Sexual Identity, Citizenship and Medical Power of Attorney: Case Illustrations from Northern Ontario, Canada

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Current analyses of sexual identity and citizenship offer complexity to debates about what it means to be a citizen in liberal democratic societies. However, thus far there is limited inclusion of ethnographic, narrative-based research that addresses how lesbians and gay men experience and negotiate citizenship in their everyday lives. In this paper, I argue that attitudes about medical power of attorney are a lens through which we can examine how lesbians negotiate and experience citizenship in their daily lives and in medical settings. My analysis demonstrates how normative citizenship structures are experienced, reinforced and challenged by four lesbians living in a community in Ontario’s Near North region, Canada. In providing case illustrations, I argue that the inclusion of lived experiences strengthens and deepens textual, historical and political analyses of citizenship.

Introduction

The literature on sexuality and citizenship is producing theoretical debates and directions that question and stretch the boundaries of citizenship. By interrogating the ways that gay men and lesbians are included and excluded from citizenship rights and responsibilities, theorists are adding complexity to debates about what it means to be a citizen in liberal democratic societies (Evans, 1993; Herman, 1994; Freitas, 1998; Richardson, 1998; Phalen, 1999; Bernstein and Reimann, 2001; Seidman, 2001; Stychin, 2001; Bell and Binnie, 2002; Cossman, 2002; Puri, 2002). However, the body of literature is limited in its inclusion of the lived experiences of lesbians and gay men. There is little ethnographic, narrative-based analysis of the ways lesbians and gay men experience and negotiate citizenship in their everyday lives and in encounters with power holders and institutions. In this paper, I argue that perspectives about medical power of attorney are a lens through which we can examine how lesbians negotiate and experience citizenship in their daily lives and in medical settings.

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Analysing local, community-based experiences strengthens and adds complexity to textual, historical and political analyses of citizenship in liberal democratic societies. My analysis demonstrates how normative citizenship structures are experienced, reinforced and challenged by lesbians living in a community in Ontario’s Near North region, Canada.

My argument is positioned within the context of the sexuality and citizenship literature. I then offer an analysis of the perceptions and experiences of four lesbians who have contemplated and discussed the creation of medical power of attorney documentation. Though preliminary, my work provides a discussion of how theoretical constructs around citizenship are encountered in the everyday lives of these women. The complexities of normative citizenship and the ‘good citizen’, market citizenship, and substantive, embedded citizenship will be examined through the ways these women consider medical power of attorney.

Citizenship and Sexual Identity: An Overview

Liberal citizenship theory is rooted in understandings of universal rights and equality. This discourse has assumed an undifferentiated citizen who has equal access to civil, social, and political rights (Marshall, 1964), and who is able to depend on the state to ensure these rights. Demonstrating the shortcomings of traditional understandings of what it means to be a citizen, feminist scholars have offered critical analyses of the ways that such approaches ignore how individual and group differences shape citizenship and social participation experiences (Young, 1989; Lister, 1997; Yuval-Davis, 1997; Werbner and Yuval-Davis, 1999). Markers of difference, including sexuality, class, ethnicity, and gender, have been shown to be relevant to discussions about and the experience of citizenship (Laclau and Mouffe, 1985; Werbner and Yuval-Davis, 1999).

Building on sexuality as a marker of difference, theorists have examined the intersections of sexual identity and citizenship through a number of analytical lenses, including the market (Evans, 1993; Freitas, 1998; Bell and Binnie, 2002), the European Union (Stychin, 2001), Republican discourse and the normative citizen (Phalen, 1998), the media and Canadian Supreme Court rulings (Cossman, 2002), gay and lesbian movements and programmatic national reforms (Flacks, 1990; Stychin, 2001), nationalism and transnationalism (Puri, 2002; Valentine, 2002), and the heteronormativity of the citizen (Richardson, 1998; Seidman, 2001).

There is a long history of constructing lesbians as non-citizens. This includes arguments that link same-sex desire with nature, not culture, and hence delegitimate citizenship claims (Stevens and Hall, 1991; Carter, 1997); eugenics and racial/cultural superiority movements (Young, 1989, p. 225; Carter, 1997); the construction of same-sex desire as threatening to the structure of family institutions and the nation (Stevens and Hall, 1991; Ussher, 1997); and the belief that lesbians (and gay men) are too hyperindividualistic to consider the common good (Stychin, 2001).

Phalen’s work on passion, citizenship and Republican discourse in the United States offers a useful analysis of the construction of bodies, norms, and the
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citizen. She argues that ‘... masculinist conceptions of bodies and passions work to exclude “others” from equal citizenship’ (1999, p. 57). Raising the issues of the normative white male body, labour, citizenship rights, family and the construction of passion, Phalen convincingly situates the exclusion of gay men, lesbians, bisexuals and transgendered individuals in a long history of concern with love for the nation and Republican discourse that is pervasive in contemporary America.

Similarly, Richardson’s (1998) analysis of the sexualization of citizenship offers a contemporary and historically based critique of exclusion. She demonstrates how lesbians and gay men are systematically excluded from full social, political and civil citizenship in Britain. Examples include an inability to legally marry, the lack of formal recognition of same-sex relationships, limited political influence and the general lack of social inclusion.

However, in an incisive analysis of consumption and citizenship, Freitas (1998) demonstrates how the recognition of lesbians and gay men as consumers renders them citizens from the perspective of the market. Building on the contrasts and connections between capitalist and nationalist understandings of the citizen, Freitas argues that the naturalization of ‘sexual aliens’ (1998, p. 362) is taking place in part through market attention to this niche of consumers. The market then can be understood as a ‘port of entry to national belonging’ (1998, p. 363), a metaphorical port likened to the traditional entry points encountered by immigrants.

Links between sexual identity politics and citizenship might be used to examine larger structures that provide citizenship rights. For example, Stychin argues that rights discourses and sexual identity politics are venues through which citizenship in the contemporary European state, a state that is part of the European Union (EU), can be examined (2001, pp. 298–99). This is a result of the intersection of private and public spheres both in sexual identity rights discourses and the politics and practicalities of the EU structure. Through his consideration of the work of the International Lesbian and Gay Association, Europe, he suggests that sexual citizenship and transnational European citizenship are not irreconcilable ideas.

Such analyses offer important theoretical insights, although, from an anthropological point of view, this body of literature is limited. Much of the writing that examines sexual identity and citizenship does so from a primarily theoretical standpoint, and does not consider the lived experiences of lesbians and gay men (however, see Seidman, 2001). There is little ethnographically based research that explores how citizenship discourse might be experienced and negotiated in international, national and local spaces. Narrative, in the sense of drawing out individual voices that demonstrate lived experiences, is minimized. From an anthropological perspective, this is problematic because it is lived experiences that demonstrate the complexity, ambiguity and fuzziness of theoretical arguments. Drawing from experiences can bring depth and dimension to ideas about citizenship. Research based on textual, historical and political analyses must be balanced by the specifics of how citizenship is worked out in particular contexts, by particular people. This allows for an analysis of how gay and lesbian citizens understand and experience the local, regional and national structures that shape
their everyday lives. Including detailed work on experiencing and negotiating citizenship, work that demonstrates the located, embedded knowledge of individuals, can only strengthen the already valuable theoretical work being done on sexual identity and citizenship.

Providing such a balance is also important to avoid a partial contradiction of the theoretical and political stances from which work on citizenship and difference has emerged. That is, it is recognized that citizenship dialogue and discourse must include difference and marginality. This means a move away from a notion of a universal citizenship that glosses over the varied positions of the individuals to which citizenship is (or is not) being ascribed. Theoretical approaches must be balanced by work that includes the voices of lesbians and gay men. Otherwise, the theory risks being as generalizing as the discourse of universal citizenship.

There are multiple ways to examine how lesbians and gay men experience citizenship. The creation of medical power of attorney documents encompasses a range of decisions that are shaped by the social positions that lesbians and gay men occupy and create for themselves. Making a power of attorney document and the subsequent act of utilizing and enforcing the legal implications of such documentation constitutes an engagement with the state and thus a negotiation around citizenship rights in a heterosexist society. However, this is only the most obvious level at which perspectives on medical power of attorney operate. Decisions and beliefs about the importance, use and implications of such documents reflect social positions, past experiences, cultural assumptions, institutional policies and practices, and in all cases, a sense of social belonging, both in local and national contexts.

Sexuality, Rights and Citizenship in Canada

The gay and lesbian civil rights movement has existed in Canada since at least the late 1960s (Adam, 1999; Cossman, 2002). It is tempting to argue that these movements have helped change discriminatory attitudes. Indeed, Bill C-23, the Modernization of Benefits and Obligations Act, expanded the rights of the Canadian gay and lesbian community. This act in theory gave co-habiting gay and lesbian couples the same rights as heterosexual common-law relationships (Demczuk et al., 2002). Nevertheless, this did not extend to marriage, and did not ensure that in everyday life same-sex couples would receive all rights and responsibilities inherent in marriage. Additionally, attitudes displayed in historical analyses (Stevens and Hall, 1991; Carter, 1997; Ussher, 1997) linger in North America. Lesbians may continue to be constructed as predators in health care settings and other locales (Gentry, 1992; Eliason, 1996; Grey et al., 1996). Limited institutional and state recognition of same-sex couples and same-sex desire can be linked to earlier constructions of gay men and lesbians as so-called ‘dangers’ to the fabric of society.

However, in the summer of 2003 Ontario and British Columbia provincial courts ruled that denying marriage to same-sex couples is a violation of constitutional rights. The federal government’s response to these rulings has
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been to declare that rather than appeal the court decision, it will eventually introduce legislation to legalize some form of same-sex marriage or civil union.

Prior to this ruling, same-sex couples in Ontario and Canada have had limited recognition of their relationships. Power of attorney measures have been one way for lesbians and gay men to assert their family composition. For example, the need for medical power of attorney documents (Chambers, 2001; Perry and Bereysso, 2001), a legal ‘fix’ for the lack of official state recognition of same-sex marriage, has signified one of the ways in which lesbians and gay men have traditionally not been granted full inclusion in Canadian society. It is with this background that I turn to the issues of medical power of attorney and health care experiences among four lesbian women² living in and around the community of Summer Lake.³

Research Background

From May–September 2000, I undertook ethnographic fieldwork in Summer Lake, a community of approximately 65,000. Summer Lake is located in Ontario’s Near North. The region, although less densely populated than much of Southern Ontario, is more urban than other areas further north. The community is relatively homogeneous, conservative and less cosmopolitan than mega-cities like Toronto. For example, visible minorities account for just over 1% of the population, as compared to 16% of the population of Ontario as a whole.

The aim of my research was to gain some understanding of the health care issues that self-identified lesbians and gay men might face in a smaller, homogeneous, conservative community. Citizenship was not the focus of this research. Rather, this theme emerged when medical power of attorney was raised and discussed by several individuals.

I conducted semi-structured interviews with 13 lesbians and three gay men.⁴ These individuals were contacted through a variety of means, including the local gay, lesbian, bisexual and transgendered social organization’s internet message board, snowball sampling, and informal introductions at social events that I attended. Most research participants were, and continue to be, active in the local gay community, participating in social and political activities. They self-identify as gay or lesbian, and consider themselves to be ‘out of the closet’ in at least some aspects of their lives. All are of Euro-Canadian descent, and are between 19 and 49 years. All individuals have at least a grade 12 education, with eight having post-secondary diplomas or degrees.

Although I draw from the body of my research data, this paper focuses on four research participants. These women are all in their mid-to-late 30s, come from lower to middle-class backgrounds, and are employed in the health care or social services sectors. They are all in co-habitating, monogamous relationships that they define as long-term, and they have all in one way or another considered creating medical power of attorney documentation.

This is not the place in which to discuss in detail all the results of my research, but a few general comments should be made. Participants spoke well of one-on-one interactions with their family physicians. Negative experiences were more likely situated in the local hospital, where men and women encountered
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homophobia and dismissal during emergency services. Emergency room staff, particularly nurses and receptionists, were identified as making homophobic remarks and, in some cases, denying access to partners undergoing medical care.

These experiences can in part be linked with a heterosexist institutional atmosphere. That is, the local hospital has no official policy with regards to same-sex couples’ rights and needs in emergency situations. In the absence of such institutional discussions and policies, lesbians and gay men recognize that they are vulnerable to the biases of individual staff that are free to act in a discriminatory matter without the potential of an official reprimand. This helps create a context where same-sex couples consider actions to protect themselves in health care settings. One such action has been the creation of a legal medical power of attorney document, which ensures that couples are given access to each other during hospitalized care.

Medical Power of Attorney: A Brief Background

The issue of medical power of attorney and same-sex couples has been debated by the mainstream and queer press. The most widely publicized case in North America was that of Sharon Kowalski and Karen Thompson. Although these women are American citizens, the case has had impacts on gay and lesbian communities throughout North America.

In 1983, a car accident left Kowalski with severe physical and neurological injuries. During Kowalski’s long-term hospitalization, Thompson was denied visitation rights by Kowalski’s parents, who were her legal next of kin. Since Kowalski was deemed incapable of making competent decisions, her father was granted legal guardianship and medical decision-making capabilities (Thompson and Andrzejewski, 1989; Bilofsky, 1994a, b).

Kowalski’s parents had been previously unaware of their daughter’s relationship. In the subsequent legal battles, homophobia, heterosexism and ableism intertwined to influence the decisions of judges and the testimonies of doctors (Bilofsky, 1994a). It was only after years of legal action that Thompson was able to regain visitation access to her partner.

In light of such stories and subsequent legal concerns, it is unsurprising that gay and lesbian organizations often give considerable attention to the issue of medical emergency decision-making. For example, medical power of attorney has been called one of the nine critical documents for lesbian and gay couples (Perry and Bereyso, 2001). Medical power of attorney designates a health and personal care decision-maker in the case of incapacitation. These documents are not limited to same-sex couples, but they can ensure that same-sex partners have the same kind of decision-making power as that of heterosexual married or co-habiting couples. Although not uncontestable, these forms are recognized as legally binding by the provincial government, courts, physicians and hospitals. Documents are not kept in a governmental registry, and need not be created in the presence of a lawyer, but it is recommended that individuals such as family members, health care providers and lawyers be given a copy (Ontario, undated). While medical power of attorney is therefore advocated as an important step,
there is little information about how it is perceived and understood by same-sex couples.

The issue of access to partners in health care situations was a source of concern for almost every individual who participated in my research. Although no one mentioned the Kowalski–Thompson case by name, comments included abstract statements such as ‘We’ve all heard the horror stories’ (Kathryn, mid-30s), and more experience-specific statements like ‘Every time we go [to the ER], the nurses refuse to let me in with her’ (Kelly, early 20s). Patients may also ask for their partners, as discussed by Kelly’s partner, Julia.

There have been a number of occasions where I’ve been in the [emergency treatment] room saying, ‘Look, my partner is outside, can you please let her in?’ And they say no, and I say, ‘But she’s the closest thing to my spouse’. And she can’t come in. And yet everybody [else] in the ER has their mother or their partner or whatever … They won’t even give her accurate information on me.

For these individuals, the concern is less about potential conflicts with families of origin, and more with the possibility that hospital staff may refuse to acknowledge same-sex relationships.

The specifics of choosing to create medical power of attorney documentation are embedded in the social contexts of limited national and provincial legal recognition of same-sex couples; hospital policies and practices; individual experiences with the health care system; and the community in which health care services are sought. In particular, the community context can play a significant role in decisions about medical power of attorney. Couples may have a history of joint decision-making, but this does not necessarily mean that power of attorney has been addressed.

Case Illustrations

This section is organized in terms of four women, Kathryn, Holly, Bernadette and Jen, and their reactions to and experiences with the creation of medical power of attorney. Although these women describe similar concerns about facing discrimination in a hospital setting, their perceptions of medical power of attorney vary. This helps to illustrate the different levels at which women think about their health care, community, and national acceptance of same-sex relationships and their personal power. These shape, and are shaped by, the civil and political citizenship experiences and social positions of lesbians in this community.

Shortly after Kathryn and Holly’s relationship began, they decided to address medical power of attorney. An early step was informing their family physician of their relationship and their wishes in the case of an emergency. The decision to create legal documentation for each other was partly a reflection of a pattern of joint decision-making, one that consolidated their assets and firmly established them as a long-term couple. However, more explicitly, the decision was related to their awareness of the very real potential for discrimination.
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Kathryn spoke of the ‘horror stories’ of same-sex couples being denied access to one another in emergency medical care situations. She went on to state,

I want it very clear that not only is she [Holly] my partner, but the person to be consulted if there’s something wrong with me. We did our power of attorney stuff very early on after we got together. And one of the main reasons for doing that … was none of this crap about one of us being sick and ‘you’re not family, and who are you and you’re not a decision-maker’. She is my decision-maker.

Kathryn works in a health-education setting where she encounters several same-sex couples. She is familiar with the struggles that same-sex partners can face in the health care system. She also states that in a local health care setting, where she has social and professional connections, power of attorney will be more readily accepted, but that this is not necessarily the case outside of their home community. In Summer Lake, they are able to access their family physician, who is supportive of their relationship, and who they consider an advocate. Elsewhere, they fear they would be dependent on the good nature or prejudices of hospital staff. This points to a concern with the difference between legal theory and the reality of whether or not individuals choose to adhere to legalities. Key here is a sense of social belonging. In the local context, where Kathryn has a good relationship with her family doctor, is knowledgeable about the medical establishment, and has contacts in the hospitals, she and Holly experience a sense of social citizenship.

Trust in local connections is not straightforward or unquestioned, however, as Kathryn recognizes the importance of legalities in ensuring that they are allowed to ‘belong’ with each other in emergency health care settings. The perceived conservative nature of Summer Lake and Northern Ontario contributes to her concerns about access denial. There is a sense that in larger cities with more cosmopolitan attitudes, discrimination in hospital settings is less likely. However, in Northern Ontario, with its small, sometimes isolated communities, same-sex couples may feel less secure. Cultural assumptions about the nature of families, the social positioning of gay and lesbian individuals as second- or third-tier citizens, and a lack of official recognition of the needs of same-sex couples in the local hospital contradict the partial sense of belonging that Kathryn experiences. Medical power of attorney strengthens that sense of belonging in terms of offering legal documentation of a decision-making relationship, even if it does not necessarily recognize the sexual nature of this relationship or socially sanction same-sex couples. The documentation does not offer a sense of national inclusion and equal rights, nor does it guarantee social acceptance by health care professionals, but it does address some gaps in rights and privileges.

Social positioning and the partial nature of citizenship and belonging are even more clearly demonstrated by a second example. Bernadette is in her late 30s. She works in social and counselling services and her partner is a stay-at-home mother. They have three children. Like Kathryn and Holly, Bernadette and her partner have a history of joint decision-making, both for each other and for their
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children. However, this has not extended to medical power of attorney documentation.

Bernadette discusses medical power of attorney in terms of the position she and her partner occupy in their community. Although Bernadette works in Summer Lake, she lives in a smaller satellite town. This town has its own small hospital that Bernadette and her partner utilize in emergency situations. They have worked out next of kin issues with their hospital, but primarily for the sake of access to the children. Additionally, next of kin has not been formalized with legal medical power of attorney documents.

We registered at the hospital as the next of kin for each other, and for the children. We’ve never had a situation where I’ve had to have access to her, or vice versa, where she wasn’t able to speak, or couldn’t tell people her intentions. And we live in a small community, people know us, so it’s … different.

The differences that Bernadette is referring to are the relationships that she and her partner maintain with others in the close-knit community that she considers to be more open to diversity than Summer Lake. Bernadette sees the small size of her town as helpful. This is in contrast to Kathryn and Holly’s feelings about Summer Lake, where they link small with conservative. Bernadette feels that a small town mean she is well known, something that can help her. Consequently, equal treatment in an emergency context is less about the documentation that they carry than about their position, connections and relationships in the community. They live in a community of a few thousand, have strong roots, and they look and act ‘normal’. Specifically, Bernadette states that

The more you look like the norm, the more privilege it buys you … You are more accepted and less oppressed if you have children, because you look normal. If you own a house, the closer you get to the norm … I work, we have a decent income, we own a home, we mow the lawn, we grow trees. We have normal things, like we look normal, we have kids, and the kids play outside. We’re not, you know, having demonstrations on our lawn, and we don’t dress in leathers, and there’s no motorcycles in the yard. They can treat us like we’re one of them, because we look the same … we drive a van. You drive a mini-van, you’re one of them.

This privilege she also believes provides them with less discrimination in the local hospital setting. It is not that they have never or will never face discrimination in any venue of their lives. Nor are hospital visits without some measure of frustration. For example, Bernadette related a story of a visit to the emergency room with one of her children. Staff and physicians at the hospital had a difficult time understanding her relationship to the child, since she is not his biological mother. She says this is because there is ‘no system’ or space on charts to indicate different family relationships.

For Bernadette, medical power of attorney is something she thinks she and her partner should create. However, they are currently in a situation where they do
not consider it necessary. They have never been denied access to each or their children, and the local hospital they use, while not fully versed in same-sex relationships and family composition, is a place where Bernadette feels somewhat comfortable. Although she is aware that she is not accorded the same rights as married heterosexual Canadians, the degree of social citizenship that she and her family experience in everyday life means she feels little impetus to create medical power of attorney. This might change should the family move to a community where they feel less socially secure.

In contrast to the above women, Jen is adamant about not creating medical power of attorney documents. This is particularly interesting because Jen and her partner work in health care/social services fields, and are therefore familiar with institutional patterns. They have been told, both by friends and lawyers, that the only way to guarantee access to each other in an emergency situation is to have such forms. Moreover, Jen and her partner have been in a number of health care situations where staff did not recognize them as legal family members, leading to access denial and considerable worry and frustration.

Jen’s gay and lesbian friends have shared their experiences before and after creating medical power of attorney. However, her personal experiences, the experiences of friends, and legal advice have not convinced her. She believes she and her partner are already entitled to the same rights as heterosexual couples.

You know, we just didn’t meet and move in together, we’re married. We’ve been married in the church, and it’s no different, as far as I’m concerned, than a husband and a wife, even if the hospitals don’t tend to treat it that way … as far as I’m concerned, she’s got the power to say ‘Yes, you do that’, or ‘No, you don’t do that’. Just like a husband and wife would. But … the only way you could do that is if you had that piece of paper … it’s just totally horrendous.

Jen knows that power of attorney will provide legal protection, and in some sense, a kind of legal citizenship. However, this is insufficient, and, as will be discussed below, she makes an argument for a citizenship that is embedded, rather than for mechanisms that provide fixes for heterosexist legislation. This entails a cultural citizenship where people have the right to be different and embrace identities that have traditionally been marginalized (Pakulski, 1997, pp. 80–3).

**Being a Citizen in the Summer Lake Area and in Canada**

Thus far I have provided narrative accounts of perspectives on medical power of attorney. On one level, such narratives are important in bringing to the forefront the voices of lesbians. However, individual accounts are also valuable because they add complexity to discourse, historical and political analyses of citizenship.

Citizenship does not exist merely in terms of the nation state (Richardson, 1998; Stychin, 2001; Puri, 2002). Limited state and provincial recognition of lesbians, gay men and their relationships indicates limited national inclusion. However, recognition of this is experienced and acted upon in the decisions that
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people make in their local communities. In the case of medical power of attorney, legal attempts to protect relationship bonds are considered and enacted through other kinds of citizenship.

Examining medical power of attorney reveals several issues around citizenship in Canada and in the Summer Lake area. It demonstrates a sense of precariousness about rights and relationships. It reveals the ways that indicators of heteronormative citizenship, market citizenship (Freitas, 1998; Puri, 2002), and the ‘good citizen’ (Shklar, 1991; Phalen, 1999; Richardson and Seidman, 2002) can be reinforced in the lives of some lesbians, even as they are challenged. Finally, it points to the demand for full citizenship and equality, a substantive, embedded citizenship. This notion of equality and full citizenship is the central aspect of gay and lesbian movements (Seidman, 2001). This is a citizenship where lesbians and gay men do not have to explain or justify their relationships to institutions or power holders. It calls for a social landscape where same-sex relationships are accorded the same privileges as heterosexual marriages and common-law relationships, and one aspect of full citizenship means being accorded those privileges without the need for special legal fixes.

Despite shortcomings, medical power of attorney forms may be seen as the most viable way to assert family relationships and citizenship rights in a heterosexist society. Kathryn and Holly have created these forms in a bid to gain equal treatment as a family. At the same time, they recognize that this is not an uncontested equality, since the way they are received and treated in medical situations is partly based on individual perceptions of same-sex relationships. Although it is tempting to think that medical power of attorney forms might enforce social equality, in everyday practice, such legalities are only worth the stock that power holders, local, provincial, and national, put in them. Indeed, medical power of attorney created in Ontario may not be fully recognized in other provinces. Nor does medical power of attorney offer protection against other forms of discriminatory behaviour, both in—and outside—of health care settings. Self-disclosure as lesbians and assertion of a relationship might exacerbate homophobic behaviour. The potential negative implications of self-disclosure in health care settings were frequently discussed by research participants.

Kathryn and Holly therefore recognize the importance of having advocates in the local medical system. Citizenship and associated rights for this couple are at least partially embedded in social and other contacts. In particular, they spoke of their family doctor as an advocate of their relationship and their rights, and of nursing friends as helping them in hospital settings. However, having advocates and medical contacts does not translate to a sense of community belonging or social citizenship. They both speak of Summer Lake as somewhat isolating for lesbians as well as for heterosexual individuals who do not have a long-term history in the community or who do not fit conservative behavioural expectations.

In discussing the norms of Summer Lake, ‘white, English, male, Anglophone’, middle-class, and heterosexual, Bernadette recognizes the numerous assumptions that are embedded in traditional, exclusionary citizenship understandings. In particular, her experiences reinforce arguments (Richardson, 1998; Phalen, 1999) that the normative citizen in liberal discourse is the heterosexual, white male.
She also views property ownership and consumption (Freitas, 1998) as key aspects of social belonging in this community, Northern Ontario, and Canada.

Bernadette’s recognition of the normative citizen shows that, beyond existing on the abstract level of discourse, this norm is experienced on the personal level. It is a daily reality, one that she reinforces even as her assertion of her sexual identity in health care and other settings challenges aspects of the social norm. Additionally, she demonstrates the contradictions and conditions in her life. Her discussion of the ‘flip side’ of appearing to be part of the norm illustrates how normative categories make it difficult to assert her sexual identity. It is because she appears to be the norm, and does not fit any of the negative lesbian stereotypes that continue to exist in much of this country, that it is difficult to access services when she needs to self-disclose as a lesbian.

The flip side is that because you look so much like the norm, and it affords you such privilege, it is more of a barrier to cross—you have that larger leap when you do need to be out, when you do need to access contextual services.

This means that Bernadette sometimes finds herself in ‘no-win’ situations, where, either way, her needs are not being met, or she is not being granted full rights.

So either way. If you’re really out, and you look what they consider to be the part, you have less of a leap to go to. Not that you’re going to get less oppression, you’re gonna have less of a leap to go through, because there’s an assumption that maybe you are [a lesbian], that maybe there’s something up. But then you get generalized oppression throughout your day. If you look more like the norm, you don’t get that.

This statement shows how, on an individual level, sexuality is a ‘contested, constructed and contingent’ (Cossmann, 2002, p. 50) aspect of everyday life, one that influences instances of social inclusion and exclusion. I would also argue that Bernadette’s words show how different definitions of citizenship are simultaneously experienced in everyday life. Her above discussion of the norm highlights issues of normative citizenship which, even if they are changing to some degree, remain powerful. Moreover, her description of herself and her family illustrates what Shklar (1991; see also Richardson and Seidman, 2002) calls the good citizen, the individual who maintains certain expected community standards. Bernadette identifies several actions that are part of being a good citizen in her community: displaying environmental awareness; mowing the lawn and maintaining a certain household appearance; letting her children participate in wider community life. Furthermore, she is a consumer, someone who adheres to normative social goals of owning a house and a mini-van. This offers a kind of citizenship as defined by the market (Freitas, 1998).

She also situates belonging in the realms of the family and labour contributions to society. These echo Phalen’s (1999) analysis of citizenship in general, and lesbian citizens specifically. However, while Phalen shows how lesbians have been constructed as bad mothers, Bernadette highlights how she is a
conforming to norms of being a good mother. She is concerned about her children’s health; she has commodities associated with good parenting, such as a nice house and a mini-van. She is in a committed, monogamous relationship (Richardson and Seidman, 2002). The children are signifiers of this, and of a normative identity. Bernadette and her partner can be seen as contributing to the social reproduction of the nation. This is built upon by other signifiers, including having a job, and being a good mother, as indicated by having active children. Enacting and reinforcing these various kinds of citizenship means that Bernadette does not feel the overwhelming necessity for medical power of attorney. Bernadette’s sense of citizenship and social inclusion may be conditional, but she still feels she is in some ways a recognized part of her community. This is unlike Kathryn and Holly, whose sense of social exclusion helps to place a high priority on legal measures that protect their relationship.

Still, Bernadette’s discussion of the ‘flip side’ of looking like the norm reveals her sense of social exclusion. She feels she is only granted citizenship rights if she conforms to some expected norms, norms which do not allow for a recognition of her sexual identity (Richardson, 1998). Heterosexuality is the normative mode, and so adherence to the appearance of the heterosexual citizen who produces and consumes allows her some status that she feels minimizes the need to create power of attorney documents.

**Highlighting Exclusion**

Richardson (1998) argues that lesbians and gays in Britain are granted partial citizenship rights. These are rights to existence, provided that existence remains in the private realm. Rights therefore do not extend to official recognition of same-sex relationships. They are legal, but not social citizens, as they do not, at least officially, contribute to ‘the construction of the “nation” and nationality’ (1998, p. 90). A similar situation exists in Canada (Cossman, 2002), although the issues of same-sex adoption, marriage, and benefits for partners are more openly addressed and considered by federal and some provincial courts. However, despite some progress such as amendments to the Canadian Human Rights Act, and various provincial human rights acts that prohibit discrimination on the basis of sexual orientation, lesbians and gay men still experience limited civil and cultural rights.

Circumscribed civil rights mean finding other methods to ensure that partners are recognized as having some kind of legal voice for one another. Freitas (1998) argues that, in the case of the market, lesbians and gay men must be cautious of the mechanisms by which they are offered citizenship. A market-defined citizenship is insufficient, because it does not necessarily translate to political and social rights, nor does it question the social construction of identities (Freitas, 1998, pp. 377–78). A similar argument can be made with regards to medical power of attorney. This argument can be made from at least two positions. First, this documentation actually highlights exclusion. That is, as a bid for inclusion and recognition, medical power of attorney is little more than a temporary measure. The documents do not represent a substantive, cultural citizenship.
Elizabeth Finnis

Second, medical power of attorney does little to recognize same-sex relationships as sexual relationships.

From civil and cultural citizenship perspectives, these forms, rather than make same-sex couples more like heterosexual couples in the eyes of health care workers, the law, and the state, actually demonstrate the partial citizenship of lesbians and gay men. As Jen’s statement above suggests, creating and using power of attorney reinforces a sense of non-belonging and social inequality by emphasizing the lack of state and provincial recognition that is automatically accorded to heterosexual couples. Jen’s words reflect ideas about cultural citizenship (Pakulski, 1997). Her discussion of the symbolic, public act of marriage in a church makes the argument that citizenship is not merely a reflection of the laws of the state, but also includes public social recognition of identities that have typically been marginalized (Delgado-Moreira, 1997; Pakulski, 1997). The cultural marginalization of same-sex relationships is signified by a number of actions and omissions, including the need for medical power of attorney. It is significant that Jen adheres to her decision not to create this kind of documentation despite several negative and discriminatory experiences with the health care system. In her case, the consequences of not having medical power of attorney papers are less important than the broader argument for an extension of civil rights and cultural citizenship.

Moreover, medical power of attorney may be seen as one way to assert a sexual identity, but in fact these forms do not necessarily recognize a same-sex relationship. They grant partners legal abilities, but do not recognize sexual, emotional and familial bonds. Decision-makers could be, for example, understood as roommates, rather than partners. A partnership is implicit in the medical power of attorney, but it is not explicit, nor does it need to be explicitly stated by patients or acknowledged by health care providers. In this sense, these forms desexualize and delegitimize lesbian and gay relationships, pushing them from the public realm, and reinserting it into the private realm. This is an example of what Cossman calls the ‘sexing of citizenship and privatizing of sex’ (2002, p. 49), although, as noted, this in fact denotes partial citizenship, while at the same time privatizing the identities and actions that exclude lesbians and gay men from full cultural and civil citizenship.

For Jen, this is unacceptable. She argues that her long-term, monogamous, church-sanctified relationship is entitled to the same rights as a heterosexual marriage. Other measures for recognizing same-sex relationships are not sufficient, a perspective that other Canadian lesbians have voiced (Demczuk et al., 2002, pp. 106–7). I would argue that by refusing to create this documentation of their relationship, Jen is asserting full citizenship rights, particularly cultural and civil aspects of being a citizen. She is making a statement for substantive citizenship, not merely legalistic fixes. She states that she and her partner should not be obliged by the state or their community to undertake additional legal measures to ensure that they are accorded the rights and treatment that heterosexual couples automatically receive. Rather, they should be able to take for granted their full inclusion in a society that embraces and recognizes difference (Delgado-Moreira, 1997).
Sexual Identity and Citizenship

Concluding Remarks

I have argued that ethnographic, narrative-based research can contribute to theoretical arguments about citizenship by demonstrating the nuances that theorists argue exist. Bringing to the forefront the voices of lesbian women is partially a political move, but it also has implications for citizenship analyses. These stories illustrate different positions and experiences, but also offer contextual examples of how different definitions of citizenship and social inclusion/exclusion exist and are enacted simultaneously. Theoretical writings on sexual identity, normative citizenship, markets and citizenship, and substantive citizenship can be augmented via a consideration of the complexities in the ways that lesbians negotiate social, political and civil inclusion and exclusion in their everyday lives.

Citizenship is enacted, experienced and asserted in a number of ways. I have demonstrated that through considerations of medical power of attorney it is possible to unearth and analyse the different social fields in which lesbians experience citizenship. Each of these women is speaking about how she negotiates everyday life in the Summer Lake region. Health care concerns are just one aspect of such negotiations. Creating medical power of attorney documents may help ensure that lesbians are able to access the rights accorded to heterosexual couples, but this does not mean that the women contemplating such documentation feel that it accords them a sense of belonging in a local or national arena. Medical power of attorney may rather be placed as a signifier of social inequality, thus reinforcing a sense of injustice. Even if such documentation is created, these women do not understand it as equal to full civil rights and cultural recognition. Rather, considerations around medical power of attorney can reinforce the image of the normative citizen, even as women challenge heteronormativity.

Additionally, medical power of attorney can highlight the social/cultural, political and civil exclusion that lesbians experience. This is partially because the document does not explicitly acknowledge legal decision-makers as partners in a same-sex, sexual relationship. Medical power of attorney may be framed in terms of being the best possible option, as it is by Kathryn and Holly. However, its value in terms of minimizing the chance of being denied access to a partner does not, at least for Jen, outweigh its political and symbolic meanings. It does not provide substantive, cultural and civil citizenship.

The 2003 Ontario and British Columbia court decisions on same-sex marriage have changed the power of attorney landscape for couples living in these provinces. Same-sex couples that choose marriage must now be recognized as family and decision-makers in emergency and other situations. Whether the right to marriage will be extended across Canada remains to be seen. If it is, this may help engender a sense of national social, political and cultural inclusion for lesbians and gay men, in that they and their relationships will be recognized by the state, and will no longer be dependent on a legal fix.

Finally, I am not suggesting that sexuality is the only identity through which these women experience citizenship status and practice. Sexuality is not necessarily the only, or primary, identity by which lesbians experience the self (see
Ross, 1997). Research participants to varying degrees correspond to the social ‘norm’: they are of Euro-American descent, some have children, they are lower-to middle-class and are generally well educated. Kathryn, Holly, Jen and Bernadette also have connections to hospitals and health care workers. These factors afford them a degree of social capital that other lesbians and women in Summer Lake may not necessarily have. These positions and identities can help shape decisions about medical power of attorney.

Notes

1. I am much indebted to my research participants for taking the time to share their thoughts and experiences with me. Douglass Drozdow-St.Christian provided invaluable support during the research process, for which I am most grateful. I would also like to thank Eva Mackey, Tina Moffat, and two anonymous reviewers for their thoughtful comments on early drafts of this essay.

2. These women represent three relationships. I was only able to talk with both members of one of these couples.

3. Summer Lake, as well as the names of my research participants, is a pseudonym.

4. This gender skew is probably partially related to my positioning in this community. I was told in one instance that had I been a man, few women would have been willing to participate in my research. It is possible that something similar contributed to the difficulties I faced in finding men willing to participate in this research.

5. Sean offered a contrast to these predominately negative hospital stories. He related his experiences when his late partner was dying of a chronic illness. They made numerous hospital visits, all of which Sean spoke of in positive, grateful terms. He emphasized the compassion of hospital staff, which he felt acted far beyond their official duties. It is interesting to note that Sean and his partner were highly visible members of Summer Lake. They had a number of personal contacts within the community and in hospital hierarchies.

6. Participants did discuss positive stories of staff in the emergency room. However, negative stories, both experienced by my research participants and related to them by friends, help to create a sense of uncertainty around the emergency room and longer-term hospital care.

7. Heterosexism here is defined as a set of beliefs and structures that reinforce the idea that heterosexual relationships are the natural and superior form of relationships (McKee et al., 1994). In contrast, homophobia refers to a fear of same-sex relationships, reflected in biases held and the expression of these biases (O’Hanlon, 1997).

8. Ableism refers to discrimination on the basis of perceived physical and mental ability.

References


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Ross, B.L. (1997) The House that Jill Built (Toronto, University of Toronto Press).