

The Lived Experiences of Nurses Who Identify as 2SLGBTQIA+ in Providing Nursing  
Care Within an Urban Prairie Setting: An Interpretive Descriptive Study

by  
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## Abstract

**Background:** Despite rapid improvement in human rights and protections for people who identify as 2SLGBTQIA+ in Canada, discrimination against people who identify as non-heterosexual and non-cisgender occurs. Heteronormativity and cisnormativity prevail within the Canadian health care system and environment nurses work and study. Nurses who identify as being 2SLGBTQIA+ are hypothesized as being one of the workforce's largest subcategories; despite this, there is a shortage of literature on the experiences of nurses who identify as 2SLGBTQIA+.

**Purpose:** This study aims to uplift the voices and lived experiences of equity-deserving nurses who identify as 2SLGBTQIA+ in providing nursing care in the urban prairie setting of Winnipeg, Manitoba.

**Method:** An interpretive descriptive qualitative study design was utilized. Data was collected through semi-structured interviews. Interviews were transcribed verbatim and coded to generate themes describing the experiences of nurses identifying as 2SLGBTQIA+. Minority Stress Theory served as a guiding theoretical framework to provide context in understanding the lived experiences of study participants. Convenience and snowball sampling was used to recruit the sample size of 11 nurse participants.

**Findings:** This study revealed findings related to five themes: discrimination, disclosure, education, allyship, and identity. Discrimination is often covert and witnessing discrimination negatively affected participants. There is nuance in choosing to disclose or not disclose one's 2SLGBTQIA+ identity as a nurse. The onus is often placed upon the oppressed to educate those in power and meaningful content about the health and wellness of people identifying as 2SLGBTQIA+ is needed for nurses and all health care providers. Allyship in practice is

actionable and consistent as opposed to the performative allyship often conveyed in practice. 2SLGBTQIA+ identities in nursing are an asset to nursing practice and patient care.

**Implications:** Many implications arose from this research and can be attributed to three areas: nursing practice, nursing education, and nursing research. Within nursing practice, leadership, regulatory bodies, active allyship and the incorporation of EDI is of utmost importance. Formal nursing education and curriculum need to recognize the existence, health, and wellness of people who identify as 2SLGBTQIA+. Education delivered by clinical facilities that nurses work within need be inclusive of the experiences of people who identify as 2SLGBTQIA+. More research is needed to better understand the lived experiences of nurses who identify as 2SLGBTQIA+. Examples include research with underrepresented identities encompassed within the 2SLGBTQIA+ acronym, the experiences of nurses working in diverse workplace settings, the intersection of numerous social identities, and moving from a deficit approach to a strengths-based approach.

**Conclusion:** Eleven nurse participants who identify as 2SLGBTQIA+ and work within Manitoba shared their lived experiences that subverts cis-heteronormativity and cis-heteroprofessionalism. Implications for how to improve the experiences of nurses who identify as 2SLGBTQIA+ have been identified.

*Keywords:* 2SLGBTQIA+, queer, trans\*, nurses, nursing care, nursing experience, interpretive description, cis-heteronormativity, cis-heteroprofessionalism, identity, allyship, discrimination, homophobia, transphobia.

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## Dedication

I dedicate this thesis to the young kids who are coming of age in rural communities and coming to terms with their sexuality and gender identity. You are valid. I dedicate this thesis to the 2SLGBTQIA+ community past, present, and future in Manitoba. We are here. We have been here for centuries. We cannot be erased. I dedicate this thesis to the eleven participants that volunteered their time and experiences with me: I see a bit of myself in all of you. I see you. I cannot thank you enough for being open and sharing your thoughts, feelings, experiences, and vulnerability with me. I dedicate this thesis to the health care providers and nurses identifying as 2SLGBTQIA+, who paved the way for many of my colleagues and me. Thank you.

Queerness in a way saved my life...often, we see queerness as deprivation. But when I look at my life, I saw that queerness demanded an alternative innovation from me. I had to make alternative routes; it made me curious, it made me ask, 'This is not enough for me...'

— Ocean Vuong (2020, 16:40)

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### **List of Abbreviations**

2SLGBTQIA+ - Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, All other non-heterosexual and non-cisgender identities

BIPOC - Black, Indigenous, People of Colour

CEF – Clinical Education Facilitator

CINAHL - Cumulative Index to Nursing and Allied Health Literature

CIS - Cisgender

HET - Heterosexual

CNS - Clinical Nurse Specialist

CRNM – College of Registered Nurses of Manitoba

DSM - Diagnostic and Statistical Manual

EDI - Equity, Diversity, and Inclusion

HCP - Health Care Provider

ID - Interpretive Description

LPN - Licensed Practical Nurse

MCNHR – Manitoba Centre for Nursing and Health Research

MS - Minority Stress

MST - Minority Stress Theory

NP - Nurse Practitioner

REB1 - University of Manitoba Research Ethics Board 1

RN - Registered Nurse

RPN - Registered Psychiatric Nurse

SOGI - Sexual Orientation and Gender Identity

UM – University of Manitoba

## **Chapter 1: Background**

This chapter sets the stage by providing the context and foundation of this thesis research study. This chapter includes the problem statement, the purpose of the study, research questions, the significance of the study for the nursing profession, researcher positionality, preliminary work completed by the researcher, researcher assumptions, and definitions of key concepts.

### **Statement of the Problem**

Despite historical improvement in rights for 2SLGBTQIA+ people in Canada, discrimination and stereotypes against people who identify as 2SLGBTQIA+ remain (Association of Women's Health, Obstetric and Neonatal Nurses, 2023; Galanza et al., 2024; Lim & Borski, 2015; Lim & Borski, 2016). Heteronormativity and cisnormativity prevail within the Canadian health care system (Beagan et al., 2023; Bizzeth & Beagan, 2023; Harding, 2007; Röndahl, 2005; Shattell, 2016; Yingling, 2019). Health care systems “tend to be highly conservative environments, with considerable pressure toward conformity,” and HCPs often come “from elite social groups” (Beagan et al., 2022, p.1). It is hypothesized that one of nursing's largest subcategories is nurses who identify as 2SLGBTQIA+ (Eliason et al., 2011; Galanza et al., 2024; Lim & Borski, 2015; Stephany, 1992a; Zurlinden, 1997). Despite this, there remains a paucity of literature on the experiences of nurses who identify as 2SLGBTQIA+ (Eliason et al., 2010; Galanza et al., 2024; Randall & Eliason, 2012).

### **Purpose of the Study and Research Questions**

This study aims to unveil the experiences of nurses who identify as 2SLGBTQIA+, to improve the environments they work and study in, which will inform policy and improve patient

care. This research aims to uplift the voices of equity-deserving nurses that previously have not been listened to. The following overarching research questions guided this study:

1. What are nurses' experiences identifying as 2SLGBTQIA+ in providing nursing care in Winnipeg, Manitoba, Canada?
2. What do nurses identifying as 2SLGBTQIA+ believe their identity brings to their nursing practice and patient care?

### **Significance to Nursing**

The findings of this study add to the literature on the experiences of one of the largest subcategories within nursing, nurses who identify as 2SLGBTQIA+. Better understanding the experiences of equity-deserving nurses provides implications for nursing practice, education, and research that will be discussed in later chapters. The new knowledge gained from this thesis provides significant implications to improve the experiences of nurses identifying as 2SLGBTQIA+ and their patients. This study provides supporting data for promoting diversity within the nursing profession and systemic policy changes.

### **Diversity and Improved Patient Outcomes**

The literature unveils the nursing workforce's need for more diversity (Hinson et al., 2022). The patients nurses care for are increasingly diverse, and the nursing workforce must be reflective of this (Loftin et al., 2013; Powell Kennedy et al., 2008). Increasing the amount of diversity within the nursing workforce could help reduce health disparities and improve the health equity of those that identify as 2SLGBTQIA+ (Gallo et al., 2022; Hinson et al., 2022; Loftin et al., 2013). The literature indicates that people accessing health care feel more

comfortable doing so when their providers share similar identities (Gallo et al., 2022). Exploring and uplifting the experiences of nurses who identify as 2SLGBTQIA+ in Winnipeg provides meaningful implications of why diversity within nursing is essential.

### **Reflexivity**

Reflexivity is the ongoing process of considering personal positionality, assumptions, and values, as these factors all affect the formation of research and the research study's direction (Creswell, 2014; Polit & Beck, 2017; Thompson-Burdine et al., 2020). This section will delve into the researchers' positionality and values, along with preliminary work that informed the underlying assumptions of this thesis.

### **Positionality**

“In ID [Interpretive Description] the researcher is a valuable instrument of the research” and “A researcher’s technical knowledge, research background and personal experiences are major sources of insight” (Thompson-Burdine et al., 2020, p.339). Recognizing my positionality as a researcher is crucial, as it informs the formation of research questions, the interpretation of research findings, and all aspects of research (Coghlan & Brydon-Miller, 2014; Polit & Beck, 2017; Thompson-Burdine et al., 2020). Reflecting upon my standpoint as a researcher in relation to this study is imperative, as my positionality "affects every phase of the research process" (Coghlan & Brydon-Miller, 2014, p.2).

I am a white settler of European descent. I am an uninvited guest on Turtle Island and have significantly benefited from living on this land. I grew up on and live on Treaty #1 territory in Manitoba, Canada. The clean drinking water in Winnipeg has been sourced from Shoal Lake 40 First Nation since 1919, and Shoal Lake 40 First Nation was without clean drinking water

until 2021 (City of Winnipeg, 2024). I attended Red River College Polytech and obtained a Health Care Aide diploma in 2011 and a Bachelor of Nursing degree in 2018. I recognize the many ways in which my blonde hair, blue eyes, European descent, socio-economic status, physical abilities, and masculinities have provided me with intertwined, un-deserved privileges in my life. I also recognize that I am on a journey to learn how to leverage these undeserved privileges to be a better ally.

My curiosity about the research topic of the lived experiences of nurses who identify as 2SLGBTQIA+ stems from my firsthand experiences as a registered nurse (RN) who identifies as queer. Since graduating with my undergraduate nursing degree, I have been a RN in acute care, and before this, I was a health care aide for six years also in acute care. My experience does not reflect that of every nurse who identifies as 2SLGBTQIA+, but historically, research has been done *on* as opposed to *with* equity-deserving groups (Samms Hurley & Jackson, 2020), and my lived experiences as a queer person, living in a cis-heteronormative society and working within cis-heteroprofessional workplaces, are an asset to this research.

### **Preliminary Work**

In preparation for this thesis and fulfillment of graduate coursework in late 2022, six informal conversations with nurses who identified as 2SLGBTQIA+ occurred. These conversations illuminated the following topics: the need for representation and diversity within nursing, the pervasiveness of heteronormativity and cisnormativity within health care in Manitoba, the need to combat heteronormativity and cisnormativity in nursing, "taking the lead" of patients when disclosing sexual orientation and gender identity (SOGI), 2SLGBTQIA+ identities are an asset to nursing practice, and the importance of anonymity in data collection when study participants are from equity-deserving groups.

## Assumptions

Polit and Beck (2017) define an assumption as "a principle that is accepted as being true based on logic or reason, without proof" (p.720). Assumptions are often accepted truths based upon beliefs, experiences, and values (McEwen & Wills, 2019). As a researcher, my assumptions stem from my preliminary work and my lived experiences as a nurse in an acute care setting in Winnipeg, Manitoba. The five main assumptions I have about nurses who are 2SLGBTQIA+ are as follows:

1. **Nurses identifying as 2SLGBTQIA+ experience discrimination:** My first assumption is that nurses who identify as 2SLGBTQIA+ experience covert and overt discrimination based on their SOGI within their nursing education and clinical work. This assumption relates to my experience of discrimination in the workplace and academia.
2. **Nursing workplaces do not have enough policies protecting nurses identifying as 2SLGBTQIA+:** The second assumption I have is that the facilities and organizations that nurses work within do not have overt policies and procedures to safeguard staff who identify as 2SLGBTQIA+, and if they do, they are not enforced. Subsequently, I assume that due to the negative effects of minority stress (MS), equity-deserving nurses do not feel safe raising concerns and challenging the status quo.
3. **Nursing workplaces do not overtly affirm people who identify as 2SLGBTQIA+:** I assume the facilities and organizations nurses work within do not display overt signs of affirmation and allyship for equity-deserving nurses. These assumptions also relate to my experiences working in acute care.
4. **Nurses' undergraduate education lacks content on caring for people who identify as 2SLGBTQIA+:** Based upon my experience as a nursing student in both undergraduate

and graduate education, I assume that most nurses' formal education lacks curriculum content on the experiences of people who identify as 2SLGBTQIA+. This assumption extends into workplace education, and I assume the study participants I interview will have a similar gap in their education.

### **Definitions of Key Terms**

This section defines the most used terms and concepts employed in this thesis. The following terms are the 2SLGBTQIA+ acronym, nursing care, equity, diversity, inclusion, minority status, equity-deserving, cis-heteronormativity, and cis-heteroprofessionalism.

#### **2SLGBTQIA+ Acronym**

The acronym, 2SLGBTQIA+, is applied throughout this thesis to describe non-heterosexual and non-cisgender identities. 2SLGBTQIA+ stands for Two-Spirit (2S), lesbian, gay, bisexual, queer or questioning, intersex, asexual, and all additional SOGIs (Government of Canada, 2023a). 2S, is intentionally placed at the beginning of the acronym to acknowledge the history that Indigenous 2S people were the first SOGI outside of heterosexuality and cisgender identities within North America (Government of Canada, 2023a). Colonization brought in ideas of the "closet" and "the intentional elimination of Indigenous people who were perceived to be neither fully male nor fully female or expressed a unique third or other gender" (Government of Canada, 2022, p.10). The plus sign, or +, is intentionally included at the end of the acronym to represent people who do not identify as the identities in the acronym and include but are not limited to gender fluid and pansexual identities (Government of Canada, 2023a). It is essential to acknowledge that the acronym 2SLGBTQIA+ is expected to evolve, as terminology and language are ever-changing (Government of Canada, 2022; Government of Canada, 2023a).

## **Nursing Care**

Nurses are essential components in the delivery of health care (International Council of Nurses, n.d.; World Health Organization, n.d.). Nurses provide care in diverse settings, and nursing care encompasses "the promotion of health, the prevention of illness, and the care of ill, disabled and dying people" (World Health Organization, n.d.). Nursing care also includes "advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education" (International Council of Nurses, n.d.). Nursing care is viewed as being relational, practical, and moral:

Relation in caring is understood as essential and requires at least two people, where one takes care of the other who suffers. Practical caring involves concrete action that can be learned and trained through practice. Moral in caring means to see and confirm the other in the light of her/his situation (Karlsson & Pennbrant, 2020, p.2).

## **Equity, Diversity, and Inclusion**

Equity, diversity, and inclusion (EDI) are three concepts with various definitions (UM, 2023). Equity describes fair, as opposed to equal, treatment (UM, 2023). The concept of diversity in EDI is the acknowledgement and respect of human uniqueness (Banister & Winfrey, 2012). Diversity considers differences between people, such as SOGI, physical abilities, race, socioeconomic background, and ethnicity (Banister & Winfrey, 2012; Gallo et al., 2022). Inclusion is focused on the environment and context where the uniqueness of everyone is affirmed, celebrated, and respected (Gallo et al., 2022). "Equity, diversity and inclusion initiatives share common goals with conversations around anti-oppression, decolonization, Indigenization, reconciliation, anti-racism, accessibility and social justice" (UM, 2023). EDI incorporates many other concepts, such as intersectionality (Cox et al., 2023), which is the theoretical concept that describes how people can be a part of various social categories, and the

overlapping intersection of oppression and discrimination based upon these categories and its effects (Bowleg, 2012; Cox et al., 2023; Walby et al., 2012).

### **Minority Status and Equity-Deserving**

The concept of minority status is the attribution of inferiority by the dominant mainstream society on a person (Brooks, 1981; Harkness et al., 2020). This view of inferiority can be due to biological factors like skin colour or non-biological factors like religion (Brooks, 1981). The term, equity-deserving, evolved from the term equity-seeking, which was found to be problematic because seeking equity was placed on the disempowered minority group who is subjected to discrimination when the obligation of seeking equity should be shared by everyone, especially those with underserved power (Wilson, 2022). Equity-deserving people have historically been left out of conversations, discriminated against, and experienced barriers to accessing resources (Queen's University, 2020; Wilson, 2022). Some examples of equity-deserving groups include Black, Indigenous, people of colour (BIPOC), women, people with disabilities, and people that identify as 2SLGBTQIA+ (Dalhousie University, n.d.; Red River College Polytechnic, 2022; Wilson, 2022). Much of the current literature describes equity-deserving people as minority groups or equity-seeking, and for this thesis, the term equity-deserving will be used.

### **Cis-heteronormativity**

Heteronormativity assumes that heterosexuality is the norm within society (Bizzeth & Beagan, 2023; Logie et al., 2019; Røndahl, 2005; Røndahl, 2011). Similarly, cisnormativity assumes that one is cisgender and identifies with the gender they were assigned at birth (Bizzeth & Beagan, 2023; Logie et al., 2019). Cis-heteronormativity is the inaccurate assumption that

everyone is and should be heterosexual or cisgender (Bizzeth & Beagan, 2023; Logie et al., 2019; Røndahl, 2005). Both heteronormativity and cisnormativity are societal norms in Canada and health care (Logie et al., 2019). Heteronormativity and cisnormativity in health care have been linked to worsening barriers to accessing health care by people who identify as 2SLGBTQIA+ (Logie et al., 2019). Cis-heteronormativity are antecedents to homophobia and transphobia (Røndahl, 2005).

### **Cis-heteroprofessionalism**

Building upon the concept of cis-heteronormativity, the term heteroprofessionalism, which was coined by Mizzi (2013), is applicable to the experiences of nurses who identify as 2SLGBTQIA+. Bizzeth and Beagan (2023) describe professionalism in relation to equity-deserving people, specifically those that identify as 2SLGBTQIA:

Within discourses of “professionalism,” some ways of being and doing, some subjectivities and some bodies are deemed acceptable and appropriate while others are disavowed. It has been argued that professionalism is structured by a politics of respectability, which demands that members of socially marginalized groups regulate their bodies and self-presentations to adhere to normative standards, (p.2)

The term *cis-heteroprofessionalism* is proposed by the primary investigator as a more inclusive term encompassing the existing diversity and the experiences of people who identify as in relation to the concept of professionalism 2SLGBTQIA+.

### **Chapter Summary**

This chapter has identified the thesis research problem statement, purpose of this study, two overarching research questions, and the significance to the nursing profession. This research study will explore the lived experiences of one of the largest subcategories within nursing. The nursing profession faces many challenges, and this research study will provide meaningful

implications to improve the cis-heteronormative environments in which equity-deserving nurses work and study.

## Chapter 2: Review of the Literature

This chapter presents a historical narrative literature review on the topic of the lived experiences of nurses who identify as 2SLGBTQIA+. Scholarly and grey literature was reviewed to map the landscape of current and historical literature available on this thesis topic. This literature review further contextualizes the state of the science and supports the significance of this thesis study.

### Search Strategy

Various search terms were utilized in this literature review search strategy to cast a wide and inclusive net. Literature was not excluded due to the publication date or location of origin, due to the dearth of literature on nurses with diverse SOGI, and the desire to provide historical context. Common search engines, like Google, were searched to find grey literature sources exploring the research topic. The following databases were used for this literature review: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline (Scopus), Pubmed, Taylor & Francis, and Web of Science. See Table 1 below for keywords used in the search strategy.

**Table 1**

*Search Terms Utilized in Search Strategy*

<b>Keywords</b>	<b>SOGI</b>	<b>Nurse</b>
	LGBTQ*, LGBT*, GLBT*, two-spirit, sexual minori*, sexual orientation, lesbian, gay, MSM, homosexual, bisexual, pansexual, transgender, transexual, gender minori*, gender varian*, gender diverse, queer, questioning, intersex*, asexual	nurs*, nurse, nurse practitioner, nurse midwife, clinical nurse specialist (CNS), registered nurse, licensed practical nurse

## Literature Review

The rights and treatment of people who identify as 2SLGBTQIA+ in Canada and worldwide have gained greater acceptance and understanding, as evidenced by the introduction of laws and policies protecting these equity-deserving groups (Lim & Borski, 2015; Lim & Borski, 2016). The Canadian federal 2SLGBTQIA+ action plan launched in August 2022, found that 39% of respondents to their survey experienced violence based upon their SOGI (Government of Canada, 2023b), and incidences of homophobia and transphobia have been on the rise in Canada and globally (Beagan et al., 2022; Dietzel et al., 2023; Egale Canada, 2024; Raycraft, 2023). Nursing is grounded in social justice and advocacy; however, the literature displays that nursing has historically refrained from acknowledging the experiences of nurses who identify as 2SLGBTQIA+ (Chinn, 2008; Eliason et al., 2010; Sharkey, 1987). The literature describes how heteronormativity and cisnormativity prevail within health care and how the nursing profession is not exempt from this (Harding, 2007; Shattell, 2016; Yingling, 2019).

Since the beginning of modern nursing, nursing has been among the first professions to welcome women (Eliason et al., 2010; Neumann, 2015). Numerous historians and nursing researchers hypothesize that many of the founding nurses that shaped the profession, like Florence Nightengale, were lesbians or identified within the 2SLGBTQIA+ acronym (Eliason et al., 2010; Neumann, 2015; Randall & Eliason, 2012; Shattell, 2016). Nurses that identify as 2SLGBTQIA+ are hypothesized as being one of the largest subcategories within nursing (Eliason et al., 2011; Lim & Borski, 2015; Stephany, 1992c; Zurlinden, 1997); however, nursing research has been slow to do research with this equity-deserving population (Eliason et al., 2010; Galanza et al., 2024; Randall & Eliason, 2012).

After the Diagnostic and Statistical Manual (DSM) of Mental Disorders removed homosexuality in 1973, nursing literature began investigating nurses' comfort in caring for patients identifying as 2SLGBTQIA+ (Eliason et al., 2011; Eliason & Randall, 1991; Galanza et al., 2024; Randall, 1989; Randall & Eliason, 2012). The body of research has begun to focus on the nuanced ways in which a nurses SOGI intersects with the provision of nursing care (Glass, 2002; Røndahl et al., 2007). This literature review will summarize and synthesize the following themes present in the literature: the historical invisibility of 2SLGBTQIA+ identities in nursing, discrimination based upon SOGI in the nursing profession, the topic of disclosure of SOGI in nursing, workplace policies protecting nurses who identify as 2SLGBTQIA+, the need for representation and inclusion of a diversity of SOGI, allyship and affirmation of SOGI in nursing. The following literature view lays the groundwork and basis for this study while providing historical context.

### **Invisibility**

In the '80s and '90s, a few articles were published exploring the experiences of nurses that identified as lesbian (Deevey, 1993; Stephany, 1989; Stephany, 1992b; Stephany, 1992c). Most of this early literature described how lesbian nurses' identities were invisible within nursing, and how the profession has knowingly continued silencing nurses who identify as 2SLGBTQIA+ (Stephany, 199b; Stephany, 1992c; Zurlinden, 1997). In local Manitoban history at this time, a former president of the Manitoba Association of Registered Nurses who identified as a lesbian, reported that nurses' licenses were removed due to "unbecoming behaviour," which was "the code word for lesbianism within the nursing profession" (Korinek, 2018, p.291). Along with professional systemic homonegativity, many nurses who identified as 2SLGBTQIA+, and specifically lesbians, felt pressure to hide their identities in academia and clinical practice

(Anonymous, 1995; Chinn, 2008; Giddings & Smith, 2001; Stephany, 1992c). Nursing researchers and historians have hypothesized that many of the founders of modern nursing were 2SLGBTQIA+ and did not feel comfortable disclosing their identities (Neumann, 2015). This is congruent with the concept of cis-heteroprofessionalism or the pressure to uphold the traditional image of a nurse (Giddings & Smith, 2001; Shattell, 2016; Stephany, 1992a), and the negative effect of minority stress (MS) being concealment (Frost & Meyer, 2023).

### **Discrimination**

The literature unveils countless descriptions of overt and covert discrimination experienced by nurses identifying as 2SLGBTQIA+ (Giddings & Smith, 2001; Glass, 2002; Røndahl et al., 2007). A few examples of the range of types of discrimination experienced are: being barred from performing specific nursing psychomotor skills based on gender identity (Duffin, 2002), job loss (Canning, 1994; Eliason et al., 2011; Korinek, 2018), along with homophobic and transphobic comments made by colleagues and patients alike (Anonymous, 2016; Eliason et al., 2011; Eliason et al., 2018; Galanza et al., 2024; Giddings & Smith, 2001; Røndahl et al., 2007; Singleton, 2021; Stephany, 1989). The literature links how discrimination against nurses who identify as 2SLGBTQIA+ results in MS that can have short- and long-term effects on the nurses, particularly their performance, which affects patient care and retention (Hunt et al., 2007). Hunt et al. (2007) propose that nursing leadership has the power to dismantle systemic discrimination in health care. The literature also shows that nurses who identify as 2SLGBTQIA+ have higher rates of substance use disorders than their heterosexual colleagues and more than the general population of people who identify as LGB, which is connected to the insidious nature of MS (Avery-Desmarais et al., 2020; Eliason et al., 2018).

**Disclosure**

Nurses work in cis-heteronormative workplaces, meaning nurses frequently and repeatedly must disclose their SOGI (Hunt et al., 2007). The literature investigates the nuances and challenges nurses face when revealing their identities in various situations (Glass, 2002; Røndahl et al., 2007). Some nurses consciously disclose their SOGI to their colleagues by observing how they treat patients who identify as 2SLGBTQIA+ (Clarke, 2017; Deevey, 1993). Research shows that nurses were more likely to disclose their identities to their colleagues if their workplaces and colleagues demonstrated overt respect for patients who identified as 2SLGBTQIA+ (Røndahl et al., 2007). The literature reveals that patients and clients identifying as 2SLGBTQIA+ appreciated when their health care providers (HCP) and nurses shared similar identities as them, and how disclosure of SOGI between HCP and patients can strengthen therapeutic relationships (Clarke, 2017; Stephany, 1989; Yingling, 2019; Zurlinden, 1997).

**Workplace Policies**

The body of literature has evolved in the past decade to include solutions and recommendations to combat the ongoing discrimination against nurses that identify as 2SLGBTQIA+, and one of the main recommendations is improving policies in the environments in nurses work and study within (Eliason et al., 2010). Despite 2SLGBTQIA+ nurses being hypothesized as one of the largest subcategories within the nursing workforce, many nursing workplaces and professional organizations do not have overt policies protecting SOGI (Eliason et al., 2010; Eliason et al., 2011; Lim & Borski, 2016). Without protection and overt affirmation for equity-deserving nurses, discrimination and stereotypes will endure, and this repeated MS in the work environment has been shown to negatively affect patient care (Harrison, 2008; Hunt et al., 2007; Lim & Borski, 2015).

## **Diversity, Representation, and Inclusion**

Sharkey (1987) proposed policy change "at every level of nursing" to encourage existing diversity in the nursing workforce and advocated for nurses to be open about their sexualities in the workplace (p.39). Similarly, Stephany (1989) urged their colleagues to disclose their SOGI by stating: "It is now time to actively recruit and support hospice personnel who reflect all of the populations we serve: Black, Latino, Caucasian, Asian, and gay" (p.13). The literature proposes that being open about one's 2SLGBTQIA+ identity to strengthen the nurse-patient and nurse-family therapeutic relationship (Clarke, 2017; Stephany, 1989; Yingling, 2019; Zurlinden, 1997).

## **Affirmation**

In the past five years, the literature has begun to discuss positive experiences of affirmation for nurses who identify as 2SLGBTQIA+ (Anderson, 2022; Sorcher, 2022; Stephenson, 2021). There are increasing first-hand accounts in the grey literature about how identifying as 2SLGBTQIA+ is an asset to nursing practice as it helps HCPs relate to their patients (Crawford, 2022; Sorcher, 2022; Stephenson, 2021). More attention is being paid to EDI in health care organizations, and with the nursing workforces issues exacerbated by the covid-19 pandemic affirming 2SLGBTQIA+ and diversity within nurses could help reduce health disparities and equity of those with similar identities (Gallo et al., 2022; Hinson et al., 2022; Loftin et al., 2013).

## **Gaps in the Literature**

Despite making sweeping statements about including nurses who identify as 2SLGBTQIA+, the literature has overwhelmingly centered the identities of lesbian and gay nurses (Chinn, 2008; Clarke, 2017; Deevey, 1993; Galanza et al., 2024; Giddings & Smith, 2001;

Glass, 2002; Harding, 2007; Randall & Eliason, 2012; Røndahl et al., 2007; Shattell, 2016; Singleton, 2021; Stephany, 1989; Stephany, 1992a; Stephany, 1992b; Stephany, 1992c; Zurlinden, 1997). Kuper et al. (2008) suggest that in qualitative research, "the sample should be broad enough to capture the many facets of a phenomenon and limitations to the sample should clearly be justified (p.687)". The literature's focus on nurses identifying as lesbian and gay does not fully represent the diversity of nurses who identify as 2SLGBTQIA+ and presents a gap in the body of literature (Sánchez et al., 2015).

The literature on the experiences of nurses identifying as 2SLGBTQIA+ lacks diversity in the participant samples, and only a few articles consider the intersection of race and SOGI (Avery-Desmarais et al., 2020; Galanza et al., 2024; Giddings & Smith, 2001; Lim & Borski, 2016; Sánchez et al., 2015; Yingling, 2019). There is an over-representation of acute care settings despite nurses working in diverse settings (Anderson, 2022; Anonymous, 2018; Duffin, 2002; Eliason et al., 2011; Galanza et al., 2024; Giddings & Smith, 2001; Harding, 2007; Harrison, 2008; Hunt et al., 2007; Lim & Borski, 2016; Røndahl et al., 2007; Sharkey, 1987; Stephany, 1992b; Stephenson, 2021; Zurlinden, 1997). The majority of the literatures samples are based in United States of America (Anonymous, 2018; Avery-Desmarais et al., 2020; Chinn, 2008; Deevey, 1993; Eliason et al., 2011; Giddings & Smith, 2001; Randall & Eliason, 2012; Sánchez et al., 2015; Sharkey, 1987; Stephany, 1989; Stephany, 1992a; Stephany, 1992b; Stephany, 1992c; Yingling, 2019; Zurlinden, 1997). The literature on nurses identifying as 2SLGBTQIA+ lacks diversity of participant identities, lacks acknowledgment of sample intersectionality, and over-represents American acute care settings.

### **Chapter Summary**

The state of science on the experiences of nurses who identify as 2SLGBTQIA+ is evolving rapidly, but many limitations remain. The gaps in the literature provide meaningful implications for future nursing research such as this thesis study. The limitations that arose from this literature review helped inform the many aspects of this research study from the theory selection to the study design.

### **Chapter 3: Theoretical Concepts**

Theories and conceptual models are how nursing research structures and organizes new nursing knowledge (McEwen & Wills, 2019). Utilizing theories "promotes rational and systematic practice by challenging and validating intuition" (McEwen & Wills, 2019, p.50). This chapter will discuss the guiding theoretical concepts of Minority Stress Theory (MST) which will inform this research study. This chapter will describe and define MST along with its application to this thesis.

#### **Minority Stress Theory Description**

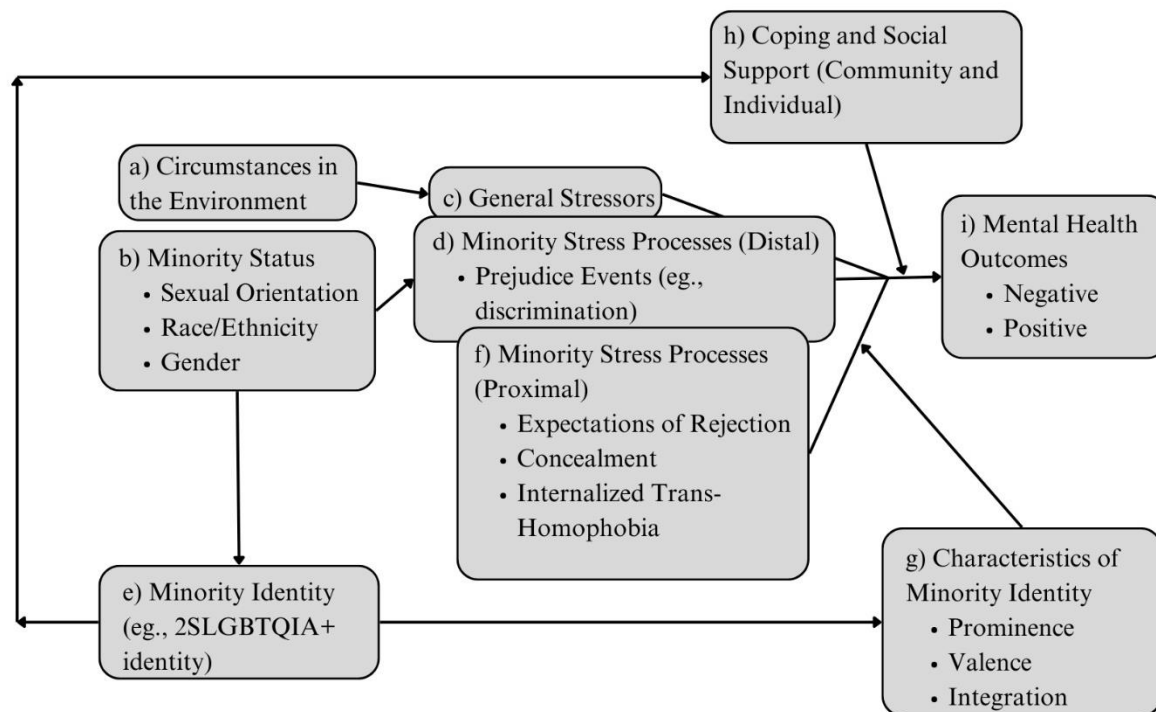
Stress is an everyday human experience; however, equity-deserving people uniquely experience repeated stressors based upon their identity such as discrimination (Government of Canada, 2022; Meyer, 2003). In 1981 Virginia Brooks first conceptualized MST and used the theory to describe equity-deserving peoples' experiences of repeated overt and covert stressors, and the detrimental effects this had (Brooks, 1981; Meyer, 1995; Meyer, 2003). MST was initially used to provide explanation of why people who identify as lesbian, gay, and bisexual displayed increased rates of illness due to MS (Brooks, 1981; Meyer, 1995; Frost & Meyer, 2023).

Meyer's (1995, 2003) conceptualizations of MST built upon previous theoretical foundations and examined various processes specific to people with diverse sexual orientations. The processes Meyer (2003) described were short-term stress, long-term stress, internalizing external homophobia, frequent anticipation of rejection, and the vigilance related to anticipation of rejection. Meyer (2003) created a model adaptation shown in Figure 1, commonly referred to

in current literature using MST involving people identifying as 2SLGBTQIA+, to depict the complex experiences of people who identify as 2SLGBTQIA+.

### Figure 1

*Meyer's (2003) Minority Stress Processes in LGB Populations*



*Note.* Figure 1 depicts the complexities and consequences of repeated stressors on equity-deserving people and was adapted from Meyer's original figure (2003, p.679).

### Theory Purpose

MST was initially used to describe why lesbian women experienced higher rates of mental illness (Brooks, 1981), but was later broadened to include gay men and people with diverse sexual orientations (Cox et al., 2010; Meyer, 1995; Meyer, 2003). MST has been utilized to examine the effects of discrimination against other equity-deserving people, such as People of Colour and gender-diverse people (Brooks, 1981; Frost, 2017; Frost & Meyer, 2023; Tan et al., 2020; Wei et al., 2008). The historical primary purpose of MST was to inform HCPs in

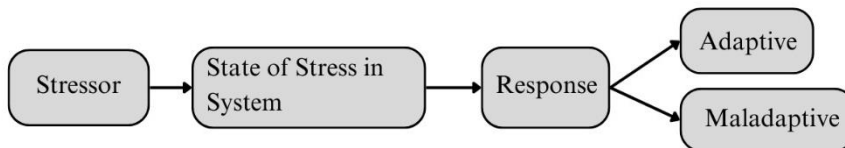
providing care to equity-deserving populations, informing policy, and working towards combating MS (Alessi, 2014; Newcomb & Mustanski, 2011). The theory's purpose has been used in the context of understanding psychological implications of repeated MS, including mental illness (Dunn et al., 2014; Plöderl et al., 2014; Rendina et al., 2017), addictions (Dentato et al., 2013; Goldbach et al., 2015), and intimate relationship conflict (LeBlanc & Frost, 2020). The connections between the theoretical concepts of stress, adaptation, and maladaptation are considered relationships, and these relationships make up the basis of the structure of the theoretical framework (Chinn & Kramer, 2018).

### **Stress**

Brooks (1981) defines stress as "any antecedent agent or situation that requires a system to readjust or adapt" (p.71). The concept of stress has numerous meanings, and the context of where stress originates from is a defining feature of MST (Brooks, 1981). Stress can start from many sub-contexts or multiple sources; whether social, individual, structural, environmental, psychological or a combination of sources (Brooks, 1981; Meyer, 2003). MST describes how stressors inflicted upon equity-deserving people are chronic, distinct from other types of stress, socio-politically and culturally rooted (Meyer, 2003). Meyer's (2003) conceptualization of MST differentiates between proximal and distal stress, where distal stressors, such as overt acts of prejudice, are externally rooted. Proximal stress describes how external oppression can be internalized, such as internalized homophobia (Meyer, 2003).

### **Maladaptation**

Brooks (1981) defines maladaptation as the "negative resolution of stress" (p.71), which is one of the two primary responses to repeated minority stressors, as shown in Figure 2 below.

**Figure 2***Brook's (1981) Stress Paradigm*

*Note.* "Stress Paradigm" adapted from Brooks (1981, p.72).

Some of the consequences of maladaptation concerning equity-deserving people in the existing literature are adverse physical and psychological health effects (Frost, 2017; Newcomb & Mustanski, 2011; Williams et al., 2020), disclosure or concealment of sexuality (Cox et al., 2010; Dunn et al., 2014; Goldbach et al., 2015; Li et al., 2021; Plöderl et al., 2014; Sun et al., 2021), internalized homonegativity (Cox et al., 2010; Dunn et al., 2014; Goldbach et al., 2015; Li et al., 2021), and vigilance associated with the expectation of rejection (Brooks, 1981; Dentato et al., 2013; Dunn et al., 2014; Williams et al., 2020). The literature shows numerous harmful coping mechanisms resulting from maladaptation to MS, such as drug use (English et al., 2018; Goldbach et al., 2015; Ogunbajo et al., 2021), risky sexual behaviours (Newcomb & Mustanski, 2011; Ogunbajo et al., 2021; Rendina et al., 2017), and concealing one's SOGI (Alessi, 2014; Cox et al., 2010; Dentato et al., 2013; Dunn et al., 2014; Goldbach et al., 2015; Meyer, 2003).

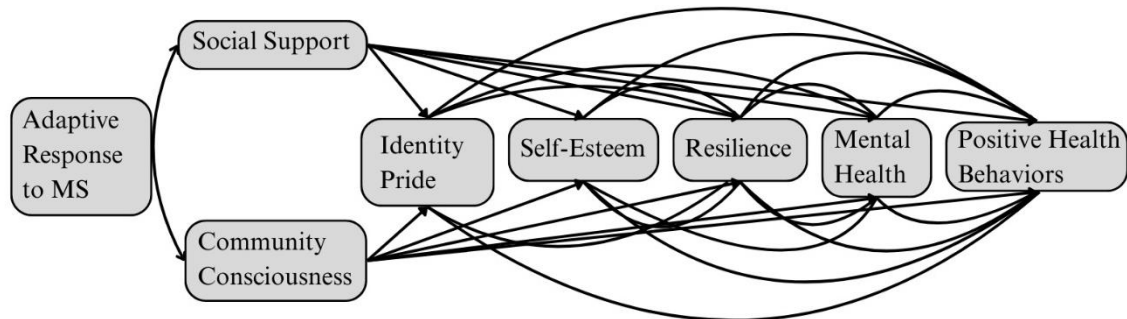
**Adaptation**

In the context of MST, adaptation is defined as the positive resolution to the experience with MS (Brooks, 1981). Most of the literature that utilizes the theoretical framework of MST focuses on maladaptation and adverse health effects of MS (Dentato et al., 2013; Dunn et al., 2014; Goldbach et al., 2015; Plöderl et al., 2014; Rendina et al., 2017); however, there is

mention of how equity-deserving people cope and adapt to MS, such as having community support (Alessi, 2014; Cox et al., 2010; Frost, 2017; Holman, 2018; Li et al., 2021; Meyer, 2003; Plöderl et al., 2014; Sun et al., 2021; Wei et al., 2008), self-acceptance (Harkness et al., 2020; Plöderl et al., 2014; Williams et al., 2020) and the rejection of stereotypes (Harkness et al., 2020). The literature overwhelmingly suggests that HCPs must provide affirmative care to promote adaptation and resilience for equity-deserving people (Harkness et al., 2020; Meyer, 2003; Sun et al., 2021).

### **Theoretical Critiques**

In the context of equity-deserving people, MST assumes that adverse health implications are not innate but can be explained by external forces (Frost, 2017; Meyer, 2003; Plöderl et al., 2014). Meyer's (2003) reconceptualization of MST explicitly states that MS is unique, chronic, and socially based. Frost and Meyer (2023) discuss critiques of MST over the past two decades, with a main critique being “the theory operates from a deficit-based approach without sufficient attention to positive outcomes and resilience among sexual and gender minority populations” (p.3). Another main critique of MST is that the theory does not consider the “lack of social safety as a cause of sexual and gender minority health inequalities” (Frost & Meyer, 2023, p.4). Perrin et al. (2019) created the Minority Strengths Model, which moves beyond the deficit-based perspective to focus on the ways equity-deserving people are forced to be resilient and resiliency is a strength that creates positive health outcomes Perrin et al.'s (2019) model that displays the relationship between many “strength-based variables” and how they “operate in a theoretical causal chain” (p.121), can be viewed as building upon Brooks' (1981) stress paradigm, specifically the adaptive response to repeated MS.

**Figure 3***Perrin et al. 's (2019) Saturated Model*

*Note.* “Saturated Model” adapted from Perrin et al. (2019, p.122).

### Theory Application

MST was selected for this thesis as the theory has historically been used to describe the experiences of equity-deserving people and people identifying as 2SLGBTQIA+ (Brooks, 1981; Cox et al., 2010; Meyer, 1995; Meyer, 2003). The literature has shown that heteronormativity and cisnormativity prevail within health care (Harding, 2007; Shattell, 2016; Yingling, 2019), and MST can help interpret and find meaning in the experiences of nurses identifying as 2SLGBTQIA+. MST and intersectionality were incorporated into demographic and semi-structured interview questions. Examples of applying theory to practice include asking about the environment participants worked and studied within and how this contributed to their likelihood of disclosing their identity. MST provides meaningful context for the study participants lived experiences and the inclusion of the ways in which the theory was used to describe and understand participant experiences will be explained in the discussion in Chapter 6 of this thesis.

### **Chapter Summary**

This chapter introduced the guiding framework of MST which was used to interpret and provide understanding of the study participants' lived experiences. The main concepts in MST were discussed, along with main theoretical critiques. The use of the theory and its application to this research study was also discussed.

## **Chapter 4: Research Methods and Design**

This chapter will describe the methodology used in this research study and the design of the study. This includes a discussion of the methodology used in this study, study setting, inclusion/exclusion criteria, sampling procedures, sample recruitment, data collection methods, data analysis, efforts to maintain trustworthiness, and ethical considerations.

### **Methodology**

Qualitative study designs are flexible and "tend to be holistic, aimed at an understanding of the whole" (Polit & Beck, 2017, p.463). Due to the broad nature of the two guiding research questions for this thesis, and the experiential focus of the questions, a qualitative research design was selected. The qualitative design was deemed appropriate to investigate the vast intersecting nature of study participants' identities and lived experiences.

### **Interpretive Description**

Interpretive description (ID) is a qualitative research methodology that highlights the conceptual framework of a clinical discipline, such as nursing, and aims to create a new understanding of phenomena that can be applied to clinical practice (Polit & Beck, 2017). ID assumes that phenomena are inherently connected, like the nursing profession's ethos of equity and its connection to the experiences of nurses identifying as 2SLGBTQIA+, and inferences can help understand other similarly related phenomena (Thorne, 2016). The methodology recognizes and "accommodates the understanding that human experiences are comprised of complex interactions between psychosocial and biological phenomena" (Thompson-Burdine et al., 2021). MST, weaves in context into this thesis' description of participants' experiences, while ID is inductive and generates themes and patterns from data (Ghorbani & Matourypour, 2020; Thorne,

2016). The main goal of ID "is to create a clinical understanding, while its secondary goal is to use this clinical understanding in patient care" (Ghorbani & Matourypour, 2020, p.1).

Thompson-Burdine et al. (2020) describe how ID is unique from other qualitative methodologies:

Traditionally, a researcher's experience has been viewed as bias and as something to be eliminated from the design. However, in ID the researcher is a valuable instrument of the research. A researcher's technical knowledge, research background and personal experiences are major sources of insight (Thompson-Burdine et al., 2020, p.339)

In nursing research, the use of ID is typically focused on the experiences of patients and clients (Thorne, 2016); however, it is suitable to explore the phenomena of the lived experiences of nurses who identify as 2SLGBTQIA+ as they navigate clinical practice and their education. This study has numerous implications for clinical practice with the results helping relate to other intersecting phenomena and experiences while informing clinical practice, nursing curricula, and policy change. Implications in relation to nursing practice, nursing education, and nursing research will be discussed in Chapter 6.

### **Study Setting**

Qualitative researchers select study settings with abundant information sources to assist them in understanding and interpreting the information gathered (Polit & Beck, 2017). This research study explored the experiences of nurses who identify as 2SLGBTQIA+ in providing nursing care in the diverse setting of Winnipeg, Manitoba, Canada. Qualitative research data is typically obtained in "real-world, naturalistic settings" with the aim to "strive to study phenomena in a variety of natural contexts" (Polit & Beck, 2017, p.464). In providing context for this study's setting, in 2022 Manitoba had 13,849 RNs practicing in the province (CRNM, 2023). Winnipeg is the capital of the province of Manitoba, with an approximate population of 783,100

(City of Winnipeg, 2023). Winnipeg has many diverse nursing practice settings, such as tertiary hospitals, numerous health care facilities, and public health organizations. This study recruited participants with diverse clinical nursing experience within the provincial capital city of Winnipeg, Manitoba.

### **Inclusion and Exclusion Criteria**

The sample for this research project consisted of RNs that identify as 2SLGBTQIA+ and have work experience in clinical care in Winnipeg. The research study's eligibility criteria are as follows:

1. Eighteen years of age or older.
2. Speak English fluently and read English.
3. Currently registered as a RN and employed as a nurse in Winnipeg, Manitoba.
4. Identify as 2SLGBTQIA+, non-heterosexual, or non-cisgender.
5. Have worked as a RN in clinical practice for at least two years in Winnipeg, Manitoba.
6. Access to a device to complete online or phone interviews.

Exclusion criteria are as follows:

1. Not 18 years of age.
2. Does not speak English fluently or read English.
3. Is not currently registered as a RN.
4. Does not identify as 2SLGBTQIA+, non-heterosexual, or non-cisgender.
5. Has not worked as a RN in clinical practice for two years in Winnipeg, Manitoba.
6. Is not currently employed as a RN in Winnipeg, Manitoba.

7. Does not have access to a device to complete a virtual or phone interview.

### **Sampling Procedures and Recruitment**

Qualitative research aims to find meaning in the experiences of study participants instead of generalizing their experiences (Polit & Beck, 2017). This study was approved by the UM Research Ethics Board (REB1) in November 2023 and approved by Shared Health Research in January 2024. See Appendix A and Appendix B for approval letters. Convenience, or volunteer sampling, was used in this study to reach an adequate sample size as it is frequently used in qualitative research (Denny & Weckesser, 2022; Polit & Beck, 2017). Once participants were recruited through convenience sampling, snowball was encouraged to reach the minimum projected sample size of eight participants. The primary researcher did not inquire as to how study participants heard about the study, so is unable to ascertain how participants heard about the study.

In late January 2024, after necessary ethics approval, an account on both Instagram (@2slgbtqia\_nurse) and X (@2SLGBTQIA\_Nurse) were created to disseminate social media graphics to promote this study and recruit participants. See Appendix C for the social media graphic recruitment materials that were designed in Canva along with the social media text posts. Social media posts encouraged potential participants to contact the researcher if interested in volunteering their time for the study and to hear more about the study. Identities within the 2SLGBTQIA+ acronym other than the over-represented identities of lesbian and gay, as demonstrated from the current state of literature, were encouraged to participate in this study in the recruitment material. Alt text was used in the posts to improve accessibility. After participants had expressed interest in participation via email or social media direct message, a

pdf letter of invitation and the consent form was sent to the interested participants. Please see Appendix D for the letter of invitation and Appendix E for the consent form.

### **Sample Size**

For qualitative research, data saturation dictates the number of participants needed (Polit & Beck, 2017); however, “Data saturation is not a desired outcome in ID because the applied and practice disciplines tend to appreciate that experience can theoretically possess infinite variation” (Thompson-Burdine et al., 2020, p.340). Previous qualitative research studies exploring the lived experiences of nurses and HCPs who identify as 2SLGBTQIA+ reached sample sizes with a 5-21 participants (Galanza et al., 2024; Giddings & Smith, 2001; Glass, 2002; Hunt et al., 2007; Røndahl et al., 2007). Sample sizes for qualitative research are often smaller than quantitative research, as the participants are studied with extreme depth (Creswell, 2014; Denny & Weckesser, 2022; Polit & Beck, 2017). Conversely, broad research questions, like the ones asked in this study, may require larger sample sizes to encompass more people who have experienced the phenomena being investigated (Polit & Beck, 2017). Topics that are difficult to talk about, like discrimination and MS, may cause participants to feel hesitant in reliving traumatic experiences, which may mean a larger sample size is required to gather in-depth data (Polit & Beck, 2017). A sample size of 11 participants helped provide a “deeper understanding of participant perspective” and answered the two research questions (Thompson-Burdine et al., 2020, p.340).

### **Data Collection Methods**

Data collection in qualitative research is often an iterative process (Polit & Beck, 2017). The data unit for this study is individual nurses identifying as 2SLGBTQIA+, as discussed

previously in sample characteristics. Data was collected through qualitative semi-structured one-on-one interviews and were conducted between January 30, 2024, until March 18, 2024.

### **Demographic Data**

Demographic data was collected at the beginning of each interview to better understand participant experiences and perspectives. Study participants were asked open-ended questions about their demographics because historically, many demographic questionnaires have not accounted for the diversity of intersecting identities, and specifically SOGI (Nguyen & Lau, 2018). The primary investigator asked participants to self-identify their: age, sex assigned at birth, gender identity, sexual orientation, pronouns, race, ethnicity, religious or spiritual community involvement, if they identify as Indigenous, and if they identify as having disabilities. Questions about the study participants' nursing practice experience, level of education, and nursing licensure were asked. Past and current practice settings were asked separately but later combined to improve anonymity. The option to choose not to disclose answers to demographic questions if the participant felt uncomfortable was provided. The demographic questions have been adapted from the UM's (2022a) guidelines. Please refer to Appendix F for the demographic questionnaire.

### **Semi-Structured Interviews**

One of the main methods used in obtaining data in qualitative research is interviewing, specifically semi-structured interviews (Creswell, 2014; Denny & Weckesser, 2022; Polit & Beck, 2017; Thompson-Burdine et al., 2020; Thorne, 2016). Thorne (2016) stated: “In the applied health professional fields, interviewing is as familiar as breathing” (p.86). Semi-structured interviews use preconceived interview questions and topics, with questions being

open-ended to include flexibility in interviews depending on the answers of the research participants (Denny & Weckesser, 2022; Polit & Beck, 2017). The interview guide used in this study was developed after preliminary work having informal conversations with community members as discussed in Chapter 1's Reflexivity section. Please refer to Appendix G for the semi-structured interview questions used as guide throughout each interview.

Some advantages of interviews are the ability for study participants to provide historical information, which is helpful when the researcher cannot directly observe the participants and gives researchers a high degree of control over questions (Creswell, 2014). Each participant in this study was offered the choice of how they preferred the interviews to be delivered to ensure participants felt comfortable and safe during the interviews. Semi-structured interviews were offered via UM Zoom video conferencing, phone call, or in person after confirmation of participants' eligibility. Adapting unconventional interview delivery modes is supported by ID (Thorne, 2016).

At the time of scheduling the interview and determining the preferred delivery of the interview, the primary investigator sent the study consent form to participants. Study participants were provided with a copy of the semi-structured interview questions prior to interviews to ensure transparency. Interviews were voice-recorded with two recorders borrowed from the Manitoba Centre for Nursing Health Research (MCNHR). A portion of the MCNHR Graduate Student Research Grant received in December 2023 was used to pay for a transcription service, Transcript Heroes (Transcript Heroes Transcription Services, 2023), to complete transcription of each interview. Transcript heroes signed an oath of confidentiality to work on this project. Please see Appendix H for the oath of confidentiality form. After transcripts were provided, the primary

investigator de-identified the data, uploaded the text documents to UM student account one drive which has two-factor authentication and deleted audio recordings.

### **Field and Reflective Notes**

Field notes, or observational records, are the researchers' interpretation of the data collection process (Polit & Beck, 2017). During and immediately after each interview for this research study, observations and interpretations were documented. Journaling is the most common way of maintaining reflective notes (Polit & Beck, 2017). Ongoing reflective notes, or memoing, were completed pre-post interviews as they allowed the primary investigator to record ongoing experiences with the interview process and preliminary interpretations of data (Polit & Beck, 2017). Reflective and field notes were compiled in a document, in the primary investigator's UM student account OneDrive, throughout the research process to maintain ongoing researcher reflexivity. These notes often contained "questions, inspirations, and evolving interpretations" from the rich interviews (Thorne, 2016, p.119). Personal and reflective notes often unveil the researcher's assumptions which are essential to acknowledge (Polit & Beck, 2017), and they were instrumental in the data analysis of this project.

### **Data Analysis**

Rich data was collected from semi-structured interviews about the experiences of nurses who identify as 2SLGBTQIA+. The interview transcriptions were analyzed to extract meaning and generate patterns and themes throughout all study participants' lived experiences (Polit & Beck, 2017). Data collection and analysis often happen concurrently in qualitative research (Polit & Beck, 2017; Thompson-Burdine et al., 2020), and this research project had an iterative process of data collection and analysis.

## **Coding**

After interviews were transcribed verbatim by the transcription service, the researcher verified the transcripts accuracy by listening to the audio recording, and de-identified the text data. Gender neutral pseudonyms were assigned to each study participant at random using an online name generator. The data was coded line-by-line and organized by the researcher. In ID, coding is an iterative process that seeks to unveil context (Thorne, 2016). The coding software, Dedoose, was utilized after an amendment from the UM REB1 was approved in March 2024. See Appendix I for the amendment approval. Funds from the MCNHR student research grant were used to pay for a temporary subscription to the software. Codes were organized into each of the semi-structured interview topics, subcategories, and categories. These overarching interview topics were the starting point for the generation of themes. I, the primary investigator, shared the first de-identified interview transcript with Dr. Lynn Scruby, my academic advisor, and we each coded the interview separately. We later met in person to compare and contrast our work. In the data analysis phase, I shared an excel sheet with all my interview codes and their organization under subthemes and themes. I met with my advisor to review the themes that were generated from this analysis process.

## **Maintaining Trustworthiness**

Qualitative researchers must gain and uphold their research participants' trust throughout the research process (Polit & Beck, 2017). Lincoln and Guba's (1985) commonly used framework as cited in Polit and Beck (2017), provide five criteria to develop and maintain trustworthiness in qualitative scholarship. The five criteria are credibility, dependability, confirmability, transferability, and authenticity (Guba & Lincoln, 1994; Lincoln & Guba, 1985).

Lincoln and Guba's (1985) trustworthiness criterium "represent parallels to the positivists' criteria of internal validity, reliability, objectivity, and external validity" (Polit & Beck, 2017, p.559). Lincoln and Guba's (1985) framework was utilized in this study to uphold trustworthiness as well as Thorne's (2016) ID recommendations.

### **Credibility**

The overarching goal of qualitative research is credibility, which refers to "the truth of the data and interpretations of them," or truthfulness and believability (Polit & Beck, 2017, p.559). Triangulation, using two or more sources of data, is a method of maintaining credibility and trustworthiness (Polit & Beck, 2017). To ensure credibility in this study, numerous data sources were used to provide an audit trail of the researcher's thoughts, actions, assumptions, and decisions. Thorne (2016) also discusses credibility and encourages the use of audit trails. The data sources used in this study were field notes, reflective notes, and interview transcripts. Stating the researcher's positionality, as seen in Chapter 1, also enhances transparency and credibility (Thorne, 2016).

### **Dependability**

Dependability encompasses the stability or reliability of data obtained (Polit & Beck, 2017). A dependable study would produce comparable results if the study were reproduced with the same participants (Polit & Beck, 2017). Like credibility, the primary investigator of this research project maintained an audit trail throughout this study, including keeping track of the raw data, digital interview files, the coding process, personal reflections, and research documents. Ongoing decisions during the coding process and selection of themes were documented.

**Confirmability**

"Confirmability concerns establishing that the data represents the information participants provided and that the interpretations of those data are not invented by the inquirer" (Polit & Beck, 2017, p.560). The criterion of confirmability is displayed through objectivity and accuracy in qualitative research (Polit & Beck, 2017). An example of how objectivity and accuracy was maintained in interpretations of participant experiences, the primary investigator verified understanding with participants during the interviews and asked for clarification when the meaning of participant responses was unclear. The primary investigator documented ongoing decisions and utilized their advisor as a valuable resource to verify decisions made, like selecting themes, to ensure objectivity was upheld.

**Transferability**

Transferability pertains to the application of research findings to other people and contexts (Polit & Beck, 2017). It is up to the researcher to provide the detailed characteristics of the sample so others can see how the findings could apply to different groups (Polit & Beck, 2017). The primary investigator maintained transferability by articulating the steps of this research study and reporting accurate participant demographics, as displayed in Appendix J. In this way, other researchers will be able to determine whether the unique experiences of nurses who identify as 2SLGBTQIA+ in this study may be transferable to other contexts.

**Authenticity**

The last criterion of authenticity describes "the extent to which researchers fairly and faithfully show a range of realities" (Polit & Beck, 2017, p.560). The primary investigator has included rich in-vivo codes and quotations throughout Chapter 5, to fairly display the

participants' experiences and perspectives. In doing so, study participants' tone and lived experiences will be shown accurately. This ensures that readers of this study "are better able to understand the lives being portrayed" (Polit & Beck, 2017, p.560).

### **Ethical Considerations**

Research involves risks for study participants, and to mitigate this, researchers can conduct a risk/benefit assessment (Polit & Beck, 2017). To ensure ethical practice this study received UM REB1 and Shared Health Research approval. A summary of the following risk/benefit assessment was provided to study participants to ensure their informed consent before participating. Minimal risk in research is:

Research in which the probability and magnitude of possible harms implied by participation in the research are no greater than those encountered by participants in those aspects of their everyday life that relate to the research," and this study posed minimal risks to participants (Canadian Institutes of Health Research et al., 2018, p.22).

### **Potential Risks**

The most significant potential risk to participants in this study is the risk of psychological harm. Many of the semi-structured interview questions focus on nurses' experiences identifying as 2SLGBTQIA+, which included MS. Participants may be reminded of experiences with discrimination and past harm related to their SOGI, like homophobia and transphobia. In anticipation of the potential risks, a list of community resources and support for nurses was compiled and shared with each participant if they desired extra support. Please refer to the consent form in Appendix E which includes a list of the resources provided to each participant prior to interviews. Throughout the interview process, the primary investigator utilized a trauma-informed approach to asking questions and responding to participants' responses to minimize potential risks.

**Potential Benefits**

The main benefit identified to study participants is the ability to discuss their experiences in a non-judgmental and confidential environment with another nurse who identifies as 2SLGBTQIA+. Thorne (2016) states interviews can “leave your study participant feeling honored by being listened to deeply” and with the recognition that sharing their experiences may “contribute to the betterment of care or service for others in the future” (p.126). This act of sharing and reflecting upon experiences may have been participants' first opportunity to do so. Sharing and reflecting upon experiences was shown by numerous participants as increasing personal insight and being beneficial to them during the interview process.

**Chapter Summary**

The qualitative ID methodology and study design used in this research has been discussed. This includes study setting, inclusion criteria, exclusion criteria, sampling procedures, recruitment, data collection methods, and data analysis. The ways in which trustworthiness was maintained along with a risk/benefit assessment that was conducted for ethical considerations has been reviewed.

## **Chapter 5: Findings**

The study findings are reported in this chapter including an abbreviated description of participant characteristics. The themes generated from the qualitative data will be presented in relation to answering the two research questions and MST. The two research questions are:

1. What are nurses' experiences identifying as 2SLGBTQIA+ in providing nursing care in Winnipeg, Manitoba, Canada?
2. What do nurses identifying as 2SLGBTQIA+ believe their identity brings to their nursing practice and patient care?

### **Sample Characteristics**

All participants were given pseudonyms after the data was de-identified to protect privacy and confidentiality. Gender-neutral pseudonyms for each participant were selected using a randomized online pseudonym generator. The eleven nurse participants ranged in age from 26 to 45 years with an average age of 32.9 years. Nine of the eleven participants were assigned female at birth. Participants identified as a range of diverse SOGIs. Three participants identified as Indigenous, and they did not identify as being racialized. One out of eleven participants identified as racialized and Asian. Two participants identified as religious, while nine did not. All participants had a bachelor's degree in nursing with one participant completing a graduate degree in nursing. The average year of graduation from an undergraduate nursing program was 2014.6, and participants graduated within the years 2006 and 2018. Participants had work experience in diverse nursing practice settings but notably, seven out of eleven participants had past or present emergency nursing experience. Please refer to Appendix J for the complete

participant-specific demographic characteristics and Table 2 below for abbreviated demographic data.

**Table 2**

*Abbreviated Sample Characteristics*

<b>Pseudonym</b>	<b>Age</b>	<b>Gender Identity</b>	<b>Sexual Orientation</b>	<b>Indigeneity</b>
Riley	26	Female – Woman	Queer, Bisexual	Yes - Métis
Elliot	28	Agender (“feminine”)	Bisexual	No
Jamie	32	Man	Gay	No
Brook	29	Female	Queer	No
Lane	34	Female – Woman	Gay, Lesbian	Yes - Métis
Brett	45	Female	Lesbian	No
Charlie	33	Female, Non-binary, Fluid	Queer	No
Val	39	Non-binary, Gender Queer, Gender Fluid	Pansexual, Queer	No
Emerson	37	Male (Cisgender)	Gay (“Kinsey 5”, bi experience)	No
Casey	30	Woman (“flexible”)	Queer (“mostly gay”)	No
Terry	29	Female	Pansexual	Yes (Métis, Ojibwe)

### **The Experiences of Nurses who Identify as 2SLGBTQIA+**

Five interconnected and complex themes arose from the data. The themes related to the following topics: discrimination, disclosure, education, allyship, and identity. The five themes are supported by several subthemes. See Table 3 below for an abbreviated overview of the themes and subthemes in this study.

**Table 3***Overview of Themes and Subthemes*

<b>Theme</b>	<b>Subthemes</b>
1.0 The Subtle Nature of Discrimination	<ul style="list-style-type: none"> <li>• Discrimination is Often Covert</li> <li>• Experience of Overt Discrimination</li> <li>• Witnessing Discrimination Takes a Toll</li> <li>• Addressing and Disrupting Discrimination</li> </ul>
2.0 Disclosing 2SLGBTQIA+ Identity is Nuanced	<ul style="list-style-type: none"> <li>• Non-Disclosure of 2SLGBTQIA+ Identity               <ul style="list-style-type: none"> <li>○ Respectability Politics and Cis-Heteroprofessionalism</li> </ul> </li> <li>• Assessing Safety Before Disclosure</li> <li>• Disclosure of 2SLGBTQIA+ Identity               <ul style="list-style-type: none"> <li>○ Active Disclosure of 2SLGBTQIA+ Identity</li> <li>○ Subtle Disclosure of 2SLGBTQIA+ Identity</li> </ul> </li> </ul>
3.0 Education is the Solution	<ul style="list-style-type: none"> <li>• The Onus is on the Oppressed to Educate and Tokenization</li> <li>• Meaningful Education is Imperative               <ul style="list-style-type: none"> <li>○ Lack of Education</li> <li>○ Valuable Education</li> </ul> </li> </ul>
4.0 Allyship in Practice	<ul style="list-style-type: none"> <li>• Performative Allyship</li> <li>• Allyship is Action</li> <li>• Examples of Allyship in the Workplace</li> </ul>
5.0 2SLGBTQIA+ Identities are an Asset to Nursing Practice	<ul style="list-style-type: none"> <li>• Shared Identity Fosters Therapeutic Relationships</li> <li>• Understanding Creates Responsibility to Advocate</li> <li>• Past Experiences with Trauma Inform Nursing Practice</li> </ul>

**Theme 1.0: The Subtle Nature of Discrimination**

The first theme lays the contextual groundwork for the basis of the experiences of the nurse participants who identify as 2SLGBTQIA+. All participants experienced discrimination, both overt and covert ways in clinical practice. Experience with covert discrimination, cis-heteronormativity and homo-transnegativity, occurred more often than overt discrimination.

***Subtheme 1.1: Discrimination is Often Covert***

The discrimination experienced by the study participants often showed up in more covert ways, or micro-aggressions. MST describes how repeated and unique stressors accumulate and

can negatively affect the person being subjected to discrimination. Some of the ways in which covert discrimination reared its head was through heteronormativity and cisnormativity.

Presumptive questions like: “Oh, what’s your husband’s name (Elliot)?” were a frequent occurrence. Cis-heteronormativity often was conveyed with assumptions from patients and colleagues alike. One participant discussed how they have not experienced many instances of overt homophobia, but have noticed the more subtle ways living in a heteronormative society have affected them:

...if me talking about “My partner is a man” or these types of things. If saying, “He does this, he does that,” or whatever. If they say, “Oh, and do they –” I think it could be subtle things. I think it could be picking up on the fact that maybe they’re uncomfortable talking about the fact that my partner is a man, things like that. I think that’s something where it’s more obvious. I’d like to say that I’d like to give people the benefit of the doubt and that unless they’re obviously slinking away from the conversation or change behaviour where they don’t talk to me anymore, or something like that. I’d like to give people the benefit of the doubt, but I think language is a big part of it is picking up on their cues and their language. And, again, I have very few instances of very overt homophobia, which I’m very grateful for in the workplace, but I think that things can be a lot more subtle or we might never even know, right, things can happen where we have no idea until afterwards, or maybe never find out that something happened a certain way, because they’ve got homophobic beliefs or whatever, at least from my experience. (Jamie)

This same participant recounted an experience where he was encouraged to apply for a promotion at work yet did not receive notification when the position was publicized for application. Jamie wondered if this was due to their sexual orientation:

I would have a fear of disclosing things like my sexual orientation to a manager that I know may have a certain management style, and how that could affect things like promotions and things like that, for example. I’ll give a specific example if I may. And again, I don’t –maybe it’s me overthinking things, but I can’t help but wonder. There was recently a upward position or a position for advancement where I work currently, where I had some folks in higher positions telling me that I should apply for it. That they’d vouch for me, things like that. And then the position was kind of posted secretly and filled very quickly. And the director, I had gotten certain, I had gotten some vibes from. And I don’t know at this point whether it was anything personal, maybe I’m making it out to be too much. But I don’t think that cis, straight people ever have to consider something like their sexual orientation, or their gender identity being a potential cause of why they don’t get a

position or these types of things. I'd like to just gaslight myself and tell me that it's absolutely not the cause, but I can't help but wonder in the back of my head, because again, homophobia is not always super outward, people calling you slurs. Most of the time it's not. It's usually a lot more subtle. And there's no way for me ever knowing, but I can't help but wonder. (Jamie)

An example of the covert discrimination experienced by one of the participants was subtle changes in relationships with colleagues after disclosing the gender of her partner:

I have a few very religious physicians that I worked with, that have a little bit more of a stand-offish approach with me [after disclosing partners gender identity]. But that really didn't bother me, they were still professional with me, I was still able to go with them with any of the concerns I had, and respectful. But you could definitely tell that once they found out that I was dating a female, got engaged to a female, marry a female, they were very different with me. Our relationship, professional relationship, definitely changed. But they were still respectful. (Brett)

When asked how Brett's relationships changed with her colleagues, the primary investigator inquired if the participants' co-workers stopped asking about her personal lives like they used to:

...definitely, that was a big component, because they're like "Oh, how's your son, how's your daughter, how's your husband?" Just kind of a small talk that you have with certain people. And then yes, once that occurred [disclosure of partner's gender identity], they did not ask about those other people that were in my life. (Brett)

The subtle changes in how colleagues and patients treated Brett was also described as a hesitancy with the participant after they had disclosed their 2SLGBTQIA+ identity:

...after I've identified that I am married to a woman, I feel that after that, the, how people treat you after. Some people are a little bit more hesitant with you after, and other people, it just doesn't even faze them, they just don't even care. It doesn't matter to them that you are married to a woman. They still treat you the same, with dignity and respect. (Brett)

Emerson described covert discrimination as a "shift," a "different vibe", and an "awkwardness" after disclosing their identity:

...people assume the default would just – heterosexuality, heteronormative, so I guess because I – to a certain degree to some people I pass, then I guess I've coasted a little bit

through with that. But I do wear a rainbow pin so I think there has been instances where they recognize it and there's – you can notice a shift definitely. Well, not all the time. For other people there's a different – a certain degree of – I don't know – like a change in – not treatment but just like a different vibe happens kind of thing. (Emerson)

Emerson elaborated that the “shift” in “vibe” was felt to be an awkwardness post disclosure of sexual orientation:

...there's a certain sort of awkwardness. Not really negative but maybe an awkwardness of how they, I don't know, interact or – I don't know how to describe it. It's just a little bit of a – just a change of like you guys are interacting in a different way and then it kind of – there's like a sense of hesitancy or a sense of – there's an air of different. (Emerson)

Another example of covert discrimination in the workplace included reductive comparisons to public figures that identify as 2SLGBTQIA+:

...micro aggressions of homophobia/transphobia, yes, where people will compare me to Ellen DeGeneres or something like that, or – I just remember this one person that was in Emergency and was yelling out that I was Ellen DeGeneres and that I was gay. Obviously, there was a lot of other stuff going on with this person. But that kind of made me feel uncomfortable. And I think (1) in the past people have said that I've kind of resembled Ellen, so maybe that was it. But I don't know, it just felt weird. More microaggression-wise, I've had people say comments about gay people, or if they're watching something on the news, when I'm in their home, and I'm providing care for them they'll say things that make me feel uncomfortable. They don't feel like a safe person to be myself around. (Val)

One participant, who identified as racialized and was internationally educated, discussed the intersection of culture and gender roles on their experience working with other racialized colleagues who share similar cultural backgrounds:

So, with some of the Filipinos, I think a lot of them are, for the most part, 90 per cent are supportive. There are some that just either go quiet because I guess they know that it's not [undiscernible 00:22:47] but maybe they just silently disagree with it. And there's also some that they see – they're supportive but also, it's weird because it's almost like a – like they're pitying you in a – does that make sense? They pity you. It's a weird sensation because in the Philippines, gays – it's fairly open but also, it's like – it's almost like “oh, oh, they're gay, that's so sad – when they grow old they won't have children,” kind of thing. Because I think it's more – it's focused on rearing children, focused I think on all that jazz. So, the assumption is always when they grow old, they'll be alone kind of thing. (Emerson)

Invasive questions and questions based upon ignorance were also experiences discussed in relation to covert discrimination:

...there's only one interaction that kind of comes to mind that was negative, and it was with a healthcare aide. And again, it was kind of like these little microaggressions of – she was always interested in wanting to talk about my queer relationship. And then, but would say things like, “Oh, you guys can get married?” And I'm like, “Yes, since 2005.” And this was back in 2016, or something. (Val)

One participant brought forth an experience that subtle disclosure of her identity risked discrimination and they experienced invasive questioning about their personal life after disclosing:

...patients say some things that weren't totally necessary. Like, “Oh, do you have – like are you married?” “No.” “Are you – do you have a husband? Do you have a boyfriend? Like do you have a man in your life?” And it's just like, OK, now you're prying into my personal life, and I got to set that boundary – I don't feel like talking about this, but I was just like, “No, like I'm dating a woman. Yeah, I basically have a wife.” And like, “Oh, like you should really consider dating men, like they'll give you what you need.” And it's just like everyone has their views, but I do risk those conversations coming up while having that pride badge on. (Riley)

Other examples of covert discrimination included misgendering. Val also discussed how their colleagues “would get it [gender identity]” yet “always misgender” them.

### ***Subtheme 1.2: Experiences of Overt Discrimination***

Nearly every participant was able to recall an example of an overt experience of discrimination in the clinical setting, whether it be derogatory slurs or discriminatory remarks invalidating their mere existence. The topic of how violence against healthcare workers is normalized was also put forward in conjunction with overt discrimination against people who identify as 2SLGBTQIA+. Two examples of the use of derogatory terms and slurs hurled at participants included:

...there was one instance where one of my residents, again, an older woman, she called me “a queer.” She didn’t like that I wouldn’t put a whole bunch of Voltaren all over her body like she wanted. And so, I told her, “Oh, I can’t, we’re only supposed to put it on certain parts. It could hurt your –” you know. I was trying to explain to her why just bathing in Voltaren wasn’t necessarily the right choice. But she said, “Well, you’re a queer, you’re just a queer.” And I’m like, I don’t know if that was a phobia or just her using the – hard to tell. (Elliot)

I’ve been called a dyke so many times at triage. And after a while, I’m just like, “Yes, OK, cool.” Like, I am a dyke; I don’t know what you want me to say. I don’t – the word sounds – the way you’re saying it sounds derogatory, but I am. So, I would just address it head on. They would call me like, “You’re just a dyke.” I’m like, “Yes, I am.” And then they just stopped, they don’t know what to say, because they’re trying to insult you. And they would say anything to just get a rise. And you’re like, I – it takes a lot to get a rise out of me if I’m at triage. I’ll just get security to kick you out. (Charlie)

A few participants attributed and reasoned their experiences with being overtly discriminated against by patients, as connected to the patient’s vulnerability, health condition, and education level. Discriminatory language was viewed as a final effort for disempowered patients to try to regain power. When asked if Brett had experienced covert or overt homophobia or transphobia, she responded with the following:

100%. Yes, I found it, obviously, I feel that I should say obviously, but for me, it was always in the emergency setting. People come in and they are either at their worst, most volatile, whatever it is, it just, it was an environment that just, I don’t know if it was, they attracted it, or it’s just the people that access that [emergency department services]. But with the, I’m being crass, I’m being stereotypical, but just the proof is there, it’s a lower socio-economic status that frequencies in these places, people that have addiction issues, people that have mental health issues, and it’s that lashing out, and they know that this is offensive language that they are using, being derogatory, and I witnessed it the most when I worked in an emergency room. And I worked in a few emergency rooms in Winnipeg. And it was the exact same, with the exact same kind of population just being vulnerable and this is how they reacted, was being derogatory. It would be your weight, it would be your gender, it would be your sexual orientation. And it was just all the flying words that they could call you. No matter what it was, they didn’t know what you identified as. But they would just be derogatory with their slander. (Brett)

Emerson also described experiencing overt homophobia when patients were in vulnerable positions where they lacked power:

I notice it's with people that are, I don't know, intoxicated or not. They're usually, I guess, better at, I guess, hiding their – their, I guess, homophobia but people who are intoxicated, they're more verbal and vocal with anything and everything, right? So, they'll call you – I have been called the F slur, not too much but still a few times to be – to I guess remember those incidences. (Emerson)

### ***Subtheme 1.3: Witnessing Discrimination Takes a Toll***

Discrimination and witnessing discrimination against people who identify as 2SLGBTQIA+ adds to the cumulative effects of MS. Like experiences firsthand of discrimination, witnessing and hearing discrimination also impacted the study participants.

...especially older adults sometimes say things that are homophobic or just sort of like talk angrily about, you know, “kids these days” or, like, people identifying as having certain pronouns. So, I haven't experienced it [homophobia/transphobia] directed towards me, but I have had conversations with people about their views on being queer. (Terry)

Terry recounted another experience with transphobia in clinical practice:

...we had a patient that was trans not too long ago and they identified as a woman, and they had a female name. But on all of their paperwork it said male and their dead name was on there. And they were, like, actively people were calling them by the wrong name, and they were getting quite upset about it. (Terry)

Brett and Charlie provided their experiences with homophobia and transphobia in their clinical workplaces:

...the derogatory comments that would come out of some people's mouths. Just the, when we would have patients that would come in that identified as trans, or lesbian, or gay. Just the comments they [colleagues] would come out of the room with, after seeing them and assessing people and, just. Some of the things were just, we're professionals. And that I think was probably the hardest thing for me to hear is people stereotyping individuals. And then saying just such derogatory comments in a professional setting would blow my mind. (Brett)

There was a physician in one of the ERs that refused to call someone by their name and called them by their dead name. And I – the three nurses working in that section, were all queer, and we were all looking at each other, like, this is going to be bad. And since then, that person – that patient took their own life, and probably, not because of that interaction but years later. And I just – because I knew them [patient] through the [2SLGBTQIA+] community. And I was like, “This, for sure didn't help” all these interactions combined. And that person didn't have the money to change their name. They were below the

poverty line, mental health issues, all this stuff. And yes, the physician just flat out refused. He's better now. That physician I know has come a long way, but at the time was – it's not that many years ago. (Charlie)

How does witnessing trans-homonegativity, while not directed at the participant, affect a person who experiences direct discrimination in their daily lives and professional lives? Two participants described witnessing discrimination in the clinical setting and how this discourages them from disclosing their identity. Disclosure of 2SLGBTQIA+ identity in the workplace is the next theme.

Working with, especially men who are more queer presenting, it's more obvious in their presentation that they're part of the [2SLGBTQIA+] community. And I have seen them be treated differently. So that makes me not want to be out, specifically to older people. (Lane)

Witnessing discrimination contributed to fear of experiencing discrimination, and the anticipation of discrimination if Brook was to be open about her identity:

I remember one time a woman [patient], I don't even know how we got on the topic, I think it was just her that brought it up. She was very, very religious and just went on this rant about how gay people were the devil, were from the devil, and that they belong in hell and all this stuff. And I just was standing there biting my tongue, didn't say anything. I kind of wish I had but didn't want to come off as unprofessional, and I just didn't say anything and left the room. But it wasn't directed at me, but obviously it would – it makes for an uncomfortable environment and doesn't – and perhaps I guess, because of that experience also, maybe that prompts me not to share, knowing – I always – and I especially feel that older generation has more of a traditional conservative view upon queer people, and it's not as generally accepted. (Brook)

#### ***Subtheme 1.4: Addressing and Disrupting Discrimination***

The act of addressing and disrupting discrimination was reflected upon. Val stated: “Yes, sometimes I will” address trans-homonegativity in the workplace “but other times, I just don't engage.” Their level of engagement is dependent on how much energy they have in that moment, “It depends if I've had a good sleep that day and I feel confident in who I am” (Val). Participants

discussed cis-heteronormative questions being a common experience and always needing to decide whether to disrupt the assumptions or not.

The most common experience that I'll have is people will just assume that I have a husband. And like, "Okay, do you have eyes?" I am very clear; I want to appear queer. I'm very queer-looking, I think. So, they just assume, "Oh, what does your husband do or what does – are you married?" And then I'll say, "Yes," and they'll say something about my husband. And sometimes I'll just go with it and not correct them and just say what my wife actually does. And sometimes I will challenge them on it and make them think a little. Like I'll say, "Well, I don't have a husband." And then they'll say, "Oh, but you're married, so are you divorced? Are you separated?" And I'll say, "No, I'm married." And then they'll – you'll kind of watch as the gears in their head are turning and trying to figure it out. And then they'll eventually get it. And then there's a moment of, okay well, how are they going to react, or? And I always feel very uncomfortable in those situations. (Val)

...the place that we work [emergency department] is such a wild chaotic space that you not necessarily on your most grounded pensive reflective kind of space. I think that I would try and – if it was a colleague especially – if it's a patient, you're only going to be here for two days and I'm probably not going to be your nurse again and I'm going to explicitly avoid you because you were very rude and disrespectful. But if it was a colleague, I think I would try and approach them and be like "hey, I know you said this, this time. Do you think next time you would be open to saying this instead?" (Casey)

One person [colleague] who transitioned from male to female, who gets just misidentified constantly at work. So, I have definitely tried to correct people, as far as "It's she/her, this person has always gone by she/her. This is how you say their name, or her name," and trying to make sure that pronouns are respected, and that people are being respectful and not whispering or whatever, that sort of thing. Someone else that I work with who is just a gay man, who's more feminine in his presentation. I have had patients be sort of like "Oh, like, you know, there's a gay guy working here. And, you know, am I safe here?" And these sorts of questions and conversations. Which is always really weird to me that, I think older men feel threatened or something. But definitely just being like "Yes, he's always worked here. He's great at what he does. No concerns there," sort of thing. "You're as safe as you are with me or anyone else." So, I would always stand up for somebody who's being misjudged, or there's a bias towards them because of the way they look or identify for sure. (Lane)

In these incidences, the onus is on the oppressed to stop discrimination from happening.

When Brett addressed a colleague who used the term "gay" to signify something was negative,

Brett expressed frustrations with how they were not seeking an apology rather a concerted effort on the oppressors' part to change behaviour.

...I was on break, we're sitting upstairs. And she [colleague] was talking to me about something and she's like "Oh, my God, that's just so gay." I just looked at her and I was like: "Pardon me?" I'm like: "Did you really just use that in a sentence?" I'm like: "Did you mean to say something else?" And she's like "Oh, like, I'm sorry. You know, I'm sorry. I didn't mean to say that. And it shouldn't have come out that way." I just looked at her and I was like: "Can you please just be cognizant that you're raising two small boys that are going to hear you and think that what you're saying is appropriate to be said?" She just completely stopped, and looked at me, and she's like: "I'm sorry." I'm like "I actually don't want you to be sorry. I just want you to change that behavior." It's unbelievable what people think is okay to say, with the amount of education that there is out in the world right now. (Brett)

Jamie, expressed not correcting his patients' heteronormative questions out of fear and anticipation of discrimination: "because the fear that it can affect your work, and the patients, and things like that, if things don't go well if you disclose that, I think is a fear that I have, for sure."

One participant discussed vigilance in listening to their colleagues' conversations when SOGI were being discussed because they felt a need to teach and interrupt potential discrimination:

I'll pay attention just out of habit to certain conversations that are happening, about – if I hear people [colleagues] talking about gender or sexuality, I'll kind of tune in, but I have had to kind of inter-, or I felt the need to interject far less in the city [compared to rurally] (Elliot).

Elliot reported they are often assumed to be cisgender and heterosexual, and this 'passing privilege,' afforded them power in situations where incorrect language was being used to correct others.

...the majority of people that I work with in long-term care are newer residents to Canada, which is not necessarily to say that they're like – they don't get it. But it is, it's always a bit more of a – again, I don't usually start the conversation, but I have sort of heard conversations or heard where things are going, and I just sort of pop in, and have either

corrected language, or just been there to sort of direct the conversation to more positive things, I suppose. Again, because I'm not overtly out, and I don't necessarily have a lot of the stereotypical looks associated, I guess, with queer women specifically, I'm like a stealth queer. (Elliot)

One participant stated they worked with a physician who was known by many staff members to make homophobic and sexist comments. So much so that the doctor's superior proactively approached Lane to ensure she felt supported if she needed to take action to address discrimination because the manager knew Lane's sexual orientation. When this physician was working, Lane consciously and physically avoided the colleague while actively choosing not to share details about their personal life. Lane stated: "There's one doctor where I work who is very homophobic, sexist, we have different beliefs. So, I just keep a distance" and further elaborated about the experience:

...I'm less at my desk; I'm less talking about my partner and what we're up to on the weekend. So, I'm definitely more closed off on those shifts, because I know that he, he hasn't said or done anything to me specifically. But he goes out of his way to make sure that people know his beliefs, and that he is very Christian. He's very, he supported Trump, he's an anti-vaxxer, he doesn't feel that women should be physicians necessarily. So, I know that he doesn't support my, me and my partner and us as women or as partners. So, I'm definitely very shut off in that kind of, in that situation at work. I will say though, his boss has come up to me and said "You know, I know that he is this way. And if you have any issues at all, please email me, call me, we can go to HR if anything is said or done that makes you feel like you're not valid, or that he's directly homophobic." So, I do feel there's support from everyone else where I work. And I just avoid, that's my coping mechanism in that situation, is just fully avoidance. (Lane)

Charlie discussed how working in a specific setting might make addressing discrimination firsthand more difficult:

I think in Intensive Care it would be a little bit different, just because it's kind of a quieter environment. And it's not as brash of an environment. You worked Emerge, you know what it's like where you're just like, people yell at you and you're just like, "Okay." But I think on the ward, and ICU, it would be different. I think it would just – you'd be a lot more, because there's just one of you, it's one-to-one most of the time unless we're short.

I think it would be harder to kind of take that if my patient was directly being homophobic or directing some of those insults at me. I'm usually good at deflecting that stuff. But it just depends how deep they're going to go. (Charlie)

### **Theme 2.0: Disclosing 2SLGBTQIA+ Identity is Nuanced**

The act of 'coming out,' revealing or disclosing one's 2SLGBTQIA+ identity, is a phenomenon that would not exist if societies normalized the pre-existing diversity in SOGI. When the participants were asked if they disclosed their identities as nursing students, and in clinical practice to patients or their colleagues, the answers were nuanced. This can be attributed to many interconnected factors such as: society, past experiences, and the anticipation of discrimination.

#### ***Subtheme 2.1: Non-Disclosure of 2SLGBTQIA+ Identity***

Non-disclosure of participants 2SLGBTQIA+ identities were explained due to many factors. Perceived lack of safety and cis-heteroprofessional, or respectability politics, on what is appropriate to disclose in the workplace were discussed. Many participants recalled the pressures of nursing school and not wanting to risk discrimination on top of the stress of being a student, so they chose not to disclose their identities.

Riley stated they "don't" disclose their sexual orientation with their patients and endorses being "closeted at work, for two years." Elliot stated disclosure is "never initiated by me" with their patients. Brook stated "90% of the time I don't disclose" and that she chooses to "stay silent" about her sexual orientation. Similarly, Emerson stated "I don't" disclose identity with patients.

Jamie and Brook view non-disclosure as a way to protect themselves from the anticipation of potential discrimination.

...I haven't experienced any outward homophobia [from management], but what I will say is I don't think I would be comfortable disclosing my sexual orientation and these types of things to my current manager out of fear of again, they're your manager, they're your director, right, and they make reports for your work performance... (Jamie)

Brook stated, "I've never experienced any type of homophobia because I don't actively disclose it to professors or co-students... (Brook)" and discussed:

...I think my own perceptions of people, that I fear the worst, because I just never truly know what their response is going to be. And people have their own opinions and may not share them with me, and so I think it makes me hesitant to tell, to disclose it to them. (Brook)

In nursing school, the stressors of maintaining academic success, and fear of discrimination, combined, to inform some participants not to disclose their identities.

I was just coming out as a student. So, I was kind of figuring myself out. Plus, figuring out like, "Okay, if I am gay, do I tell people I'm gay?" Plus, you're in nursing school. So, you're trying to be as small as possible, not get noticed. That's how I felt I was like "Just be invisible and don't screw up." So definitely, I was not out as a student. (Lane)

...I just didn't want to risk anything at all. I just wanted to pass, and I didn't want that to factor in, into – like what if they're [faculty] homophobic and then they'll find something to fail me or to – so I – no, I did not want to risk anything. I didn't feel like I should – it would come out just like the – it could – there's always a possibility that that could jeopardize something kind of thing. So yeah. No, as a student I was – I didn't – like it did cross my mind. I was like no, I should – I should not disclose anything at all. (Emerson)

...when you're looking at these power dynamics sometimes, right, CEFs [Clinical Education Facilitators] and instructors and things like that, you have to, when I say you I mean me, but you have to kind of mentally weigh the pros and cons of every situation that you're in, and every interaction that you have. Where it's like, if I want to, again, bring up this part of my life, which is a big part of my life, your sexual orientation, it's not just who you are with or who you love, but it's who you are. And that's a pretty big deal. And to bring something up like that and risk it affecting the years of schooling that you've done, or the things like that, it's something that for me, I would say, probably wasn't worth the risk. (Jamie)

Brook and Charlie both discussed how context matters when it comes to disclosure, and the context of where they are working informs their perceived safety or lack thereof.

...I work agency long-term care in small towns, and I definitely would not disclose anything to patients just for the sense that I think they're more religious in small towns, or even to staff. I'm very cautious... (Brook)

...working in small towns, I do not wear my pride badge. I choose – I switch out and I wear a different badge, which sounds not great when I say it out loud, but that's my comfort level. (Brook)

When I worked in a rural community, I was a lot more careful about what I said, just in fear of my own safety. I worked with a lot of communities that aren't typically safe for the LGBTQ community. So, I would just say, like, "My significant other or my partner," I would never identify a gender... (Charlie)

Similarly, Lane discussed the context of her patient's age and how her assumption that older adults may lack understanding of diversity is linked to her perceived lack of safety:

Typically, with an older person, I don't disclose [sexual orientation]. Or if they ask, I even sometimes go as far to like "Oh, are you married?" Or "Who's the lucky guy?" Sometimes I'm like "Oh, yes, he's at home." Because it's just easier. (Lane)

***Subtheme 2.1.1: Cis-hetero professionalism and Respectability Politics.*** The dominant idea or ideal of what is respectable in a professional setting does not often include people who identify as 2SLGBTQIA+ and other equity-deserving people (Bizzeth & Beagan, 2023). Is disclosing personal information, like SOGI, appropriate in a professional setting? This question and other questions about professionalism was discussed by some participants. Some of the participants in this study discussed being indirectly or directly told not to disclose their SOGI in practice and as a student because it was deemed unprofessional. Charlie expressed the following: "I was told in school to never disclose that I was gay, or queer and just stick – don't tell your patients anything personal, just stick to professionalism."

...I know the College of Nursing [College of Registered Nurses Manitoba, CRNM], you don't disclose personal information, but we all know as nurses you just kind of have to – you do – we do have normal conversations with our patients and things come up like that all the time. (Brook)

There's been one instance lately where I did have a family of Muslim faith that were really very Muslim. The person giving the report was like, "I don't know if you identify as female, but you should today." I was like, "Yes, okay, I guess." It was kind of a joke,

but also a warning of like, “they’re very strict so maybe put on your fem voice” – but it’s hard, I’m full of tattoos and have short hair, so it’s very hard to hide my identity. (Charlie)

Even during nursing [school], I was told to strictly not say it [sexual orientation]. We had a project with a Christian university, and they were like, “You can absolutely not tell anyone that you’re gay here, because –” and I was like, but maybe there’s other gay people here they’re just Christian and (a) maybe closeted, (b) maybe not. And you can be Christian, okay, that’s fine. But the university had a, the Christian University had a policy about like no gays. (Charlie)

...I’ve always been told to just kind of keep it on the DL [downlow] to make others comfortable. Now I’m like, I shouldn’t have to make others comfortable. Yes, they should make their stay at the hospital comfortable, but hiding who I am is not making anybody comfortable. (Charlie)

Casey discussed how “not responding” to questions about their personal life and identities “because it’s a professional setting and I’m like you [the patient] don’t need to know this about me” (Casey).

### ***Subtheme 2.2: Assessing Safety Before Disclosure***

Because we live in a cis-heteronormative society that does not guarantee safety for people identifying as 2SLGBTQIA+, choosing to disclose one’s identity or “coming out of the closet” is something that is constantly decided upon.

Participants used many phrases to explain the ways in which they assess safety before disclosing their 2SLGBTQIA+ identities. Brett uses the term “read the room” to assess safety and described this phenomenon as: “I read the room, is how I feel. If I walked in and I am dealing with, it’s just kind of a feeling, how I feel when I walk into a room.” Jamie used the phrases of taking “baby steps” or “dip your toe into the water” to describe how they assess safety in the workplace:

...taking baby steps and assessing every situation differently to figure out whether I feel safe or comfortable disclosing this to colleagues, being protective in that sense probably

has shielded me from some issues. Again, I can't say this with confidence, but I feel that if I were to disclose it without hesitation, right, if I weren't to be so guarded sometimes in certain situations, my guess would be that I probably would experience some more outward discrimination. So, I think that that's kind of a protective reflex, probably. And in that sense, it has protected me, but I mean it's at the cost of not being able to be myself in some ways. (Jamie)

I don't know if I'm the only one, but I feel like it's a situation of you kind of dip your toe into the water and you see what their reaction is like. And if everything seems okay and they're not reacting in a way that is not great, then you kind of dip a little deeper and dip a little deeper. (Jamie)

Elliot named this personal safety assessment as "testing the waters" and discussed this phenomena when they had a nursing job interview:

...I did an interview at; it was just an acute unit. And the manager there, I don't want to say that I was testing, but I guess I was testing the waters of how it would be handled. Instead of saying "husband" during the interview, he was just asking like – it was specific – we had just moved into the city, so was asking like "How it was like the city so far?" And I mentioned my partner, as opposed to saying, like, "My boyfriend," I guess, at the time. And he was very respectful of that and continued to use "partner" the whole time and used gender-neutral terms which was great. (Elliot)

Elliot described assessing safety in their practice as more of an assessment of what their patients feel comfortable talking about and taking their lead.

I'll see what they're comfortable with. Not every patient wants to talk to me about my whole life story but some, especially in long-term care, some residents like hearing, they just like talking to you, right, so they're a little more chatty. And with those ones, I'll be open. Not always, it is sort of the stereotype of the older generation not really understanding as much. But at the same time, I've also had queer older patients who I think feel very comforted by the fact that we're out there. (Elliot)

Casey stated they "scope out the vibe":

When I first started, I didn't know anybody so I kind of did more of a – I waited to see – to have stronger relationships with my colleagues before I started disclosing things, just as like a – a basic kind of safety or like – or not – just like not that I thought that anyone would hurt me but just to scope out the vibe, before I exposed myself. Which is weird to even think about saying that you're gay would be exposing yourself because I'm like oh, well, it's – it's so much more accepted, being queer than it was 20 years ago (Casey).

***Subtheme 2.3: Disclosure of 2SLGBTQIA+ Identity***

The previous subthemes are evidence of the nuance leading up to the decision of disclosing one's 2SLGBTQIA+ identity. This subtheme of disclosure is divided into two distinct types of disclosure that the participants described, active and subtle disclosure.

***Subtheme 2.3.1: Active Disclosure of 2SLGBTQIA+ Identity.*** Many participants actively disclosed their identities when they felt perceived safety, whether with patients, colleagues, management, or when they were students. Context matters when choosing to disclose ones 2SLGBTQIA+ identity:

...I didn't talk about it a lot when I first started nursing. And then as I was more and more comfortable being a nurse, then I just gave less Fs [expletive] about who knew and who didn't. I found that the more I open up as a health professional, the more people open up to me. (Charlie)

...people still assume that everyone's straight until they're not. I just say it [SOGI] and just see what the reaction is and go from there. I mean, even if it's a bad reaction, I don't care. I'm just at that point in my life, where I'm like, I just am who I am, I don't really have to – I don't know, I'm not going to get fired because I'm gay, which is great. I mean, the employer will most likely have my back, I hope. The Union at least will. (Charlie)

Active disclosure, along with humor, was a way Brett challenged and disrupted cis-heteronormative assumptions:

...when I would speak, that I'm married to a woman, because lots of times it was "Oh, that's a, that's a beautiful ring. What does your husband do?" Or "Oh, your husband picked out a nice ring for you." And I would be like "No, I actually upgraded to a wife." Kind of make light of it, so it wasn't that they were offending me. Because I feel that it's just a, as a generalized statement. When growing up, it was always what you saw, what you heard. And being older, later in life lesbian, let's say. And that is a term that I hear a lot. I feel that it is, it's very, it's appropriate that people feel that men marry women, women, marry men, I get it. When you see the picture books, and you were being raised, the TV shows, it always showed men and women together. (Brett)

***Subtheme 2.3.2: Subtle Disclosure of 2SLGBTQIA+ Identity.*** Some participants describe disclosing their identities in more subtle ways. The method of subtle disclosure was

wearing rainbow pins or pins with their pronouns. In this way, allyship was shown with others, and this allyship and subtle disclosure “sparked conversation” (Riley):

I don't believe that it's [sexual orientation] something that I need to express to everybody, like I don't need to say that I'm currently dating a woman, though that does come up with certain patients when we are having that rapport and they're like, “Oh, are you married? Do you have kids?” that kind of conversation. I do wear a rainbow pin. I do have my pronouns attached to my badge, so those conversations will naturally come up. (Riley)

One participant described feeling safe to use their pronouns in their work email and subtly disclosing to their colleagues over email:

One of my past managers, I started feeling comfortable signing my name with my credentials, and then my pronouns after. And she [manager] picked it up right away and from then on out, in any email, referred to me as my proper pronouns and everything. So that was really positive. (Val)

### **Theme 3.0: Education is the Solution**

The topic of education was discussed with many of the study participants, both the quality of nursing curriculum about people identifying as 2SLGBTQIA+, the experience being 2SLGBTQIA+ in nursing school, and the need to educate their colleagues. Semi-structured interviews included a portion of questions that focused on the participants' experience being 2SLGBTQIA+ in nursing school and questions about what they believe needs to change to improve the experience of patients and nurses who identify as 2SLGBTQIA+. One participant described how “the lack of understanding can come across as like judgment” which supports the need for more comprehensive education is needed within health care professionals' education (Riley).

#### ***Subtheme 3.1: The Onus is on the Oppressed to Educate and Tokenization***

Many participants felt that they were forced to educate their colleagues to prevent future harm to themselves, their patients, and colleagues who identified as 2SLGBTQIA+. Jamie stated,

“It is my personal crusade to educate my coworkers on these subjects because no one else is doing it.” He also stated: “...I would prefer to be in a world or a workplace where the onus didn’t fall on me. I think that the lack of education out there is that it’s never been brought up before.” (Jamie). Lack of education surfaced as a fear of saying the “wrong thing” and avoidance of educating oneself:

...I think I’ve talked to nurses before and they’re like, “I’m just afraid to put my foot in my mouth. I am afraid to say the wrong thing, I’m afraid to offend somebody.” And like we all are in general, like we’re human, like we’re not, yeah, always afraid of that. But if you educate yourself a little more, there’s nothing to be afraid of. (Riley)

Emerson mentioned that when they educate their colleagues it is often in “informal” settings, like during “break time” and he is able to leverage his own experiences as educational opportunities.

...it’s more like an informal sort of setting where queer topics kind of come up and I guess – I think it’s more of like my [unintelligible 00:25:03] queer experience that’s in sort of that space that – like during break time people talk about things and then I guess sometimes it just naturally – it comes up in conversation and, yeah, so kind of say oh, this is my experience. Other people’s experience could be different but this is kind of like what it is for me kind of thing. (Emerson)

Casey discussed how a queer colleague took it upon themselves to educate their colleagues by placing information in the break room in their facility:

There is [education] in the break room. There is like a best practice guide for queer folks. Yeah, and it’s right in the center. It’s on the wall so I don’t know how often people are reading it but – one of my colleagues was very – was really pushing the – for - she had more to do with meetings behind the scenes and stuff and I feel like she pushed for that... (Casey)

Terry described a situation where a patient was being misgendered and deadnamed. She coached her colleagues on why this was inappropriate and why the patient might be reacting the way they were.

...I was able to obviously call this person by the name that they identify as but then also, like, talk to my co-workers who were annoyed and upset that this person was getting so upset about us calling them the wrong name and say, like, “hey guys, you know, how would you feel if you were seeking care and people are calling you by the wrong name and they’re not – you know, like, you’re already scared. You’re already in a vulnerable position. Like, this is a really simple thing we can do to make this person feel so much more comfortable, so let’s just do it.” Like, just put your opinions aside and do this for the patient. (Terry)

Similarly, Jamie also took it upon themselves to educate their colleagues about the difference between sex assigned at birth and gender identity. He also informally educated their colleagues on why respecting patients who are transgender is important.

...I feel like this is more of a personal crusade that I’ve taken to try to change things at my workplace, but specifically for trans callers, I’ve had to do a lot of personal educating of colleagues that and I think especially for trans patients, things have a long, long way to go in a lot of aspects because if you don’t have any kind of knowledge about who trans people are, people think that they’re being nice, but they’re doing horrible [things]. (Jamie)

I make it a point to try to tell some of my coworkers that there’s a difference [between sex and gender]. And it comes down to what I personally feel like should be very bare minimum teaching and understanding of trans people, especially again, when we interact with trans people on a reasonably regular basis, putting up alerts that indicate, for example, what the person’s preferred pronouns are. So that’s something that I’ve been putting into files, and I’ve been encouraging colleagues to put into files, because I think that if someone reaches out for help, and the first thing that you do is misgender them and dead name them, your rapport is done. Any trust is done; it’s dead. I can’t speak from experience, but my understanding speaking to trans folks and hearing from a lot of trans folks is that navigating the healthcare system is extremely challenging, because you’re constantly disrespected and mocked and ridiculed. I think that small changes would make people feel a lot better. Even if you don’t have a breadth of knowledge and understanding of trans people, you can understand the basics of how to respect another person. That’s a little crusade that I’ve taken upon myself to try to discuss with some of my colleagues... (Jamie)

...no one else has ever taken the initiative to explain to coworkers what pronouns are and explaining to people even, things that I think of as very basic concepts but that clearly aren’t about the difference between sex and gender. I think that that is something that I can do for the benefit of patients that’s important. (Jamie)

One participant educated their colleagues in a more formal setting, by taking it upon themselves to weave in content about people identifying as 2SLGBTQIA+ into a workplace course:

...I, first of all work with like some queer doctors and queer nurses, and I am openly queer at work – everybody knows that I’m just open about my sexuality all the time – I talk about. But I also teach a course on our unit, like our supportive care and labor course, which is dedicated to just teaching literally that supportive care and labor, and we do add units about just like how to support families better, that also includes – like I individually put a little portion in there about sexual orientation versus gender expression, versus how to be – you know get people to talk about their preferred pronouns, not like dead-naming somebody, you know so about stuff like that. I do laugh a lot at the fact – like laugh, ironically, at the fact that it’s on me, and it’s on our community, to have to educate these people. (Riley)

The pressure that is placed upon the oppressed person to educate and explain themselves to other professionals while potentially reliving traumatic life experiences adds to the pre-existing burdens of MS they already experience in a cis-heteronormative society.

...back to nursing school, if I didn’t feel like I had to be the one to explain things to people, it would just make my life easier. I think we would have a lot less judgment, a lot more understanding. I don’t mind people asking questions, but it’s also like I don’t want to be the one to have to educate them. (Riley)

I was talking to one of our openly queer doctors for friends now, and she was just like, “Isn’t that funny how like we are the ones that have to do the teaching.” And it’s just like I think people just assume that we always want to talk about it [SOGI] or always want to educate people – I don’t know why. But we are the resource. (Riley)

One participant described “constantly” educating their colleagues and assessing how they can protect themselves by setting boundaries:

Yes, constantly. To the point where I just don’t, because one: it’s exhausting, two: if you really care, then you need to educate yourself, that’s not our job as queer people to educate. You just know that they have no hot clue of what your life experiences are or what’s going on around them. They’re so focused on their life and whatever. If they don’t have anyone queer in their life, then that doesn’t matter to them kind of thing. (Val)

...it’s that fine line of how much energy do I have today to deal with this? Particularly with people that I work with, that aren’t in the queer community, clients that they have that aren’t in the queer community. It [educating others] can be exhausting. (Val)

This added stressor and pressure of needing to educate others was described as tokenization:

...it's kind of comparable in just being different. If you're Black, then you're the expert on everything Black. If you're gay, you're the expert on everything gay. I find I get a lot of questions about trans [people] and I'm like, "Well, I'm not trans." (Charlie)

I don't know the trans experience [personally]. I don't have that level of body dysmorphia that most trans people have. I try to answer the best that I can. But then I mostly direct people to, either trans people, not trans people themselves because that's a lot to put on them, but just to trans organizations or people that help trans people, because I'm like, "You'll get a lot more information, accurate information there than you will from me." I can tell you from my experience and my friends, but I also – I can't tell you how it is to be a gay man, I'm not a gay man. So, I can tell you what it feels like to be queer in this world, but I can't speak for everyone. But it is – I don't know. Big organizations do this too, work will do this, the union will do this, where they're just like, "Okay, you're queer and therefore we're inclusive, you're spearheading this or we're taking advice from you." And it's like, that's cool, but I'm only a small part of the queer community so I can do the best that I can. (Charlie)

In some situations, participants expressed feeling grateful that their colleagues viewed them as a safe person to bring forth questions in good faith about their community and how good faith questions were welcomed as they became meaningful teachable moments:

...I've gotten to a point where I've had certain coworkers come up and ask me questions about it, which is nice. There was a trans boy, he was young, he was, I think, 16. He was working. He was he's working in the kitchens, I think. And I remember people talking about his gender and whether or not, which pronouns were appropriate. And I just told them, like, "Why don't you ask, you know, you're allowed to ask, it's probably better than just assuming and, you know, maybe making him upset." And yeah, we – that time at like lunch one of them just sort of went over, asked, and got confirmation that he used he/him pronouns. And then it was all fine from there. They were – yes, it was a good experience... (Elliot)

The onus was on the participants to teach their colleagues, but also when they were patients themselves, where participants had to teach their HCPs and disrupt normative assumptions:

I went to the doctor last month and the doctor goes, "Oh, I see you're not on any contraceptive." And I'm like yeah, because I have a girlfriend." And they're like, "Oh yeah, but like what are you using for contraceptive?" And I'm like – "wait, like, literally that means that I am with a woman." (Riley)

...my own GP, he's an amazing doctor and I love him, but he definitely made a weird comment to me once. I remember telling him that I was going to be off birth control. (Brook)

...I told him [family doctor], "No, I'm not going to be on birth control, because I'm in a relationship with a woman." And I don't know if he thought that I was joking or not, because he made a really odd remark. I can't remember what his exact words were, but it was something along the lines of like, "Oh, you're really trying to get out of being on birth control" or something. And I was like, "Oh, no, like, I am actually dating a woman" or I said something like that. And he was just like, "Oh, oh, okay. Okay, so I guess you don't have to be on birth control?" And I was like, "No." He's like, "Okay." But he just made the experience very awkward, and he kind of laughed. I think he thought that I was joking or making some sort of excuse as to why I didn't want to be on birth control when it was a legitimate rational reason. (Brook)

...I have a friend who's a lesbian who's trying to get a mastectomy. Because she feels she's nonbinary. And having those types of conversations with doctors who aren't part of the [2SLGBTQIA+] community, or maybe you don't understand some of the identity issues, and just health issues that our community faces. I think it would be nice to have someone who does know. I had a doctor ask me if I really need paps [pap smears], because I'm a lesbian. That's insane to me. I could still get cancer! I still have all the same parts. So, yes. I feel like having a doctor whose part of the community would make me feel safer and more understood. (Lane)

### ***Subtheme 3.2: Meaningful Education is Imperative***

When participants were asked about what needs to change to improve their experiences and the experiences of patients who identify as 2SLGBTQIA+ the findings indicated more education was needed. The type of education and the way education could be delivered was emphasized too. Riley discussed how the onus should be on the individual, who often has more power and privilege than people identifying as 2SLGBTQIA+, to seek out education themselves and the facility in which nurses work to provide the most up to date education about people who identify as 2SLGBTQIA+.

...take the time, and on your own, and educate yourself, but it would start by the system providing more courses even in school. Because you know you always have those like education days and those like luncheon learns. I've been waiting – maybe I've just missed it, I could be totally blind, but like I've been waiting for something that just talks more in-depth about the queer community and how to better support them. And not just like, you know, what all the different letters stand for in LGBTQ – like you know something more in-depth. (Riley)

The content of the education needed, and how it is delivered mattered to the participants.

Charlie discussed relying on expert community organizations within Winnipeg that are already doing the work to deliver the education:

...I think there needs to be more education in nursing school just about how to approach queer people, just how to go about it, really going into different identities, not assuming identities, how to talk, how to ask about pronouns. And it's basically just ask, like, "What are your pronouns?" And just getting comfortable with asking those questions. I think as a nursing student, it's hard because every question is kind of awkward. Asking someone about their smoking history is awkward, just everything feels like this big thing. I do think that every facility needs to have LGBTQ education in their orientation and not just an LMS module because I will just click through that and do it within five minutes, not get anything out of that. But actually educate, just like they do with Indigenous people, so like the modules that we have to take in that. And that's great. We had an elder come in and talk to us, and that was so powerful to get firsthand experience about what it is to navigate the healthcare system as an Indigenous person. And I think if we could partner with Rainbow Resource or with Sunshine House or with one of these organizations to kind of just hammer that in, not just someone from the WRHA coming in and being like, "I'm queer, and this is my experience." No, I need someone, that's their whole life, that's their whole job is to come educate people and go to schools. And you can pay them, you can partner with them, it's just going to make healthcare a better place. (Charlie)

A few participants identified the need to prioritize education about gender identity and gender diversity because of increasing misinformation and discrimination within Canada.

...having like an education seminar for people in the workplace about safe spaces for queer-identifying people, an education seminar on gender identity. That seems to be the big one. Trans identity, how to respectfully address someone who identifies that way, how to be supportive, or not just for employees either but for clients. I've had a number of clients now who, of course, their legal name they don't go by because they don't identify as whatever they were assigned at birth. And some people – I have a client that is non-binary, but I don't think a lot of nurses respect their pronouns or their chosen name. (Val)

The need for in-person learning sessions was identified as well as the need to facilitate safe(r) spaces for learners that foster reflection on assumptions and nursing practice.

...some sort of thing where you practice – some sort of thing about practicing different pronouns or giving scripts about these are respectful ways to ask these questions. These are ways that can feel quite disrespectful to ask these questions. I think that would be

good. I think that if we just did like a one-hour Zoom education or two-hour Zoom. Anything Zoom, I really don't think would be valuable because people just check out. I think it would have to be in person. There would have to be a really solid instructor. It would be with other emerg [emergency department] staff. We already have a good group dynamics. And then taking breaks between doing things together, like watching a thing and then breakout groups and then sharing what they said and different ways to – we could list the – before the education day and be like what are the top four goals of – main things we want to learn and have practice dealing with and then kind of find some way to go through it in the day. (Casey)

***Subtheme 3.2.1: Lack of Education.*** The education that is available to nurses is often lacking, as evidenced by the “outdated” resources Jamie’s workplace encourages staff to use.

We have some truly horrific, outdated health education documents. For folks [colleagues] who have very limited understanding of trans folks, who would just assume that this information is appropriate, is really, really dangerous. I actually did bring this forward to a higher-up person saying, “This stuff needs to go because it basically describes, you know, trans identities from like a 1970s kind of mindset, where it says, “It can be really challenging to live as who you really are. It’s totally legitimate if you want to dress in your assigned sex at work and then dress in your preferred gender on your personal time.” (Jamie)

Terry discussed how every year there is a day dedicated to educating staff about several topics and people who identify as 2SLGBTQIA+ have not been included.

...we do education day every year and I don't think in, like, the six years that I've been there that we've ever talked about, like, anything regarding, like, queerness or sexuality. So, it would be nice to even just educate people a little bit about, you know, what that is and, like, what people are experiencing... (Terry)

Brook mentioned how there is irony that the nursing profession is consistently rated as one of the most trusted professions, yet is behind in many areas, specifically with the recognition of why stating pronouns is important.

...we're in the process right now of fighting for pronouns on our badges. So, and it's funny to think that nursing is the number one trusted profession and yet, we are the last to jump on board with the current trends. For example, if you email someone from your bank, they'll put their pronouns, or a teacher will put their pronouns, university professors. And I think I've heard from other facilities that they do, do that. But I remember when we first brought it up my staff was like, “No, like, absolutely not. We are not doing pronouns,” and this and that. And they're just stuck in their ways. But now

they've kind of come to terms with it. And it's also – it's your choice, if you want to put it on you can. We're not forcing you to do it. But it's finally coming around, but it still hasn't happened. And this is probably been almost a year of us trying to get it with our HR Department. (Brook)

***Subtheme 3.2.2: Valuable Education.*** A few participants received valuable education about the experiences of people identifying as 2SLGBTQIA+ and their health, but they were in the minority. One participant discussed having a professor who was a champion for weaving content about people identifying as 2SLGBTQIA+ in numerous areas of curriculum.

...we had an amazing Prof who, at the time, went by she/her, and now is non-binary. And never really expressed their personal life at the time, but like was so, so passionate about the queer community that they said like, nobody puts it in – the curriculum – like nobody puts it in there to say like, “Oh, we should add like a unit and talk about it.” Like it should be like a full class, obviously, or a half-class or something, to go more in-depth about it. Because they would always say like, “We are studying the typical like the cisgender white male in all of science all the time.” So, where's the place for our trans patients? And like, you know, even just women in general, and then you have like all the different categories, like where is the place for them. And so, they really added that in, in every sector of everything that they taught, and they taught us – over the four years, I think multiple different classes. So, it was really nice to see like when we talk about it in ethics, and we'll talk about it in – even like palliative care. Like I just remember it was always brought in, like surprisingly, and it was just so like normalized. (Riley)

Another participant recalled being appreciative of having a lecture related to gender identity and pronouns in their undergraduate education.

There was one class for at least half of a lecture that talked about how somebody – like pronouns. I was actually quite impressed. She was asking the questions about – I don't know. Someone who – it was in the gender and reproduction class. And kind of how sometimes – it was an example of how sometimes how you self – you're just like oh, yeah, I'm a woman but also, I have they pronouns. And how those don't – they're not exactly lined up. They can kind of do this. And yeah, so I thought she was pushing the envelope a little bit which I was impressed by, and it was only half of one class that was three hours long, so probably an hour. (Casey)

## **Theme 4.0: Allyship in Practice**

Questions about the experiences of affirmation and support were asked of each participant. Participants discussed their experiences with what support looked like in clinical settings and how allyship was shown or not shown.

...sometimes I can't help but think that not experiencing homophobia, sometimes I feel like I have to take that as an affirmation in the sense that it's not particularly positive. It's not forthcoming. It's not outright. But it's not bad. So that means it has to be good. Right? Well, I think that there can be a lot more positivity that's just, "Oh, I'm not being discriminated against, therefore, you're affirming my identity." I don't think that's enough. I don't think that's enough. (Jamie)

### ***Subtheme 4.1: Performative Allyship***

What is allyship in clinical practice? Many participants described what it does not look like and how performative allyship was more commonly witnessed. Performative allyship was viewed as displays of support for one month a year, like during Pride month in June, as opposed to every month and every day of the year. Emerson stated, "...they've [management] always been a lot more supportive during Pride – I guess everyone's supportive during Pride season."

...active intent and not just oh yeah, we support – right? Hey, it's Pride Month. Hey, here you go. And then July comes. You know that meme where like – I follow. It's an Instagram page. It's like oh, Pride month. During Pride month this, and then after Pride month it's just bam, erase everything or like everything's just gone right away. (Emerson)

Pride Month, they are so proud of us for one month. I think they try. I think there's effort. It's just like every other big organization and it's just like June is Pride Month, but there's not much done in terms of support throughout the year. (Charlie)

Performative allyship was seen as doing something, like sharing pronouns, but not following through with action or understanding why this is important for people who identify as 2SLGBTQIA+.

Other people though, they wouldn't see the pronouns beside my name. I think a lot of people, they feel like they have to put that now, because it's the thing to do. But they

don't understand why and so they'll say, like, their name and she/her after. And they'll see that I signed my name and they/them after, but then they'll still refer to me as she/her. (Val)

#### ***Subtheme 4.2: Allyship is Action***

Allyship was viewed by numerous participants as more than just words, rather, consistent action to respect 2SLGBTQIA+ identities.

...I think active intent by management to – you can't just be like a passive – or I think in my opinion, anyway, management can't just be a passive, like yeah, we support LGBT, like our queer people, our queer staff and especially only during Pride month. I feel like there's – there is, maybe needs to be active continuous intent because I think, especially too with – like things are happening in the U.S. They always trickle down to us and there's always – and I feel like there's – recently I think there's a recent wave of pushback... (Emerson)

...if people are not accepting, even they kind of tend to keep it privately, right? But I feel like because of what's happening in the U.S. and a lot of things that are blowing back, it's almost like it's whiplashing and it's going into Canada too and people are becoming more overtly homophobic. Whereas before, it got so it kind of emboldens them so I feel like management, and I guess facilities in this regard should be more active. We don't tolerate speeches like this. We don't tolerate things like that. And be active for the staff, in their support for the staff and not just be passive, right? So that it kind of reinforces the notion that no, these things are not acceptable anywhere here in our facility or in Canada at all. (Emerson)

Well intended words meant nothing without following through with meaningful action:

...real support for me is through action, and not just signing your name with your pronouns, or saying like, "We're a gender diversity supportive establishment." That's just lip service, you actually have to show in action, use the right pronouns, or when you first meet an employee, ask their pronouns, I've never had that before. Yes, I think there needs to be more work on the action side of things. And that will probably come from some sort of workplace training or some sort of action like that. (Val)

One example of actionable allyship was when Val's manager noticed their subtle disclosure of pronouns in an email signature:

...I started feeling comfortable signing my name with my credentials, and then my pronouns after. And she [manager] picked it up right away and from then on out, in any email, referred to me as my proper pronouns and everything. So that was really positive. I think she was in the queer community as well, though, so she definitely got it. (Val)

### *Subtheme 4.3: Examples of Allyship in the Workplace*

What does true, active, meaningful allyship look like in clinical practice for nurses?

Overt policies protecting nurses who identify as 2SLGBTQIA+ were identified.

If management were to, in some way, overtly make it aware that we are a workplace that does not tolerate discrimination of any kind, including all the above, it would make me feel more comfortable at work. If I feel more comfortable at work, I might feel more comfortable, again, making those better connections with patients, that could lead to them having better health outcomes potentially, again, if they have a nurse that they're talking to, or that's caring for them that they can connect with. And again, it would probably make me feel more comfortable to disclose my sexual orientation to coworkers and build a stronger team. And that, again, if I experience something like any kind of homophobia or something like that, I would actually feel like I wouldn't potentially get any kind of professional repercussions by bringing it forward. If I were to experience some kind of outward homophobia from a coworker or something like that, I don't think I would bring it forward, to be completely frank. Because – I don't necessarily feel like I work in an unsafe environment, but it's never been explicitly stated or known or shown by any kind of actions that it is a safe environment. (Jamie)

Something as seemingly small as having colleagues wear rainbow badges or rainbow flags in management offices created an environment where participants perceived support.

It's nice to know that my coworkers, who I never thought would be wearing that [rainbow] badge or wearing them, and it makes me feel supported by my coworkers. I feel that if anything were to happen to me, or if a patient ever said something about me, I feel that my coworkers would have my back. I wouldn't necessarily have thought that if I was dating a woman and still in the closet and they didn't know about it. I feel like they – they weren't educated and didn't have enough knowledge to do that. But I feel confident that my coworkers would really stand up for me, most of them anyway. (Brook)

If I went to the hospital, I had a nurse who identified as LGBT, if they had a little pin, I think that would make me feel a lot more safe. I think that would make me feel a lot more comfortable. (Jamie)

...I've been at my current site for three, almost three years. And I have noticed within the last year, more people putting signs up on their office doors, the ally signs with the flags and pronouns, and "Everyone, welcome, this is a safe space." Within the last six months, we've put signs up at triage "Please let us know, preferred pronouns or what your pronouns are, and what name you go by, if it doesn't match your health card." So, I think they're trying to change it with signage, for sure. There are some of the doctors that actually are wearing, I think physicians of Manitoba has a new thing on their badge that

they can put on with their pronouns. So, some of the doctors are wearing those now. Not all of them, but probably about half. (Lane)

...it would be really cool to have pronouns on our name tags. I know I have one co-worker who doesn't go by their birth name. They had to physically put a little piece of tape over their ID badge with their chosen name on it. And that hasn't been an issue. We all call them by that name. Just the fact that that wasn't an option for them when they started working at the hospital is definitely unfortunate. I think we might have a pride flag outside of the hospital but, to be honest, I'm not sure. (Terry)

One participant was a part of a facility wide EDI committee that has spearheaded many initiatives supporting diversity within their workplace:

...ever since I – my whole unit, everyone on the unit I think knows that I'm marrying a woman. The unit has really took a shift in – we have like an equity diversity, I can't remember what the exact wording is. Equity Diversity and Inclusivity Committee, and I sit on that Committee. (Brook)

...for Pride Week, or Pride Month, we did a big thing, our EDI Committee, because our, one of our charge nurses is also part of the Committee. She also brought – she went above and beyond and talked about pronouns, and we did a little education wall. It talked about transgender, all aspects of the LGBT community. (Brook)

### **Theme 5.0: 2SLGBTQIA+ Identities are an Asset to Nursing Practice**

The experiences of nurses identifying as 2SLGBTQIA+ and how their identity relates to their clinical practice, are inherently connected. The participants in this study believed that their SOGI's were directly and indirectly related to their nursing practice in positive ways. Lane linked their identity to their nursing practice and stated it makes them overall a better health care practitioner: "Yes, I think it makes me a better nurse." Val stated: "I think all of our identities, no matter if you're cis, hetero; I think all of our past experiences that we bring into our nursing career have to affect it in some way." Terry discussed how her identity as pansexual and her past experiences were viewed as affecting her nursing practice:

I think it [SO] overall just, like, makes me a bit more open. I think, now that it's, you know, been a few years I'm more established where I'm working. I feel a lot more comfortable disclosing that to individuals. And, like, more recently I've become more

active in the queer community, and I think that that's sort of, like, given me more of a voice to, like, talk against people who are, you know, like, being judgmental or who are not being kind to the queer community. (Terry)

One participant stated that their world view changed when they became aware of their sexuality and how it relates to their nursing practice.

I think 100 percent it [identity affecting nursing practice] does. I didn't think it would. I've seen a shift in how I see the world in general – it's so cheesy to say – but since the summer when I was like fully just accepting of my queerness, I was like I'm going out, you know. And I think it – I mean, okay when I was out as like straight, I was a straight cis woman, I still was like the passionate like ally. So, I always made sure to like have a safe space for the queer community. (Riley)

Experiencing cis-heteronormative assumptions helped make one participant see how important neutral language was to their practice.

I honestly think it brings a lot of – I try not to assume things about people. And I don't know that – and it's probably because over my whole career things have always been assumed of me, you have a husband, you want to have children, you are, I don't know, you're, just you're straight and cis, and that's your – you're going to have babies because that's your job kind of thing. That was more rurally but –. I think it has – I never liked when people do that to me so I really try in my practice to not assume anything if I can help it about people. (Elliot)

### ***Subtheme 5.1: Shared Identity Fosters Therapeutic Relationships***

Participants described how disclosure of their identity was sometimes stimulus to create connection with the patients and colleagues. Two powerful examples of this connection with patients are as follows. Elliot described learning queer vernacular that was historically used to assess safety in 2SLGBTQIA+ communities when it was unsafe to be open about their identities in public.

...I learned about the term “A friend of Dorothy,” I think through, Drag Race or something. This patient was like – because residents can change their room up, literally had so much Wizard of Oz stuff. And not to say that it was obvious, but they had – it's – they were pretty – they weren't trying to hide who they were. And it was nice kind of being able to go in. And I just – I think he [resident] was the only one I ever started the

discussion with, because I knew he liked to chat. I asked, “I’ve learned about this thing called, like the Friends of Dorothy, does that mean anything to you?” (Elliot)

One participant described being asked heteronormative questions about their personal life from one of their clients. Val disrupted the assumptions by disclosing the gender of their partner, which allowed room for their elderly client to reflect on their own past which they had not disclosed before.

I have a client who’s in their 70s. And we were slowly building a rapport getting to know each other while I was providing treatment, and she would ask me about a husband all the time. And she would try and tell me things about her country of origin, her culture. And she would always assume, and she knew that I had a daughter and so she just assumed that it was a nuclear heterosexual family. And I didn’t feel comfortable yet. I wasn’t sure. I just had to get to know her a little bit more before I did kind of challenge her on that. And eventually I did. And that was another time when she like, “Oh, you’re not married?” And I said, “No, I am married.” And she’s like, “Okay, so you don’t have a husband?” And then she finally got it. She said, “You’re a lesbian.” And I was like, “Well, I guess for like – I don’t identify as lesbian, but I can see how you see that.” And there’s a bit of a language barrier as well. So, a bit difficult trying to explain things. And I’m with this client for a good 15 minutes of just sitting with her. But because I divulged a bit about me, and my queerness, she started telling me about an experience that she had. And she said she’d never told a soul before, that she, back in her home country, had an experience with a woman. And she thought she was in love, and then when she came to Canada, she fell in love with a Canadian woman. And she was – she described her, as like big and strong and, I don’t know. It really touched me because she, number one, said that she had never told a single soul, but that she felt comfortable to tell me. Yes, I just, I love going to see her now. We talk about all sorts of things. But she definitely feels, I think, safe in my presence, and that makes me feel really good as a nurse. But it could have gone either way, for sure. She was married before in a heterosexual marriage, very traditional roles of such. So, I was quite shocked when she started to divulge stuff about her identity and past and questions that she has. And she’s in her, almost her 80s. So, it was a really nice experience. (Val)

Another example of a participant disclosing their identity and viewing disclosure as a way to strengthen their therapeutic relationships with patients was as follows:

And anytime I go in there she always asks me about my partner. Yes, we have nice conversations. I ask her about her wife, and it’s just a nice, very wholesome conversation. I feel like it’s a safe space, for me and her. She probably doesn’t feel as comfortable perhaps talking to her, to another coworker that she may not identify, that may not identify as queer about her wife. So, she’s told me a lot of personal things about her and

her wife that have probably been therapeutic for her, for her to be able to talk to someone about it in a professional manner. So, I think that that's really helped her and definitely strengthened our therapeutic relationship. (Brook)

Val stated, "I try and use my experiences to make connections with my clients, particularly in this position." Terry discussed having colleagues that identified as gender diverse and stated "I've been able to really connect with them as well. We've been able to talk a lot more about our sexuality." Similarly, other participants discussed how sharing vulnerabilities with patients and colleagues alike was viewed as a way to connect and affirm others:

I'd have to say people that struggled with mental health, I always, as a practice, was very open with those individuals. Just because it is, I think it just proves your vulnerability when you're able to identify. And then maybe would be able to let them know that this is a safe environment, I'm showing you my vulnerability, and I'm hoping that this can make a connection on a different level. (Brett)

I think it [identity] just brings a bit of more of an openness, to just share and listen. I think a lot of my colleagues have disclosed things to me that they probably don't disclose to other people. Or if they're questioning – I've had some colleagues kind of question their sexuality, or their orientation, and we've had discussions about it. (Charlie)

I also find in my current job that other colleagues that might not be visibly queer, outwardly, if I come out in the workplace and identify as, however I identify, I found that they have also felt safe enough to then come out to me and be like, "Oh, actually, I'm trans or I'm whatever." But – and I know for a fact that they're not out to the rest of the staff or whichever. So that, I feel like representation is important, so that other people in the workplace or in whatever feels comfortable that they can tell me who they are. (Val)

...we had a trauma patient come in and they were in the collar on a board and they were feeling – they had disclosed that they were queer and they were pretty – they were in their like early 20s and how they didn't feel comfortable because we had to – because of the injuries that they had, we had to cut around their clothes. And – or like generally, if you're in a big trauma we need to see what your skin looks like because safety. And the three nurses that were on were all queer, which was really funny and then they were like okay let's do it. So – but it was mostly because they were – they disclosed about themselves and then we were like oh, that's so funny, we're actually all queer here... (Casey)

### ***Subtheme 5.2: Understanding Creates Responsibility to Advocate***

Like the previous subtheme of connection, past negative and positive experiences create understanding of others' experiences like other equity-deserving people. This understanding

propelled participants to advocate for their patients and specifically their equity-deserving patients.

I feel like even now more so than ever, but obviously because I am in that community, and I can share stories, and I just feel more – I don't know how to say it – like I just hold a special place in my heart. For example, like last month I had a patient who was a teenager, and I just saw in the chart that they went by she/they and chose a different name to go by, not in their – like on their charting. And that was only written – like in the charts handwritten by the doctor, like you would have had to go looking for it. And everybody was calling this person by, like their birth name and saying, she/her. So, I went up to them, and I just said, “Hey, like which do you prefer?” And like just like allowing them to have that space. And they were kind of shocked by me asking that simple question. And maybe me, being in the community, I just know to ask. I shouldn't have to be queer to know that these are normal things to ask and to allow a space for it. But they were just so grateful that I would have asked that, and they're like, “Oh, yeah, like I do prefer this name. And yeah, I do prefer like they/them actually.” And just to feel like I asked a simple question for them to have a safer space. (Riley)

We have gay clientele or trans clientele, and I try to advocate because you know, right, you know how it feels like to be – you're already in a vulnerable space when you come to the emerg because you're sick and then the last thing you want to deal with is discrimination or even overt or whatever. (Emerson)

It [identity] brings a responsibility to make sure – to help other people feel safer that normally feel exposed. Especially in emergency. Everyone's scared in emergency. And so I can't imagine – everyone's scared. It's a scary place. And people that are there are usually – feel unwell and unable to take care of themselves. And being queer, trans on top of that, that's a lot. So yes, I definitely feel responsibility to make sure – give some sort of buffer so that people feel less scared and overwhelmed. (Casey)

### ***Subtheme 5.3: Past Experiences with Trauma Inform Nursing Practice***

Past experiences with MS helped participants to recognize the traumas other equity-deserving people experience and propelled them to practice in trauma-informed ways. Lane discussed how they want to “create a safe environment” for their patients:

I'm less judgmental. And I think I can create a safe environment for people who come to urgent care or emerge, who are part of the community, who might be scared to talk about certain things, or scared to say “Oh, hey my health cards not updated, but I go by this or,” you know, “I would prefer to be they/them, so if you can put that on my chart somewhere.” And I'm very loud about it, when someone tells me that they, their name is, let's change it to this or we can change the pronouns in the computer. I put it everywhere, so that when they get called for bloodwork, or the doctors know when they go to grab the

chart, please do not screw this up, because someone who's already got something going on, whether it's physical or mental, don't also need to be misgendered. Let's not make their day worse. They're obviously already having a terrible day. So, I do my best to make sure that they're taken care of in a way that they feel respected and that they feel like we're, yes respecting what they go by and who they are. So definitely, I think also just being open minded with things related to lifestyle and things like that. Whether it's STI's, or substance abuse, or people having issues with their mental health. I feel our community [2SLGBTQIA+ community] goes through a lot more issues and in a different way than the cis straight people. So, I think that just providing care to our community, I'm a lot better at that than someone who's not part of the community. (Lane)

Especially because I haven't always identified this way, I think I'm more cognizant of being respectful to others, because I would really like it back in return. So, when I worked in primary care, I advocated for us to start identifying at the beginning of our conversations, when we're doing new patient intakes, identifying people's pronouns. I know that it was starting in primary care. But it was one of the things where I was very passionate about it, because I wanted to be so respectful of other people. And I know that just assuming is so hurtful. So, I was able to kind of change a practice in an entire clinic, which was great. And we had a lot of trans individuals that were coming to our clinic. So, they were kind of flagged because they got referred from [Community clinic that works with lots of trans patients]. (Brett)

Val stated how they are able to leverage their experiences to be more compassionate to others that have experienced discrimination:

I think I have maybe more of an awareness than say my colleagues that aren't queer of how someone might feel. I want to say too, the queer community is a marginalized community, so I can use my experiences and try and understand other marginalized communities. They're not the same in any way, but having more, I guess, of an understanding, compassion, like a gentleness. I want to be a safe caregiver to people. So, I think my queer identity and my past experiences as not feeling safe all the time hopefully affects that. It's hard to put into words, you know. (Val)

We do have some trans clientele and then that – we can – and it's hard, like especially when people are just – I understand people are just trying to do their jobs when they're trying to call for people for like say, blood work and treatments and all that jazz. And then I guess they go by the legal, like dead name that they don't want to use. And I guess sometimes that causes friction, so I try to make – in the note I'll be like goes by this, goes by this and in the comment section on EDIS, just like just go to like their preferred name or their – the name that they're using and whatever pronouns that they're using too. So, I don't know if that helps, just a tiny bit helps, right, or at least not pile onto their oh, I'm already sick and then there's this person. (Emerson)

### **Chapter Summary**

The characteristics of this study sample were described. All participants voices were represented throughout the findings chapter along with direct quotes illuminating their diverse lived experiences being nurses who identify as 2SLGBTQIA+. The findings of this research study were presented along with supporting quotes and subthemes that arose from the rich data. The five interconnected and complex themes generated from the interview data were presented.

## **Chapter 6: Discussion**

The thesis findings, directly and indirectly, answer the two research questions centering the experiences of nurses identifying as 2SLGBTQIA+ and their perspectives on if or how their identities affect their nursing practice. This chapter will show how MST relates to the findings and compare the themes of this thesis to the existing literature while discussing novel knowledge illuminated by the participants' experiences in relation to the five themes. This chapter will discuss the strengths and limitations of this study. Thorne (2016) describes ID as looking "beyond mere description and into the domain of the 'so what' that drives all disciplines" (p.36). The reasons why the findings of this study are significant to the nursing profession as well as the implications and knowledge translation plan, will be discussed in this chapter.

### **Minority Stress Theory in Relation to the Findings**

MST describes the unique stressors equity-deserving people face in society and the consequences of repeated discrimination, whether overt or covert (Frost & Meyer, 2023). MST contextualizes the lived experiences of the nurse participants identifying as 2SLGBTQIA+ in this study and provides possible explanations for why common themes arose from the data. Semi-structured interview questions included questions asking about participants' experiences with MS, like the experience with cis-heteronormativity and discrimination based upon 2SLGBTQIA+ identities, but did not delve into the intricacies of the consequences of experiencing repeated discrimination. MST was not tested but raises further questions for future research and enriches the discussion of the findings. MST provides context to the overarching societal norms and clinical practice settings in which nurses identifying as 2SLGBTQIA+ work within and are subsequently forced to navigate.

Cis-heteronormativity prevailed in the participants' lives, both in nursing school and clinical practice. Knowing this, the phenomenon of experiencing discrimination is not surprising. The lack of education about people identifying as 2SLGBTQIA+ provided in the nursing curriculum, lack of facility education, and how some participants felt tokenized when asked to educate their colleagues without compensation is explained by an environment participants live and work within that assumes everyone is cisgender and heterosexual. The phenomena of needing to 'come out of the closet' and disclose one's identity while navigating what is acceptable as appropriate in a cis-heteroprofessional setting would not exist without the greater societal expectation of heterosexuality and gender identity matching one's sex assigned at birth. MST posits that equity-deserving people experience an accumulation of MS, which creates "a hostile and stressful social environment" (Meyer 2003, p.674), which is why allyship is needed to combat societal norms and discrimination.

In MST, maladaptation is a response to experiencing unique stressors (Brooks, 1981). Avery-Desmarais et al. (2020) studied the effects of MS with a participant sample of equity-deserving nurses and found that because of the MS they were subjected to, participants displayed increased negative coping mechanisms. The literature, and this study, show that many nurses identifying as 2SLGBTQIA+ experience discrimination (Giddings & Smith, 2001; Glass, 2002; Røndahl et al., 2007), and further research into how they cope with MS is warranted. Probing questions inquiring about coping with MS were posed to some participants in this study after discussing traumatic experiences, but the concept of coping was outside of this study's scope.

Adaptation is described in MST as a positive response to discrimination (Brooks, 1981). A significant theme generated from this study found that participants viewed their 2SLGBTQIA+ identities as an asset to their nursing practice. This shift from a deficit-based

perspective to seeing how past experiences with discrimination benefit their current nursing practice, displays MST's concept of resiliency and adaptation. Meaningful and active allyship was brought forth as a possible way to improve experiences, and thus, displaying how allyship could help nurses identifying as 2SLGBTQIA+ adapt to ongoing MS. MST raises adaptation as being a possible response to adversity; however, it does not center the narrative of a strengths-based lens; instead, it centers the experience of the adverse effects of maladaptation (Perrin et al., 2019).

### **Theme 1.0: The Subtle Nature of Discrimination**

The first theme of this study, The Subtle Nature of Discrimination, reflects the current state of literature, which focuses on the discrimination faced by equity-deserving nurses (Canning, 1994; Duffin, 2002; Eliason et al., 2011; Eliason et al., 2018; Giddings & Smith, 2001; Glass, 2002; Korinek, 2018; Røndahl et al., 2007). The health care systems that nurses work in are not immune to systemic norms and harmful assumptions (Logie et al., 2019). Human rights have improved for many years for people who identify as 2SLGBTQIA+; however, in the past few years, there has been a concerted effort to attack queer and trans people, as evidenced by recent right-wing politics weaponizing human diversity and fear of equity-deserving people for political gain (Dietzel et al., 2023). The discrimination experienced by the participants in this study was often covert. Covert discrimination, or micro-aggressions, aligns with the greater societal context of improved human rights and acceptance of 2SLGBTQIA+ identities and that overtly and openly discriminating against people who identify as 2SLGBTQIA+ is less socially acceptable.

The incidences of overt discrimination can be rationalized using MST. At its core, MST is about the power of undeserved privileges and those who are disempowered based upon their

social locations and identities. In a profession that historically was one of the first to welcome cisgender women (Eliason et al., 2010; Neumann, 2015), it does not come as a surprise that violence against nurses occurs (Kim et al., 2023), as women lack power based upon their gender and the hierarchies that remain within health care (Nelson et al., 2024). Nelson et al. (2024) found that equity-deserving people that work in health care, like 2SLGBTQIA+ people, have higher risk for experiencing violence in the workplace. Literature has shown that discrimination against nurses who identify as 2SLGBTQIA+ can influence their performance which negatively impacts patient care (Hunt et al., 2007). The repeated minority stressors that 2SLGBTQIA+ nurses face has been found to lead towards higher rates of substance abuse than their heterosexual colleagues (Avery-Desmarais et al., 2020).

Witnessing discrimination directed at people identifying as 2SLGBTQIA+, while not directed towards the participants, was an experience that weighed negatively on participants. This likely contributed to the accumulation of MS and their perceptions of whether their workplace environments were safe to be open about their identities. After witnessing discrimination or experiencing it directly, participants were faced with two choices, either avoiding the conflict and ignoring the harm in the interim or addressing the discrimination head-on. Avoidance of conflict was seen as a way to protect oneself from discrimination. MST explains how repeated MS like witnessing discrimination, creates fear and anticipation of discrimination, which explains why someone may not feel safe to disrupt discrimination and avoidance of disrupting discrimination. Addressing discrimination took bravery as safety was never guaranteed and risked further discrimination. Some participants bravely used disclosure of their 2SLGBTQIA+ identities as a way to challenge heteronormative assumptions.

**Theme 2.0: Disclosing 2SLGBTQIA+ Identity is Nuanced**

The study theme centering on the nuance in the decision participants make when choosing to disclose their 2SLGBTQIA+ identities in their nursing education and in clinical settings was discussed in interviews. The context of living within a cis-heteronormative society, provides the explanation to why disclosure of 2SLGBTQIA+ identities, and coming out of the closet, is a phenomenon common place for people who do not fit into societies presumptive box of cisgender and heterosexual. Disclosure, in cis-heteronormative and cis-heteroprofessional environments, risks discrimination (Beagan et al., 2023; Bizzeth & Beagan, 2023). The state of the current literature involves discussion about disclosure of nurses 2SLGBTQIA+ but focusses on disclosure to other colleagues (Clarke, 2017; Deevey, 1993; Røndahl et al., 2007), as opposed to the experience of disclosure in various contexts of this study.

Disclosure was viewed in many ways, with some participants viewing disclosure of personal information, like SOGI, as inappropriate in a professional context. The idea that professionalism is not inclusive of 2SLGBTQIA+ identities is reflected in the term heteroprofessionalism (Bizzeth & Beagan, 2023). There is little literature discussing this concept of heteroprofessionalism in nursing and the existing literature fails to incorporate cismativity into this concept, which is why the primary investigator has extended the term to inclusive of gender identity by using the term cis-heteroprofessionalism. One participant viewed disclosure of their SOGI as inappropriate and attributed this to their understanding of nursing's code of ethics. Non-disclosure of 2SLGBTQIA+ identity due to perceived inappropriateness was reflected in the literature (Beagan et al., 2023). Some participants discussed how as they progressed in their careers, they felt more comfortable disclosing their identities which is also congruent with the literature (Beagan et al., 2023). Of course, disclosing personal information is not appropriate in all situations if it is not patient-centered or benefits patients; but if it is appropriate for a nurse in

a heterosexual relationship to disclose their relationship status, why would it be inappropriate for a nurse identifying as 2SLGBTQIA+ to disclose theirs?

Before choosing to disclose one's 2SLGBTQIA+ identity, participants discussed in many different analogies, the process of either subconsciously or consciously assessing safety of the environment they were in. Participants discussed being vigilant in consistently assessing and reassessing their environment's safety as this was subject to change. The literature describes how nurses identifying as 2SLGBTQIA+ observe how their colleagues treat patients who are 2SLGBTQIA+, and this helps nurses recognize which of their colleagues are more likely to be respectful of them prior to disclosure (Clarke, 2017; Deevey, 1993). Beagan et al. (2022) describe how commonplace hyper-vigilance is for people who identify as 2SLGBTQIA+ and state: "In the face of heteronormativity and potential heterosexist (micro) aggressions, queer people often become expert risk assessors, constantly vigilant to avoid harm" (p.2). This thesis study's findings build upon existing literature and add more context to how equity-deserving 2SLGBTQIA+ nurses assess their safety prior to disclosure.

Study participants displayed disclosure in subtle and active ways. Subtle disclosure included: non-verbal displays of allyship or of being a part of the 2SLGBTQIA+ community like wearing a pronoun pin or a rainbow pride pin. Other examples of subtle disclosure were: offering up one's own pronouns before asking their patients pronouns or using gender neutral terms when referring to their personal relationships. Active disclosure of 2SLGBTQIA+ identity by participants was mostly viewed as a mechanism to improve rapport with patients who also identified as 2SLGBTQIA+ or had family 2SLGBTQIA+ family members and a way to strengthen therapeutic nurse-patient working relationships. The finding of identity creating

connection will be discussed in detail further in relation to the fifth theme of 2SLGBTQIA+ identities being an asset to practice.

Non-disclosure was often viewed as self-protection from potential discrimination. Non-disclosure is afforded to people that can pass as cisgender or heterosexual (Beagan et al., 2022). Non-disclosure, or concealment of identity, can have numerous negative health benefits and added minority stressors like a decreased “sense of belonging, job satisfaction, social support, and overall wellbeing” (Beagan et al., 2022, p.2). The first literature about the experiences of nurses who were 2SLGBTQIA+ discussed how they felt invisible, with one nurse urging other 2SLGBTQIA+ nurses to disclose their identities and improve visibility (Stephany, 1989). This thesis findings reflect that non-disclosure remains an issue for nurses identifying as 2SLGBTQIA+.

### **Theme 3.0: Education is the Solution**

A main theme that was generated from the data included the participants' experiences with education in relation to the health and wellness of people identifying as 2SLGBTQIA+. Subthemes included: the need for formal education about people identifying as 2SLGBTQIA+, the delivery method of education, and how the onus is often placed on the oppressed to teach those with undeserved power and privilege. The literature reflects the historic gap in nursing education and the importance of including people who identify as 2SLGBTQIA+ in education content (Galanza et al., 2024).

The literature did not reflect the subtheme of the stressors placed upon equity-deserving nurses identifying as 2SLGBTQIA+ to educate their colleagues. The participants in this thesis discussed how the onus was often placed on them, the oppressed, to defend their existence and explain their experiences. Similarly, tokenization of one's identity to be called upon to do this

often-unpaid extra labor, on top of their workload as nurses, was experienced by some of the participants. This extra effort placed on the systemically disempowered nurses identifying as 2SLGBTQIA+ by the systemically empowered adds to pre-existing MS.

Participants often stressed the need for more education about the health and wellness of people identifying as 2SLGBTQIA+ and how if there was more education about their communities' lived experiences, their experiences and the experiences of patients identifying as 2SLGBTQIA+ would likely be improved. Participants discussed how the type of education was of utmost importance rather than just its mere inclusion in curriculum and on-the-job training. Participants desired multi-modal delivery of educational content, in various class curriculums, as people identifying as 2SLGBTQIA+ are cared for in all areas of clinical practice. Additionally, to nursing undergraduate curriculum, participants also expressed a desire for on-the-job training carried out by the facilities they work for, to improve allyship of their colleagues and leadership. Similarly, Perales (2022) found that “workplace diversity training” improved the wellbeing of employees that identified as 2SLGBTQIA+ (p.1).

The participants discussed varying experiences in undergraduate and graduate education. Many did not receive adequate formal education, and many did not receive needed on the job training about people who identify as 2SLGBTQIA+. The few participants that did receive undergraduate education about people identifying as 2SLGBTQIA+ had faculty members that championed content related to the experiences of people identifying as 2SLGBTQIA+ along with the desire to create safer spaces for students. These faculty members often identified as 2SLGBTQIA+ themselves. The discussion of the lack of formal education in nursing curriculum is reflected as a topic in the literature (Galanza et al., 2024).

**Theme 4.0: Allyship in Practice**

The concept of support, and what support looks like to the participants in clinical practice was discussed. This support was often discussed regarding meaningful allyship and the lack thereof, in the settings the nurse participants studied and worked in. One participant discussed that they previously had thought their workplace was supportive, but upon reflection, they viewed lack of discrimination as a supportive environment. Lack of discrimination should be the bare minimum and does not imply affirmative support if and when discrimination occurs. A few participants raised the concern that allyship shown in clinical practice by management and the facilities they work within, displayed intent to be allies, and were performative in nature. Without meaningful and consistent action, signs of allyship fall short. The literature raises similar sentiment like: “the need for concrete actions to address discrimination, underscoring the importance of a supportive environment in which LGBT staff nurses can express themselves freely and achieve their full potential” (Galanza et al., 2024, p.544).

Participants viewed meaningful support and affirmation as consistent action to affirm those identifying as 2SLGBTQIA+. An example of actionable allyship in the literature is the implementation of overt policies to protect nurses identifying as 2SLGBTQIA+ as a way to address discrimination in the workplace (Eliason et al., 2010; Eliason et al., 2011; Lim & Borski, 2016). Policies aren't solely reactive and could be proactive if they were communicated in the workplace, but without follow-through would be performative. Allyship involves critical reflection and is something that is consistently worked towards.

Participants described examples of allyship in practice. The examples provided began with the intent of their colleagues and faculty with concerted follow-through. Intent on being an ally, without action, is merely performance and not productive. Allyship didn't have to be grand gestures of support and was often described as small tokens of support. Examples of this support

included open-ended questions to avoid assumptions, mirroring language, displays of support throughout every month of the year and not just during Pride month, rainbow badges and stickers, and EDI workplace committees to name a few.

### **Theme 5.0: 2SLGBTQIA+ Identities are an Asset to Nursing Practice**

Much of the early literature focusses on the negative experiences of nurses who identify as 2SLGBTQIA+, but what strengths do equity-deserving nurses bring to clinical practice? Do 2SLGBTQIA+ identities impact patient care? Focusing on the negative experiences further pathologizes equity-deserving identities and does not get to the root cause of why negative experiences occur. A deficit-based perspective provides context to lived experiences but takes away from the conversation about why diverse identities in nursing are an asset to the profession and patient care. MST helps us understand that equity-deserving people are subjected to negative experiences due to greater societal norms. There is growing literature supporting the desire for equity-deserving patients to have HCPs that share similar identity to them and how shared understanding improves health outcomes (Gallo et al., 2022). A portion of the semi-structured interview questions for this study asked participants about their experiences as patients, and many of the participants desired HCPs that identified as 2SLGBTQIA+.

Past experiences were viewed by the participants in this research as informing and enriching their current nursing practice. Identifying as 2SLGBTQIA+ affected participants worldview and helped provide understanding about other equity-deserving people's experiences. Disclosure of shared identity was raised by the participants as a way to foster therapeutic relationships and connect with their patients who also identified as 2SLGBTQIA+ or had connections to the 2SLGBTQIA+ community. Shared identity and understanding what other equity-deserving people experience created a personal responsibility to address and advocate for

change. Beagan et al. (2023) similarly found LGBTQ+ HCPs “recognized that disclosing LGBTQ+ identity could foster therapeutic rapport”, “more able to advocate for others”, and “disclosure was a kind of responsibility, acting as a role model for students, junior colleagues, and patients/clients” (p.6). MST explains that equity-deserving people experience unique stressors, and these stressors and past experiences with trauma help the participants be trauma-informed.

### **Study Strengths**

This study is one of the first, if not the first, set in Winnipeg, Manitoba, Canada, focusing solely on nurses who identify as 2SLGBTQIA+. The two research questions focused on understanding experiences, and the qualitative nature of this study was another main strength as it allowed the participants to illustrate their nuanced experiences. The literature about nurses identifying as 2SLGBTQIA+ over-represents American settings. The literature also centers on the experiences of nurses who are cisgender, Caucasian, lesbian, and gay. The participants in this study, please see Appendix J, included many diverse identities more representative of the 2SLGBTQIA+ acronym. Demographic questions were asked in a way that allowed participants to self-describe and included more options than the typical demographic surveys to better encompass pre-existing human diversity. Participants were provided with the opportunity to select the delivery of the interview to promote comfort during the potentially vulnerable interview process. The strengths of offering virtual, phone, or in-person options to study participants will fit nurses' schedules and comfort levels. The primary investigator, self-disclosed positionality in the recruitment material and at the beginning of each interview, which is a strength of this study effectively practicing the commonly used statement "nothing about us

without us.” Participants attended diverse nursing schools and had diverse past and present nursing practice settings.

### **Study Limitations**

In ID, "the limitations of the resulting knowledge must be clearly communicated" (Thompson-Burdine et al., 2020, p.342). The main limitation to this research is its qualitative design and small sample size that lacks representation of all Winnipeg nurses who identify as 2SLGBTQIA+. Most of the participants selected virtual interviews as their preferred mode of interview. Weaknesses of virtual or phone call interviews may make it difficult to notice the nuances of study participants' experiences. Archibald et al. (2019) found that participants appreciated the flexibility of Zoom platform for interviews but research with digital interviews and their potential limitations need to be studied more.

Another majority of limitations this study presents are based upon the sample characteristics, which also may not reflect the makeup of the average demographics of nurses in Winnipeg, Manitoba, Canada. Nine out of eleven participants were assigned female at birth, and no intersex nurses participated in this study. Two out of eleven participants were assigned male at birth. The lack of intersex participants and participants assigned male at birth unintentionally leaves out an important demographic. Most participants in this study are cisgender, with two participants identifying as non-binary. Despite utilizing the acronym 2SLGBTQIA+ throughout this study to accurately represent human diversity, no participants identified as Two-Spirit, transgender, or as asexual. Romantic attraction, relationship status, monogamy, and polyamory occasionally came up in the interviews; however, these important demographics were not asked. Three participants identified as Indigenous while one participant who identified as having Asian heritage identified as being racialized. Seven out of eleven participants had emergency nursing

experience, and this was over-represented in the sample. No participants identified as having disabilities. Assessing and analyzing intersectionality between the participants numerous social identities was outside of the scope of this study; however, the sample diversity speaks to the pre-existing diversity within the nursing workforce in Winnipeg, Manitoba, Canada.

### **Implications for Nursing**

Numerous implications arose from the interviews with participants and through the process of data analysis. All the participants were asked what they viewed as possible ways to improve their experiences as nurses who identify as 2SLGBTQIA+. The three primary areas of implications that arose from this study fall under the categories of: nursing practice, nursing policy, nursing education and nursing research.

#### **Nursing Practice**

The study participants discussed numerous ways in which nursing practice could change, in the treatment of all patients but specifically ones that identify as 2SLGBTQIA+, along with the treatment of colleagues who identify as 2SLGBTQIA+. Simple and seemingly small displays of allyship were seen as extending 'olive branches' to nurses that identify as 2SLGBTQIA+. At its core, examples of small displays of allyship were asking open-ended questions when assessing patients to set the stage for avoiding assumptions. Nursing leaders and nursing managers have the opportunity to show meaningful allyship and advocate for their colleagues and patients that identify as 2SLGBTQIA+ to create safer spaces. Nursing regulatory bodies can provide clarity on professionalism definitions and advocate for equity-deserving nurses who are 2SLGBTQIA+.

## **Nursing Policy**

Facilities the study participants worked within lacked policies specifically protecting patients and nurses who identify as 2SLGBTQIA+, and facilities lacked communication of pre-existing anti-discrimination policies. Facilities lacked inclusive forms and electronic patient records. They also lacked the ability to change patients' gender markers or the ability to add pronouns into patient charts. One participant's facility had an EDI committee that was able to implement impactful changes to improve the care of people identifying as 2SLBTQIA+ which in turn improved the experiences of nurses who identify as 2SLGBTQIA+. Having nurse-led committees working to address problems met in practice relating to EDI, where nurses are compensated for their time, would be beneficial for nurses and patients identifying as 2SLGBTQIA+.

Provincial regulatory bodies, like the CRNM, include a jurisprudence model each year that every registered nurse in Manitoba must complete as a part of their continuing competencies. CRNM's purpose is to protect the public (CRNM, n.d.), and could include education about the experiences of people who identify as 2SLGBTQIA+ and specifically their experiences in health care. Assessing and improving nursing program admissions processes and hiring processes to be more inclusive of people who identify as 2SLGBTQIA+. This could increase the number of nurses in the profession who are 2SLGBTQIA+. Provincial and national nursing organizations need to implement overt policies fostering EDI, improving care and education about people who identify as 2SLGBTQIA+. National and international organizations have position statements that include gender diversity (International Council of Nurses, 2023) and advocacy for 2SLGBTQIA+ people (Stokes, 2018). A few provincial nursing organizations and unions in Canada have committees to improve EDI for nurses who identify as

2SLGBTQIA+ (British Columbia Nurses' Union, 2025; Registered Nurses' Association of Ontario, n.d.). More nursing organizations should follow suit and enact policy change improve equity for nurses identifying as 2SLGBTQIA+.

### **Nursing Education**

Education about people who identify as 2SLGBTQIA+ should be included in nursing undergraduate curriculum. Nurses work in a diverse array of clinical settings and curriculum should reflect the experiences of people who identify as 2SLGBTQIA+ in numerous settings. The onus should be shifted towards the people who hold power to educate, as opposed to tokenizing people who experience oppression to complete unpaid labor as demonstrated by the thesis participants. Study participants suggested relying on community organizations that are already specialists in education about people identifying as 2SLGBTQIA+ to deliver education while ensuring they are adequately compensated for sharing their experiences. Education must include the experiences of equity-deserving nurses identifying as 2SLGBTQIA+ in health care along with the history of nurses who identify as 2SLGBTQIA+ involvement in the profession. Clinical facilities nurses work at often complete facility-wide education days or sessions and increasing the amount of education for people who identify as 2SLGBTQIA+ is lifesaving. The inclusion of experiences of people identifying as 2SLGBTQIA+ would be beneficial for all nurses to maintain cultural competencies.

### **Nursing Research**

Many areas of research have been identified as ways to further understand the experiences of nurses identifying as 2SLGBTQIA+. This study focused on the experiences of nurses in clinical practice within the urban prairie setting of Winnipeg, Manitoba, Canada. Research based in one practice setting, like an emergency department, would provide further

specific findings. Further research should include non-clinical nursing practice settings within Winnipeg, such as the experience of public health nurses, nursing leaders, nursing managers, and nursing educators that identify as 2SLGBTQIA+. Participants in this project discussed how their experiences varied working in rural Manitoba clinical settings compared to urban settings, and further research in this area is warranted. The short-term and long-term effects of MS on equity-deserving nurses and the ways in which they cope with these effects necessitate further research in relation to patient care and the well-being of nurses.

The Minority Strengths Model (Perrin et al., 2019) centers on the resiliency that many equity-deserving people are forced to have in response to societal MS and attributes this resiliency to adaptation. Utilizing a strengths-based model as opposed to a deficit-based perspective in future research with nurses who identify as 2SLGBTQIA+ would provide further context for the benefits of diversity within the nursing profession. Further research into the experiences of equity-deserving researchers, completing research with participants that share similar identities to them, and the experience of vicarious trauma is also needed.

### **Knowledge Translation Plan**

Disseminating knowledge gained from research is an essential part of research projects (Polit & Beck, 2017). Knowledge translation and the “practical application of the empirical knowledge derived from identification of experiential phenomena” is an advantage of ID (Thompson-Burdine et al., 2020, p.342). Study participants were asked in the consent form if they would like to receive a copy of the preliminary research findings. Preliminary research findings were sent to participants in March 2025. See Table 4 below for past and future presentations related to this thesis.

**Table 4***Knowledge Dissemination*

<b>Date of Presentation</b>	<b>Location of Presentation</b>	<b>Conference Name</b>	<b>Presentation Content</b>
October 20, 2023	Winnipeg, MB, Canada (CA)	Caring Queerly: Queer Health Symposium	A poster presentation of an early draft of the literature review for this thesis.
March 4-5, 2024	Winnipeg, MB, CA	Helen Glass Research Symposium (HGRS)	Thesis Proposal poster presentation.
May 27-28, 2024	Calgary, AB, CA	Canadian Association of Schools of Nursing	Poster presentation of the preliminary findings from the first six interviews from this study.
April 24, 2025	Winnipeg, MB, CA	HGRS	Oral presentation of the major theme of disclosure.
June 9-13, 2025	Helsinki, Finland	International Council of Nurses Congress	E-poster presentation of the major theme of identity.

In the weeks after the defense of this thesis and after completing any necessary revisions, this thesis will be submitted to the UM's Institutional Repository, MSpace, where university student theses and scholarly works are open access to all UM faculty and students (UM, n.d.). Future UM students will have access to this thesis research study findings. A manuscript of this thesis is being prepared for publication in an appropriate journal. Summarized findings from this thesis will be shared with local nursing organizations, for example the Association of Regulated Nurses of Manitoba, to encourage policy change. Lastly, more opportunities to present at applicable conferences will be sought to share new knowledge gained from this research.

### **Chapter Summary**

The participants' experiences, both negative and positive, provide numerous implications in the context of a society that normalizes people who are cisgender and heterosexual. MST was

utilized to provide meaning to the findings. Strengths and limitations of this study were identified along with the provision of implications that would be beneficial for nursing leaders and nursing regulatory bodies to implement in their policies and procedures. Implications for increasing diversity and inclusion of people identifying as 2SLGBTQIA+ were identified in undergraduate nursing curriculum and on the job training. Further research examining the many facets of the new knowledge generated from this study in diverse nursing practice settings is needed.

### **Thesis Conclusion**

Nurses who identify as 2SLGBTQIA+ are hypothesized to be a large subcategory within the profession, yet little research has been conducted with them (Galanza et al., 2024). This study aimed to ameliorate this, within the study setting of Winnipeg, Manitoba, Canada. The eleven nurse participants in this study who identify as 2SLGBTQIA+ shared their impactful lived experiences while answering the two overarching research questions. The experiences of the participants challenged the hypotheses discussed in the introduction chapter, while simultaneously empowering and inspiring the primary investigator. Historically, people who identify as 2SLGBTQIA+ have been researched *on* as opposed to *with*. This research study centers equity-deserving people and helps shift the focus from a deficit-based perspective to the strengths of human diversity. In the face of rising homophobia, transphobia, and attempts at erasing 2SLGBTQIA+ identities; a research study such as this one, that uplifts the experiences of nurses who identify as 2SLGBTQIA+ and honors their existence, is an act of *resistance*.

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**Appendix A: University of Manitoba Research Ethics Board (REB1) Approval**

University of Manitoba | Research Ethics and Compliance

Human Ethics - Fort Garry  
208-194 Dafoe Road  
Winnipeg, MB R3T 2N2  
T: 204 474 8872  
humanethics@umanitoba.ca

**PROTOCOL APPROVAL**

Effective: November 23, 2023

Expiry: November 22, 2024

Principal Investigator: Adam Brandt  
Advisor(s): Lynn Scruby  
Protocol Number: HE2023-0308  
Protocol Title: *The Lived Experiences of Nurses Who Identify as 2SLGBTQIA+ in Providing Nursing Care Within an Urban Prairie Setting: An Interpretive Descriptive Study*

Merissa Daborn, Acting Chair, REB1

**Research Ethics Board 1** has reviewed and approved the above research. The Human Ethics Office (HEO) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*- TCPS 2 (2022).

This approval is subject to the following conditions:

- i. Approval is granted for the research and purposes described in the protocol only.
- ii. Any changes to the protocol or research materials must be approved by the HEO before implementation.
- iii. Any deviations to the research or adverse events must be reported to the HEO immediately through an REB Event.
- iv. This approval is valid for one year only. A Renewal Request must be submitted and approved prior to the above expiry date.
- v. A Protocol Closure must be submitted to the HEO when the research is complete or if the research is terminated.
- vi. The University of Manitoba may request to audit your research documentation to confirm compliance with this approved protocol, and with the UM *Ethics of Research Involving Humans* [Ethics of Research Involving Humans](#) policies and procedures.

## Appendix B: Shared Health Research Access and Approval



Shared Health Research and Innovation

MS7 620 Sherbrook Street  
Winnipeg, MB R3A 1R9  
Phone: (204) 926-7020  
shresearch@sharedhealthmb.ca

January 16, 2024

SH2023:178  
REB: HE2023-0308

**Project Title: The Lived Experiences of Nurses Who Identify as 2SLGBTQIA+ in Providing Nursing Care Within an Urban Prairie Setting: An Interpretive Descriptive Study**

Dear A. Brandt,

The Shared Health Approval Committee for Privacy, Impact and Access in Research has considered your request for the above project. Your request is conceptually approved and as all applicable stipulations have been met, your project now considered active at Shared Health.

If your project requires accessing services within Shared Health, please consult with the individual service areas to confirm readiness of the area to provide the approved services.

The following documents were reviewed during the assessment of this request. Note that any changes to documentation listed below will require re-review by this committee.

Document Name	Version and/or Date
Research Application	Signed 17-Nov-2023
Protocol	Undated
Consent Form	Undated
Letter of Recruitment	Undated
Social Media Recruitment	Undated

Approval has been granted based on the following caveats:

- Findings must be submitted to Shared Health Research and Innovation prior to dissertation for review and must include details regarding final sample size and confirmation on how recruitment was completed

**Approval is subject to the following:**

- Appropriate acknowledgement of Shared Health, the WRHA and/or affiliated organizations in any peer-reviewed publications resulting from this study is required.
- For any results that may have an impact on the health system, a summary of the final results for the study must be submitted to Shared Health Research and Innovation along with a copy of any peer-reviewed publications arising from the study.
- For any results where Shared Health has contributed significant information, appropriate interpretation and/or privacy review may be required prior to publication. Shared Health Research and Innovation must receive notification, in writing to SHReserach@sharedhealthmb.ca, at least thirty (30) calendar days in advance for intended publication in learned journals or thesis presentations; and at least ten (10) calendar days prior notice is require for every poster or oral presentation unless otherwise mutually agreed between Shared Health Research and Innovation

PB/lc

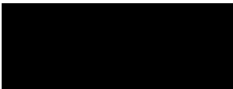
and Principal Investigator. If there is an agreement/contract with stipulations regarding these conditions, the conditions within the agreement/contract will prevail.

- Shared Health Research and Innovation must receive notification, in writing, within thirty (30) calendar days of project closure and/or termination.
- All supplies required to provide the services outlined in the protocol and/or supporting documentation must be on hand prior to project initiation.
- All departmental set-up, including resolving any items/questions related to logistics, must be concluded prior to initiation.
- All REB approvals are to be submitted to Shared Health Research and Innovation immediately upon receipt as well as the Annual Study Status Report and Final Study Status Report.
- All amendments for revised documents are submitted to Shared Health Research and Innovation for review. Changes to services and/or permitted procedures, including but not limited to use of consent form or revised study advertisements, will not be permitted within an affiliated Shared Health/WRHA facility, program or service until such amendments have been activated by Shared Health Research and Innovation.
- All other external approvals and/or authorizations are to be submitted to Shared Health Research and Innovation immediately upon receipt.
- All members of the research team have completed PHIA training, and will maintain this training, renewing it every 3 years from date of issue, as required.
- For any confirmed breach to privacy, any costs incurred by Shared Health/WRHA for the investigation and/or ratification of the breach will be at the expense of the researcher.
- Shared Health reserves to cancel and/or suspend services without notice based on availability to provide required services.
- All current Public Health measures/restrictions must be adhered to, including entering all health care facilities and/or program spaces.

Please note that this authorization to access services, does not constitute site approval for those sites that do not fall under the purview of Shared Health ACPIAR. It is the responsibility of the principal investigator to ensure that all adequate approvals have been received prior to initiation.

Please let us know should you encounter any difficulties during the course of your project.

Sincerely,



Laura Curtis on behalf of  
Dr. Paul Beaudin, MSc-SLP, PhD  
Director of Research and Innovation, Shared Health  
Chair, Approval Committee for Privacy, Impact and Access in Research, WRHA & Shared Health

### Appendix C: Social Media Recruitment

The following image will be used in social media posts on Twitter, Instagram, and Facebook to garner interest and recruit project participants. The images will provide the most critical information to pique the viewers' interest along with captions providing contact information for the primary investigator to learn more. Alt text will be used to describe the image for visually impaired people. If little interest is expressed by nurses who are underrepresented identities of the 2SLGBTQIA+ acronym, identities other than lesbian and gay, graphics displaying the flags of the under-represented identities will be shared.



[Alt text: blue background with a rainbow pride flag on the right side. Progress pride flag in the left lower corner. Image text states: University of Manitoba. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. STUDY RECRUITMENT, Are you a Registered Nurse? Do you identify as 2SLGBTQIA+? WE WANT TO HEAR ABOUT YOUR EXPERIENCES. Small honorarium provided! \*\*Underrepresented 2SLGBTQIA+ folks encouraged to participate!]

Accompanying image caption: Are you a Registered Nurse who also identifies as 2SLGBTQIA+? Do you work in Winnipeg? We want to hear about your lived experiences!

My name is Adam Brandt, and I am completing my Master of Nursing degree at the University of Manitoba and am carrying out thesis research entitled “The Lived Experiences of Nurses Who Identify as 2SLGBTQIA+ in Providing Nursing Care Within an Urban Prairie Setting: An Interpretive Descriptive Study”. Please contact me (brandta2 AT myumanitoba.ca) or my University of Manitoba academic advisor, Dr. Lynn Scruby PhD RN (lynn.scruby AT umanitoba.ca) if you are interested in participating or would like more information.

Study eligibility criteria:

1. Eighteen years of age or older.
2. Speak English fluently and read English.
3. Currently registered as an RN and employed as a nurse in Winnipeg, Manitoba.
4. Identify as 2SLGBTQIA+, non-heterosexual, or non-cisgender.
5. Have worked as a RN in clinical practice for at least two years in Winnipeg, Manitoba.
6. Access to a device to complete online or phone interviews.

Study participants will participate in a 1:1 interview (45-60min, via Zoom/phone call/or in person), and a small honorarium will be provided.

Additional information: Queer-identified nurse researcher, this research study is approved by the University of Manitoba Research Ethics Board, and underrepresented 2SLGBTQIA+ (e.g., two spirit, non-binary, transgender, intersex, asexual etc.) nurses are strongly encouraged to participate.

#research #universityofmanitoba #diversity #nurse #LGBT #2SLGBTQIA

## Appendix D: Letter of Invitation for Potential Study Participants

### Letter of Invitation for Potential Study Participants



**University of Manitoba** | Rady Faculty of Health Sciences

College of Nursing  
Helen Glass Centre for Nursing  
89 Curry Place  
University of Manitoba  
Winnipeg, MB R3T 2N2 Canada  
[nursing@umanitoba.ca](mailto:nursing@umanitoba.ca)  
T: (204) 474-7452  
F: (204) 474-7692

**Research Project Title:** The Lived Experiences of Nurses Who Identify as 2SLGBTQIA+ in Providing Nursing Care Within an Urban Prairie Setting: An Interpretive Descriptive Study

**Principal Investigator:**

Adam Brandt RN, BN (he/they)  
Master of Nursing Student  
College of Nursing  
Rady Faculty of Health Sciences  
University of Manitoba  
Email: [brandta2@myumanitoba.ca](mailto:brandta2@myumanitoba.ca)  
Phone: [REDACTED]

**Research Supervisor:**

Dr. Lynn Scruby RN, Ph.D. (she/her)  
Assistant Professor  
College of Nursing  
Rady Faculty of Health Sciences  
University of Manitoba  
Email: [lynn.scruby@umanitoba.ca](mailto:lynn.scruby@umanitoba.ca)  
Phone: [REDACTED]

**Internal Thesis Committee Member:**

Dr. Wanda Chernomas RN, Ph.D. (she/her)  
Associate Professor  
College of Nursing  
Rady Faculty of Health Sciences  
University of Manitoba  
Email: [wanda.chernomas@umanitoba.ca](mailto:wanda.chernomas@umanitoba.ca)  
Phone: [REDACTED]

**External Thesis Committee Member:**

Dr. Nathan Nickel MPH, Ph.D. (he/they)  
Associate Professor  
Max Rady College of Medicine  
Department of Community Health Sciences  
University of Manitoba  
Email: [nathan.nickel@umanitoba.ca](mailto:nathan.nickel@umanitoba.ca)  
Phone: [REDACTED]

**Subject:** Study Recruitment – 2SLGBTQIA+ Registered Nurses

Dear Nurse:

My name is Adam Brandt, and I am a graduate student in the Master of Nursing program at the University of Manitoba. I identify as queer and am a practicing clinical nurse. I am working under the supervision of my advisor, Dr. Lynn Scruby. I am completing interviews with Registered Nurses who identify as 2SLGBTQIA+ to explore their experiences providing nursing care in Winnipeg, Manitoba. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus.

The time commitment will be 20 minutes to review the consent form and 45-60 minutes for an interview with me to discuss your experiences. If you volunteer to participate, you will receive a \$25 coffee gift card as compensation for your time. Interviews will take place via phone call, UM Zoom, or in person, depending on what is most convenient for you. UM Zoom, in-person

and phone interviews will be recorded with a handheld recorder. Pending your eligibility (see below) and written consent, interviews will be conducted and recorded with a voice recorder. Once the interview is complete, interviews will be given a numerical code. Recordings and transcripts will be stored in a password-protected file on my personal computer, and only I (the principal investigator) and my research supervisor (Dr. Lynn Scruby) will have access to the personal information.

Study participants will be selected upon meeting the following eligibility criteria:

- Eighteen years of age or older.
- Speak English fluently and read English.
- Currently registered as an RN and employed as a nurse in Winnipeg, Manitoba.
- Identify as 2SLGBTQIA+, non-heterosexual, or non-cisgender.
- Have worked as a RN in clinical practice for at least two years in Winnipeg, Manitoba.
- Access to a device to complete online or phone interviews.

Participation in this study is voluntary, and you may choose to stop participation and leave the study at any time. Minimal risks to participation in this study have been identified. The findings of this study will add to the research on health care providers who identify as 2SLGBTQIA+ while providing a nursing perspective. The findings may help create policy change to protect nurses who identify as 2SLGBTQIA+.

If you have any concerns about this study, please contact my advisor or the Human Ethics Officer at the University of Manitoba ( [humanethics@umanitoba.ca](mailto:humanethics@umanitoba.ca) 204-474-7122).

Thank you for your time and consideration for participating in this study. If you have any further questions, please let me know via email or phone call. I am excited to hear back from you!

Sincerely,

Adam Brandt RN BN (he/they)  
Master of Nursing Student  
University of Manitoba  
[brandta2@myumanitoba.ca](mailto:brandta2@myumanitoba.ca)  
Phone: [REDACTED]

## Appendix E: Consent Form

### Consent Form



**University of Manitoba** | Rady Faculty of Health Sciences

College of Nursing  
Helen Glass Centre for Nursing  
89 Curry Place  
University of Manitoba  
Winnipeg, MB R3T 2N2 Canada  
[nursing@umanitoba.ca](mailto:nursing@umanitoba.ca)  
T: (204) 474-7452  
F: (204) 474-7692

**Research Project Title:** The Lived Experiences of Nurses Who Identify as 2SLGBTQIA+ in Providing Nursing Care Within an Urban Prairie Setting: An Interpretive Descriptive Study

**Principal Investigator:**

Adam Brandt RN, BN (he/they)  
Master of Nursing Student  
College of Nursing  
Rady Faculty of Health Sciences  
University of Manitoba  
Email: [brandta2@myumanitoba.ca](mailto:brandta2@myumanitoba.ca)  
Phone: [REDACTED]

**Research Supervisor:**

Dr. Lynn Scruby RN, Ph.D. (she/her)  
Assistant Professor  
College of Nursing  
Rady Faculty of Health Sciences  
University of Manitoba  
Email: [lynn.scruby@umanitoba.ca](mailto:lynn.scruby@umanitoba.ca)  
Phone: [REDACTED]

**Internal Thesis Committee Member:**

Dr. Wanda Chernomas RN, Ph.D. (she/her)  
Associate Professor  
College of Nursing  
Rady Faculty of Health Sciences  
University of Manitoba  
Email: [wanda.chernomas@umanitoba.ca](mailto:wanda.chernomas@umanitoba.ca)  
Phone: [REDACTED]

**External Thesis Committee Member:**

Dr. Nathan Nickel MPH, Ph.D. (he/they)  
Associate Professor  
Max Rady College of Medicine  
Department of Community Health Sciences  
University of Manitoba  
Email: [nathan.nickel@umanitoba.ca](mailto:nathan.nickel@umanitoba.ca)  
Phone: [REDACTED]

You are invited to participate in this research study voluntarily. This consent form, a copy of which will be left with you for your records and reference, is only part of the informed consent process. It should give you a basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information. It should take you approximately 20 minutes to thoroughly review this form. If you have any questions or require clarification before deciding on your future voluntary participation, please contact me, Adam Brandt, or my supervisor, Dr. Lynn Scruby.

**Thesis Committee Members**

Internal Member: Dr. Wanda Chernomas, RN, Ph.D., College of Nursing, Rady Faculty of Health Sciences, University of Manitoba

External Committee Member: Dr. Nathan Nickel, MPH, Ph.D., Max Rady College of Medicine, Department of Community Health Sciences, Rady Faculty of Health Sciences, University of Manitoba

#### Sponsors

Funding for this research project was obtained from the Foundation of Registered Nurses of Manitoba Inc. Graduate Award, Irene E. Nordwich Foundation Scholarship, and Graduate Nursing Students Association Award.

#### Purpose of this Study

This research project aims to unveil the experiences of nurses who identify as 2SLGBTQIA+ in hopes of improving the environments these nurses' work and study. Historically, nurses that identify as 2SLGBTQIA+ have not been listened to. The overarching research questions guiding this thesis research are:

1. What are nurses' experiences identifying as 2SLGBTQIA+ in providing nursing care in Winnipeg, Manitoba, Canada?
2. What do nurses identifying as 2SLGBTQIA+ believe their identity brings to their nursing practice and patient care?

#### Participant Selection

Study participants will be selected upon meeting the following eligibility criteria:

1. Eighteen years of age or older.
2. Speak English fluently and read English.
3. Currently registered as an RN and employed as a nurse in Winnipeg, Manitoba.
4. Identify as 2SLGBTQIA+, non-heterosexual, or non-cisgender.
5. Have worked as a RN in clinical practice for at least two years in Winnipeg, Manitoba.
6. Access to a device to complete online or phone interviews.

#### Study Procedures

If you decide to participate in this research project, the Principal Investigator, Adam Brandt, will contact you to have an interview. The interview will take place by phone, UM Zoom, or in person. You will choose the date/time of the interview at a time that is convenient for you. The interview will take 45-60 minutes, and the audio will be recorded. You will first be asked demographic questions (e.g., gender identity, sexual orientation, the highest level of education you have obtained, and years working as a nurse). Adam will then interview you about your experiences as a nurse identifying as 2SLGBTQIA+ with people you care for, your colleagues, management, and a nursing student. After the interview, Adam will state when the recorder is stopped and provide space to debrief.

During and after the interview, Adam will be taking field notes on personal reflections that arise. After the interview, Adam will send the audio recording to a research transcriptionist, Transcript Heroes, who will transcribe the audio into text format and return it to Adam. Transcriptionists are required to sign an oath of confidentiality before participating in this project. Once Adam has completed interviews for this research project, approximately interviews with 8-12, Adam will begin analyzing the data. Participants will be given a pseudonym at random. Pseudonyms for each participant will be selected using a randomized online pseudonym generator. For each study

participant, a new name generator will be run after selecting the gender-neutral option and the first name that appears will be selected to refer to the participant. Direct quotes may be used to illustrate findings. If you indicate at the end of this form that you would like a preliminary summary of the findings from your interview and the interviews with other study participants, Adam will email this to you.

#### Risks and Discomforts to Participation

Minimal risks to participation have been identified. The main risk to participants identified is the risk of psychological harm. Participants in this study may be reminded of experiences with discrimination, oppression, and past harm related to their sexual orientation or gender identity. In anticipation of the potential risks, a list of resources and support for nurses has been compiled below. If you require a break or would rather not answer a specific question, please let Adam know.

Immediate Resources	Long-Term Resources
<ul style="list-style-type: none"> <li>• <a href="#">Adult Mobile Crisis Service</a> <ul style="list-style-type: none"> <li>○ Call: 204-940-1781</li> </ul> </li> <li>• <a href="#">Crisis Response Centre</a> <ul style="list-style-type: none"> <li>○ 817 Bannatyne Ave</li> <li>○ Open 24/7</li> </ul> </li> <li>• <a href="#">Klinic's 24/7 Crisis Line</a> <ul style="list-style-type: none"> <li>○ Call: 204-786-8686</li> <li>○ Toll-Free: 1-888-322-3019</li> </ul> </li> <li>• <a href="#">Manitoba 24-Hour Suicide Prevention &amp; Support Line</a> <ul style="list-style-type: none"> <li>○ Call: 1-877-435-7170</li> </ul> </li> <li>• <a href="#">Trans Lifeline</a> <ul style="list-style-type: none"> <li>○ Call: 1-877-330-6366</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <a href="#">WRHA Employee Assistance Program (EAP) Program</a> <ul style="list-style-type: none"> <li>○ Phone: 204-786-8880</li> <li>○ TTY: 204-775-0586</li> <li>○ Toll-free: 1-800-590-5553</li> </ul> </li> <li>• <a href="#">Shared Health Mental Health &amp; Addictions Community Intake</a> <ul style="list-style-type: none"> <li>○ Call: 204-788-8330</li> </ul> </li> <li>• <a href="#">Nine Circles: Black, Indigenous, and People of Colour (BIPOC) Mental Health Worker List</a> <ul style="list-style-type: none"> <li>○ The BIPOC Mental Health Worker List is an open-source and free resource for Black, Indigenous, and People of Colour identifying individuals seeking low-barrier BIPOC therapists, counsellors, and mental health workers in Winnipeg, Manitoba.</li> </ul> </li> </ul>

#### Benefits to Participation

The main benefit identified to you is the ability to discuss your experiences in a non-judgmental and confidential environment with Adam, who identifies as queer. Sharing your experiences may provide increased personal insight into your own experiences. You will actively contribute to the literature on the experiences of nurses who identify as 2SLGBTQIA+, which is currently lacking in this area.

#### Costs and Compensation

There are no identified costs to you attending the interview for this project unless you choose an in-person interview, there may be costs associated with travel. As a token of gratitude for your

participation, you will be offered a \$25.00 coffee electronic gift card after the interview is finished.

#### **Confidentiality**

During the recording of the interview, names and identifying information will not be discussed. If this does occur, specific identifiers will be removed. Any names or contact information will be kept securely so Adam can send you preliminary study results and the electronic gift card should you request. All field notes, transcribed interviews, and audio recordings will be kept on a password-protected computer which only Adam can access. Audio recordings will be destroyed after they have been verified with the transcriptions. Confidential data, consent forms, emails, documents will be kept for a maximum of 7 years after the thesis defence, 2031. Anonymized data will be kept indefinitely.

#### **Voluntary Participation or Withdrawal from the Study**

If you decide to participate in this research project, your involvement is voluntary. If you choose to stop participation at any time, you may do so. The deadline to withdraw your anonymized data from this study will be 2 weeks after your interview, as after these two weeks, your data may be analyzed. If you withdraw your participation in this research project within the 2-week time frame after your interview, all data connected to you will be removed. If you would like to withdraw participation, please notify me, Adam Brandt, or my advisor, Dr. Lynn Scruby, via the phone number or email listed above.

#### **Knowledge Translation**

In translating the findings of this study, direct quotes may be used from your interviews. General descriptions and pseudonyms will be used to refer to study participants. Pseudonyms for each participant will be selected using a randomized online pseudonym generator. After each interview, a new name generator will be run after selecting the gender-neutral option and the first name that appears will be selected to refer to the participant.

The plan to share the knowledge generated from this research project is as follows:

1. Send preliminary results to study participants if requested.
2. Publish revised thesis on the University of Manitoba's Institutional Repository, [MSpace](#)
3. Publish thesis in appropriate nursing journal.
4. Present findings at applicable nursing conferences.

#### **Questions**

If any questions or concerns arise, please contact the Principal Investigator, Adam Brandt, at [brandta2@myumanitoba.ca](mailto:brandta2@myumanitoba.ca) or Adam's advisor, Dr. Lynn Scruby, at [lynn.scruby@umanitoba.ca](mailto:lynn.scruby@umanitoba.ca). If you have concerns or questions about your rights as a study participant, please contact the University of Manitoba Research Ethics Board at [humanethics@umanitoba.ca](mailto:humanethics@umanitoba.ca).

#### **Consent Signatures**

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the

study at any time and /or refrain from answering any questions you prefer to omit without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way.

This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus. If you have any concerns or complaints about this project, you may contact any of the above-named people or the Human Ethics Officer at 204-474-7122 or [HumanEthics@umanitoba.ca](mailto:HumanEthics@umanitoba.ca). A copy of this consent form will be given to you to keep for your records and reference.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (day/month/year)

Participant Printed Name: \_\_\_\_\_

I would like a copy of the preliminary study findings: \_\_\_ (YES) or \_\_\_ (NO)

- Expected to be sent by March 2024
- If you would like a copy of the preliminary study findings, please enter your email contact or mailing address:

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I, the undersigned, have fully explained the details relevant to this research study and the above participant. I believe that the participant has understood and knowingly given their informed consent.

Researcher Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (day/month/year)

Research Printed Name: \_\_\_\_\_

*Please fill out this consent form and send it to Adam Brandt's  
University of Manitoba student email: [brandta2@myumanitoba.ca](mailto:brandta2@myumanitoba.ca)*

*Thank you for agreeing to be a part of this study and sharing your experiences.  
We appreciate the time it takes to participate in this important study.*

### Appendix F: Demographic Questions

The following is the demographic questionnaire asked at the start of each semi-structured interview. The interviewer informed participants that they do not have to answer questions they are uncomfortable with. The questions below are adapted from the University of Manitoba's (2022a) demographic questions guidelines.

#### Demographic Questions:

1. What is your age in years? \_\_\_\_\_
2. What was your sex assigned at birth? \_\_\_\_\_
3. What gender do you identify as? \_\_\_\_\_
4. What are your pronouns? \_\_\_\_\_
5. How would you describe your sexual orientation? \_\_\_\_\_
6. Are you Indigenous? \_\_\_\_\_
  - a. [if yes] Which group do you belong to? \_\_\_\_\_
7. Do you identify as a racialized person? \_\_\_\_\_
  - a. [if yes] What race/ethnicity do you identify as? \_\_\_\_\_
8. Are you a person with a disability? \_\_\_\_\_
9. Are you a part of a religious or spiritual community? \_\_\_\_\_

#### Nursing and Education History Questions:

9. What year did you graduate from your nursing program? \_\_\_\_\_
10. What is the highest education you have attained? \_\_\_\_\_
11. What nursing practice settings have you worked in? \_\_\_\_\_
12. What nursing practice setting do you currently work in? \_\_\_\_\_

## Appendix G: Semi-Structured Interview Guide

Date of interview: \_\_\_\_\_

Place of interview: \_\_\_\_\_

Interviewer name: \_\_\_\_\_

**Introduction:** My name is Adam Brandt (he/they); I am a registered nurse completing my Master of Nursing degree at the University of Manitoba. This research study aims to explore the experiences of nurses who identify as 2SLGBTQIA+ in providing nursing care in Winnipeg, Manitoba. This interview will be recorded. If there is a question you prefer not to answer, require clarification, or would rather answer later in the interview, let me know! If you require mental health support, I have a list of resources available that I can provide as well.

After I begin recording, please do your best not to include specific identifiers (e.g., name of workplace, your name). If you do mention a specific identifier, this will be removed from the transcription of your interview. If you do not have any questions, I will begin recording now.

*Start recorder.*

*Ask demographic questions.*

### Experience with patients/clients

- What has your experience been providing nursing care to patients/clients being a nurse who identifies as 2SLGBTQIA+?
  - Are you "out" to your patients/clients?
  - Prompt - Why or why not?
- How do you choose to disclose your 2SLGBTQIA+ identity?
  - Prompt - Do you disclose your 2SLGBTQIA+ identity to strengthen therapeutic relationships?
  - Prompt - Do you "take the lead" of your patients? (e.g., disclose your SOGI after your patient/client discloses first)
- Have you experienced homophobia, transphobia, heteronormativity, and/or cisnormativity directed at you from your patients/clients?
  - Prompt - If yes: Can you share an example of an experience?
  - Prompt - What types of situations have you witnessed?

### Experiences with colleagues

- What has your experience been as a nurse identifying as 2SLGBTQIA+ with your colleagues?
  - Are you "out" to your colleagues? (e.g., fellow nurses, healthcare aides, physicians, allied health)

- Prompt - Why or why not?
- Prompt - How do you choose to disclose your 2SLGBTQIA+ identity?
- Have you experienced homophobia, transphobia, heteronormativity, and/or cisnormativity from your colleagues? (e.g., from other nurses you work with, from health care aides, from physicians)
  - Prompt - If yes: Can you share an example of an experience?
  - Prompt - What types of situations have you witnessed?

### **Check-in**

- I recognize that some of what is being discussed may be difficult to reflect upon. Would you like to take a break?
  - Prompt - If yes: stop recorder and discuss when to continue
  - Prompt - If yes: provide resources
  - If no: continue interview

### **Experiences with organization management**

- What has your experience been as a nurse identifying as 2SLGBTQIA+ with leadership in your organization?
  - Are you "out" to your managers?
  - Prompt - Why or why not?
  - Prompt - How do you choose to disclose your 2SLGBTQIA+ identity?
- Have you experienced homophobia, transphobia, heteronormativity, and/or cisnormativity from your management?
  - Prompt - If yes: Can you share an example of an experience?
  - Prompt - What types of situations have you witnessed?
- Is your organization/facility supportive of 2SLGBTQIA+ employees? (e.g., overt policies protecting 2SLGBTQIA+ staff, pride flags, gender-inclusive bathrooms, pronouns on name badges)
  - Prompt - Why or why not?

### **Experience as a nursing student**

- Think back to your time as a student nurse. What was your experience like as a nursing student who identifies as 2SLGBTQIA+?
  - Were you "out" to fellow students? Teachers or professors? Clinical instructors?
  - Prompt - Why or why not?
  - Prompt - How do you choose to disclose your 2SLGBTQIA+ identity as a student?
- Did you experience homophobia, transphobia, heteronormativity, and/or cisnormativity as a student?
  - Prompt - If yes: can you share an example of an experience?

- Prompt - What types of situations have you witnessed?

### **Check-in**

- I recognize that some of what is being discussed may be difficult to reflect upon. Would you like to take a break?
- Prompt - If yes: stop the recorder and discuss when to continue
- Prompt - If yes: provide resources
- If no: continue interview

### **Coping with MS:**

- Prompt - If the participant has mentioned experiencing homophobia, transphobia, heteronormativity, and/or cisnormativity: How do you cope with these challenges?

### **Representation in healthcare**

- Have you had a 2SLGBTQIA+ HCP before?
  - Prompt - If yes: Do you prefer when a HCP shares a similar identity to you?
  - Prompt - If yes: Did you actively seek this out?
  - Prompt - If actively sought out: Why or why not?

### **Future Orientated Questions**

- What could improve your experience as a 2SLGBTQIA+ nurse?
- Prompt: Would the following examples be helpful? Why or why not?
  - With patients:
    - E.g., Intake forms that consider gender diversity and various sexualities
    - E.g., Pronouns in documentation
  - With colleagues:
    - E.g., Pronouns on our ID badges
  - With your organization:
    - E.g., Mandatory education sessions on the care of 2SLGBTQIA+ patients
    - E.g., Mandatory education sessions on respectful workplaces

### **Conclusion**

- Were there any questions you would like to return to?
- Were there any questions you thought I would ask but did not?
- Any closing remarks?

*Stop recorder.*

**Conclusion:** I have stopped the audio recorder, and this concludes the interview! How are you doing? Thank you so much for participating in my research project. If you requested on the consent form you would like me to contact you with the summarized preliminary results of the rest of this research study, I will touch base with you in the next few months!

Prompt - If needing more research participants: If you know of any nurses who identify as 2SLGBTQIA+ and fit the eligibility of this study, please put them in contact with me as I am actively seeking more participants.

Thanks again.

## Appendix H: Oath of Confidentiality for Transcriptionist

This oath of confidentiality was adapted from the University of Manitoba's (2022b) template.



**University of Manitoba** | Rady Faculty of Health Sciences

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**Research Project Title:** The Lived Experiences of Nurses Who Identify as 2SLGBTQIA+ in Providing Nursing Care Within an Urban Prairie Setting: An Interpretive Descriptive Study

**Principal Investigator:**

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Phone: (██████████)

I, ANDREW DODSON (Transcript Heroes Transcription Services Inc.), am involved in the research project entitled "The Lived Experiences of Nurses Who Identify as 2SLGBTQIA+ in Providing Nursing Care Within an Urban Prairie Setting: An Interpretive Descriptive Study" (the "Research Project").

In connection with the Research Project, I hereby agree as follows:

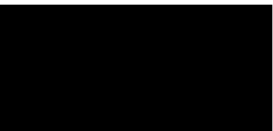
- I will respect the right to privacy and confidentiality of all the participants in this research project.

- I will keep all the research information shared with me, including but not limited to recordings, transcripts, data, research results, and data files (hereinafter the "Research Information") secure and confidential.
- I will not disclose or share the Research Information with anyone outside the research team.
- I will store all research information in the data management methods outlined in the approved ethics protocol while in my possession.
- I will store and use the Research Information as the research ethics board approved it.
- I will not make copies, duplicate, or transmit the research information unless approved by Adam Brandt, the Research Project's principal investigator.
- In consultation with Adam Brandt, the Principal Investigator, I will adhere to the methods and deadlines of disposal/destruction and retention outlined by the approved ethics protocol.

I will notify the principal investigator if I discover that the Research Information is not being managed as approved by the research ethics board or is not kept confidential or secure as required by this Oath of Confidentiality.

**Oath of Confidentiality Signature**

Your signature on this form indicates that you have understood to your satisfaction the 2 pages of information regarding participation in the research project and agree to participate as a transcriptionist.

Transcriptionist Signature: 

Date: 21.02.2024 (day/month/year)

Transcriptionist Printed Name: ~~ANDREW DODSON~~ (Director)

**Appendix I: University of Manitoba REB1 Amendment Approval****University of Manitoba** | Research Ethics and ComplianceHuman Ethics - Fort Garry  
208-194 Dafoe Road  
Winnipeg, MB R3T 2N2  
T: 204 474 8872  
humanethics@umanitoba.ca**AMENDMENT APPROVAL**

March 21, 2024

Principal Investigator: Adam Brandt  
Advisor(s): Lynn Scruby  
Protocol Number: HE2023-0308  
Protocol Title: *The Lived Experiences of Nurses Who Identify as 2SLGBTQIA+ in Providing Nursing Care Within an Urban Prairie Setting: An Interpretive Descriptive Study*

Human Ethics Office as designated by , REB1

Research Ethics Board 1 has reviewed and approved your Amendment Request submitted on March 20, 2024 to the above-noted protocol. The Human Ethics Office (HEO) is constituted and operates in accordance with the current *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans- TCPS 2 (2022)*.

This approval is subject to the following conditions:

- i. Approval is granted for this amendment only.
- ii. Any further changes to the protocol require subsequent amendment approvals from the HEO before implementation.
- iii. Any deviations to the research or adverse events must be reported to the HEO immediately through an REB Event.
- iv. Amendment Approvals do not change the protocol expiry date. Please refer to the original Protocol Approval or subsequent Renewal Approvals for the protocol expiry date.

**Appendix J: Demographics**

<b>Pseudonym</b>	<b>Riley</b>	<b>Elliot</b>	<b>Jamie</b>	<b>Brook</b>	<b>Lane</b>
Age	26	28	32	29	34
Sex	Female	Female	Male	Female	Female
Gender Identity	Female - Woman	Agender (“feminine”)	Man	Female	Female - woman
Pronouns	She/Her	Any/All	He/Him	She/Her	She/Her
Sexual Orientation	Queer/Bisexual	Bisexual	Gay	Queer	Gay, Lesbian
Indigeneity	Yes - Métis	No	No	No	Yes - Métis
Racialized	No answer	No	No	No	No
Disability	No	No	No	No	No
Religious	No	No	No	Non-practicing catholic, spiritual	No
Graduation Year	2020	2018	2015	2016	2013
Nursing School	Université de Saint-Boniface	Université de Saint-Boniface	UM	UM	Red River College Polytech
Highest Education	BscN	BN	BN	BN	BN
Past and Current Nursing Practice Settings	Obstetrics	Acute, subacute, maternity, LTC, emergency	Acute, emergency, telehealth	LTC, stroke rehab, acquired brain injury, ventilator unit, respiratory chronic care, palliative	float (hospital wide at tertiary site), emergency, urgent care

<b>Pseudonym</b>	<b>Brett</b>	<b>Charlie</b>	<b>Val</b>	<b>Emerson</b>	<b>Casey</b>	<b>Terry</b>
Age	45	33	39	37	30	29
Sex	Female	Female	Female	Male	Female	Female
Gender Identity	Female	Female, Non-binary, Fluid	Non-binary, gender queer, gender fluid	Male (cisgender)	Woman (“flexible”)	Female
Pronouns	She/Her	She/They	They/Them	He/Him	She/They	Her/She
Sexual Orientation	Lesbian	Queer	Pansexual, Queer	Gay (“Kinsey 5”, bi experience)	Queer (“mostly gay”)	Pansexual
Indigeneity	No	No	No	No	No	Yes (Métis, Ojibwe)
Racialized	No	No	No	Yes (Asian)	No	No
Disability	No	No	No	No	No	No
Religious	No	No	No	Yes (Catholic)	No	No
Graduation Year	2006	2013	2017	2007	2018	2018
Nursing School	Red River College and UM	University of New Brunswick	Red River College Bridging Program	Cebu Normal University, Red River (Bridging)	UM	UM
Highest Education	BN	BN	BN	BN	BN	BN
Past and Current Nursing Practice Settings	Emergency, dialysis, primary care, acute care (ward nursing), occupational health Clinic	emergency, labour and delivery, surgical, ICU, community	Acute medicine, emergency, community health	Community (casual), surgical obstetrics, emergency	surgery, ortho, emergency, SICU	LTC, HC, wound care clinic, medicine, surgery