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'He's a Gay, He's Going to Go to Hell.': Negative Nurse Attitudes Towards LGBTQ People on a UK Hospital Ward: A Single Case Study Analysed in Regulatory Contexts

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ABSTRACT

Lesbian, gay, bisexual, trans and/or queer (LGBTQ) people experience profound health and social care inequalities. Research suggests that staff with negative attitudes towards LGBTQ people, are more likely to hold strong, traditional, religious beliefs. This article reports on a single case study with a newly qualified UK nurse who has since left the National Health Service. This is based on a single interview taken from a larger dataset derived from a funded scoping research study exploring religious freedoms, sexual orientation and gender identity rights in older age care spaces. The interviewee described a toxic nursing culture on a hospital ward for older people. She recounted various incidents involving homophobic and transphobic practice and LGBTQ microaggressions which reportedly impacted the quality of nursing care. The findings are considered in relation to standards for anti-oppressive practice in nursing care, and how nursing students and staff can be supported in addressing practice relating to equality and diversity issues, specifically LGBTQ issues. They confirm the direct significance of addressing the needs and circumstances of LGBTQ people in nursing curricula and ongoing professional practice, and the need to further research, evaluate and progress translation of learning into improved quality care for diverse populations.

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Introduction

There is growing awareness about lesbian, gay, bisexual, trans and/or queer (LGBTQ) health and social care inequalities in the UK (Women and Equalities Committee 2019). Older LGBTQ people, in particular, are concerned that care providers will not understand their needs, and that they may encounter homophobic and/or transphobic prejudice and discrimination (Guasp 2011; Westwood 2016; Westwood and Price 2016; Almack 2018; Löf and Olaison 2020). This can lead to them missing health promotion opportunities, and

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their assessments, diagnosis and treatment being delayed, with associated poorer health outcomes. With over one million older LGBTQ people in the UK (Age UK 2020), that number set to rise with the ageing population, this is a pressing concern.

As a key profession, nursing holds a pivotal role in the delivery of healthcare to older people: in the community, on hospital wards, and in care/nursing homes. Nurses can potentially take on an emancipatory role in healthcare delivery through anti-oppressive practice and culturally competent compassionate care (Papadopoulos, Shea, and Taylor 2016), which understands the impact of minority stress (Baiocco et al. 2022). Nursing also has the potential to compound minority exclusions, via implicit or explicit bias and/or the reinforcement of oppressive values and ideologies. The UK Nursing and Midwifery Council (NMC) Code (Nursing and Midwifery Council (NMC) 2018) states that nurses, midwives and nursing associates must: 'Treat people with kindness, respect and compassion' (1.1); 'Respect and uphold people's human rights' (1.5); 'Avoid making assumptions and recognise diversity and individual choice' (1.3) and 'Act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care'. However, the Code makes no specific reference to LGBTQ-inclusive and/or LGBTQ anti-oppressive nursing care (Nursing and Midwifery Council (NMC) 2019).

There is a growing body of literature suggesting that some nurses, nursing assistants, student nurses and nurse educators hold negative attitudes towards LGBTQ people (Westwood 2022) and that this is heightened among highly religious individuals. However, there is a dearth of literature on whether/how those attitudes inform practice and how these are experienced by and impact LGBTQ people. This article considers a single case study, taken from a larger scoping study which explored what is known about the balancing of religious freedoms, sexual orientation and gender identity rights in older age care spaces. The scoping study comprised a small survey and interviews. The case study is based on one of the interviews with a survey participant, 'Clare' (pseudonym), whose survey responses suggested she had first-hand experience of encountering problematic practice towards LGBTQ patients, and that she was willing to be interviewed. Her detailed and insightful narratives are discussed within the context of current literature. They are not intended to indicate issues of scale, but rather some of the ways in which negative attitudes towards LGBTQ people can potentially affect practice. Exploring and reflecting on such issues can provide a way of thinking through the points of learning and change, to inform what anti-oppressive practice means in day-to-day care and understand some of the barriers and facilitators from professional perspectives (Baiocco et al. 2022). It may also contribute to wider debates on the role of religiosity and spirituality for LGBTQ people and the challenges for integration of their own beliefs and support systems to develop resilience, coping strategies and enhance wellbeing (Halkitis et al. 2009; Westwood 2017).

Background

Regulatory context

The UK Equality Act 2010 prohibits discrimination in the delivery of goods and services on the grounds of nine protected characteristics, including sexual orientation and gender reassignment. UK regulations relating to the delivery of healthcare in general and

nursing in particular emphasise the importance of respectful, non-discriminatory practice. The English NHS Constitution (NHS England 2021) refers to valuing 'every person' and making sure 'nobody is excluded, discriminated against or left behind' The Scottish Charter of Patient Rights and Responsibilities (NHS Scotland 2019) also commits to the patient expectation that 'I will be treated fairly and equally and will not be discriminated against' and that 'I have the right to be treated with consideration, dignity and respect when accessing and using NHS services'. Similarly, Principle 5 of the NHS Wales Core Principles (NHS Wales 2016) also emphasises 'valuing and respecting each other', and 'zero tolerance of bullying or victimisation of any patient, service user or member of staff'.

Nursing practice concerns

There are ongoing concerns about prejudice and discrimination in nursing, particularly in relation to racism (Brathwaite 2018; Kline 2015), homophobia and transphobia (Fish and Evans 2016). There is a growing body of literature which suggests that nursing staff lack basic knowledge and understanding about LGBTQ people and their holistic healthcare needs, with calls for increased inclusion of LGBTQ issues into nursing curricula (Carabez et al. 2015). Research has also suggested that some nurses may make heteronormative and/or cisnormative assumptions about patients, rendering LGBTQ patients and their needs invisible (Stewart and O'Reilly 2017). Some nurses may also hold negative attitudes towards LGBTQ people, particularly highly religious nurses (Westwood 2022).

In the UK, research has highlighted the under-preparedness of nursing to meet the needs of LGBTQ people, both in general and in certain specialties, notably cancer care (Berner, Webster, and Hughes 2021), dementia care (Westwood 2016), mental health services (Fish 2020), midwifery (McCann et al. 2021), stoma care (Chandler 2020), and end-of-life care (Curie 2016). Studies have suggested that there may be 'unhealthy attitudes' (Stonewall 2016) towards LGBTQ people in the NHS, involving bullying, harassment and abuse, negative comments, support for conversion 'therapies', and a reluctance to challenge colleagues who make disparaging remarks about LGBTQ people (Royal College of Nursing (RCN) 2016).

Many older LGBTQ people have experienced prejudice and discrimination in healthcare contexts across their lifespans, some having been subjected to forcible psychiatric 'cures' or 'conversion' attempts in earlier years (Government Equalities Office 2021). Many have also supported older friends and family members at the end of life. These experiences inform present-day concerns about needing formal care in later life. Older LGBTQ people are afraid that they will again experience prejudice and discrimination, while also being less able to defend themselves due to vulnerabilities associated with older age (Westwood 2016; 2022). While religiosity is known to promote wellbeing among some older LGBTQ people (Bower et al. 2021; Foster, Bowland, and Vosler 2015; Halkitis et al. 2009), many are concerned about receiving care from religious organisations and/or staff who may hold negative religious beliefs about them (Westwood 2017).

However, despite this growing body of literature, there is little evidence about actual nursing practice in relation to older LGBTQ people, including care delivered by nurses who hold negative attitudes towards them. This article contributes to remedying this knowledge gap, considering the narratives of a single nurse who recently encountered problematic attitudes towards LGBTQ people on a UK hospital ward for older people.

Methodology

This article reports on a single case study, based on an interview with a newly qualified nurse (NQN) who has recently left the nursing workforce. A case study approach involves intensive study of individuals and/or groups, which can enable thorough study of particular phenomena, and, in terms of nursing, taking an holistic approach to nursing practice (Sandelowski 1996). It can afford researchers an in-depth understanding of a particular theme, issue or concern, allowing for a more continuous and less fragmented analysis than that offered by other approaches such as thematic analysis (Heale and Twycross 2018). Anti-oppressive case studies provide an opportunity to identify and reflect upon when and where discriminatory and/or oppressive practices and systems require challenging and deconstruction, how this can be most effectively achieved, and associated barriers and facilitators (Raineri and Calcaterra 2018). They can be of particular use in workforce development and professional education, for example in Schwartz Rounds, i.e. structured discussions involving both clinical and non-clinical staff aimed at reflecting on the personal and social aspects of working in healthcare (Flanagan, Chadwick, and Goodrich 2020).

The data informing this paper were taken from an interview conducted as part of a scoping study which explored what is known about the balancing of religious freedoms, sexual orientation and gender identity rights in older age care spaces. The project was approved by the University of York's Economics, Law, Management, Politics and Sociology Ethics Committee (ELMPS). It was fully data protection compliant, maintained participant anonymity, confidentiality, and participants were provided with a detailed information sheet prior to giving their informed consent to participate.

The study comprised a small survey of older LGBTQ people and health/social care providers, focus groups with older LGBTQ people, and expert interviews. Survey participants could indicate if they were interested in being invited to participate in an interview. One survey participant who indicated she was willing was Claire (pseudonym), whose survey responses suggested she had first-hand experience of encountering problematic practice towards LGBTQ patients. She was invited to interview. The interview was recorded, transcribed, anonymised, and analysed using content analysis (Krippendorff 2018). The data were so original, rich, insightful, and raised such significant themes, they merited more detailed analysis which now forms the basis of this article.

Participant profile

Claire (pseudonym) is a White British woman, aged 41, who qualified as a nurse just over two years ago, but has since left the NHS.

Findings

Context: a toxic working environment

Claire experienced bullying from her first day on the hospital ward for older people. She felt that she was disrespected because she was both newly qualified and new to the ward:

> There's an odd culture in nursing which is often referred to as "eating the young" where there seems to be kind of running through nursing as a thread, a general kind of tendency towards bullying, towards not being supportive of colleagues or newer nurses.

This bullying involved nurses of the same rank, but with greater experience, criticising her practice in front of patients. She recalls being told to use a particular method to take a patient's temperature which she had been taught would produce false readings, and despite the use of this method being contravened in recent guidance. According to Claire, when she politely refused, citing her reasoning, another nurse took the patient's temperature using the prohibited method. She recalled the stress and distress this caused:

> … this was on my first day, on my first shift. [I felt] awful because you feel like, in front of a whole bay of patients who, bless them, didn't know where to look because they were just embarrassed for you and you can't really come back at them, because it's not professional and you don't want to make it any more awkward for your patients …

Claire felt the issue was personal, especially as when she tried to discuss it in private with the other nurse, she was aggressively rebuffed:

> … I sort of said, "Can I just ask, have I done something to upset you?" … And [the other nurse said] "No, I just don't like you."

Claire recalls feeling devastated that this should have happened on her first day as an NQN. She quickly realised that nursing leadership was unwilling to intervene in disputes between nurses, especially involving nurses of long-standing, and that it 'was a very toxic ward'. She differentiated this ward from others she had worked on:

> And there are good places, I've seen them, I've worked in them, there are good wards out there, it's like a lottery, you never know … Funnily enough, they never need staff because they don't have turnover because people are happy, they're productive.

The ward Claire found herself on as an NQN, by contrast, had a high turnover, and was reliant on the arrangements for supplementing shift work with nurses who work casual shifts (bank nursing). This permitted the culture of a group of nurses able to continue engaging in questionable practices in a kind of 'we do it like this here' (Hughes et al. 2012) culture of care.

> … the worst one had been there 30 years, same band, but had a lot of experience, had been passed over for promotion a number of times because of their attitude … And it turned out, when I started to go down the formal process of, you know, saying, "Look, there's a problem here," it turned out that there had been hundreds of complaints [about her] … [but she is] still there.

There are widespread concerns about bullying and toxic nursing cultures, including in the UK, with implications for patient safety, staff burnout, absenteeism, high staff turnover, and reputational damage to the profession and employing organisations (Wilson 2016; Johnson et al. 2019). They can potentially prevent the delivery of compassionate care and create fertile environments where discriminatory and oppressive practice can flourish (O'Driscoll et al. 2018). Nursing cultures also have a profound influence on whether nurses feel safe and secure in whistleblowing, as starkly illustrated in the Mid Staffordshire Inquiry, which reported on systematic patient abuse and neglect in a UK

hospital (Francis 2013). Effective preceptorship (mentoring) programmes have been found to promote resilience among NQNs, however these are not consistently implemented across all nursing contexts (Alshawush, Hallett, and Bradbury-Jones 2021). In Claire's experience, she only saw her preceptor (a mentor for NQNs) once in six months, which contributed to her feelings of being unsupported (Allan et al. 2016).

Encounters with homophobia and transphobia among nurses

Claire encountered some problematic attitudes towards LGBTQ people. She gave several examples of casual homophobia among nursing colleagues:

> … everybody thinks older people just become asexual, inanimate objects. And it's like … "Oh, but you know, they couldn't be gay, they're 82."

This reflects one of the major concerns of older LGBTQ people, both in terms of being misrecognised because they are seen through a lens of hypersexuality (i.e. being seen only in terms of the sexual) and rendered invisible because of the association with older age and asexuality (Hafford-Letchfield 2021). Claire gave further examples:

> It's the snide, side comments … It's things like, "Oh, well they're a gay." "They're a what?" "They're a gay and I don't agree with that, it goes against my beliefs." … Or, "I don't like going in there. I don't like being around them."

Older LGBTQ people are concerned about attitudes just like these (Guasp 2011; Westwood 2016; Westwood and Price 2016), namely that they will be disapproved of, disrespected, avoided, and that they will consequently receive inferior care.

> And it's other things like, oh, well, "Their husband [gay male patient] wants to visit but I don't want to let them in because it's just encouraging their lifestyle." I'm like, "How about you jog on. How about that?"

This reflects some of the major fears of older LGBTQ people. Firstly, that their relationships will not be respected, even when they are protected in law and recognised in society. Secondly, that they will encounter LGBTQ microaggressions (Nadal et al. 2016) communicated verbally and non-verbally (through body language, avoidance, heterosexist and cissexist assumptions), with their associated harmful emotional and psychological effects (Dean, Victor, and Guidry-Grimes 2016). Claire also witnessed casual transphobia among nurses:

> It's all things like I was saying, you know, [colleague saying] "I don't want to go into the room because I don't trust them," is one I've had a lot. "I don't feel it's right. I don't feel we should be supporting them. I don't feel they should be on this ward." "Why?" "Because they're [referring to a trans woman] not a woman."

Older trans people, especially those who have transitioned, are extremely fearful of needing personal care in later life, being concerned about transphobic attitudes such as these, and about nurses being shocked and/or disgusted by bodies which may not conform to gender binaries (Willis et al. 2020).

> … somebody who is gender fluid who uses they/them pronouns. They [a nurse colleague] failed to get their name right about six times, deadnaming them. And then when I challenged them on it, said, "Well, it's ridiculous … God created man and woman and that is all there is."

Misnaming ('deadnaming') trans people who use different pronouns from those assigned to them at birth and/or the singular/plural 'they/them' for gender non-binary individuals is also a major concern. When overt and explicit, it can lead to the implementation of disciplinary procedures, as in the case of David Mackereth, the registrar who was dismissed from his hospital job for refusing to use the correct pronouns for trans patients, on the grounds of conscientious objection (Flanagan, Chadwick, and Goodrich 2020). However, more low-key misnaming can go un-challenged.

'I'll pray for you'

Some older LGBTQ people are particularly fearful about receiving care from religious providers (Guasp 2011; Westwood 2016; Westwood 2017; 2022). Claire described a worrying incident involving a religious nurse:

> It was a bank nurse … [a man was in] for a bit of a rehab, get their COPD [Chronic Obstructive Airways Disease] under control before they headed home. And … we were chatting … and it came up just in conversation about [his] husband and we were chatting away … and, you know, he was telling me about his life … And then this bank nurse said, 'You have a husband.' And he went, 'Oh, yes, yes, we've been together 20 odd years.' … And he said, 'Yes, he doesn't tend to visit me in hospital because [..] it just always causes bother.'

This encounter highlights how some older LGBTQ people, even those whose marriages are recognised in both law and society, can choose to conceal themselves in healthcare contexts or fear they may have to do so (Almack et al. 2018; Furlotte et al. 2016). This includes not naming their partners/spouses as next of kin or their loved ones not visiting them, to protect that concealment. Claire describes making the following suggestion:

> I said, "Well, if you want [him] to come in and I can just say he's a friend, that's fine, we can. I'd rather, obviously we didn't have to, but if you're worried, we could just put him down as your next of kin as a friend and then no one needs to know if that concerns you." And he was like, "Oh, that would be great."

While Claire's suggestion was supportive, and pragmatic, it nonetheless reflects her acknowledgment of homophobic oppression in healthcare contexts, and ongoing concerns about non-recognition of same-sex spouses/partners as next of kin in healthcare contexts (Royal College of Nursing (RCN) 2016). Rather than being able to reassure the gay patient that he would be perfectly safe to be open about his sexuality and his relationship, she recognised that this was not possible and offered a further concealment solution instead. Claire continued:

> … And then this nurse just went, "Oh, well, I'll pray for you." And I was like, "I'm sorry, what?" To the patient, "I'll pray for you." … He looked pretty bemused, I don't think he'd clicked, like that she didn't mean in terms of, like the whole situation with getting his husband in safely …

Claire decided to ask the nurse what she had meant,

> And then I caught her, because she was at the meds trolley and went, "Look, I just want to ask, what did you mean when you said you'd pray for him?" … . I think she was in her early 40's … And then she went, "Oh, no it was because he's a gay, he's going to go to Hell." … I said, "I understand that you have, you know, deep seated religious beliefs that you believe that is the case, but you can't express it to patients, that's not acceptable, because you are basically

> disapproving of their life and that's not good." … Well, she looked at me, I don't think anyone has ever called her on it before, she sort of looked at me sideways and went, "Well, I'll pray for you too."

The fear of religious preaching in healthcare contexts is a particular concern among some older LGBTQ people, especially those who have experienced religious conversion attempts in the past (Westwood 2017; 2022; Government Equalities Office 2021). Many religious individuals consider religious-based negative attitudes towards LGBTQ people not as prejudice per se, but rather logical adherence to selected biblical texts essential to their understanding and engagement with the world (Jowett 2017). There is much debate about sexual identities and clashes with religious text and how selective use of religious texts is used to justify prejudice (Herek and McLemore 2013). Notwithstanding, the detrimental impact of prejudice upon LGBTQ people, especially older LGBTQ people, is compounded when it has religious authority attached to it including for those who may also hold personal religious or sectarian beliefs (Lomash, Brown, and Galupo 2018).

Claire observed that there was a racialised element to religious objections to LGBTQ people, which can heighten tensions and potential to openly discuss the issues:

> … there's a lot of nurses who are very strongly religious … Christian mostly … and there's a significant proportion of them who do not support LGBTQ + people. But then there is a minority of those people who let it affect their work.

Claire acknowledged the challenges in respecting religious beliefs in terms of her colleagues cultural background and the importance of not labelling minoritised groups given the discourse of beliefs and practices that legitimate racial inequality and racism in nursing in the UK (Harris et al. 2017; Likupe and Archibong 2013). There are major concerns about racist bullying and discrimination in the UK nursing workforce (Alshawush, Hallett, and Bradbury-Jones 2021). As a consequence, internationally trained nurses face 'multidimensional challenges affecting their acculturation process in a foreign country' (Brathwaite 2018). This needs to be addressed, both to support internationally trained nurses in their acculturation, tackle racialised discrimination and also address and resolve any conflicting values (Balante, Broek, and White 2021), including those relating to LGBTQ-inclusive practice.

Claire reflected on the distinction between religious doctrine and individual interpretation:

> I think you can be a fantastic carer and strongly religious, there's nothing saying if you have a strong religious identity you can't be … It doesn't matter that if it's religious or if it's not religious, any extreme view is dangerous. And I think that's the key for me, I don't want to demonise people who have faith, there's nothing wrong with having faith, it's when it becomes bigoted that the problem is there.

Claire is making an important point, also reflected in the literature, which is that it is not religious doctrine per se that is the issue, but rather how it is interpreted by religious individuals and how that is, in turn, reflected in their nursing practice (Valentine and Waite 2012).

Impact on care quality

Claire observed that qualified staff are often reluctant to challenge colleagues who are behaving in discriminatory ways:

> But it's hard work, and a lot of people can't be bothered to put it in and are just like, "Oh, just ignore them." And I'm like, "Well, no, because that doesn't achieve anything." Most of them will, to be perfectly honest, most people will just walk away and just not be bothered. Those guys, they would say it didn't affect their care.

However, from Claire's perspective, it did affect care quality.

> Most of them it did [affect their care] because you could see it … . It's the way, if someone comes into a room to care for you, you can tell, straight away from 100 little clues how happy they are to be there … So, even though they may not say anything, or act deliberately in a way that is, you know, exclusionary or prejudiced, you can tell, it's the million clues.

The interpersonal subtleties Claire refers to here involve microaggressions: 'subtle forms of discrimination, often unintentional and unconscious, which send negative and denigrating messages to various individuals and groups' (Nadal et al. 2015). LGBTQ microaggressions are expressed in a range of ways (Nadal et al. 2016): discomfort, unease and/or disapproval when in the company of LGBTQ people; assuming their deviance/pathology/sinfulness; discounting/denying anti-LGBTQ prejudice and oppression; language/assumptions which devalue LGBTQ relationships; and misgendering trans people, including not using their correct pronouns. Religious microaggressions may be compounded by their implied moral/spiritual authority (Lomash, Brown, and Galupo 2018). Unlike explicit discrimination microaggressions can be difficult to pin down and are often discounted by claims that the person experiencing or witnessing microaggression(s) is being overly sensitive. However, they can have a powerful 'dripping tap' effect, eroding confidence in, and willingness to engage with, healthcare services (Dean, Victor, and Guidry-Grimes 2016).

Claire highlights here the impact for care quality, not in terms of *whether* but rather *how* tasks are performed:

> Like, I've had patients say to me, " … I'm pretty sure that other nurse doesn't like me very much." Even though they've never said anything or done anything and they've delivered everything, they've dotted all the I's and crossed the T's of care that needed to be given, but the difference is, they're not giving care, they're performing tasks. So, they have helped them to have a wash, they have helped them to get dressed or they have helped them with their medication and they have done everything, you know, appropriately, nothing untoward or wrong has happened, but they have basically ticked a list of tasks, they haven't actually provided care, that's the difference. And I think that's what the patients pick up on.

Claire described a conversation with a patient, an ex-Care Quality Commission (CQC) inspector:

> [He said] "It's the difference between tasks being done and care being given." And he said, "You can tell, in here, which nurses do which. And it's about what you don't say and do, more than what you do." And that's always kind of stuck with me.

This is an important distinction, and one which goes to the heart of many older LGBTQ people's concerns about care. Although some are fearful of abusive care, many more are concerned about perfunctory care, where tasks are performed as quickly as possible and where subtle, positive, human interactions afforded to non-LGBTQ patients are avoided with LGBTQ ones (e.g. asking about a photograph someone's partner [Peel and McDaid 2015]).

Discussion

The literature calls for the need for more evidence on how negative attitudes towards LGBTQ people can mediate practice and impact care quality, particularly among staff with strongly held religious objections to LGBTQ people. Claire's observations offer insights into how negatives attitudes towards LGBTQ people can sometimes inform practice, and that these can be, but are not always, informed by strongly held religious beliefs. These challenges are beginning to emerge in UK case law. For example, Sarah Kuteh, an evangelical Christian nurse, has recently claimed unfair dismissal after being sacked from her job in a UK hospital run by Dartford & Gravesham NHS Trust (Kuteh v Dartford and Gravesham NHS Trust 2019). She interrogated patients about their religious beliefs, asked those who said they did not believe in God to explain why not, told a cancer patient about to undergo major surgery that 'if he prayed to God he would have a better chance of survival' (Adams 2019), gave patients bibles they had not requested, told patients she would pray for them, and asked them to sing psalms with her. She gave hospital managers assurances that she would desist but did not. Mrs Kunteh's claim failed.

This may be an extreme and unrepresentative case, but it was widely reported in the national press (Adams 2019), and serves to fuel the fears of older LGBTQ people. It also highlights the tensions for healthcare, social care and social work practitioners with strongly held religious beliefs, in terms of balancing those beliefs with secular, liberal, professional norms and values. Overt discrimination towards LGBTQ people by healthcare professionals, while it clearly does take place, will likely be rare, because it is explicitly prohibited by law and professional standards. However, it is possible that not all such cases are reported (Jack et al. 2021). It is also likely that less obvious, casual, everyday prejudice (such as microaggressions) of the type described in this article, is of greater concern, while also posing challenges for formal regulatory mechanisms (Dean, Victor, and Guidry-Grimes 2016).

Nursing can intervene in reducing LGBT health inequalities in a range of ways (Medina-Martínez et al. 2021; Traister 2020), including by: being sensitive to, and promoting better understandings of, those inequalities; advocating for LGBTQ healthcare rights; modelling LGBTQ-inclusive practice; including LGBTQ health inequalities and LGBTQ-inclusive practice in nurse education curricula; and establishing health equality audit procedures to ensure there is not only anti-discriminatory nursing care but also anti-oppressive nursing care. The silence on explicit commitment to LGBTQ-inclusive practice in the NMC Code (Nursing and Midwifery Council (NMC) 2019) is a concern and a statement to that effect would go a long way to set an important tone in the profession about the unacceptableness of intolerance towards LGBTQ people and the importance of anti-oppressive practice.

It is important that nurse education is underpinned by anti-oppressive principles (Brathwaite 2018; Traister 2020). Good practice in relation to minority groups, including LGBQ people, should be addressed theoretically and practically, including via simulated learning opportunities (McCann and Brown 2020). It is essential, too, for students and qualified nurses to be helped to explore their own personal values and how they might impact the quality of their nursing practice (Morris et al. 2019). Papadopoulos, Shea, and Taylor (2016) and Papadopoulos (2018) refer to the significance of culturally competent

compassion in nursing, which engages with human qualities beyond demonstrating sympathy and empathy, and requires proactive behaviours. Baiocco et al. (2022), in their study of nurses in seven European countries, concluded that there is an urgent need for nurse education to become more LGBT-inclusive, focusing on reducing negative stereotyping and bias; improving LGBTQ knowledge, awareness and understanding; and developing 'the specific skills and attitudes that could lead to increased quality of care for vulnerable and minority groups' (Baiocco et al. 2022, 33). Increased critical reflection via training, formal guidance, leadership through constructive challenge, and learning around cultural and religious tensions, could help to develop essential skills, knowledge and, most importantly, positive attitudes towards LGBTQ people and their care.

The wider healthcare systems within which nurses practice and their LGBTQ inclusivity also need to be explored, to ensure they provide safe, supportive nursing cultures in which good practice, including anti-oppressive nursing practice, can flourish (Dean, Victor, and Guidry-Grimes 2016). This should start at the top, via systems and policies which mandate these behaviours and interventions, cascaded down via implementation strategies and nursing leadership, and encouraged/facilitated at an individual level, supported by healthy nursing cultures where there is zero tolerance for prejudice and discrimination of any kind.

Limitations

While a case study approach offers the opportunity to analyse in-depth experiences, its limitations include that it is not amenable to generalisations, is not indicative of scale, and it is particularly susceptible to researcher bias. The participants in the wider study self-selected and were therefore more likely to have strongly held views about religion and LGBTQ rights in older age care. The narratives analysed in this article were chosen because they gave specific practice examples, which are lacking in the literature. However, they do not give examples of good practice with LGBTQ people, which engagement with a wider sample would very probably have provided.

Conclusion

This paper has confirmed that there can be occasions of prejudiced/discriminatory nursing practice towards LGBTQ people in the UK, suggesting that the fears and concerns of older LGBTQ people are not unfounded. There is a need for more research in this area, to better understand the extent to which attitudes reported in this study are present among nursing staff, ways in which they can be addressed, and the complexities involved in promoting integrated, culturally compassionate and sensitive holistic care. This is not only in relation to nursing, but also other healthcare professions, social care and social work. Until this happens, older LGBTQ people, and LGBTQ people of all ages, cannot be guaranteed that they will experience equitable, LGBTQ-inclusive and safe care.

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