of acquiring the ability to make rapid and selective judgments about technical aspects of patient care but also a matter of learning how to grasp the larger picture of the patient's well-being. The rich examples of clinical skill development that Benner uses often involve psychosocial judgment and providing help to patients who are marginalized; that is, they are not solely about clinical skill, narrowly understood, but also about ethical practice—in Varela's sense of relating compassionately and wisely to others. We suggest that the insights of Benner's model might usefully be brought to bear on explaining existing deficiencies in the ways providers relate to queer women patients and on suggesting novel strategies for cultural competency training.

Critique of Practice

In our interviews, we noted that despite verbal claims to the contrary many providers continue to assume that all their patients are serially monogamously, heterosexually active, having non-commercial, vanilla sex. When they run up against a patient's queerness they must then make sense of a new context. As nurse Anna described:

I do remember one time, I totally, it was, 'cause you have to think of these things all the time because you know as a heterosexual it's like you don't think, you know, you think according to your own identification a lot of times right so ah, I remember I was seeing somebody and oh I had neglected to say that I think, I can't remember, it was a few years ago, I can't remember and then

they listed their partner and then, and I was like oh I'm sorry, I'm sorry, like I was all apologetic like that I had wrongly made this assumption and she was like very cool, she was like that's fine, it happens.

Not infrequently, in such circumstances many providers revert to what Benner labels novice behaviors—trying to remember the right terminology or rules to follow in future interactions (and retrospectively going over the course of earlier interactions with the patient to see if there were instances in which they may have made mistakes or violated the rules). In such cases, the patient is often inadvertently reduced to an object the practitioner must correctly “identify and categorize” (Hanssmann, Morrison, and Russian 2008, 17). Like the expert pilot, whose performance actually worsens when asked to follow the guidelines or formal rules, the practitioner's self-evaluation and reversion to novice-like behaviors inhibits engaging the practical skills of the involved performer. These “skills” are not restricted to being adept with assessing and handling sick patients' bodily needs, but also extend to affective and embodied knowledge (Shotwell 2011). The expert nurse knows how to encounter a patient's fear or anger—including when she has provoked it—while (and by) managing her own emotional responses; she knows that a firm squeeze of the shoulder might be calming at this moment. Overcome by chagrin at having “got it wrong,” many of the HCPs interviewed lost touch with the affective and embodied knowledge they did have and thereby lost important connection to the patient. In effect, the practitioners stepped outside of the situation. Thus, in one and the same move, practitioners revert to detached observers of both the patient (as someone who requires the right “handling” after their recategorization or through the application of rules) and themselves (as a holder of propositional knowledge of what those categories and rules are). Particular terminology or instructions on how to behave typically derive from formal training within the first or second year of undergraduate programs before clinical training commences. Pedagogical methods in cultural competency programs tend to be didactic and case-based, often comprised of reviewing formulaic lists of dos and don'ts (Reitmanova 2011). This approach encourages students to adhere to specified modes of interaction, often leaving them ill-equipped to deal with more complex situations. As Obedin-Maliver et al. state:

“It is possible that students are taught to initiate sensitive conversations but lack the breadth of training to continue them in meaningful ways” (Obedin-Maliver, Goldsmith, and Stewart 2011, 976). In other words, once the preliminary scripts have been followed, many providers do not know how to proceed further.

Patients often experience this reversion as a form of distancing, in which their queerness overwhelms the encounter, their specific situation is forgotten, and an already vulnerable situation is made more so. Physician Gina spoke to the importance of being aware of one's own biases so as to moderate one's reactions when patients divulge personal information. She stated:

You know you look shocked or something, you know they can pick it up. And like I said I'm sure living as a queer person in a heterosexual society, there's a reason why you're hypervigilant 'cause you always worry and so yah and especially if something as important as your health care, I means sure and again that's part of the reasons why I'm, I try to be aware. Like again I'm aware of the importance of this relationship and I'm aware of my role in it, that yah, that I have to be aware of my own biases because it will come out and so the best thing to do is to be transparent about it and that's what I like to do because my biases are my biases.

Gina is exceptional in that she both recognizes *and* admits that despite her self-awareness she is not always able to keep her biases in check. Perhaps tacitly recognizing this difficulty, many providers we interviewed were adamant that queerness is irrelevant to patient care. As nurse Clara put it:

I don't really, you know, because I don't really care. Ah, as long as it's not publicly displayed, I, I don't, you know, I'm just looking at the patient. I don't look at the, who he is, or what, you know, who she is. I just go after the goal that I want to make them feel better. So, that's, you know, that's all.

In claiming that she doesn't “really care” about a patient's sexuality, Clara captures the ethical dilemma: On the surface she is saying that she doesn't discriminate, yet the double meaning of “I don't care” in English also comes through. By *not* looking at “who the patient is” Clara risks not really caring in the second sense of being

indifferent to her well-being. Further, she collaborates with the system that expects queer patients to conceal their sexuality (“as long as it's not publicly displayed”) and manage awkward disclosures. In other writing based on the same data, Beagan, Fredericks and Goldberg have argued that the nurses in the study could only conceptualize an emphasis on queerness in practice as a way of stereotyping or discriminating and made “treating everyone the same” or “treating everyone as an individual” their ethical objectives (Beagan, Fredericks and Goldberg 2012). “Treating everyone the same” seems to be understood as providing the same quality of care to all-comers (as when Clara is asked, “Do you think that, you know, you would work differently with a patient who's disclosed that they're queer, or not, in any way?” she replied, “I don't think I would. I, I want to believe that I, you know, I think I would give same care, you know, as, as I'd, you know, people who are straight”). “Treating everyone as an individual” implies acknowledging all the complexities of the patient's situation without treating her generically. In some ways the imperatives cut against each other, but both index to not allowing negative generalizations about social groups to diminish care. This is obviously an admirable ethical goal, but it creates no conceptual space for recognizing the different political realities that shape the experience of different patients. For example, when asked how important it is to her practice on a pediatric medical floor that she knows that either the patient or the patient's family members identify as queer, one nurse (Abigail) responded:

You know, like if the family dynamics are affecting the child in some way, then I would say that it's an important piece of information. But if it's a loving family that's functioning just fine, then it's really not that important.

She continued:

I mean, I suppose that maybe you would be a little careful about subjects that you would broach, because you wouldn't want to offend them in any way. But I just feel like I, I am comfortable enough with the whole gamut of families that I just treat everybody the same.

Benner briefly alludes to the practice of hiding behind rules and policies as a defense against anxiety, a sort of coping strategy. More current research supports

this, suggesting that this “retreat into professionalism” functions as a means of “avoiding discrimination” (Beagan and Kumas-Tan 2009, e25).

In our study, on several occasions patients reported that even a gentle correction or mild challenge to the way providers interacted around queerness could provoke defensiveness or attempts at self-justification or justification of the existing system. For example, one interviewee, Heather, described an experience in which a nurse asked her if the woman accompanying her to her appointment with a specialist was her daughter, when in fact she was her somewhat younger partner:

That was crap, that was really bad on a lot of levels. Number one, I found it insulting because I don't think there is that obvious an age difference between us. I found it insulting because I know that nurses do receive training in diversity and that was just swept out the window with this woman's assumptions. And thirdly because it seemed inappropriate for the circumstances, we were, she and I, my partner and I were walking into the office to hear about the results of the test.

She also offered an analysis:

The defensiveness I sometimes see in health care providers leads to that, like who's this, why is there another person in your appointment, why is there somebody else here, is somebody testing me, is this an interview, is this, no it's because I can't remember things very well and this is my closest person. ... And when that defensiveness comes out, I think there's a greater opportunity to lead into the “oh this must be ...” which can really take you on the wrong path.

Another interviewee, Kim, described her experience of bringing her baby into emergency and attempting to negotiate the intake process when asked to provide information about the baby's parents—herself and her female partner:

So I'm sitting there, I think this is probably the most uncomfortable I've ever felt, with this sick baby and feeling vulnerable and afraid, and not sure what's going on and nobody can tell me why she's coughing till she's blue in the face, and she can't tell me, and ah, the woman [doing the intake] was just so insensitive and she said, well what's the relationship, and I said mother, and she says

aren't you the mother? I said yes, she has two mothers. Well how can that be? And I said well she does. ... And then I had to dig through my bag to find this piece of paper that I carry around that confirms this legal guardian in health care, so she looks at it and the whole time she's looking at me like I've got six heads and she's saying all of this loudly enough that the people behind me are hearing and I noticed people looking at me, and then she's looking at my document and then she goes well that's not going to fit in my slot.

In her failure to grasp the broader context of the encounter, the intake person's novice-like, rule-abiding behaviors remove her as an involved performer, adding to the vulnerability and distress of an already frightening situation.

Sometimes defensiveness can escalate into completely severing a relationship with a patient. For example, Rachel is a sexually active young woman who identifies as queer and has multiple sexual partners of different genders. She sometimes uses a fertility awareness method (FAM) “when I'm in relationships where I need birth control and where the risk of STI and HIV isn't [an] issue.” Rachel is not diffident, and she knows what she wants from the health care system. This confidence, however, is not always well received by HCPs:

I was talking to this doctor about you know my body and about my sexual health and you know about getting tested and I was saying that, I use this sort of birth control and I told him about sometimes I used condoms and sometimes I use dams and sometimes I use FAM depending on sort of who I'm with and what body parts they have and what we're talking about, and what's the history. And he got really upset and told me that I shouldn't use FAM and I don't know my body and he knows what's going on and that I could get pregnant and I don't know what's going on, and just like started yelling at me, and we got into this yelling fight, like full on yelling, like who knows more about my body. Ah, and so I left and that was horrible and like I remember leaving the office just like shaking, just like being really, really upset, that this white dude, that this white man was telling me that he knew more about my body than I did.

To avoid this kind of escalation, in many instances, then, queer women will attempt to micromanage

practitioners in order to reconnect them to the possibility of involved performance. Several respondents told us that they use humor when addressing providers' questions or correcting their misassumptions in order to deflect providers' defensiveness and potential feelings of guilt. For example, before undergoing X-rays one woman respondent (Camille) was repeatedly questioned regarding the possibility of her being pregnant:

And every time: Is there any chance that you could be pregnant? No, I'm not pregnant. Have you been sexually active in the past three months? Yes, I have. Are you taking any form of contraception? No, I'm not. "Are you really sure" and then at one point I just looked at the nurse and said "she had a very low sperm count." And the nurse kind of looked at me and went "fair enough" and then just went behind and didn't comment on anything. Was not rude about it, I think she was more amused, probably, I hope, thought damn you know why do you always assume that people are straight maybe, but that was the only time where I kind of replied, and trying to make it a funny thing rather than why are you assuming that I am straight and you know, but kind of said yeah.

She continued:

I think a lot of times if you present a very human, nonthreatening perspective I think a lot of people are more willing to be okay with things.' Cause people hate feeling guilty and I find like as soon as they have this feeling of feeling guilty then they retract or you know hide behind this barricade and that's it, they're never going to come out of it and they're never going to do whatever works.

Implications for Training

Part of Benner's approach is to recommend that clinicians examine incidents both where they felt their interventions were successful and where they were unsatisfied with their performance (Benner 2001, 31). The use of case studies and sharing of past experience form a central part of her suggestions for more effective nursing training. A simple extrapolation from Benner's work leads us to recommend similar strategies; indeed, many medical programs have already been criticized on the

grounds that they treat cultural competence as a classroom rather than a clinical skill, offering only initial rules of engagement with a culturally different Other rather than a holistic sense of how to conduct a clinical relationship (e.g., Dogra, Reitmanova, and Carter-Pokras 2009; Obedin-Maliver, Goldsmith, and Stewart 2011).

These critiques often posit increased self-reflexivity as the answer to prejudicial beliefs and discriminatory care (e.g., Coren et al. 2011, 67). There are certainly merits to this approach. On our interpretation, however, self-reflexivity can be an intellectualist epistemological gesture that is in tension with Benner's model. If self-reflexivity means gaining self-knowledge by looking inside one's own head, and perhaps comparing what one is able to find with the propositional knowledge offered in cultural competence training, then it simply recapitulates a faith in the epistemic and ethical value of introspection, rather than fully attending to the nuances and complexities of how heteronormativity is learned and practiced intersubjectively and institutionally. Varela (1999) is also critical of this kind of ethical education, pointing out that while measuring moral dilemmas abstracted from life against moral rules or theories is one valuable kind of ethical reflection, it tends to have relatively little purchase on the myriad of ethical decisions we confront every day. Even the common pedagogical practice of pulling out one's ethical "intuitions" to test against moral theories is epistemically limited in the face of somatic, affective, and practical limitations that press us to act counter to them.

As the burgeoning psychological literature on implicit bias reveals, our avowed beliefs that we are not prejudiced and do not discriminate are frequently belied by our behavior, which indicates a commitment to socially mediated racist and sexist views. Experimental results show that subjects are more likely to pair black faces with negative adjectives (and white faces with positive ones) when making associations at speed (see Kelly and Roedder 2008 for a summary of this literature) or to rate the same résumé more highly when it comes under a male name than when the same information is presented under a female name (e.g., Steinpreis, Anders, and Ritzke 1999). Yet these same subjects would typically deny that they thought black people were collectively inferior in any way or that men and women with the same qualifications should be treated differently in a job application. Because implicit bias cannot be changed only by knowing progressive theories, it is especially

cognitively dangerous: People who have spent some time propositionally rehearsing their anti-racist or anti-sexist views still have implicit biases, although they may have made themselves more likely to believe that they do not. Thus, if these empirical findings are correct, existing cultural competency education may risk inflating the confidence of future health care providers that they have overcome discriminatory beliefs, without touching their implicit biases.

Thus far our argument has been both epistemic and pedagogical. Heteronormativity is a set of embedded practices that are not propositionally learned and cannot be straightforwardly propositionally undone. Queer-positive health care may need to start from “dos and don’ts” but it cannot end there if we hope that HCPs will become skillful experts rather than awkward novices. So what follows for health care education? We might start by grasping that anti-heteronormative practice is more like the hands-on skill acquisition that HCPs typically learn through physical demonstration and assisted repetition (how to insert a catheter or deliver a breech baby, for example) and less like the kind of knowledge learned in a lecture hall (the biochemistry of diabetic shock or the cellular functioning of HIV). This would already mark a paradigm shift for cultural competency training as it is currently practiced. As the original example of training airline pilots shows, what is required is a transition from more passive to more active, practice-based forms of learning. Cultural competency training thus needs to shift away from its narrow emphasis on obtaining specialized knowledge sets in the early years of training toward an integration, throughout undergraduate programs, of more active role-playing, problem-based, narrative approaches to medicine and cultural competency. This suggestion might mean that while listening to someone from the queer community speak about his or her experiences is an important facet of competency training, knowledge gleaned from such encounters also needs to be put to work in repeated interactions.

Note that any simulated situation is likely to be significantly different in terms of power relations than the real dynamics we heard described. Many of the women interviewed in this study undertook what Mary Bryson (2012) has called “choreographic labour” in their interactions with HCPs. That is, they carefully danced around the ignorance and anxieties of the person from whom they needed care, taking pains not to expose or threaten the more powerful interlocutor. (The alternative, as we saw in Rachel’s case, was to confront the

power dynamic directly and risk outright negative judgments about sexual choices or even the end of the health care relationship.) While entirely necessary and understandable, these behaviors often work to leave implicit bias untouched. They are also, as Bryson points out, enacted “under conditions that are in some fundamental way unmanageable by individual patients” (2012, 5). This brings us to our final conclusion: Although we have held onto the belief that existing educational models can usefully be revised toward more effective anti-heteronormative health care practice, ultimately the literature’s focus on individual and typically dyadic interactions between a provider and a patient cannot reveal the institutional networks that generate the subjectivities and communicative possibilities we are describing. For example, establishing protocols to ensure that transwomen are able to use their preferred name in all interactions and documents are important, but they cannot negate the fact that many regions of Canada have no psychiatrists, endocrinologists, or other experts in trans health to whom the well-intentioned GP might refer. Thus, many Canadian transwomen must remain for protracted periods in gender limbo, without the hormone treatment, surgeries, or psychiatric evaluations that would enable them to move toward their chosen gender presentation. This is only one small example of how institutional under-resourcing and neglect contribute to iterative communicative conflicts.

Conclusion: Know-How as Ethical Practice

Heteronormativity in health care is clearly an ethical issue: It is a negation of the patient’s social world and a denial of her way of being in that world, as well as a straightforwardly bad way of practicing medicine in light of the poor health outcomes to which it contributes. An objection to the way we are conceptualizing heteronormative practice might be that we have provided no way of holding HCPs accountable for their actions. Specifically, if we are right that implicit bias is part of the problem, and that it cannot be overcome by adding to the store of propositional knowledge that countermands it, we are faced with an interesting ethical challenge. Can someone be held responsible for actions they did not consciously take? For most people, this question is intuitively answered with a “no,” and this intuition explains the unease many progressive commentators seem to feel about challenging HCPs on their anti-queer practice. For

example, in an early article Michele Eliason writes that “homophobia and heterosexism are not the fault of individual nurses, as they are the legacy of their socialization” (1993, 18; also quoted in Beagan et al. 2012, 46). While mostly true, this seems to take an overly narrow and exclusively retrospective view of ethical responsibility in the face of an ongoing structure of power and privilege.

One response to evidence of implicit bias is not to retrospectively blame others (or oneself) for the initial judgments that made it possible to say such bias exists, but rather to look prospectively at likely future instances. One way that the propositional knowledge of cultural competency might be recast (given existing dependence on conventional pedagogical models) is by conveying not only facts about sexual minority health, or lists of dos and don'ts, but also encouraging *epistemic modesty*—an active sense that one's own practices may not live up to one's stated beliefs in ways that cannot be accessed by introspection.⁸ Our point is *not* that HCPs shouldn't improve their basic knowledge about sexual health. (We were disturbed to hear in the interviews that one GP, for example, believed that women who have sex only with women do not need to get pap smears and that a woman seeking information about whether she could get oral cancer by performing cunnilingus on her partner who had cervical cancer was unable to get an answer from several providers. The near-total ignorance among primary care providers about the hormone protocols for transwomen also was shocking.)⁹ Rather our point is that even a knowing-that model of cultural competence education might productively harness and discuss some of the discomfort and anxiety that attends awareness of one's own epistemic failings (see also Harbin, Beagan, and Goldberg 2012). For us, ethical practice is less a matter of establishing rules for correct action and more a matter of shaping the conditions of possibility for better engagement, where that engagement is at once wiser, more compassionate, and spontaneous.

⁸ The phrase “epistemic modesty” is also used in a philosophical literature where it has related but more narrowly defined connotations. We are not concerned with that literature here.

⁹ Women who have sex only with women are advised to get regular cervical cancer screening, as HPV can be transmitted between female sexual partners (see Henderson 2009 for a recent summary of research). Although HPV can be transmitted between women via oral sex, and HPV does appear to raise the risk of oral cancer, cancer itself is non-transmissible.

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