QUEERING BIOMEDICINE: CULTURE AND (IN)VISIBILITY IN A MEDICAL SCHOOL

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DEDICATION

This thesis is dedicated to the memory of Matthew Shepard.

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by

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QUEERING BIOMEDICINE: CULTURE AND (IN)VISIBILITY IN A MEDICAL SCHOOL

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What can the experiences of queer medical students tell us about the existence of homophobia and heteronormativity in medical environments? This thesis focuses on the experiences of queer medical students and physicians as they are enculturated into biomedical theory and practice. I begin by laying out the historical and theoretical trends in the study of sex/gender and sexuality, with a particular focus on how these trends have affected the anthropological study of sex/gender and sexuality. Next, I review the literature on queer health and medical education in order to situate the results of the research within the broader medical education and queer health disparities literatures. After detailing the methods used to gather and analyze the data that makes up this thesis, I explore my informants' experiences with their medical education and training with particular focus on medical case studies as an example of the ways that heteronormativity becomes internalized by informants in medical environments. Next, I examine the interaction between my informants' ideas about (in)visibility in medical environments, and I introduce the concept of the irrelevance narrative as a means of making sense of how informants view the role of their queerness in their practice of medicine. I conclude with a discussion of the limitations of this research and provide a list of best practices for medical education, training, and practice on queer health issues informed by the literature and my discussions with informants.

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INTRODUCTION

"If you are not like everybody else, then you are abnormal, if you are abnormal, then you are sick. These three categories, not being like everybody else, not being normal, and being sick, are in fact very different but have been reduced to the same thing."
- Michel Foucault (1975)

Visibility and social acceptance of queer[1] people in the United States is on the rise. Social institutions such as marriage and family are being rapidly reframed and reshaped in increasingly inclusive ways. New laws, such as the Matthew Shepard Act that extends federal hate-crimes protections to gay, lesbian, and transgender[2] citizens (Library of Congress 2009), are codifying human and civil rights of sexual minorities. This increased visibility also sheds light on areas of concern, including homophobic bullying directed at children and teens by their peers, physical violence towards queer people, and institutionalized heteronormativity[3] and homophobia that can negatively impact the everyday lives of queer individuals. Another area of concern brought about by this increased visibility is the lack of information regarding the health needs of queer people.

As a marginalized group, queer people are more likely to experience differences in health than non-queer people. Queer people are less likely to feel healthy, less likely to have health insurance, more likely to delay seeking or not seek medical care, experience higher incidences of poor mental health, have increased rates of substance abuse, are at increased risk for violence and injury, and experience higher rates of diseases and STIs. These differences in health and access vary depending upon which queer subgroup people fall into, whether that be gay or bisexual men, lesbian or bisexual women, or transgender people.

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[1] The term "queer" is used throughout this thesis in two ways: as an adjective, "queer" refers to non-normative sex, gender, and sexual subject positions; as a verb, "queer" refers to the exploding of assumptions that underlie the construction of sociocultural norms. See chapter one for discussion.
[2] In this thesis, "transgender" is used to refer to people whose gendered subjectivity does not match the sex/gender they are assigned at or before birth. See chapter one for discussion.
[3] "Heteronormative" is used here to refer to the reproductive heterosexual binary gender model that is assumed to be the default subject position of patients in biomedical practice.

In 2011, the Institute of Medicine (2011a) produced a report for the National Institutes of Health (NIH) indicating a vital need for further research on queer health issues. The report concluded that "lesbian, gay, bisexual, and transgender individuals have unique health experiences and needs, but as a nation, we do not know exactly what these experiences and needs are" (Institute of Medicine 2011b: 4). In other words, we know that queer people have unique health issues and experiences with medical care, but we still have not figured out how to address these concerns. This thesis seeks to help fill this gap in knowledge by focusing on how future queer providers are enculturated into biomedical systems that often reinforce the stereotypes and prejudices that lead to queer health disparities. Examining how physicians take up, reproduce, and resist oppression experienced by queer people will allow for medical education curricula to better include information on queer health issues that will allow physicians to provide better care for their queer patients.

Research Questions

Research shows that trust between patients and their health care providers is an important factor in the efficacy of healing or treatment regimens (Mead & Bower 2000; Wechsler et al. 2011). Trust between patient and provider is enhanced when patients can raise stigmatized issues without facing censure (Herek et al. 2007; Platzer 2006), when providers come from diverse backgrounds (Beagan 2003), and when providers are educated about and trained to discuss issues important to people from diverse backgrounds (Sanchez et al. 2006). The necessity to better understand the experiences and needs of queer individuals in biomedical environments requires attention to the education and training of health care providers. This thesis focuses on the experiences of queer medical students and physicians at a medical school in Texas as they are enculturated into a profession that is generally homophobic and heteronormative (Schuster 2012; Ridson et al. 2000; Eliason et al. 2011; Scherzer 2000; Sanchez et al. 2006; Diaz et al. 2001).

The research underlying this thesis was originally envisioned as part of a larger collaborative project on queer bioethics that seeks to examine the experiences of queer people in multiple medical environments, including as medical students, as practicing physicians, and as patients. The broader project is ongoing as of this publication, and it will further utilize the data used to develop this thesis in seeking to better understand what bioethical issues are specific to queer people. This thesis slightly shifted away from focusing on bioethics towards the experiences of biomedical students as they are enculturated into heteronormative and homophobic in medical environments, although that information will likely be of use in informing bioethical issues important to queer people and their health needs.

First and foremost, I wanted to document queer experiences in medical school and explore how being queer affects education in this particular setting. This research was guided by the following research questions: What is it like to be a queer medical student? How does being queer affect the experience of medical school? What can the experiences of queer medical students tell us about the best ways to promote visibility and sensitivity to queer health and health care needs? The experiences of queer medical students and physicians in the course of their training and education can help illuminate the ways that heteronormativity and homophobia become normalized in medical practice. Based on answers to these questions, what improvements can be made to medical education that could diminish the extant heteronormativity and homophobia? Once it is better understood how heteronormativity and homophobia manifest in the biomedical training and practice at this medical school, steps can be taken to make education and training improvements to ameliorate how providers engage with queer patients.

Thesis Overview

This thesis is divided into five chapters, bookended by this introduction and a conclusion. The first two chapters contain a literature review that I am framing as a primer on anthropological approaches to sex/gender, sexuality, and biomedical culture for medical students and professionals. Much of the content in these first two chapters is absent from the medical school experience as described by my informants. I have fronted the thesis with this information to better illuminate later discussions of the results of this research.

Chapter one is divided into two sections: the first section reviews historical trajectories of theories of sex, gender, and sexuality, which is necessary for understanding the anthropological approaches to sex, gender, and sexuality discussed in the second section of the chapter. Chapter two covers issues relevant to queer health and biomedical culture, including a discussion of biomedical practice, authoritative knowledge and medical authority, cultural competency training and education, patient-provider relationships, the minority stress model, and specific queer health disparities. Chapter three lays out the methodological approaches and concerns behind the research making up this thesis.

Chapters four and five address the findings of the research. Chapter four discusses the lack of training and education on queer health issues and how the absence of queer visibility in biomedical training and education contributes to an internalization of heteronormativity in queer medical students and physicians. Chapter five explores issues of queer (in)visibility and (ir)relevance in biomedical environments and how different medical subfields are perceived to have greater or lesser amounts of homophobia. The conclusion provides a summary of the thesis’ important points as well as a list of best practices for improving training and education on queer medical issues.

CHAPTER ONE: QUEER LIVES: THEORIES OF SEX, GENDER, AND SEXUALITY

It is impossible to separate studies of human beings from the sociocultural histories within which they are embedded (Marks 2012). As such, any attempt to produce knowledge about human lives will always already be political. This is clearly evidenced in the history of theories of human sex, gender, and sexuality. This chapter consists of two sections. In the first section, I explore historical trends in the study of sex, gender, and sexuality, paying particular attention to the importance of terminology. The second section reviews how these trends have interfaced with anthropological studies of non-normative[4] genders and sexualities.

Theorizing Sex, Gender, and Sexuality

Before the Enlightenment, gender and sexual acts were considered spiritual or religious matters in Euro-American cultures. Same-sex desires and non-normative gender behaviors occurred, but there were not identities or subjectivities built around these desires and behaviors (Abelove 1989; Lacquer 1990; Foucault 1990; Sullivan 2003). Changes in political power from monarchies to democratic republics concomitant with the birth of science and biomedicine during the Enlightenment shifted gender and sexual behaviors from the purview of the Church to juridico-medical realms. The scientific project to categorize and catalogue the world changed and increased discourse[5] about gender and sex, and, by the end of the 19th century, sexuality emerged (Foucault 1990; Abelove 1989; Weeks 1985; Katz 2007).

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[4] "Normative" here means behaviors that are considered ordinary according to the cultural logic of a particular society. Normative and "normal" are not used interchangeably as *normal* is seen to make moral and political claims and often has stigma attached to it whereas *normative* is an indicator that a particular behavior is considered out of the ordinary by members of a particular group without necessarily implying any moral or political features.

[5] Discourse is here defined as ways of communicating that establish and maintain culturally intelligible social norms.

In the mid-19th century and continuing through the early 20th century, the academic discipline of sexology sought to scientifically explain gender and sexuality (Weeks 1985; Sullivan 2003). Early sexologists such as Richard von Krafft-Ebing (1886), Havelock Ellis (1897), and Magnus Hirschfeld (1919) theorized both sex and gender as biologically derived, with sex as the immutable form a person's body took and gender as the person's innate psyche or soul. Sexual abnormality, *e.g.*, homosexuality, was considered a congenital defect of a mismatched psyche and body. For example, a homosexual man was a biological male with the psyche of a female. Sexologists referred to such persons as "gender inverts," which was a broad category that referred to people who today would be thought of as gay, lesbian, and transgender.

Beginning in the early 20th century, psychology gradually overtook sexology in the theorizing of sex, gender, and sexuality (Sullivan 2003). Psychologists conceived of sex and gender in the same way as sexologists, *i.e.*, sex as biological and gender as psyche, but for psychologists—and Freudian psychoanalysts in particular—gender inversion (and later homosexuality and transgenderism) was a psychological pathology curable through therapy or other medical interventions. This position is still held by the American Psychiatric Association with regards to transgender individuals (Kamens 2011).

It was not until the late 1960s that second-wave feminism began to move sex, gender, and sexuality away from psychological and sexological conceptualizations. One of the key features of second-wave feminist theory was the establishment of the sex/gender dichotomy (Rubin 1975), which is largely still used in the social sciences today. Under this paradigm, sex is viewed as the biological/bodily framework upon which gender is socioculturally built and elaborated. Rubin (1975: 94) proposed that societies build gender roles on top of understandings of bodily sex that are usually integrated with kinship and marriage practices.

This dichotomy was politically important for feminists because it destabilized oppressive patriarchal gender norms by separating biological sex and social gender into two distinct ontological categories such that a person's sexed body did not determine their gender roles in society. Thus, the type of body a person inhabited is necessary for but does not determine their gender and by extension the gender roles they fill. Rubin drew sexuality out of the sex/gender system, arguing that sexuality was independent of gender-specific behaviors. Sex, gender, and sexuality, though related, were ultimately three separate modalities in Rubin's sex/gender system.

Serious challenges to the sex/gender dichotomy have been raised in the last 30 years. Perhaps the most important critique addresses the lack of intersectionality[6] in the conceptualization of woman as a universal category (Mikkola 2011: 3.1.1). Second-wave understandings of "womanhood" were based on white, straight, American middle-class women's lived experiences and mostly ignored the experiences of the poor, women of color, and lesbians, and they assumed that the most important forces of oppression that all women faced were based on gender (hooks 2000; Anzaldúa 1999). These critiques have mostly been addressed in third-wave feminism, which arose beginning in the late 1980s. Third-wave feminists seek to explore the interconnectedness of gender, race, socioeconomic status, sexuality, and disability (for examples, see hooks 2000; Anzaldúa 1999, 2009; Butler 1990, 1993, 2004; Frank 2000).

Another challenge to the sex/gender system arose from poststructuralist reconceptualizations of the body, gender, and sexuality. Poststructuralist-inspired attention to discourse influenced scholars to begin thinking of gender as more than an enculturated or

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[6] Intersectionality can best be thought of as the ways that different axes of oppression and prejudice intersect with one another. For example, an intersectional approach to gender would pay attention to the ways that experiences and expressions of gender are different depending on a person's race, socioeconomic status, sexual orientation, and disability status.

socialized way of being. Instead, gender began to be thought of as (re)produced through discourse. In particular, the work of Judith Butler (1990, 2004) has been pivotal in revolutionizing theories of sex and gender.

Under a Butlerian paradigm, sex, gender, and sexuality are all discursive. Sex is not a biologically neutral given upon which culture builds gender, but a way of categorizing material bodies that is based on already existing understandings and discourses of gender. If sex is a category of embodiment, then gender is something different. For Butler, gender is not something a person is or possesses, nor is it the expression of an innate, essential state of being. Rather, gender is something a person *does*. This idea is the basis of Butler's theory of the performativity of gender.

British philosopher and linguist J.L. Austin originally proposed performativity as a type of utterance that is active rather than descriptive, "a way of 'doing things with words'" (Hall 2000: 184). Performative speech acts are contrasted with constative speech acts (Stryker 2006: 10-11). Performative speech acts are utterances that perform a particular action; they are not descriptive and they are not demonstrably true or false. An example of a performative speech act is "I apologize," where the words perform the action of apologizing. A constative speech act, on the other hand, is a declarative statement that is demonstrably true or false; it seeks to share information about a situation or condition. An example of a constative speech act is "it is raining outside." Butler (1988, 1990, 2004) applied the concept of performativity to gender, extending the basic idea behind performative speech acts—that speech utterances can be the productive source of action—to potentially cover any conscious or unconscious discursive or bodily practices as the (re)productive source of gender. In other words, it is not *just* discourse that (re)produces gender, but also the bodily practices that emerge out of, respond to, and reinforce such discourses.

For Butler, performativity "is not a singular act, but a repetition and a ritual, which achieves its effects through its naturalization in the context of a body, understood, in part, as a culturally sustained temporal duration" (1990: xv). Gender, then, is produced through repeated, non-conscious acts of performance that reinforce and reconstruct gender even as they are being performed. Similarly, sex is assigned to bodies through performative actions. For example, when a person is born in an American hospital, the physician will take a cursory glance at the genitals and, if there are no obvious ambiguities, the physician makes the performative utterance of "it's a boy/girl!". This performative declaration has the effect of "officially" creating that person's sex based on the physician's gendered understandings of what constitutes a "normal" sexed/gendered body (Fausto-Sterling 2000; Karkazis 2008). Interestingly, biotechnology such as ultrasonography machines now allow for this performative utterance to occur before birth, as early as 12 weeks into pregnancy (Efrat et al. 2006).

Butlerian performativity has been criticized for its vagueness, a point Butler has conceded and sought to correct (see "Preface (1999)" to *Gender Trouble*; Butler 2004). One attempt to remedy this ambiguity has been to distinguish between involuntary (performative) and voluntary (performance) acts (Sullivan 2003: 88-90). This interpretation elaborates performativity as lacking agency due to being a mostly unconscious activity, while making performance an agentive act of intentional expression. The example often provided to make this distinction is drag performance, where drag queens are "performing" "woman" while performatively doing their own gender, which may be labeled anything from "gay man" to "transgender" to "drag queen". Susan Stryker (2006) neatly summarizes Butler's theory thusly:

> To say that gender is a performative act is to say that it does not need a material referent to be meaningful, is directed at others in an attempt to communicate, is not subject to falsification or verification, and is accomplished by "doing" something rather than "being" something. A woman, performatively speaking, is one who says she is—and who then does what woman means. The biologically sexed body guarantees nothing; it is necessarily there, a ground for the act of speaking, but it has no deterministic relationship to performative gender. (10).

Another critique of the sex/gender system comes from Anne Fausto-Sterling (2000). Fausto-Sterling, extending Butler, poses that the categories of sex and gender are not separate:

> Our bodily experiences are brought into being by our development in particular cultures and historical periods. But especially as a biologist, I want to make the argument more specific. As we grow and develop, we literally, not just "discursively" (that is, through language and cultural practices), construct our bodies, incorporating experience into our very flesh. To understand this claim, we must erode the distinctions between the physical and the social body. (Fausto-Sterling 2000: 20)

Further, Fausto-Sterling (2000: 110), following Suzanne Kessler's (1998) critique of her tongue-in-cheek five-sex system, suggests that there are no discrete categories of sexed bodies, only a nearly infinite range of biological variation; that we attempt to fit this variation into one of two narrowly defined categories affects how bodies develop.

Extensions of this biocultural critique of the sex/gender system have emerged from medical anthropology as well. Katrina Karkazis (2008) argues that sex and gender are both socially constructed because biological sex as a category only makes sense as "an *effect* of gender" (13, emphasis original). Fausto-Sterling and Karkazis both provide empirical evidence for Butler's (1990) critique of the sex/gender system, which questioned how useful it is "to define gender as the cultural interpretation of sex, if sex itself is a gendered category" (10).

The realization of the inseparability of nature and culture (Haraway 1991; Marks 2012) further reshapes understandings of sex and gender, shifting from viewing them as separate, specific categories to deeply and complexly interconnected categories that are not easily extricated from one another. Our understandings of biological sex, to paraphrase Fausto-Sterling, come already wrapped up in understandings of gender. In this way, it is not that gender is built on top of biological sex as Rubin (1975) suggested, and it is not that sex is built out of gendered discourse as Butler (1990) suggested, but rather that sex is bioculturally co-produced (Fausto-Sterling 2000; Marks 2012) and gender is performatively produced and embodied.

In addition to third-wave feminist critiques, queer theory also challenged the sex/gender system, though from a slightly different perspective. The foundations of queer theory are built around Foucault's (1990) discussion of sexuality as a recent sociohistorical phenomenon and Butler's (1990) theory of gender performativity. Queer theory differs from third-wave feminism in that queer theory seeks to disrupt heteronormative understandings of and assumptions about sexuality and, by extension, gender, though this is a later and secondary concern to queer theorists. "Heteronormative" refers to the cultural logic that values oppositional and complementary binary sex/gender and sexual roles as natural and normal. Heteronormativity presumes the normative baseline by which to categorize and judge behavior is a reproductive, heterosexual, gender-normative subject position. Queer theory challenges heteronormativity on both ontological and analytical grounds by privileging non-heteronormative experiences and subject positions. As such, one way to get at the extant heteronormativity and homophobia of medical environments is to talk to queer people about their experiences of such environments.

Further, queer theory's focus on abjection, or that which disrupts normative social order (Kristeva 1982), allows for queer theory to be applied outside of the realm of sex, gender, and sexuality to a variety of topics, including marriage and family, personhood, class and social status, religious practices, or any other topic that includes the study of social organization, as well as in a variety of disciplines, including all four subfields of anthropology, sociology, psychology, cultural studies, history, science studies, philosophy, and literature, among others.

Queer theory is also "suspicious of categorization and is attentive to the process of categorization itself" (Valentine 2007: 24). Indeed, even the word "queer" is a problematic term. Some scholars consider it an umbrella term covering any non-normative sexual behaviors, including non-normative heterosexual behaviors such as kink and polygamy in non-native North America (Halperin 1995: 63). Others think of "queer" as a set of strategies and actions for enacting a radical questioning and challenging of sociocultural norms (Sullivan 2003: 44). Yet, "queer" has been critiqued as a falsely unifying term that attempts to group together a heterogeneous group under one identity category, thus erasing difference in the process and upholding the false binary that heteronormativity presumes, *i.e.*, heterosexual/non-heterosexual (Anzaldúa 2009: 164).

Where queer theory focuses heavily on sexuality, transgender studies seeks to further theorize gender by bringing attention back to "queer" (non-normative) genders as well as sexualities. Transgender studies stands at the intersection of feminism and queer theory (Whittle 2006), though it emerged out of a lack of attention and often outright hostility (*cf.*, Raymond 1979) towards trans people from queer and feminist scholars. Trans people were, and to an extent still are, viewed by assimilationist[7] gay and lesbian people as being *too* gender variant and, thus possibly a threat to the push for social equality.

The transgender label (and thus subject position) emerged in the late 1990s (Valentine 2007). In some ways, the emergence of this category mirrors Rubin's (1975) sex/gender dichotomy in that the "gender" part of "transgender" is often separated from sexuality, pushing it out of the main focus of the gay and lesbian liberation movement. Like "queer," "transgender"

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[7] There is an ongoing—if not outdated—debate among gay and lesbian rights advocates as to the goals of the queer rights movement. The assimilationist camp seeks to be accepted into and made one with mainstream society; the liberationist camp seeks freedom to recognize gender and sexual norms free of the bonds of traditional notions of gender. There are few people who are either strict assimilationist or strict liberationist as the ultimate goal of both camps is recognition of and respect towards non-normative genders and sexualities by mainstream society.

can be a problematic term. In its contemporary popular usage, “transgender” is an umbrella term applied to any non-normative gender, including drag queens and kings (gay men and lesbians, respectively, who cross-dress for entertainment purposes), transvestites (typically heterosexual men who cross-dress for fetishistic reasons as opposed to identifying as another gender), transsexuals (people who are transitioning or have socially and/or physically transitioned to another sex), and androgynous and genderqueer people (people who do not fit neatly into—and typically eschew—gender binary categories) (Sullivan 2003). While it is certainly important to recognize that there is a deep history to gender non-conformity and non-normativity (Stryker 2008), the application of the term “transgender” retro-historically and cross-culturally is not without issues as it is a sociohistorically recent concept that does not necessarily graft neatly onto other gender systems (Sullivan 2006: 14; Towle & Morgan 2002; Valentine 2007).

There are many trans critiques of feminism and queer theory (Stryker 1998, 2004, 2006; Hines 2006; Hausman 2001). Perhaps the most important trans critique of feminist theory concerns on-going battles over the category of “woman.” According to many trans theorists, the idea of “woman” has often been used to further specific agendas, typically at the expense of people of color, poor people, certain religious and ethnic groups, specific ideologies or politics, disabled people, and queer people (Stryker 2006; Koyama 2006; Valentine 2007). The battle by trans women[8] to be recognized as women continues in this vein. Thus, trans theory disputes “woman” as an ultimate unifying category (Stryker 2006; Koyama 2006; Hausman 2001).

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[8] There is often confusion stemming from the terms “trans woman” or “trans man” because medical providers and trans people use them differently. For medical providers, a “trans woman” is a person who was assigned female at birth but has transitioned to “man”; for trans people, a “trans woman” is a person who was assigned male at birth but has transitioned to “woman.” This is interesting as it demonstrates the privileging of assumed immutable nature on the part of medical providers and the privileging of agency and experience on the part of trans people. For the purposes of this thesis, I follow the conventions of trans people; thus, “trans woman” here means a person who was assigned male at birth but has transitioned or is transitioning to a woman.

Concomitant with the questioning of the category of "woman" is a struggle over concepts of masculinity. Known now as "the border wars," these heated debates contested the distinctions between butch (masculine) lesbians and female-to-male (FTM) transsexuals (Halberstam 1998; Hale 1998; Rubin 2003; Valentine 2007). Like feminism with womanhood and queer theory with sexuality, the border wars are an example of trans theory seeking to work out extant theoretical issues surrounding masculinity (Connell 2005; Gutmann 1997, 2007; Lancaster 2006). One serious concern about the effects of the border wars is the lack of an "analogous culturally valorized space for male-bodied 'transgender fems,' gay men who adopt, play with, or assert femininity as a central aspect of their senses of self, beyond the figure of the performing drag queen" (Valentine 2007: 153), which leads to the unquestioned assumption of certain male-bodied feminine people, particularly drag queens and transvestites, into the "transgender" category.

Trans theorists have also criticized queer theory for its own perpetuation of normativity. Queer theory's recognition of heteronormativity is predicated on a focus on same-sex sexualities at the expense of gender variance. This leads to *homonormativity*, which Stryker (2004, 2006: 7) defines as viewing homosexual variance as the most important or most valid divergence from heteronormativity, which often promotes assumptions about other queer differences and experiences. In other words, the privileging of gay and lesbian subjectivities in the larger queer movement creates a homonormativity that transgender studies fights against. This homonormativity is also most often lacking in intersectionality, centering the queer rights movement around the experiences of white, middle- to upper-class, gay men and lesbians.

Heteronormativity and homonormativity both depend upon varying degrees of visibility and invisibility among heterosexual, homosexual, and transgender people. Visibility can be defined as the ability to be perceived or noticed. Queer rights movements have brought queerness into a state of visibility by making queer lives more able to be perceived and noticed by non-queer people. Historically, this visibility has been driven by gay and lesbian liberation movements, but other types of queer movements—especially transgender and transsexual movements—over the last 20 years have also contributed and have brought attention to the ways that gay and lesbian liberation movements have marginalized and ignored non-gay and non-lesbian queer people.

If visibility is the ability to be perceived or noticed, then invisibility is the state of being hidden. Invisibility can be voluntary, such as "staying in the closet," and it can be involuntary, such as being forced to the margins of society—quite literally in some cases (Biehl 2005). Experiences of visibility and invisibility differ for various marginalized peoples. For example, some gay, lesbian, and bisexual people can "pass" as heterosexual, some people with disabilities have invisible disabilities that are not immediately apparent, and clothing may permit people to hide or alter the appearance of their bodies in order to be perceived as a certain gender. On the other hand, people of color and people with physical disabilities cannot readily make themselves invisible, though the way they are treated in society may often render their suffering and oppression invisible.

One way this increased visibility can be measured is through the increased presence of queer people and issues in mainstream (as opposed to queer) media. American attitudes towards queer people have changed dramatically over the last 40 years. Just between 2003 and 2013, American opinions on queer people—specifically gay and lesbian people—have shifted radically (Pew Research Center 2013). Sixty percent of Americans (up from 47 percent in 2003) now say that homosexuality should be accepted by society, and only 31 percent (down from 45 percent) say that it should be discouraged. Seventy-two percent (up from 59 percent) now say that marriage equality is inevitable.

This sea change can be attributed to increased queer visibility. Today, 87 percent of Americans personally know someone who is gay or lesbian, compared to only 61 percent in 1993 (Pew Research Center 2013). Nearly half (49 percent) have a close family member or friend who is gay or lesbian, and 31 percent know gay or lesbian people raising children. Trans Americans are also increasingly visible, with celebrities like Chaz Bono and former Navy SEAL Kristin Beck (Beck & Speckhard 2013) publicly sharing their stories of transitioning, in addition to a plethora of trans characters in television and film over the last decade. Queer people have even become such a fixture in American media that Americans severely overestimate how many Americans are gay or lesbian, with slightly over half of Americans believing that at least 25 percent of the population is gay or lesbian (Morales 2011). The number is actually closer to 3 to 5 percent (Gates 2011).

The situating of these various concepts of sex, gender, and sexuality as a locus of how people make sense of themselves is a recent sociohistorical development (Foucault 1990; Lacquer 1990; Weeks 1985). This is typically described in terms of identity; however, identity is a problematic concept (Barth 1969; Handler 1991, 1994; Rouse 1995; Anzaldúa 2009; Valentine 2007), specifically because of the implicit accompanying identity/behavior binary (Elliston 1995; Boellstorff 2011) that separates identity from behavior. Further, the concept of identity sometimes makes it hard to tease out the relationship between agency and structure. An interesting alternative is the subject position/subjectivity framework (Boellstorff 2005). Subject positions are culturally intelligible categories of persons, and subjectivities are the senses of self that are generated while inhabiting subject positions. This allows for a more nuanced view of how a person develops a sense of self while inhabiting multiple subject positions; for example, a queer person's subjectivity can arise from inhabiting multiple subject positions simultaneously (man, woman, non-gender conforming, homosexual, androsexual, and polyamorous). In this way, their sense of self is not compartmentalized into different identities that intersect, but rather their sense of self arises out of inhabiting myriad subject positions. Subject positions and subjectivities—much like agency and structure—shift and change over time in relation to each other.

Given this framework, the previously established understandings of sex and gender, and borrowing from Blackwood (2010: 29), I define gender as *the performative and embodied processes of subjectivity formation that are continuously (re)enacted through and contingent upon distinct social relations that develop recognizable subject positions*. Gendered subject positions and subjectivities are produced along axes of *masculine*, *feminine*, and *androgynous* characteristics that shift across time and space.

Ultimately, this research depends upon theoretically sound and anthropologically informed conceptions of sex, gender, and sexuality in order to clearly define the population and methods proposed to answer the research questions. As such, it is necessary to next discuss how queer lives have been examined in anthropology.

Anthropological Approaches to Sex, Gender, and Sexuality

Anthropological approaches to non-normative genders and sexualities are reflective of larger disciplinary movements. According to Lewin & Leap (2002), anthropology has made three major "turns" over the last fifty years. In the late 1960s, anthropology experienced the "justice turn," with much anthropological research that began to question modernization and development projects around the world. In the mid-1970s, anthropology experienced the "feminist turn," which challenged androcentrism in anthropological practice and focus, as well as in the discipline's structure. In the mid-1980s, anthropology underwent the "reflexive turn" in response to postmodern critiques, which drove anthropologists to more carefully consider their own roles in the kinds of data they collect.

In the mid-1970s, feminist critiques began to radically shift anthropological analysis as the recognition of male privilege and patriarchy within anthropology informed feminist critical theories. It was during this time that the sex/gender system came to be used in anthropology (Rubin 1975). Second-wave feminist writings tended to treat women as a universal category based on the straight, white, middle-class woman as a default, and much of the feminist anthropology written at that time fell into a similar trap (see Lewin 2006 for discussion). Third-wave feminism brought greater attention to the widely varying lived experiences of women (Haraway 1984, 1991; Scheper-Hughes 1992; Moore 1994; Frank 2000; Lewin 2006; Wardlow 2006; Abu-Lughod 2008; Blackwood 2010). Feminist anthropology—like feminism more generally—is also enmeshed in political activism. This is especially evident in medical anthropology, where feminist anthropology has been engaged with issues of reproduction and women's bodily autonomy (Ginsburg 1989; Davis-Floyd 1992; Scheper-Hughes 1992; Ginsburg & Rapp 1995; Rapp 2000; Martin 2001; Browner & Sargent 2007; Galvez 2011).

Gay and lesbian anthropology began taking shape in the early 1970s, and it focuses exclusively on the lives of gay men and lesbians. Older scholars have tended to maintain a distance from queer theory and ethnography due to what they feel is an overextension into a "complex gender politics that transcends differences" (Lewin & Leap 2002: 11). Leap (2002) in particular specifically rejects queer approaches to language because they would necessarily involve intersectionality, which he claims would move inquiries of "gay languages" away from a focus on sexuality. This sort of "gay/lesbian exceptionalism" that ignores intersectionality is present in some earlier anthropological inquiries of non-normative sexualities, but it is not as common as inquiries that utilize queer theory.

Laud Humphreys' (1970) controversial ethnographic study of male-male sexual encounters in public restrooms (known as "tearooms" in American gay slang) was the first ethnography that focused on homosexuality. Humphreys' methods are considered highly unethical today, and the text is often used as an example of how *not* to conduct ethnographic research.[9] Esther Newton (1972) published the first ethnography of a homosexual community. *Mother Camp* is a multi-sited ethnographic study of the lives of female impersonators (drag queens). Newton's ethnography is cited ubiquitously in queer ethnography as a foundational text. Further gay and lesbian ethnographic work can be found in Kath Weston's (1991) and Ellen Lewin's (1993, 2009) texts on gay and lesbian parenting in the United States.

An interesting connection between feminist theory and gay and lesbian liberation is how homophobia is inextricably linked to misogyny and sexism and is often derived from perceived gender differences and the connections between gender and sexuality (Parrot et al. 2002; Dreyer 2007; LaFont 2009; Kulick 2009). To this extent, homophobia is not only an issue of sexuality, but also of gender differences, real or perceived. This exposes a weakness of gay and lesbian ethnography because it deliberately focuses on the hetero/homo dichotomy to the exclusion of more nuanced intersections of power implicated in gendered subject positions.

Early anthropologists observed or heard of non-normative sexes, genders, and sexualities. Unfortunately, many of them neglected to report their findings until decades after their fieldwork was completed, if they ever reported on them at all (Murray 1997; Murray & Roscoe 1998;

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[9] Humphreys regularly invaded people's privacy and had no informed consent for informants.

Weston 1993; Boellstorff 2007a). Evans-Pritchard (1937), for example, did not discuss male homosexual behaviors among the Azande in his text *Witchcraft, Oracles, and Magic Among the Zande*, although he did bring up female same-sex relationships because they were relevant to the context of the traditions he was studying. Evans-Pritchard initially published his findings on male homosexuality among the Azande in an obscure and inconsequential journal (Evans-Pritchard 1957) before later detailing Azande male homosexuality in a more widely read anthropological journal (Evans-Pritchard 1970). In these articles, Evans-Pritchard illuminated the pre-colonial Azande practice of taking on boy wives, where warriors would practice age-stratified homosexuality by temporarily marrying boys who functioned as the warriors' wives. This practice was institutionalized among the Azande such that these marriages were modeled on the more typical male-female marriages to the extent that warriors paid boy wives' families a brideprice. The boys were viewed as women, proclaimed that they were women, and were addressed as "my wife" by their warrior husbands (Evans-Pritchard 1970: 1429-1430). Murray & Roscoe (1998: xiii) note that had Evans-Pritchard not published this information before his death in 1973, it is possible that we would never have known about these practices among the Azande.

In part due to third-wave feminist emphasis on the diversity of women's experiences, the first anthropological forays into studying non-normative aspects of gender and sexuality as central themes came about in the late 1980s and early 1990s. Gilbert Herdt (1987, 1993, 1996) helped establish the "third gender" concept in contemporary anthropology, which he used as an analytical framework for his fieldwork in Papua New Guinea. "Third gender" refers to institutionalized gender subject positions that exist within non-binary gender systems. This concept has been adopted and utilized by many other anthropologists, including Roscoe's (1991, 1998) and Blackwood's (1984) examinations of the *berdache* in Native North America, as well as Nanda's (1998) examination of *hijras* in contemporary India. The concept has been criticized for failing to trouble assumed gender binaries in that "third" is often used to mean "other," in opposition to "normal" binary genders (Towle & Morgan 2002). The "third gender" concept is still used today, though it is almost exclusively applied to non-Western societies that appeared to institutionalize what anthropologists considered gender-variance. Thus, the term "transgender" has quickly been picked up and applied to Western societies in lieu of utilizing the "third gender" category. Over time, the term "transgender" has been haphazardly applied cross-culturally (Valentine 2007: 91; Towle & Morgan 2002: 473-474; Stryker 2006: 14) despite the fact that this category is often not a recognized subject position in the societies being examined by anthropologists.

In the mid-1990s, anthropologists began to take the critiques of queer theory into the discipline. Many anthropologists, already engaged in the methodological cultural relativism typical of anthropological inquiry, found it unproblematic to employ queer theory's normative-disruptive project. The utilization of queer theory in ethnographic inquiry expanded the realm of inquiry beyond gay and lesbian lives to include all non-normative sexualities and gender variation. It also began to problematize the ways that "gay" and "lesbian" have been unquestioningly applied across time and space, though as previously mentioned other categories such as "transgender" continue to be carelessly applied cross-culturally (Towle & Morgan 2002).

Queer anthropological work in Indonesia by Tom Boellstorff (2005, 2007b) and Evelyn Blackwood (2010) exemplify the application of queer theory to anthropological inquiry. Boellstorff's ethnographies incorporate research on the Indonesian islands of Java, Sulawesi, and Bali. In *The Gay Archipelago*, Boellstorff (2005) queers the concept of scale by treating Indonesia as one ethnographic unit instead of multiple "ethnolocalized" sites where the spatial scale where “ethnicity” and “locality” merge into a single concept. He calls this approach “multi-sited in one place” (20) and compares it to doing ethnography in different neighborhoods in one city and calling the whole city the fieldsite. In this way, Boellstorff examines how “gay” and “lesbian” have been “dubbed” into Indonesian culture and created the “authentically Indonesian” (6) subject positions of *gay* and *lesbi*. In other words, gay and lesbian subject positions are not “local” or national in origin, but they are now a particular part of the national Indonesian character. Boellstorff’s (2007b) follow-up, *A Coincidence of Desires*, uses his fieldwork in Indonesia as one case study among others from across Southeast Asia to explore the connections between anthropology and queer studies.

Blackwood’s (2010) fieldwork took place on the island of Sumatra in Indonesia. Her work focuses almost exclusively on *lesbi* subjectivities and *tombois*, or masculine *lesbis*. Blackwood examines how concepts of gender are wrapped up in these sexual subject positions, noting that *tombois* will only date *lesbis* and refuse to date other masculine women. Blackwood argues that the *tombois* are not transgender, but are rather performatively doing masculinity and femininity in various ways, extending Halberstam’s (1998) work on female masculinities, which sought to detach masculinity from men and male bodies.

There are a multitude of other queer anthropological texts, including many edited volumes (Robertson 2005; Lewin & Leap 1996, 2002, 2009; Leap & Boellstorff 2003; Murray & Roscoe 1998; Murray 2009), reflexive accounts of being a queer anthropologist (Newton 2000; Lewin & Leap 1996), and various ethnographic works focusing on myriad topics and regions (Nanda 1998; Bunzl 1999; Manalansan 2003; Sinnott 2004; Lewin 1993, 2009; Gray 2009; Weiss 2011). There are also queer approaches in other subdisciplines, most notably archaeology (Blackmore 2011; Cobb 2005; Croucher 2005; Dowson 2000, 2006; Geller 2008; Ransley 2005;

Schmidt 2002; Strassburg 2000; Voss 2008; Voss & Schmidt 2000), but also linguistic anthropology (Leap 1995, 1996; Leap & Boellstorff 2003; Kulick 2000) and biological anthropology (Geller 2009).

More recently, anthropologists have begun to focus on transgender and transsexual subjectivities. Don Kulick's (1998) work in Salvador, Brazil, looks at the lives of *travestis* (a particular kind of Latin American transgendered subject position) as they take on feminine gender roles just prior to puberty. The male-bodied *travestis* do not identify as men or women, but as *travestis*, even as they take on feminine names, dress in women's clothes, and modify their bodies using industrial-grade silicone injections to look more feminine. *Travestis* express a sexual subjectivity centered on active/passive sexual roles such that they will only date masculine men who are active in sexual encounters. At any sign that their boyfriends wish to take on the passive role, they abandon their boyfriends to find a "real man." Thus, Kulick argues that gender norms for *travestis* are indicative of a man/not-man binary rather than a man/woman binary.

David Valentine's (2007) "ethnography of a category" examined how "transgender" came about as a category of identity in New York City in the late 1990s. Valentine critiques how transgender has been "imagined" by social scientists—particularly anthropologists—and how these imaginings can do violence to people as they erase their experiences for the sake of fitting them into a universalizing umbrella category. Valentine (2012) also problematizes the gender-normative assumptions that many queer anthropologists make concerning transsexual lives. He challenges those who have an interest in queer and trans studies to think about the ways that they inscribe gender on their bodies. He concludes that it is a difference of degree, not kind; going to the gym every day to build up one's physique is still a gendered form of body modification, just as is sex-reassignment surgery. In this way, Valentine problematizes the naturalization of the non-transsexual body by pointing out how we are all complicit in gendered body modifications of one sort or another.

There are few other ethnographic works that examine the lives of transgender and transsexual people. Those that do exist examine *kathoey* (or “lady boy”) subjectivities in Thailand (Totman 2004), *hijra* and gender variance in India (Nanda 1998; Reddy 2005), fa’afafine in Samoa (Schmidt 2010), transsexual men in America (Rubin 2003), and transsexual women’s transitional “rites of passage” (Bolin 1988).

Anthropological scholarship on queer subjectivities continues to move in new and interesting directions; however, there remains a dearth of anthropological approaches to the health and well being of queer people.

CHAPTER TWO: QUEER HEALTH: BIOMEDICINE, MEDICAL AUTHORITY, AND HEALTH DISPARITIES

As with sex, gender, and sexuality, health and illness are always intimately connected to the political (Fassin 2007; Singer & Baer 2007). For example, biomedical approaches have historically been used in the oppression of marginalized groups (for examples, see Washington 2006; Skloot 2010; Sullivan 2003). Fortunately, bioethics has advanced to include stricter guidelines governing scientific and medical research and experimentation in an effort to avoid such abuses. Despite its variable presentations and practices, biomedicine remains a privileged institution in American society (Kleinman 1995).

This chapter will address many important factors that contribute to queer health disparities, including the role of authoritative knowledge and the hidden curriculum in biomedical education that works to reproduce cultural norms in biomedical praxis; how patient-provider interactions help and hinder the efficacy of health care; the role of cultural competency in medical education; and the minority stress model as an explanation for queer health disparities.

Biomedicine, Authoritative Knowledge, and the Hidden Curriculum

Biomedicine can be understood as a set of theories and practices that seek to address health and illness from a biological perspective. Biomedical approaches focus on pathology and how disease affects the normal functioning of human bodies. Within American biomedicine, particularly among MDs, there are certain common patterns of socialization, including biologically reductionist approaches to human bodies that seek biological rather than sociocultural bases of disease and positivist scientific epistemologies that privilege objective, rational, and empirical methods of knowledge generation.

Biomedicine as a practice and institution is a form of biopower, which refers to the ways that power actively shapes and molds bodies (Foucault 1990). Biopolitics, then, are the ways that state apparatuses utilize biopower to manage individuals and populations. Biomedicine, as a biopolitical practice, is often lauded in Euroamerican societies as the best means by which to produce "good" and "healthy" citizens, and is thus intimately tied to the production of cultural knowledge and the exercise of power. For example, social workers categorize transgender people based on biomedical definitions of sex and gender that conflate sex and gender as a biological phenomenon, often against the expressed identity of the trans individual. As such, social workers' understandings of transgenderism, derived from biomedical practice, can be viewed as a means of making sense of bodies in order for the state to better categorize them, manage them, and ultimately have them discipline and manage themselves with the goal of producing good citizens (Valentine 2007).

In order to be a useful biopolitical tool, biomedicine must operate as a source of authoritative knowledge. Authoritative knowledge is defined by Brigitte Jordan (1997: 56-58) as any knowledge that participants in a community agree is consequential to such an extent that it informs their decision-making and supplies justifications for actions resulting from those decisions. Authoritative knowledge is considered legitimate, consensual, meaningful, official, and appropriate by people within a community such that the knowledge becomes hegemonic, is naturalized, and renders other ways of knowing unthinkable. In this way, authoritative knowledge is actively, routinely, and unreflexively produced and reproduced.

Unfortunately, the types of knowledge that are valued by biomedical educators and practitioners tend to exclude social and psychological data because they are not viewed as important aspects of case reports or clinical presentations (Good et al. 2005). Thus, educators and providers often ignore the sociocultural aspects of biomedicine, thereby reinforcing the sense of a “culture of no culture” (Taylor 2003) and obfuscating the role of culture in biomedical authoritative knowledge production.

One way that physicians take up and reproduce the authoritative knowledge of biomedicine is through what is known as the “hidden curriculum” of medical education (Davis-Floyd 1992; Hafferty 1998; Patenaude et al. 2003; Woloschuk et al. 2004; Newton et al. 2008; Gaufberg et al. 2010; Neumann et al. 2011; Rosenthal et al. 2011; Hafler et al. 2011). Frederic Hafferty (1998) distinguishes three kinds of curriculum in medicine: the formal curriculum, which is the official, explicit coursework and training; the informal curriculum, which is the unscripted and interpersonal teaching/learning moments between faculty and students, and the hidden curriculum, which Hafferty (1998) defines as “a set of influences that function at the level of organizational structure and culture” (404). The hidden curriculum of medical education thus refers to the implicit ways that medical education is structured to systematically expose physicians-in-training to biomedical objectification of patients to the extent that the physicians become alienated from their patients.

Gaufberg et al. (2010) note that anthropological examinations of medical education have uncovered a few common themes of the hidden curriculum, namely “the loss of idealism, the prominence of hierarchy, the adoption of a ritualized professional identity, and emotional neutralization” (1709). Robbie Davis-Floyd (1992) describes the hidden curriculum as part of a biomedical rite of passage (van Gennep 1966; Turner 1969) that entails separation (graduation from undergraduate studies and acceptance into medical school), liminality (typically four years of medical education), and reintegration (a gradual process that begins with graduation from medical school and continues over the course of four years of residency).

This biomedical rite of passage has the effect of re-organizing the cognitive patterns of physicians such that they learn to detach information about bodies and diseases from actual persons. The first two years of medical education are an “intellectual overload” (Davis-Floyd 1992: 264), most of which is forgotten by the time the physicians-in-training reach the hands-on training that begins in the third year of medical school. During these first two years, medical students often develop “the kind of cynicism and intellectual arrogance that can only arise from such detachment” (265) from the diseases studied and the people who have them. Clinical experience has traditionally not been allowed until the third year, at which time the medical students have “internalized the basic attitudes and values underlying this scientific worldview” (266), though this practice is changing as medical educators and researchers continue to illuminate how detrimental the hidden curriculum can be to biomedical practice. Over the last couple of decades, changes have been made to many medical education programs (perhaps most notably UCLA and Harvard) to begin hands-on training earlier in the course of medical education and to better incorporate sociocultural approaches as well as cultural competency into medical education and training. These shifts are starting to become institutionalized in the broader biomedical educational establishment as organizations like the Association of American Medical Colleges push for medical school admissions to alter prerequisites to better allow for the admissions of applicants from varied backgrounds (AAMC 2013). Despite the changing nature of American medical education, the hidden curriculum continues to reproduce the deep intellectual history and heritage that predisposes practitioners to the biomedical objectification of patients, which is compounded by a broader cultural heritage of gendered and sexual discrimination and exclusion.

Patient-Provider Interactions

One result of the hidden curriculum of biomedical education is the objectification of patients by physicians. Foucault (1994) termed this the medical gaze, which indicates an epistemological separation of body from identity on the part of physicians. This separation leads biomedical practitioners to see a patient not as a whole person, but as a medical problem. Foucault explains that, over the course of the 18th century, the questions used in biomedical discourse shifted from "what is the matter with you?" to "where does it hurt?" (Foucault 1994: xviii). Once this shift occurred, "the whole relationship of signifier to signified, at every level of medical experience, [was] redistributed" (xi), and this change rippled through the entirety of biomedicine and out into the broader Euroamerican societies, which further established biomedical authority because of the importance of the clinic as a site of scientific and biomedical discovery and, thus, cultural knowledge production.

One example of medical students taking up the medical gaze comes from a study of a cohort of medical students at Harvard School of Medicine by Good & Good (1989). The medical students learned to reconstruct patients as cases, focusing in great detail on physical and physiological characteristics while ignoring sociocultural and individual personality characteristics and thus objectifying the patient through the medical gaze. Students noted in interviews with Good & Good (1989) how they began to see people differently after spending long spans of time learning the anatomy of human bodies by exploring inside cadavers. It is in this context that there is a reordering of moral norms:

> Several steps are important in the phenomenological reconstruction of the person. The laboratory is demarcated as a separate order, having distinctive moral norms. Within this redefined context, the human body is given new meaning, and a new manner of interacting with that body is appropriate. … Students describe a variety of changes in their perception that occur within this demarcated space. In normal reality, the body surfaces—the skin, the hands, the eyes, the face—convey personhood. The interior of a

> person in his or her thoughts, experience, personality. In the laboratory, a different "interior" emerges. This "whole other world" becomes the paramount reality in the anatomy lab. (306)

Good & Good (1989) go on to note the medical gaze is a necessary component of the development of a professional self as it enables providers to re-define their personal boundaries and those of their patients in ways that allow them to engage in what would otherwise be considered invasive or transgressive acts on "foreign" (308) bodies, *e.g.*, closely examining a stranger's genitalia or cutting into a patient's body. The work of Good & Good (1989), as well their individual work (Good 1995; Good 1994), helps illuminate how the medical gaze has manifested in the patient-provider relationship. The tendency in biomedical practice to privilege the physician as an objective source of (authoritative) knowledge can strip patients of power and agency. Patients over-depend on physicians to make decisions as they buy into the biomedical position that understanding one's body requires years of dedicated specialized education and training.

Byron Good's (1994) discussion of how biomedical education produces physicians who are simultaneously detached from patients-as-persons and seek to "save" patients from pathophysiological predicaments illuminates one reason that the patient-provider relationship is often so lopsided. Good acknowledges the conventional criticisms of biomedical practice:

> Disease is resident in the individual body, and the goal of treatment is to understand surface phenomena with reference to a deeper ontological order, to link symptoms and signs to physiological structure or functioning and to intervene at that level. Disease has a natural course; the story of the disease is one without a personalized agent. The narrative and phenomenological structure of illness experience, and the person who is agent of suffering, are relevant to routine clinical practices only insofar as they reveal the pathophysiological order, enabling the physician to formulate and document the case as a medical project. The clinical narrative—that is, the case as presented in rounds—and associated clinical stories most often conceive the patient as person and actor only so far as patients are seen as morally responsible for their diseases…or as willing agents in conforming to recommended treatments. (Good 1994: 83)

For Good, such conventional critiques are accurate, but do not go far enough. The clinic is not merely a productive site of medicalized bodies as Foucault (1994) argued; it is also a site of moral drama constantly infused with soteriological (dealing with suffering and salvation) motives. As such, biomedical providers are not always non-agentive actors within biomedical structures—they also use their agency to transform biomedical structures. Analyses of biomedical systems must thus take into account not only the ways that biomedical practice (re)produces cultural knowledge and objectifies patients, but also the ways in which practitioners resist such (re)productions as well as how they view themselves as actors and saviors in moral dramas of life and death (Good 1994; Davenport 2000).

Over the last 30 years, research into the patient-provider relationship has shown that more equality in these relationships, which requires physicians taking into account the experiential and phenomenological aspects of their patients as agents, leads to better health outcomes. One recent study (Wechsler et al. 2011) clearly demonstrates the importance of good patient-provider relationships in improving health outcomes. The study altered the treatment regimens of 40 patients with asthma every few days by giving them an active bronchial dilator (albuterol) via an inhaler, a fake inhaler with no active ingredients, fake acupuncture, and no treatment because sometimes asthma can improve just by sitting and doing nothing. The lack of treatment operated as a control for the placebo effect and to make sure that the asthma was not just clearing up on its own regardless of the treatment. The researchers found the fake treatments made no meaningful change on the objective measures (the amount of air pushed out of the lungs in one second) of the pathophysiology of asthma and that there was no placebo effect. However, there was a placebo effect on the subjective measures (how the patient feels and is experiencing their health or illness); as long as the patients were receiving attention and care, they *felt* much healthier whether or not that care had any pathophysiological effects. It was only when there was no attention and no treatment at all that the patients' subjective experiences of health matched the objective measures.

As this and other studies demonstrate, patient-provider relationships are important because the quality of the relationship affects health outcomes. When patients have bad experiences with physicians or do not feel that they are receiving quality care, the patients may cease seeking health care until an emergent problem arises. Or they may seek health care from alternative sources that provide improved subjective experiences of health while often neglecting to solve any underlying pathophysiological issues. Thus, increased levels of trust between patients and physicians can improve health and decrease health disparities (Mead & Bower 2000; Wechsler et al. 2011). Patients must feel that they can bring up stigmatized issues with their providers without being condemned (Herek et al., 2007; Platzer 2006). Achieving trust on the part of the physician is made easier when physicians come from diverse backgrounds themselves (Beagan 2003) and when physicians are educated about and trained to sympathetically discuss important issues with patients from diverse backgrounds (Sanchez et al. 2006). Training physicians to engage with patients as persons and to take seriously the concerns and issues brought up by patients is thus a necessary step in diminishing health disparities as well as improving health outcomes. This is particularly true when queer patients feel that they can visit physicians and be completely open about their lives without fear of reprimand or censure.

Cultural Competence

One of the ways that medical education has sought to sensitize physicians to the potential diversity of their patients is through cultural competence training (Beagan 2003; Gregg & Saha 2006). Queer people do not make up a distinct cultural group *per se*; the term "queer" attempts to unite a heterogeneous group of people with myriad varying concerns (Anzaldúa 1999: 164). Yet, if cultural competency in medical education is intended to reduce health disparities (Gregg & Saha 2006), it stands to reason that cultural or diversity sensitivity programs would be a logical place to include education and training on queer health issues. This all assumes, however, that cultural competence is a successful paradigm.

Cultural competence refers to the idea that providers should be educated about and trained to recognize and respond appropriately to patient diversity. Operationalization of cultural competency has remained elusive (Kleinman & Benson 2006), arguably due to the lack of critical engagement with the concept of culture. Culture is usually defined in biomedicine as a static trait list associated with ethnic minorities (Kleinman & Benson 2006; Fox 2005; Taylor 2003; Seeleman et al. 2009). This means that cultural competence in medical education too often pushes providers to focus on stereotypes when engaging with ethnic minorities and reinforces the idea that medicine is a cultureless profession (Taylor 2003; Kleinman & Benson 2006). When cultural competence education and training focuses on patients, it allows providers to ignore their own cultural biases and assumptions. These assumptions creep into biomedical education and training through the hidden curriculum, particularly in the ways that language is utilized in scientific literature (Martin 1995; Upchurch & Fojtová 2009). The "culture of no culture" (Taylor 2003) in biomedicine thus allows for the formation of authoritative knowledge through the institutionalization of an unbiased, objective, "cultureless" knowledge, and it is this process that sets up biomedicine as a site of stigma reproduction (Kleinman & Benson 2006). As long as biomedical education reproduces the idea that the culture of the physician and the clinic are unimportant, cultural competence will likely continue to have little effect on health disparities.

Gregg & Saha (2006: 542-543) assert that the ways cross-cultural education programs are designed (to alleviate barriers to effective health care) do not match the motivations (to eliminate health disparities). The problem seems to be unexamined assumptions about biomedicine's ability to accomplish either of those goals through physician education and training alone, and these assumptions usually have the effect of reinforcing health disparities, *e.g.*, by conflating race and ethnicity in medical practice (Dressler et al. 2005). Kleinman & Benson (2006: 1674) recommend replacing cultural competency training with training in ethnographic methods for providers because it abandons the stereotypical trait lists associated with cultural competency training and instead focuses on engaging with patients as individuals rather than as the embodiment of their particular ethnicity. This approach brings into biomedicine a "cultural humility" (Tervalon & Murray-García 1998) that seeks to rejuvenate the moral meaning of health *care* (Kleinman & van der Geest 2009). The idea behind these approaches to biomedical training is to instill reflexivity into the practice of medicine so that providers are better equipped to recognize how their own culture may be influencing their perceptions of and interactions with patients as well as how the "local worlds" (Kleinman & Benson 2006: 1674) of patients affect their experiences and perceptions of disease and illness rather than making assumptions about patient experiences and perceptions based on static stereotype traits.

Of particular relevance to the present work, there is a distinct lack of understanding about sexual minorities among biomedical practitioners (Platzer 2006; Hatzenbuehler et al. 2010; Risdon et al. 2000; Eliason et al. 2011; Scherzer 2000; Institute of Medicine 2011a). This lack of knowledge inevitably allows heteronormative sociocultural assumptions to creep into biomedical practice, become internalized as authoritative knowledge, and in turn reinforce the heteronormative public understandings of and policy decisions about said sexual minorities that informed such assumptions in the first place as well as drive queer health disparities. Queer people do not make up a distinct cultural group *per se*; the term "queer" attempts to unite a heterogeneous group of people with myriad varying concerns (Anzaldúa 1999: 164).

Queer Health Disparities and the Minority Stress Model

Despite the increasing visibility of queer people in American society, biomedical practice remains largely heteronormative, homophobic, and transphobic (Schuster 2012; Risdon et al. 2000; Eliason et al. 2011; Scherzer 2000; Sanchez et al. 2006; Diaz et al 2001). This is unsurprising given the ubiquity of heteronormativity in American society writ large. Such heteronormative bias creates unique health disparities for queer people.

Dressler et al. (2005) define health disparities as "differences in morbidity, mortality, and access to health care among population groups defined by [various] factors" (232). There are some health disparities that are common among all queer people as well as some that are more common among certain queer subgroups. The following information on queer health disparities is summarized from The Institute of Medicine (2011) and the Center for American Progress (Krehely 2009).

General Queer Health Disparities

- Queer people are less likely than non-queer people to report having excellent or very good health.
- Queer people are less likely to have health insurance.
- Queer people are more likely to delay or not seek medical care and prescription medicine.
- Queer people are more likely to receive health care services in emergency rooms.
- Queer people experience higher incidences of poor mental health, including increased rates of depression, anxiety, and suicidal ideation.[10]
- Queer people have increased rates of substance abuse, particularly alcohol and tobacco.

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[10] The Center for American Progress (2009) reports that suicidal ideation is slightly higher for gay, lesbian, and bisexual people, but it is significantly higher for transgender people. According to their report, about two percent of heterosexual people and five percent of gay, lesbian, and bisexual people reported suicidal ideation, while 50 percent of transgender people reported suicidal ideation.

- Queer youth are at an increased risk for violence, including being bullied in school, threatened or injured with weapons in school, and being involved in physical altercations that require medical treatment.
- Queer people experience at least equal rates of domestic violence as non-queer people, though some data suggests a higher prevalence of domestic violence among gay men and lesbians. Queer people are also less likely than non-queer people to seek and receive help regarding domestic violence.
- Queer people experience higher disease rates, including increased rates of STIs such as HIV/AIDS and hepatitis, as well as increased risk for cancer.

Health Disparities Among Lesbian and Bisexual Women

- Increased risk for being overweight and obese (75 percent of lesbian women are overweight as opposed to 50 percent of heterosexual women).
- Increased risk for breast cancer (less likely to visit providers and get mammograms).
- Increased reproductive health issues, including increased risk of cervical cancer (less likely to visit providers and get gynecological exams, and they are still at risk for HPV) and the costs associated with accessing biotechnology for pregnancy.

Health Disparities among gay and bisexual men and MSM[11]

- Increased risk for oral and anal cancer (due to infections from HPV virus. HPV infection rates among gay and bisexual men range from 61 – 78 percent for HIV-negative men to as high as 93 percent among HIV-positive men). Unlike cervical cancers from HPV infections that have peak prevalence in women’s 30s, anal and oral HPV infections in men remains steady over the life course.
- Increased risk for hepatitis A (hepatitis A is spread through fecal matter, thus there is an increased prevalence among gay/bi/MSM men who engage in anal sex).
- Increased rates of illicit drug use, especially cocaine and meth.
- Increased prevalence of eating disorders compared to heterosexual men.

Trans Health Disparities

- Unique access problems, including increased rates of neglect and denial of care, lack of insurance coverage for medical transitioning, *e.g.*, hormones and surgeries, and provider lack of knowledge.
- Risks associated with hormone therapies, depending upon what kinds of hormones are being taken. Hormone therapies can increase risks for stroke, heart attack, blood clot, breast cancer, Alzheimer’s disease, and osteoporosis.
- Complications from transitioning surgeries that can lead to long-term health problems.
- Trans men (female-to-male or FTM) who still have uterus, ovaries, or breasts are at risk for cancer in these organs; trans women (male-to-female or MTF) are at risk for prostate cancer, and penile and testicular cancer if they still have those organs.
- Increased rates of cardiovascular disease due to increased smoking rates, obesity, stress, and hormone use.

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[11] MSM means men who have sex with men but do not identify as gay or bisexual (Boellstorff 2011).

Given these health disparities, the question becomes how to explain their existence. Dressler et al. (2005) discuss five types of explanatory models for health disparities: (1) the racial-genetic model, which proposes genetic differences between populations as the root cause of ethnic health disparities; (2) the health-behavior model, which proposes behavioral differences related to health (such as poor dietary choices) as the cause of health disparities; (3) the socioeconomic status model, which proposes overrepresentation of certain groups in lower socioeconomic categories and the attendant unequal access to resources as the cause of health disparities; (4) the psychosocial stress model, which proposes the undue stress of being a member of a minority group, particularly in relation to real *and* perceived discrimination, as the cause of health disparities; and (5) the structural-constructivist model, which proposes to explain health disparities by examining the intersections of biological, cultural, and psychological structures and the construction of health and illness. Much of the research on queer health disparities has depended upon a version of the psychosocial stress model known as the minority stress model.

Ilan Meyer (1995) proposed the minority stress model to explain queer health disparities, particularly as they relate to gay men. Meyer argued that the incongruence of minority status and dominant values results in a hostile social environment that stigmatizes minority group members, resulting in chronic stress that produces detrimental health outcomes. One possible problem with using the minority stress model, as Meyer notes, is that using this model to make comparisons across groups has led to problems with biasing data, specifically a sampling bias within studies of gay-straight differences. This sampling issue arises because individuals who struggle with their sexual identities or who have not fully come out are less likely to participate in studies of queer health. Since self-acceptance and being comfortable with one's self tend to lead to better psychological health and less distress, there can tend to be an overrepresentation of healthier queer people in studies, which leads to an underestimation of distress rates. To overcome this methodological issue, Meyer proposed studying the underlying processes of minority stress (in this case, the social stigma of homosexuality) and using that information to study intragroup variability in the effects of minority stress. Doing this allows researchers to examine the effects of minority stress as opposed to comparing stress levels between groups.

The minority stress model explanation of queer health disparities is supported by empirical evidence. For example, Mark Hatzenbuehler (2011) and his colleagues examined the healthcare-seeking behaviors of 1200 gay men for 12 months prior to and 12 months after the enactment of Massachusetts's marriage equality law. They found a 13 percent decrease in healthcare visits in the 12 months after marriage equality passed. The researchers controlled for partnership status and found that the decrease was present in *both* partnered and non-partnered gay men. This indicates that the improved social status of marginalized groups can improve their health as fewer physician visits indicates fewer health problems.

The minority stress model explains why queer health disparities exist. Activism and advocacy on behalf of the equal and fair treatment of queer people in society will help to alleviate queer health disparities as it will diminish the stigmatization and discrimination faced by queer people. Until such a time as queer people are better treated by society at large, physicians must be better educated about the lives of queer people and trained to engage with queer patients in more sensitive and sympathetic ways if they are to be of any help in diminishing queer health disparities. Physicians who are better educated and trained on queer health and queer lives more broadly, along with more openly queer physicians with whom queer patients will be better able to identity, will lead to better health outcomes for queer patients and less queer health disparities in the long run.

Gaps in the Queer Health Literature

Research on the causes and effects of queer health disparities is increasing, but there remains a lack of literature that specifically examines heteronormativity in biomedical culture. The research that does exist largely takes heteronormative cultural attitudes for granted and instead focuses on the social stigma faced by queer people (Institute of Medicine 2011a). Many of the studies that make up the bulk of the research on prejudice aimed at queer patients are outdated (Institute of Medicine 2011a). The small amount of recent research that does exist shows a decline in prejudice among health care providers towards sexual minorities since the mid-1980s, though it does not address prejudice towards non-gender-normative patients (Smith & Mathews 2007). Unfortunately, an approach focused on prejudice alone obfuscates the ways in which the heteronormative cultural attitudes that pervade American society are reinforced by everyday medical practices. Such heteronormative attitudes are institutionalized and create structural barriers to social equality, which are beyond the scope of biomedical practice but are nonetheless important for physicians to be knowledgeable about in order to avoid reinforcing the very barriers that create the adverse health outcomes they are seeking to remedy.

This research aims to help fill this gap in the literature by examining the ways in which queer medical students interface with heteronormativity in biomedical culture. I seek to examine how heteronormativity manifests both in this medical school and in the biomedical knowledge produced at this school. By getting at the experiences of queer medical students, it will be easier to understand the types of implicit heteronormative attitudes that go unnoticed in medical education and training. Once there is a better picture of how heteronormative bias manifests in biomedical training and physician practice, it will be easier to produce a meaningful list of best practices for improving the training that physicians receive on queer health issues, which can lead to improved health outcomes and diminished health disparities for queer people.

CHAPTER THREE: METHODS

The main goal of this research is to better understand the extant homophobia and heteronormativity at a local medical school as experienced by medical students. In order to achieve this goal, I employed qualitative methodologies to elicit and analyze data from informants about their experiences as medical students, as queer medical students, as queer health care providers, and as queer persons in their everyday lives. I used this data to build explanatory theories (see chapters four and five) and generate a list of best practices (see Conclusion) for improving biomedical education, training, and practice on queer issues at the medical school.

Site Description

The fieldsite was a medical school in central Texas. The site was chosen for its convenience and ease of access to the population. I utilized a connection with a faculty member at the medical school who put me in touch with the campus' queer student organization, providing a way of accessing students and faculty to promote the research project and recruit informants. The medical school is located near a major interstate with access to routes of public transportation. Further, the medical school campus is easy to get to for informants, as most live near the medical school campus.

Informant Identification and Recruitment

One of the first challenges to overcome was the identification of informants (Robertson 1998). Defining gay men, lesbians, and bisexuals based on behavior is problematic because sexual orientation labels do not always match sexual behaviors (Hutchinson et al. 2006; Hiller et al. 1998). Accordingly, this research sought informants who self-identify as queer, typically as, but not limited to, lesbian, gay, bisexual, or transgender.

Another impediment to studying queer populations is access (Meyer 2001). The heterogeneous and dispersed nature of the queer community, as well as everyday experiences of discrimination and homophobia, often create difficulties in locating people willing to participate in research. Fortunately, access was made easier in this research because of the presence of an active queer medical student group on campus.

I made use of a variety of recruitment methods. First, I used convenience sampling (Weller 1998) to establish contacts among the medical students. I used personal and academic contacts to begin discussing the research project with people who might have been interested in participating. Next, I used purposive sampling (Bernard 1995) to establish contacts in the queer medical student group. I sent e-mails and made telephone calls to various people within this organization, as well as sent out IRB-approved notices indicating the type and purpose of study and asking interested persons to contact me to schedule an interview. The contacts established using these methods served as a base from which to utilize snowball sampling (Bernard 1995; Trotter & Schensul 1998) to expand the sample size.

The eleven informants included in this research ranged in experience from new first-year students to a faculty member who has been practicing medicine for many decades. Informants included gay men, lesbians, bisexual women, and a queer woman. Unfortunately, I was unable to recruit any transgender or transsexual informants. Four informants were women, and seven were men. Informants varied in ethnicity and socioeconomic background, though these were not focal points of any interview questions.

Data Collection

Data collection consisted of conducting interviews with medical students and practicing physicians at the fieldsite. Interviews were formal, semi-structured, in-depth, and person-centered (Levy & Hollan 1998). Formal interviews involve selecting a specified meeting time and place and spending anywhere from 45 minutes to a few hours in the interview. Semi-structured interviews are intended to provide a level of consistency and reliability by asking different informants similar questions about relevant topics; however, questions were open-ended in order to allow informants to elaborate. Person-centered interviews consist of two types of questions: informant questions, which seek information about a culture or community, and respondent questions, which seek information about how the informant perceives the culture or community (Levy & Hollan 1998). For example, an informant question could be, “How are medical students taught to ask patients about their sexual orientation?” while a respondent question could be, “How do you ask patients about their sexual orientation?”

By getting informants talking about the issues brought up in during interviews, I sought to elicit perceptions of health care, the environment of the medical school, and the medical school’s curriculum and training on queer-health-related issues. Prompts and topics addressed with informants included: experiences of “coming out” both in everyday life and in medical settings; how sexual orientation and/or gender variance is discussed both in everyday life and medical settings; and how informants feel that their sexual orientation and/or gender-variance impacts their everyday life, their health care experiences, their education and training, and their own health-care seeking behaviors (see Appendix B for sample interview questions).

All but one interview were conducted in a conference room at the medical school; the other was conducted in the informant’s apartment living room. I asked informants for permission to digitally record the audio of the conversation, and I took notes during the interviews to help with memoing and coding in data analysis. The recordings of the interviews and focus groups were transcribed and used as data. Interviews were transcribed in whole and in part, depending on their usefulness as data. For example, sometimes conversation would meander off topic, and these parts of the interview were not transcribed as they were not relevant to the research.

Every effort has been made to protect the identities of informants. All informants were given pseudonyms, and identifying information was redacted from transcripts. The informants taking part in this research are:

- Grace, a first-year medical student who identifies as a lesbian woman
- Carol, a first-year physician's assistant student who identifies as a lesbian woman
- Ingrid, a first-year medical student who identifies as a queer woman
- Danny, a first-year medical student who identifies as a gay man
- Filipe, a first-year medical student who identifies as a gay man
- Brandon, a second-year medical student who identifies as a gay man
- Ellie, a second-year medical student who identifies as a bisexual woman
- Alex, a fourth-year medical student who identifies as a gay man
- Hector, a fourth-year medical student who identifies as a gay man
- Dr. Finn, a cardiologist working in medicine for over 10 years who identifies as a gay man. Dr. Finn was a medical student, did his residency, and now works at the field site medical school
- Dr. Harvey, a pediatrician working in medicine for over 30 years who identifies as a gay man. Dr. Harvey was a medical student and did his residency elsewhere. He is included in this research because he is a faculty member and practices at the field site medical school.

All informants provided a verbal confirmation of informed consent on the audio recording before the interview began. It was made clear to all informants that participation was completely voluntary and that they may withdraw from participation at any time for any or no reason without repercussion. The interview questions as well as the promotional flyers received ethics approval on January 31, 2012, through the University of Texas Health Science Center San Antonio Institutional Review Board (see Appendix A).

I was originally going to collect and analyze data on the curriculum itself, both in the form of participant observation and the collection of cultural texts. Cultural texts are materials not generated through research activities that provide insight into the cultural practices under investigation. For this research, that would have included items like information on the curriculum, training materials, course materials, academic texts used for education and training, or any other items that would have shed light on the curriculum my informants learned from. Due to time constraints on this project as well as the fact that the curriculum changed after I finished conducting interviews, I decided not to pursue this type of data. However, because I had a focus on the curriculum when I formulated interview questions, I was able to explore questions about the curriculum within my interview data. Using informants' experiences as medical students as well as the literature discussed in chapter two, I have constructed a list of best practices for improving medical education, training, and practice in regards to queer health issues (see Conclusion).

Data Analysis

Data was analyzed using grounded theory, which is an inductive analytical methodology that identifies emergent themes in the text of interview transcripts (Bernard & Ryan 1998; Birks & Mills 2011; Angrosino 2005). Coding, or tagging sections of text to act as reference markers for important emergent themes (Bernard & Ryan 1998:613-614), occurred in three recursive parts: initial coding, intermediate coding, and advanced coding (Birks & Mills 2011).

Initial coding involves identifying important words or phrases in the interview transcripts. Initial coding is used to generate a list of preliminary categories or themes, which become "theoretically saturated" when new analysis generates codes that only fit into already existing categories or themes. During initial coding, data collection and analysis occur concurrently, with data being coded and memoed as it is being collected. Memos are the recorded thoughts of the researcher while analyzing and collecting data that can help illuminate grounded theory findings. Throughout all steps of grounded theory, there is a "constant comparative analysis" (Birks &

Mills 2011: 11), where the researcher constantly compares codes, categories, memos, and themes to one another.

Intermediate coding involves fully developing individual categories by connecting sub-categories and linking categories together. While initial coding can seem to break apart the data, intermediate coding reconnects the data in theoretically sensitive ways. It is also during this step that a core category may be identified (Birks & Mills 2011). A core category "encapsulates and explains the grounded theory as a whole" (Birks & Mills 2011: 12). The core category can be realized after the category and its sub-categories have achieved full theoretical saturation.

Advanced coding involves making use of a "storyline" (Birks & Mills 2011: 117). A storyline is a way of explaining the relationships of categories and themes generated in parts one and two. It utilizes a narrative technique to improve thematic cohesion and comprehensibility. Another aspect of advanced coding is theoretical coding, which are "advanced abstractions that provide a framework for enhancing the explanatory power of [a] storyline and its potential as theory" (Birks & Mills 2011: 123). When advanced coding is complete, there should be an identified core category, theoretical saturation of major categories, and a collection of analytical memos that work together to integrate data into a theoretical framework that can be used to answer the research questions.

The qualitative methods employed in this research are intended to help gather and analyze data on the experiences of queer medical students as they are acculturated and become embedded in biomedical praxis. Eliciting the experiences of queer medical students in their education and training will help shed light on the areas of medical education and practice that are still heteronormative and homophobic, which is important information to be aware of if there is any hope of reducing queer health disparities.

CHAPTER FOUR: RESULTS: QUEER EXPERIENCES OF MEDICAL EDUCATION AND TRAINING

In 2015, the Medical College Admission Test (MCAT) will begin including sections on social and behavioral sciences as well as critical analysis and logic (Association of American Medical Colleges 2013). The inclusion of these types of material on the MCAT reflect and in some cases influence changes in medical education to be more inclusive of a variety of academic backgrounds. It is also reflective of a shift in biomedical practice away from bioreductivism towards recognition of the sociocultural factors that influence health and illness.

The World Health Organization (2003) defines *social determinants of health* as the roles that social environments, particularly social injustice and inequality, play in determining the health of individuals and groups. The fact that “people’s lifestyles and the conditions in which they live and work strongly influence their health” (World Health Organization 2003:8) is beginning to filter into medical education curricula. The sociocultural aspects of people’s lives that drive their health and illness are finally starting to be taken more seriously in many medical environments.

Being queer is one of many social determinants of health. The ways that being queer impacts negatively upon the health of individuals and populations is demonstrated by the minority stress model (Meyer 1995), which argues that real or perceived discrimination builds psychosocial stresses in queer people that negatively influence their health and well-being. With queer people making up between 3 and 5 percent of the American population (Gates 2011), it is important for health care providers to be made aware of the social determinants of queer health disparities in order to avoid reproducing the psychosocial stresses that lead to those disparities. My informants have received little or no education on the social determinants of queer health, and the heteronormative training that they do receive could actually be contributive to queer health disparities in their patients.

In this chapter, I draw on my informants' experiences as medical students and as providers to critique the lack of education and training related to queer health disparities. The type of medical education and training experienced by my informants contributes to queer health disparities in many ways and at multiple levels. According to my informants, the formal curriculum pays little attention to the unique health issues faced by queer people. It is important to note again that I did not collect data on the formal curriculum and thus have no way to substantiate or contextualize my informants' experiences with it. The informal curriculum, or the unscripted and interpersonal teaching/learning moments between faculty and students, often appears to be discouraging of queer visibility in medical settings. For example, some informants have experienced or witnessed homophobic or heteronormative comments from faculty that have affected how they behave in medical environments.

The hidden curriculum, or the implicit structuring of medical education that affects the production of physicians, also serves to re-enforce stereotypes about and prejudices toward queer people. Using the content of medical case studies as an example, I argue that the hidden curriculum works to instill heteronormativity in medical students as well as perpetuate queer and gender stereotypes. By limiting medical students' exposure to queer people to a narrow view of gay men with HIV, the case studies are one example of how the hidden curriculum of medical education may actually be contributing to queer health disparities rather than reducing them. I conclude with a look at the ways my informants view queer health from a strictly biological perspective in order to demonstrate the lack of understanding about queer health disparities at this institution, even among those students who are regularly subjected to the causes of disparities.

A Lack of Education and Training

Every informant I talked to indicated a near absence of education and training related to queer health issues. Further, every informant said the inadequate amount of education and training they had received on queer health issues should be remedied with increased attention to queer health issues. The education and training they did receive was limited to small pieces of information scattered across their education and training, with the most concentrated information relegated to a single lecture on sexuality in a social and behavioral health class.

When queer health issues did come up during their education and training, they appeared in one of two ways. The first example that my informants cited was being trained to ask about sexual behavior:

> *The only training I can even think of at this point is that we're trained clinically to ask our patients about their sexual orientation, about their sexual activity, you know? We're asked to say, "Do you have sex with men, women, or both?" and if so, "How many partners do you have?", "Your last sexual encounter?" et cetera, et cetera. That stuff is a good lesson, it is clinically relevant to what we're doing, but broader issues like queer lifestyles or alternative lifestyle in health care and things like that? I can't think of much training we've had.*
> - Alex

This refrain—"do you have sex with men, women, or both?"—was mentioned by nearly all of my informants. For example:

> *I always say, "Do you have sex with men, women, or both?" That's my script. Any patient I come in contact with, that's what I say.*
> - Brandon
>
> *I guess in our clinical skills, we do talk a little bit about when you're talking to a patient, you say, "Do you have sex with men, women, or both?" That's, like, the extent of anything we've learned about gay issues.*
> - Grace

> *They kind of mentioned a couple of things to keep in mind when you're talking to patients. You know, "Do you sleep with men, women, or both?" That's the one question that everybody thinks about when they're in these classes. But that's where it stops.*
> - Ellie

> *We're instructed to ask patients if they have sex with men, women, or both.*
> - Danny

Dr. Finn also echoed this phrase:

> *The social history is where you talk about the patient's sexual life. Do they have sex with men, women, or both? What do they do for a living? How much do they drink? Do they smoke? Things like that.*

When I asked him if this meant that sexuality in case studies is based on behavior rather than identity, he said, "Yeah. It's more, sort of—yeah. Not how they define themselves."

All of my informants appeared to conflate this question of sexual behavior with inquiring about a person's sexual orientation or identity, and none of my informants acknowledged that asking a person's sexual behavior does not necessarily get at their sexual identity. Conflating sexual behavior with sexual orientation demonstrates a risk-based understanding of sexual orientation in medicine; my informants believe this question gets at sexual orientation/identity because the common medical practice is to inquire about behavior (to assess risks) and infer identity rather than to ask about and accept patients' professed identities.

The other example my informants gave concerning how queer health issues came up in their education and training was "homosexual men with HIV," especially in case studies. Again, the perspective here is one of a risk-behavior model rather than a health disparities model. For example, when I asked Hector what kind of training or education he received on queer health issues, he said:

> *Not a whole lot. I mean, first we learn about HIV/AIDS, which disproportionately affects the gay community, but it's all from a medical point of view—everybody can get HIV/AIDS. They just kind of view men having sex with men as a risk factor for*

> *contracting HIV. We don't really get a whole lot, though, of specific gay topics. So I would say very little.*

Felipe expressed his frustration with the curriculum:

> *There's very little teaching that goes on with dealing with different populations. A couple of months ago, the—pretty much the only gay patients we see on tests are—they all have AIDS! Naturally. I mean, if you just read in the question stem "gay male patient," then it's AIDS. I mean, there's nothing more to them. And so that infuriates me. And I know we're working on that with a new curriculum, too. Maybe you can see some gay people that don't have HIV. Because, you know, those people exist, too.*

Not only do those people exist, gay and other queer people have other health issues[12] that are not related to their HIV status, and these health issues are being ignored in the education and training of these medical students.

Other informants shared similar experiences and concerns with the only queer presence in their education and training being limited to gay men with HIV:

> *I feel like, you know, that's kind of the only exposure that a lot of us get to homosexual people, you know? Homosexual man, HIV. There's kind of that word association. I mean, the only exposure that I feel like students get in medical school is like a test question, and it will always be a homosexual man who has HIV or AIDS.*
> - Danny
>
> *Then the fact that they automatically assume a lot of these questions, especially if it's a gay male, they lead to all this other stuff. And I'm like, just because they're gay does not mean that they have all this stuff! And it's really, really frustrating whenever we have a case study and it talks about HIV patient and it's obviously a homosexual male. It pisses me off so much because there are so many people who are HIV-positive who are not gay. And it drives me crazy!*
> - Ingrid

Dr. Finn perhaps summed up the education and training in the most detail:

> *We had the lecture that I was telling you about in our social and behavioral sciences about homosexuality. And then it comes up a little bit in discussions of HIV. But outside of HIV and sort of the stuff that you hear about, the biological basis of homosexuality and it not being a choice and things like that, you know, not being a disorder and the psychiatric diagnostic manual, we hear about that. And that's basically—I think that's really basically it.*

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[12] See chapter two for an in-depth discussion of queer health disparities.

When I asked what training on queer issues he'd received since completing medical school, he said:

> *Not much. Again, it's really focused on HIV. Which I think is a big deal, so I'm happy about that. And maybe other sexually transmitted diseases in men. But in terms of transgender issues, I don't think we get a lot. You know, most of what I've learned, I think, has been from watching TV. Honestly. Or looking things up on my own. And I think that we're just—I think we're just learning more about these issues. We're just learning about transgender people now that, you know, we're seeing people like Chaz Bono and other people like that, I think we're all learning.*

Dr. Finn is right that it is important that medical students are receiving education about HIV/AIDS and are being made more aware of that particular disease. As many informants pointed out, it is unfortunate and vexing that HIV/AIDS awareness is being attached almost exclusively to homosexual men in their medical education and training. To highlight why this is a problem, let us look briefly at the content of case studies as recalled by my informants.

The Problematic Content of Case Studies

According to my informants, the only queer-related content they could recall in case studies was the presence of homosexual men with HIV/AIDS. Homosexual men with HIV/AIDS in case studies, then, serves as one of the only means by which queer people are visibilized in my informants' medical education and training. As discussed in the next chapter, all of my informants assume that patients presented in case studies are heterosexual unless explicitly labeled otherwise. The fact that people other than homosexual men are never explicitly labeled in case studies influences students to heteronormatively view patients. For example, when I asked Brandon whether or not heterosexual patients were explicitly labeled in case studies, he said that he could not recall any questions that did, but he could recall one question that he had not realized was heteronormative at the time:

> *A specific question just came to mind. This 24-year-old is traveling in world business and he has slept with several prostitutes. That's all it said. Then all the medicine of it. But they didn't identify if that dude was heterosexual with female prostitutes or homosexual with male prostitutes—you know? They didn't identify that. You're just supposed to, I guess, make that assumption. And come to think of it, I did assume heterosexual, which is really bizarre now.*

But it is not bizarre, at least not by the cultural logic of American biomedicine (and, by extension, American heteronormative gender roles). Brandon's assumption is a demonstration of how the hidden curriculum can influence even a person who has a decent grasp of queer health disparities and who helped establish the campus's queer student organization to take a heteronormative perspective of patients. It is not bizarre because it is an example of the system working exactly as it has for generations. What would be bizarre is if Brandon had been cognizant of the system instilling heteronormativity in his practice of medicine and then queered it by bringing to light the assumptions made in the case study.

In addition to these case studies working to instill heteronormativity in future physicians, they also perpetuate queer and gender stereotypes among medical students. Physicians who are not queer and who do not know anything about queer health disparities quite likely could leave medical school with the stereotype of "HIV is a gay man's disease" reinforced. This has the potential to reproduce queer health disparities, as well as the health disparities of people of color as black men and women and Latino men are disproportionately represented in new HIV infections in the United States (Center for Disease Control 2013). It also subtly implies to students that the only queer-related health problem homosexual men may come to them with is HIV/AIDS. This plays out in the experiences that some gay men have when coming out to their health care providers. For example, Brandon told this story of an ex-boyfriend's visit to a provider:

> *He was having eye problems. It was painful or whatever. And they were doing—you know, it was a female ophthalmologist or optometrist, I'm not sure—but he was going through the whole thing and then towards the end was like, you know, I'm gay as well—I don't know how it came out, he never said, you know, "I'm gay, thanks for treating me today." But as soon as it actually came out, she stopped and went all the way back and started testing him for STDs and things. And he was like, just because I told you I'm gay doesn't mean we now have to go all the way back and test me for herpes. Like, if that was not in your original plan to do, if you do it now, it's offensive. And he was very vocal about it to her. And she ended up stopping and apologizing. She was just like, "That's where my brain went."*
>
> *I think she's a very forward-thinking person. Did she mess up? Yes. But the fact that once he called her out on it, she was like, "Oops, sorry about that." That is the step that physicians should be taking now. So, hasn't happened to me, but definitely happened to him. And I would say it happens all the time. All the time. Because if you're gay, you're going to have hepatitis A because fecal-oral transmission, and you're going to have HIV because all gay guys have HIV. You know, that's a lot of people's perceptions.*
>
> *And so, does it make it higher up on your differential diagnosis? Of course. A gay male has a higher chance of having HIV. Just that's the epidemiology of it these days. It's becoming more heterosexual due to IV drug use and prostitution—heterosexual prostitution and all that. So that's going to change over the next few years, because right now it's taught, oh, it's a gay disease, oh and those IV heroin users, they also get it. And so, now that we're getting away from the 80s, you know, it's not the gay disease anymore. So people are understanding that it doesn't matter if you're gay or straight—you always need to think about HIV.*

Dr. Harvey shared a similar sentiment.

> *The most common thing that—hasn't happened to me, but my partner has more health problems than I do. Invariably the second that his docs find out he's gay, they invariably want to do an HIV test. And it's kind of like, I have only been with one man for 18 years, I have not been with anybody else. I have been negative more times than you can count. Don't waste my money on an HIV test. And if I'm going to get HIV tested, I'm going to get tested anonymously. But that's the one thing that he's been through. I've not been through that. But maybe the assumption is from my health care professionals that because I'm a health care professional I wouldn't lie to them—ha ha ha! But, no, I wouldn't. But that's—I would say in my own personal experience, no. I think my partner has seen a little bit of it. But it's just kind of that—it isn't like I'm squeamish or uncomfortable taking care of you because you're gay. It's more like, because you're gay then you have AIDS or maybe you've got AIDS.*

Queer people who are not gay men are completely absent from case studies; thus, they are made invisible by the heteronormativity and homophobia of the case studies. My informants recognize this and express disdain at the fact that only gay men are visibilized in case studies (despite being visibilized in problematic ways). Because the case studies do not visibilize queer health disparities, and queer health disparities are not discussed elsewhere in the curriculum, medical students are completing their education and training without a basic grasp of queer health disparities and their causes. Unfortunately, this leaves room for some misunderstandings about the causes and scope of queer health disparities.

Queer Health Disparities Misunderstood

The poor quality and lack of robust education and training on queer health issues filters into how my informants talk about queer health. For my informants, the effects of minority stress on queer health are mostly unacknowledged and, instead, they focus on biology, disease, and behavior. It is important to point out that this focus is expressed *despite* their own experiences with the psychosocial stresses associated with queer health disparities.

When most of my informants discussed queer health, in addition to the pervasive presence of the HIV-positive homosexual male, it was from the perspective of risky behaviors that lead to disease. Alex, for example, said that the queer community is stigmatized by "the stereotypes of promiscuity and disease." He also claimed that he did not come out to his own provider because his sexuality was irrelevant to his health issues, even though he described how being closeted to his parents was stressing him out to the point of disrupting his day-to-day activities.

Dr. Finn said that he could not think of any queer health disparities outside of HIV and syphilis, which he described as an epidemic that was going unrecognized because of the focus on HIV. Carol also focused on disease pathology, noting that HIV "obviously isn't specific to gays or lesbians, but in terms of health care issues that might affect the gay and lesbian population, that's—you think about it, population with AIDS." Dr. Harvey concurred that HIV is "the obvious one," but he also brought up other disparities that no other informants did: "I think that issues related to alcohol and cigarette use have traditionally been probably substantially higher just by the nature of the culture of where people meet, where people get together." Dr. Harvey speculated that those disparities are perhaps no longer an issue due to cultural changes, but alcohol abuse, drug abuse, and tobacco use are, in fact, still disproportionately high among queer people (Institute of Medicine 2011a; Krehely 2009).

Interestingly, Hector made the claim that a woman's sexual orientation is unrelated to her breast cancer treatment:

> *Unless [sexual orientation is] pertinent to the case, it's not something that I even think about. If it's not pertinent to the care—like, if it's a patient with breast cancer or something like that, it doesn't really matter if she's a lesbian or if she's straight unless it's an ethical case we're being presented with and her partner's being denied visitation, because in that cause it would of course be given to us that that was the issue. So, it's not something like her being a lesbian would affect the treatment that she gets for her breast cancer, so it's not something that I even think about.*

The problem with this particular example is that being a lesbian increases a woman's risk of having breast cancer (Institute of Medicine 2003, 2011a). In fact, queer people in general have an increased risk for cancer compared to non-queer people (Institute of Medicine 2011a; Krehely 2009). Considering lesbian health disparities, the breast cancer treatment a woman receives may or may not be affected by the fact that the woman is lesbian. However, what absolutely does matter and what is overlooked by views like the one expressed by Hector is that being a lesbian puts a woman into a higher risk category for breast cancer. While there is certainly no evidence that being a lesbian *causes* breast cancer, that higher risk factor is not inconsequential. Further, queer people are less likely to be covered by health insurance, are more likely to receive health care in an emergency room, and are more likely to experience discrimination in medical environments (Krehely 2009), so being a lesbian *can* affect the treatment that a woman gets for breast cancer.

The fact that Hector and most of my other informants think of queer health disparities so narrowly has the potential to further reproduce those health disparities because the social determinants of queer health are ignored in favor of bioreductivist, behavior-based explanations. In fact, the social causes of these queer health disparities are completely unremarked upon by my informants to the extent that I question whether or not their medical training addresses social determinants of health in any meaningful detail. If they do not receive such training, it is unsurprising given that medical education focuses on individual pathology rather than a holistic view of a person's health and illness that also addresses the sociocultural factors at work. This is due in part to an epistemological split between biomedical science and public health that separates individual and group health as two distinct disciplines with different sets of specializations, which sets up a medical education system that produces physicians who are not trained to look at the whole picture of health and illness, but are rather trained to consider only the behavior and pathology of their individual patients decontextualized from their sociocultural environments. And this is how the hidden curriculum works to instill cultural stereotypes into physicians: as physicians are trained to pay little or no attention to social determinants of health, the normative stereotypes of their trainers can silently work into the training such that physicians come out of their training with implicit understandings of group health that are unsupported by (and sometimes radically different from) research on social determinants of health.

* * *

My informants' experiences as medical students and providers illuminate the lack of education and training on queer health issues and disparities. The case studies they discussed with me serve as an example of how heteronormativity is instilled through the hidden curriculum in that students are taught to assume a heterosexual orientation about their patients. The case studies also further perpetuate queer and gender stereotypes, such as HIV is a gay man's disease. Unfortunately, this inattention to queer health issues has the possibility of producing physicians who inadvertently contribute to queer health disparities. By viewing queer health from a strictly biological perspective and ignoring the social determinants of queer health disparities, my informants demonstrate their institution's lack of education and training on queer health disparities and the role of culture in health and illness.

CHAPTER FIVE: RESULTS: QUEER (IN)VISIBILITY AND (IR)RELEVANCE

It is clear that increased queer visibility decreases ignorance and raises levels of tolerance and acceptance; on the other hand, a lack of queer visibility allows for heteronormative and anti-queer prejudice to flourish. This is as true in medical environments as it is in the broader American society. Visibility, or the lack thereof, is a key theme that links the experiences of queer medical students and physicians to the prevalence of heteronormativity and anti-queer prejudice in medical environments.

In this chapter, I examine how (in)visibility and heteronormativity are intrinsically linked in the ways my informants experience and participate in biomedical education and practice. I then explore the politics of visibility as experienced by my informants. I follow this with an examination of how my informants approach the patient-provider relationship. Finally, I argue that my informants engage in what I call the *irrelevance narrative*, a prevalent narrative among my informants concerning the relationship between their queerness and the delivery of care to their patients.

Visibility and Heteronormativity

Neither total visibility nor total invisibility is possible for queer subject positions in American society. This is because heteronormativity renders queerness invisible and situates reproductive heterosexuality as the assumed default subject position; in other words, all people are assumed heterosexual until shown otherwise, and being shown otherwise is what visibilizes queerness. Coming out is the most common method of visibilizing queer people in the United States; yet, the very existence of coming out as a performative act and the celebration of coming out as a rite of passage are indicative of the heteronormative nature of American society. After all, heterosexual people do not explicitly declare their heterosexuality; it is assumed. Further, when queer people do not come out, they do not raise queer visibility, which allows for the reproduction of heteronormativity to go unchallenged.

When I asked my informants whether or not they assume strangers in public places are heterosexual until shown otherwise, they gave a variety of answers. Informants who felt they did not make assumptions about strangers' sexualities often included hedging language such as "not really" and "not necessarily" to avoid an absolute answer:

> *I think it's human nature that we observe and sometimes we draw conclusions, or make assumptions rather. And so whether that's a bad thing or not, I'm guilty of it. I can see someone and assume that they're gay or make an assumption. That's just a judgment on my part. Of course, it's not really a negative judgment. I'm gay, so it's not a bad thing. But yeah, to answer your question, I don't automatically assume everyone I see is heterosexual until proven otherwise.*
> – Alex
>
> *Not really. Not necessarily. I don't just peg anyone as straight or gay.*
> – Danny
>
> *Not really. Like, I don't usually pin people as—whenever I see somebody, the first thing I think in my head isn't "oh they're straight" or "oh they're gay." It's just not something that I really think about on a regular basis whenever I meet people or see people. Yeah, so I guess that it's just—I don't really think about.*
> – Hector

Informants who said they did make assumptions about strangers' sexualities included similar hedging language:

> *Usually. Unless maybe they look—you know, there's something about them that says they're not straight, maybe they're queer.*
> – Carol
>
> *For the most part, I do think so. I would assume, yeah. Which, I don't know why [laughs].*
> – Grace
>
> *For the most part I do. Just because that's pretty standard for what everybody else does. It's always in the back of my mind, you know, this person could be queer or something. But I don't assume anything really.*
> - Ellie

> *I would say default, yeah, I'm going to assume everybody's straight. And society assumes the same thing, which is why I get in so much trouble with the patients, you know? –* Brandon

Interestingly, both of the practicing physicians—who are both older than all of my medical student informants—I interviewed unequivocally stated that they have heteronormative perceptions of strangers:

> *Yes. Completely. I think that's the way we're enculturated.*
> – Dr. Harvey

> *I think so. [Laughs.] I think so. I have that bias.*
> – Dr. Finn

In contrast, every informant stated that they *do* assume that patients presented in case studies are heterosexual unless told otherwise. Brandon said that assuming patients in case studies are heterosexual is at "the core of our academics." This statement is supported by other informants, who indicated that the only times patients in case studies would not be heterosexual was when they were explicitly identified as homosexual. In case studies recalled by my informants, patients were *never* explicitly identified as heterosexual. Many of my informants speculated that the people writing the case studies were making assumptions about case-study patient sexualities, and thus they were merely adopting the same stance. This is indicative of a medical gaze that is both heteronormative and desexualizes patients. A patient's sexuality is only relevant to biomedical practitioners when it concerns pathology. Students are trained to utilize the medical gaze on bodies to view them as objects of pathology, not as subjects or as sexualized objects. When the medical gaze is turned on sexual behavior, it is heavily focused on heterosexual reproductive functioning rather than sexual subjectivity (as indicative of good health).

By adopting the same heteronormative gaze as the case-study authors, students may internalize heteronormative understandings of patient health issues. As such, case studies are one means by which the hidden curriculum operates. Case studies make patient heterosexuality an invisible default, and queerness is only brought up in case studies in relation to stigmatized health issues.[13] Students readily adopt the perspective of the case-study authors, shedding their own lived experiences of heteronormativity and instead take on a heteronormative medical gaze that sees patients whose gender and sexuality is only relevant when those higher up in the medical hierarchy say it is.

All of my informants expressed some understanding of or experience with heteronormativity or homophobia. A few informants who do not exhibit stereotypically queer traits, defined by informants as visible deviations from heteronormative gender roles in people's mannerisms, speech, and dress, are able to pass through their everyday lives under a cloak of heteronormativity. Unfortunately, the ability to maintain invisibility seemed to be accompanied by some internalized homophobia for at least one informant.

Alex echoed a homophobic trope common amongst people with unexamined straight privilege: "I'm almost of the mindset that if there's not an organization for heterosexuals on campus, why must there be an organization for homosexuals on campus?" This type of homophobic rhetoric is often aimed at the celebration of gay pride, when many heterosexual people often inquire as to why there should be a gay pride parade when heterosexuals do not go around proclaiming their sexuality and making parades to celebrate it, a perspective that conveniently ignores the fact that, as the assumed default subject position, heterosexuality *is* celebrated in American society and heterosexuals *do* show their sexuality in public. *A lot*. Yet,

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[13] See chapter four for a more detailed discussion of the problematics of case study content.

members of the queer community who are capable of flying under the heteronormative radar sometimes internalize these homophobic tropes and often direct them at the non-normative, gender-variant members of the queer community, particularly feminine men and masculine women.

This internalized homophobia and ability to maintain invisibility undoubtedly has implications for how Alex has been treated in medical school compared to other informants who are more stereotypically and visibly queer. While most informants claim they have had little or no trouble in medical school—at least as far as their queerness is concerned—Alex was adamant that being gay was just another part of his sense of self, like his right-handedness: "Being gay is just as inherent to me as me being right-handed. And I don't really flaunt that I'm right handed, and so, as such, I don't really flaunt that I'm homosexual either. It's just one part of me." This is another common homophobic trope, that the open and explicit expression of one's queer subjectivity is "flaunting" it, whereas for non-queer people it is simply an expression. This trope relies on heteronormativity's naturalization of heterosexual behaviors, such as holding hands in public or talking about opposite-sex partners, in order to label the visibilizing of similar behaviors by queer people as "flaunting."

Further, Alex is not out to his health care provider or to his parents. Despite Alex's claims that he is "very comfortable" with being gay, his decision to remain invisible to certain people stems from the recognition that there is stigma attached to queer sexualities. He may very well be comfortable with being gay, but since others are not, he hides it. The constant self-surveillance that must accompany invisibility in order to maintain it is what leads to the psychosocial (minority) stresses associated with queer health disparities. And Alex recognizes this.

When I asked him how being gay affects his everyday thoughts and experiences, he explained that, while it is usually just an unremarkable part of who he is, it has been on his mind more in recent months:

> ***Will:*** *How much do you think being gay is a part of your everyday life? Like, how often—is it something that comes to your attention? Because I know you said earlier that it's just kind of part of your—*
> ***Alex:*** *Sure. Well, more recently it's probably an everyday part of my life. It's on my mind a lot recently because I'm going through the residency search process, and I'm hoping to land in an area, a geographic location, that is more conducive to my lifestyle. But, looking back to a year ago when I was a third-year medical student, I don't think it ever came up in my head, you know, during my daily work. Like, when I'm seeing patients and I'm in the hospital and I'm busy, me being gay is not something that's like in the back of my head or anything.*
> ***Will:*** *Okay.*
> ***Alex:*** *I don't know if that answers your question.*
> ***Will:*** *No, it does. So, you said now that it's a little more on your mind. In what ways do you think it affects your everyday thoughts or experiences? If you could think of any examples?*
> ***Alex:*** *My everyday thoughts and experiences. [Long pause.]*
> ***Will:*** *And this can be outside of a medical school setting as well, just your everyday—*
> ***Alex:*** *Well, I mean, another reason why it's been on my mind more lately is because I'm contemplating telling my parents sometime soon. The reason for that being I'm graduating from medical school soon and I know it's a very proud moment for me and for them and I'd like them to experience that moment knowing their son a hundred percent. So that probably weighs on my mind a lot these days. Other than that, that's really the only, I guess, influence it has on my thought processes everyday right now.*
> ***Will:*** *So you think after you come out to them, it will go right back to where it's really not an everyday sort of—*
> ***Alex:*** *I would think so and hope so. Yeah. Yeah. There have been days recently—being in the last two months or so—where it really gets to me. You know, like, enough to slow down my day and I have to kind of sit aside, think, have a glass of wine or something.*

Alex is able to keep his queerness invisible, but this makes it more difficult to come out both to his own parents and to people in his daily life, though perhaps it makes the stigma easier to deal with on a daily basis.

My conversation with Alex also illuminates the bioreductive nature of biomedicine. Alex claims that he does not need to come out to his health care provider because his health issues have nothing to do with his sexuality; yet, being in the closet to his parents and during his residency search process is clearly taking a toll on his mental health to the extent that it "really gets to him" enough that it disrupts his daily life. This is a quintessential example of minority stress, and it is ironic (though unsurprising given the bioreductive culture he has been enculturated into over the course of his medical education) that Alex is unaware of how the stresses of being a sexual minority may be adversely affecting his health even as he argues that it has no bearing on his health issues.

Invisibility is not an option that is available to everyone, nor does everyone desire to be invisible. Brandon and his friend helped to re-start the queer student group on campus because, as he puts it, "there's no way we can be in the closet here." Ellie noted that even after coming out to people as bisexual that they would often treat her as if she was heterosexual. When I asked her if she was treated differently as a patient due to her bisexuality, Ellie said, "not really. But I do think that I am treated as a straight person." When I asked her to elaborate, she shared a story of visiting a psychiatrist in town whom she had previously come out to but had recently asked her if she had a boyfriend. This struck Ellie as problematic: "She *assumes* that I would have a boyfriend rather than asking, 'Do you have a significant other?' or 'Are you in a sexual relationship?' or 'Are you emotionally involved with anyone?'" In this way, Ellie was disturbed by the lack of recognition by her psychiatrist of her expressed sexual identity, a concern that Ellie brought up with her psychiatrist in an e-mail after the incident. The psychiatrist never replied, and Ellie did not indicate if they had discussed it at a future date, if she was planning on bringing it up with her psychiatrist in the future, or if she found another psychiatrist.

The Politics of Visibility

The heteronormative and homophobic climates in the medical environments my informants inhabit was articulated by all of my informants as a problem of politics. My informants identified socially conservative ideologies and living in "conservative Texas" as important factors contributing to the presence of homophobia and heteronormativity. Ingrid explained it in this way:

> *Texas is obviously an awful place to be, I think, if you are [queer]. Because the majority of people just—even if they seem okay when you tell them, they're actually not, and they just try to act like they didn't know or like they don't want to know. I went to Colorado for Christmas and it was awesome because everyone was just loving and free-spirited, and I felt like no one really cared. But I feel like here I have to watch it a lot more, especially walking down the street or something. I feel kind of weird whenever I hold my girlfriend's hand. Because there are a lot of really crazy instances that happen in Texas because people are just a little too conservative.*

Carol also had reservations:

> ***Carol:*** *One of our professors talked about how he was a very religious conservative member of a church, and I just thought, "fuck!" You know?*
> ***Will:*** *Yeah.*
> ***Carol:*** *I feel more comfortable around people who will not espouse that. Like, and for better or for worse, I grew up in small little towns, so when I hear, you know, conservative religious Christian, the end result of that for me is that, "I don't like gay people" or "I think gay people are going to hell," so there's a little bit of an assumption on my part when I hear that. It's like, "Oh, you're not going to like me if I'm open to you about who I am."*

Filipe brought up age as well as:

> *There's an increasing number of people that are not caring what your orientation is, and that's fantastic. But there are still the older generation or the ultra-conservative that care. Or, as I've heard through the grapevine, people that are trying to convert you back to being "normal." And being in Texas is a little different, because it's more conservative here. I would imagine if I was up in the Bay Area or the Northeast, it's probably much less big of a deal.*

Dr. Finn, who did his residency at the school that makes up the field site, said that he felt he had to work harder than his heterosexual colleagues in order to prove himself and his worth. He linked this to medicine's conservative culture:

> *I think just sort of overcoming some of the conservative culture in some of the fields has been challenging. As a medical student going through surgery rotations, things like that were really hard because you have to hear sort of locker room talk and, you know, a lot of discriminating types of things. Not just against gay people, but everybody. So that's*

> *been hard to go through. I think even a lot of the types of conversations go on behind the scenes. Just in terms of the culture of medicine is very conservative. And if you don't fit it, you don't fit in a lot.*

While it may be true that Texas is home to more conservative-leaning people than other parts of the country, the assertions of my informants that these problems are likely minor or non-existent in places outside of Texas is not supported by the literature, which shows that biomedical professions, like the broader culture in which they are embedded, are generally heteronormative and homophobic across the United States (Eliason et al. 2011; Schuster 2012; Sanchez et al. 2006; Diaz et al. 2001; Scherzer 2000) and Canada (Ridson et al. 2000).

The framing of heteronormativity and homophobia as a conservative problem has the unfortunate side effect of obfuscating the insidious nature of both heteronormativity and homophobia. Neither phenomenon is specific or inherent to conservative politics; rather, as many informants point out, the infusion of conservative religious beliefs with the broader conservative body politic is an apparently bottomless well from which many anti-queer sentiments are drawn. Unfortunately, this positioning of heteronormativity and homophobia lets those who do not identify as conservative off the hook of self-reflection, providing cover for heteronormativity and homophobia to creep into biomedical praxis, even possibly through the practices of my self-professed less conservative-minded informants.

As previously stated when discussing case studies, my informants often take on the mantle of those considered higher up the medical hierarchy during their medical education and training. They are expected to do this; their education and training serves as a process of enculturation as they are assimilating into the norms of medical culture and practice. Like many sociocultural groups, there is a strong tendency to emulate and work within the structure, to fit in and be "normal," something that the students generally do without questioning or resisting. And this makes sense. For the most part, they do not go to medical school because they have an interest in queer issues or in social justice or in how medical education produces particular kinds of health care providers; they go to medical school because they want to help people or because they are interested in human health and disease. Most people go about their daily lives without investing a lot of thought into why they are doing the particular things they are doing in the particular ways they are doing them. It would make my informants' education much more challenging and stressful were they to question and resist every pedagogical and structural facet of their education.

When they do resist any heteronormativity or homophobia that they encounter, however, the strict hierarchical structure often prevents them from explicitly challenging it. For example, Hector was once observing a surgery when, in the middle of the operation, the surgeon began to wax political about the good old days when homosexuality was still considered a mental disorder in the DSM. This put Hector in an awkward position:

> *How do you deal with those attitudes or really difficult—it was like, should I really call him out in the middle of surgery—because he's operating on a patient—and end up picking a fight? That's probably not the most appropriate time to pick a fight with somebody. But it's like, you know, he's also an attending and above me. In normal day-to-day life, I would call somebody out if they said something like that. But medical society is very, very hierarchical. Medical students are at the bottom of the totem pole, then interns, then residents, then attendings. And it's very, very structured on that hierarchy, and that hierarchy is how it works. And since I'm at the bottom of that hierarchy, it's really intimidating to go up to the top of the hierarchy and correct somebody when whatever they say is not correct. But, it's also that they make you uncomfortable whenever something like that comes up.*

Essentially, in order for the heteronormativity and homophobia prevalent in medical environments to disappear, they will have to be erased from the praxis of the higher-ups. As Hector later noted, this means that efforts to curb heteronormativity and homophobia are probably more effective when aimed at younger people just entering medical school:

> *My feeling with [training on queer issues] is that you would have to get people with it early. The older physicians, they don't care. They're already at the top of the pyramid. It takes a lot of wrongdoing on their part to bring some kind of action against them. So, I guess they're above—like, they would go to the training and they would do the training, but I don't think it would affect anything.*

One thing has become clear from discussions with my informants concerning how they negotiate the politics of visibility: they appear to be struggling to reconcile the prevailing hegemony of biomedical praxis as objective and cultureless (Taylor 2003) with their experiences as students and as patients of biomedical praxis as heteronormative, homophobic, and conservative. This struggle plays out in the ways my informants discuss how being queer intersects with their own education and practice of biomedicine.

The Patient-Provider Relationship

Despite my informants' misunderstandings and ignorance concerning queer health disparities, they readily and openly acknowledged that visibilized queerness influences patient-provider interactions. Many of my informants expressed their own frustrations in dealing with medical environments as queer patients. They recognized how visibilized queerness can make both patients and providers more or less comfortable in medical settings; remarkably, there was no recognition among my informants of how the level of comfort and trust between patients and providers can affect the efficacy of healing regimens.

My informants described the patient-provider relationship differently depending upon whether they were taking the provider subject position or the patient subject position. When taking the provider subject position, many informants denied the importance of their queerness on their practice of medicine. By taking this stance, they expressed a view that maintained the illusion of a "culture of no culture" (Taylor 2003) in medicine, as if providers are more easily able to set aside their biases and prejudices as they employ the medical gaze.

On the other hand, many informants had a more realistic perspective on the patient-provider interaction when they took the patient subject position. Danny, for example, said that being gay would have no bearing on his professional identity and how he would treat patients; however, he also said that he had been treated differently as a patient due to his sexual orientation:

> *I don't think a lot of doctors are comfortable with sexual orientation. Um, they just haven't had—maybe, you know, enough experience. Or haven't like, you know, known gay people. So they really don't know how that changes anything or if it changes anything or how they should react or act.*
>
> *I went to the health clinic once and I think the issue came up and it was kind of awkward. We just had an awkward situation. I don't really remember why I was there, it was several years ago, or what the situation was. But I definitely remember, you know, disclosing my sexual orientation and having it not be the best experience.*

When I asked him if it made him hesitate to share his sexual orientation as a patient now, he said:

> *Well, being in medical school makes me more likely—less hesitant to disclose that information. But certainly before medical school I think I was more hesitant about it.*

Danny's experience highlights how visibilizing queerness in a patient-provider interaction can lead to awkward and uncomfortable encounters. Once Danny's queerness was visibilized in that setting, it made the physician uncomfortable because they were trained in a heteronormative system that allows for cultural biases and prejudices to go unnoticed until non-normative patients challenge them.

When I asked Ingrid if she was out to her own health care provider, she said that the only regular health care provider she had was her gynecologist, whom she was not yet out to, and she was nervous about going back to see her again in her hometown during the summer because, as a recently-out queer woman, she was worried her gynecologist might ask questions about her sexuality.

I also asked Grace if she was out to her own health care provider, and she said no as well. When I asked why, she said, “I guess I haven’t specifically been asked, ever. Like, even when I go to the gynecologist or something and they make it neutral enough that I don’t ever specifically have to answer.” Grace’s experience of not being asked by her gynecologist about her sexuality is not surprising in light of a recent study examining the types of questions gynecologists ask their patients (Sobecki et al. 2012). The study found that only 63 percent of gynecologists asked about their patients’ sexual activities, and only 28 percent asked about their patients’ sexual orientations. This is staggering considering the nature of gynecological medicine. On whether she would be treated differently if she did come out to her provider, Grace said:

> *I don’t think I would be treated differently. But, like, my family medicine doctor that I’ve gone to for as long as I can remember is also a family friend. And I think that has something to do with [not coming out to him], too. Because my parent’s don’t feel comfortable with [my sexuality], so I feel like I can’t talk to him about it because he’s friends with my family.*

Hector said that he does come out to his health care providers when he feels that it is appropriate for whatever health care he is seeking. Hector went on to say that past providers have treated him differently once his queerness was visibilized:

> *It’s very care-provider specific. I’ve never explicitly felt like I’ve been discriminated against or anything like that. You can just kind of tell, I think, when a provider is comfortable with you being gay and when a provider is a little uncomfortable with it. But in all cases, they’ve always maintained professionalism and things like that. It’s just more of their personal comfort. Because I feel like I can tell when somebody’s comfortable with me and when they’re not comfortable, and so it’s more subtle things. When I’ve gone to get HIV tested before, I could tell that the provider wasn’t particularly comfortable with it, but she was still very professional. She was still—didn’t discriminate against me or give me sub-standard care in any way. Just on a personal level, I could tell it was something she wasn’t used to dealing with. And she was a little uncomfortable with it. But I would say that’s the extent that I’ve been treated differently.*

Alex brought up the point that provider orientation can be used to make patients feel more comfortable:

> *Sometimes, for example, in the field of OB/GYN, I know of—there are physicians who are openly gay—male physicians who are gay, and female patients sometimes take a liking to that. They prefer to have—if they're going to have a male physician and they know he's gay, sometimes it's just a little more comfortable for them because they know there are no sexual undertones to the physical exam and things like that.*

What these statements by my informants demonstrate is an understanding that, despite the ideal of an objective, unbiased provider who does not let their background influence their delivery of care, in reality providers and patients both come to the relationship with their own sociocultural baggage, which both subtly and obviously influence how those relationships unfold.

For some non-queer patients, having a queer provider is offensive and something they want to avoid, as experienced by Brandon when one of his patients demanded a new provider when he found out Brandon was gay:

> *I did have one patient [get awkward]. I was in the VA and I did correct him. And he literally just got really stand-offish, angry, kind of, wouldn't even let me—I couldn't touch him anymore. You know? How am I supposed to do a physical exam if I can't even touch my patient? He got that uncomfortable. And so I did, I had to leave and get somebody else to come in and basically do my job for me because he was uncomfortable with it. And from that day one, it was like, I don't know if I'm really going to tell people. And I hate that. I really hate that.*

Other non-queer patients may seek out queer providers because they are more comfortable and still other non-queer patients may not care at all. For some queer patients, keeping their queerness invisible from providers for as long as possible is preferable while other queer people make no effort to hide their queerness. For non-queer providers, the visibilizing of queerness in their patients may be surprising and may make the provider uncomfortable, which can translate into an uncomfortable visit for the patient. And for queer providers, maintaining queer invisibility is sometimes viewed as the obvious choice while other queer providers maintain queer invisibility because it is a necessary evil for delivering health care to certain people.

Ultimately, any assertion that a provider's sexuality—queer or otherwise—has no bearing on their delivery of care or on the patient-provider relationship is simply wishful thinking perpetuated by a heteronormative hidden curriculum.

The Irrelevance Narrative

When asked how much being queer is a part of their professional identities, nearly all of my informants initially indicated that it had a small role or no role at all.[14] Informants followed up this position with the claim that being queer had little or no bearing on how they delivered or would deliver care to patients. I have termed this the *irrelevance narrative*, a prevalent narrative among my informants that being queer is irrelevant to the delivery of care despite the recognition that being queer affects how they interact with patients.

For example, Danny said that being gay has no part in his professional identity because his professional and personal identities were "just separate things." However, he says that being gay is a big part of his personal identity and that *it shapes how he interacts with people*. This is indicative of a cognitive dissonance; the urge to maintain a strict separation between personal and private identities means that Danny does not recognize how being gay shapes how he interacts with patients despite his acknowledgment that it shapes how he interacts with people in general.

Like Danny, Alex said that being gay was a mostly unimportant part of his professional identity: "I mean, I am going to be a doctor because I love patient care and I love the ability to bring a person from not-in-good-health to good health. But everything I just said, me being gay has no bearing on that."

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[14] An interesting exception to this was Dr. Harvey, who has been practicing medicine since the early 1980s. Dr. Harvey said that being gay is "completely" part of his everyday professional life in that it has given him "an awareness that, at its most fundamental, we are all different. That we all have unique characteristics, we all have unique life experiences, and that you should not make assumptions about people's lives."

Ellie, on the other hand, noted that her sexuality is "very much a part of who I am as a person, so it's hard to extract that from who you are professionally. I'm not going to make that a huge part of my professional life." She went on:

> *If I have a patient, I'm going to treat the patient. My identity won't influence my care of them. But it definitely will come into play because I'm more aware of the issues that—you know, like queer people would face in either medically relevant or everyday relevant, you know, in terms of depression or something like that that people could have. And I guess it makes me more sensitive to those issues that not everybody thinks about usually, but I kind of have that always at the back of my mind at least.*

Carol said that her sexuality currently had very little bearing on her professional identity, but that she would not rule out making it an important part of her practice as a physician's assistant in the future, particularly if she was able to make her way into medical practice in queer communities.

Filipe also said that his sexuality had very little bearing on his professional identity:

> *My sexual orientation has no bearing on my competence. And my skills. It really, I mean, in a way it really doesn't matter. But on the other hand, because I am gay, then, naturally, I'm much more aware of certain issues with patients that not everybody else is. And LGBT patients might have an easier time or might be more comfortable seeing a doctor that's also gay or that they realize have a better grasp on their issues and can provide them with better care. For the most part, it doesn't and it shouldn't matter. But there are some situations where it does.*

He later added:

> *Being gay just kind of has this domino effect, and I feel like it just affects so many parts of your life that you don't even realize until at some point it just kind of hits you. And all of a sudden, you're making life decisions because being gay affects it.*

Grace also said that her sexuality was mostly irrelevant to her professional identity because she tries to keep her sexuality a secret when it comes to patients because "I would just rather not deal with it." Brandon concurred, stating that he was torn because being gay "factors into how I treat every patient, but then I'm also like "no" because I hide it from a lot of people as a professional." Brandon took this position because he had a patient who found out he is gay and completely shut Brandon out and stopped responding to the point that Brandon had to find a colleague to take over the case.

Hector went into some detail as to why he felt that being gay was not important to his professional identity:

> *I feel like your sexuality shouldn't be part of your profession. It's a part of you and in that sense it's important, but I don't feel like me being gay affects the quality of care I give to patients. It doesn't affect lab tests I'm going to run, it doesn't affect how I'm going to treat patients. It might affect how they're going to treat me if they find out and don't approve of it or something like that. But other than that, it's not one of those things that I go into a room and introduce myself to a patient and be like, "I'm gay." So, I don't think that from that perspective it's really all that important. I'll be out to my co-workers and things like that. But the culture now is more—it's not okay to discriminate against people or to treat them differently as co-workers because they're gay. Maybe in small, rural areas I know it still is, but yeah. It's just not something that enters into my equation whenever I'm at work. Just like a heterosexual person wouldn't identify their sexuality as important to them doing their job, my homosexuality doesn't really affect how I do my job.*

It is interesting that Hector compares his own perspective to that of heterosexual physicians, whose sexuality is the assumed default and thus they do not have to think about how it impacts upon their treatment of patients. But a physician's heterosexuality can influence how they do their job because it can influence how they view and interact with queer patients. The heteronormative approach is thus reproduced, remains unquestioned, and is instilled into straight and queer medical students and practitioners through the hidden curriculum. Perhaps if there was more reflexivity embedded in medical education, training, and practice, there would not be nearly as many instances of queer patients being treated poorly by medical professionals, and maybe more queer patients would be more trusting of their heterosexual providers.

Ingrid ranked her sexuality as a little more important to her professional identity than most other informants; however, she still claimed:

> *I don't think it affects how I interact with people or how I—I should say, I don't think it affects my medical knowledge or how I will be handling patients. But it obviously, even*

> *though I was really open-minded to begin with, it really makes me sit back and consider other people's views.*

Finally, Dr. Finn indicated that being gay was "a big part of my daily professional life. I think maybe it, you know, it's just a part of who I am and maybe it affects my view of the world." He followed this up by saying that he thinks being gay gives him a certain perspective that, perhaps, makes it easier to understand his patients, but all things being equal, "my sexuality doesn't really have a lot to do with how I practice medicine, except for the things that I mentioned."

What my discussions with these informants demonstrate is that they want to believe that their being queer is irrelevant to how they deliver care, as well as their competence as health care providers. There is a tension present in their understandings of themselves as queer and as health care providers, resulting in contradictory statements that appear to be an effort to reconcile these professional and personal identities. It is a struggle fueled by the hegemonic "culture of no culture" (Taylor 2003) perspective instilled in biomedical praxis through the hidden curriculum. Informants seem to be wrestling with the prevailing biomedical narrative that physician background and culture is irrelevant to the practice of medicine. This friction is likely due to the fact that they have all experienced or acknowledged how their own backgrounds shape their worldviews as well as their engagements with biomedical praxis, often from the patient end, though they also recognize the disfunctionality of their own education concerning queer health issues.

Thus, the queer physician subject position inhabited by my informants seems something of a paradox. The irrelevance narrative demonstrates that informants are working to separate out their personal and professional identities while simultaneously recognizing and valuing how they are interconnected. In this way, the irrelevance narrative helps maintain the cognitive dissonance necessary for the hidden curriculum to instill the medical gaze into students. Once the medical students take on the mantle of the medical gaze, with its concomitant narrative of objectivity and culturelessness, it becomes more difficult to reconcile the reality that their queerness is inseparable from and always already informing their approach to the world, including their practice of medicine.

As the medical education curriculum continues to ignore issues relevant to the lives of queer patients, it remains up to queer students and their allies to visibilize queerness in biomedical environments. Until the medical hierarchical structures are re-shaped to be more inclusive of difference and to begin to acknowledge the sociocultural factors of health, queer medical education will continue to produce students who believe that it is actually possible to separate one's self from the biomedical context within which that self operates. Thus, a critical examination of the state of education and training on queer health issues is necessary in order to better formulate a plan for improving medical education curricula.

CONCLUSION

The research underlying this thesis was guided by the need to document the experiences of queer medical students in the process of training to become health care providers. I asked them questions about what it was like to be a queer medical student, how being queer affects their education and practice, and what kind of training they have received on queer health issues. Based on my discussions with informants, their experiences as queer medical students vary depending upon how visible they are or choose to be and what kinds of medical environments they are in. I gathered from my informants that there is a tension between visibilizing their queerness and their status as biomedical health care providers. They recognize that their queerness influences their worldviews and patient-provider relationships, but they are adamant that they will be successful in maintaining an objective, unbiased position as a health care provider that will be utterly uninfluenced by their queerness.

It is also apparent that my informants have received no meaningful education or training on queer health issues. The little bit of training and education that the students do receive is both inadequate and highly problematic. Based on the experiences my informants shared with me, it is clear that the training and education on queer health disparities at this institution is in need of an increase in both quantity and quality. But what improvements can be made to medical education, training, and practice that might help improve queer health disparities and diminish the extant heteronormativity and homophobia found in these medical environments? I will address this question presently; but first, I will briefly outline some of the limitations of this research and make recommendations for future research on this topic.

Limitations

The first limitation of this research is that the only data collection method utilized was interviews. Other ethnographic methods such as participant observation, textual and discourse analysis, and focus groups were not utilized due to the short project timeframe and problems with recruiting informants, namely a lack of response or interest in participating. This is perhaps most limiting due to the lack of data on the curriculum itself. Thus, all curricular data in this thesis are the result of impressions, perceptions, and experiences of my informants and are not contextualized in the actual curriculum.

The short duration of data collection involved with a Master's Thesis does not lend itself to a sufficient amount of participant observation in such a diffuse and heterogeneous population. Without participant observation, it is difficult to contextualize the experiences of informants elicited through interviews. Typically, participant observation would be used to get at what informants are actually doing, as opposed to interviews and focus groups that get at what informants are thinking in order to place informant perspectives into the context of their everyday activities.

Another limitation was that only queer-identified students and physicians were interviewed. How might answers to some of the interview questions from non-queer informants be different? What about non-queer informants who are allies and are educated about queer issues versus non-queer informants who are ignorant of queer issues versus non-queer informants who disapprove of queer people? Talking to non-queer providers and medical students might help support the claims I have made regarding the reproduction of heteronormativity through the hidden curriculum, and the irrelevance narrative might even be expanded to include both queer and non-queer subjectivities.

Related to the relative lack of diversity in the sample is the insufficient attention to intersectionality, including the lack of transgender and transsexual informants, and an inattention to how gender, race, ethnicity, socioeconomic status, and disability intersect with heteronormativity and sexual minority status in medical environments. In future or follow-up research, closer attention should be paid to the intersecting axes of marginalization and oppression that influence student and provider worldviews. Further, lumping a diverse, heterogeneous group of people under the label "queer" can obscure issues of importance to medical students; for example, students may experience more issues or problems in their education and lives due to their gender or race than their sexual orientation. It would also be interesting to discover if there is a similar tension between personal and professional identities among non-queer minorities in medical education and practice.

Another limitation is the scope of the research. This study will help explain particular issues at a particular time and place. Because of the small, non-random sample, findings cannot be generalized to other populations or settings. Further similar studies would have to be conducted and the results compiled and analyzed, or a larger-scale quantitative survey would have to test the findings of this research, before any generalizations about heteronormativity in general biomedical environments could be reliably produced.

Given more time and a slightly broader focus at the beginning of this project, it might have been useful to compare and contrast the literature on more general formalized schooling with the literature on medical schooling. What do formalized schooling practices in other kinds of settings have in common with biomedical schooling practices? Are there broader cultural patterns that link these practices together? Perhaps some interesting similarities would emerge with other EuroAmerican education systems that would illuminate how the hidden curriculum operates in other contexts that cross institutional and disciplinary boundaries.

Finally, an interesting possibility for future research on this topic would be to follow two cohorts through medical school, where the first cohort goes through a curriculum that does not provide training on queer health disparities and the second cohort (and subsequent cohorts) do receive training on queer health disparities. The first cohort would serve as a control group to see how student attitudes towards and understandings of queer health disparities may change, which could be measured through surveys and interviews. The second cohort could take pre-training and post-training surveys to gauge any changes.

Best Practices for Incorporating Queer Health Issues Into Medical Education

The literature on queer health disparities and the need for more research on queer health issues cited in chapter two clearly demonstrates that there is a general lack of attention to queer health in biomedical education and training not just in the United States, but in Canada and the United Kingdom as well. Based on this literature, I originally intended to collect data on the medical school's curriculum, and thus included questions in my interviews asking informants about their experiences with the curriculum. As mentioned in chapter three, specific curricular data were not collected due to time constraints as well as changes made to the school's curriculum while data collection was underway. This meant that any curricular data collected through participant observation, for example, might have been different from the curriculum that my informants discussed with me, though perhaps not in ways that would have made a difference with regards to queer health issues.

Despite the lack of data collected on the curriculum itself, I have decided to generate a list of best practices for improving medical education, training, and practice on queer issues. I have created this list by combining the literature discussed in chapter two with informants' experiences as medical students, at whom the education and training is directed, and as queer people, whose health needs the education and training should address. There are a number of improvements that could be made to medical education and training that would guide medical students toward a better understanding of queer health disparities, which will better prepare them to interact with queer patients in future encounters. These recommendations are made based on my own analysis as well as specific suggestions and comments from informants elicited during interviews.

1. Take more seriously the findings of the social and behavioral sciences regarding health and health care.
   Overemphasizing biological and pathological factors of disease does a disservice both to students and to their future patients. Encouraging students to be more aware of non-biological factors contributing to health and illness will make them better physicians.

2. Provide more lectures devoted to health disparities from a sociocultural perspective.
   Ideally, such lectures would be required coursework so that all medical students have a better grasp of social determinants of health. When this type of information is absent or made optional, it further reinforces the biomedical assumption that all health and illness issues stem from biology, which has the effect of contributing to health disparities rather than diminishing them.

3. Include information about queer people in cultural competence education and training, and make all medical students take some coursework on social and cultural diversity.
   If there is no other place in the curriculum to situate information on queer people, perhaps a good choice would be along with other cultural competency training. Requiring medical students to participate in coursework or training on cultural diversity will enable them to provide more sensitive care to their patients.

4. Provide ethnographic training for health care providers so that they are better able to evaluate and assess patient needs.
   Along the lines suggested by Kleinman & Benson (2006), training health care providers in ethnographic methodology may help to alleviate some of the problems produced through cultural competence education and training because it will push providers to stop treating patients as lists of (stereotypical) traits and require them to engage with patients as individuals rather than as manifestations of their particular social group. With education on the issues faced by particular queer populations, physicians will be able to combine their understandings of the social determinants of health and health disparities

with a more rigorous and patient-centered care that will better help diminish queer health disparities (as well as other kinds of health disparities).

5. Diversify the types of queer representations that are present in case studies.
   Limiting queer representations in case studies to homosexual men with HIV has the unintended consequence of reinforcing stereotypes about gay men and making all other queer people invisible. Inserting more diverse queer patients—and more diverse patients in general—into case studies will help diminish the shock many non-queer providers experience when their patients come out to them because they will be used to thinking through situations with queer patients.

6. Identify the sexual orientation of all patients in case studies where social history is present.
   Instead of having "a 47-year-old man" and expecting students to assume heterosexuality—or ignoring heterosexuality all together—give the students more information: "a 47-year old heterosexual man." It may, on first glance, appear to be irrelevant; however, having students be more aware of the assumptions they are making has the potential to improve their health care delivery as they become more reflexive.

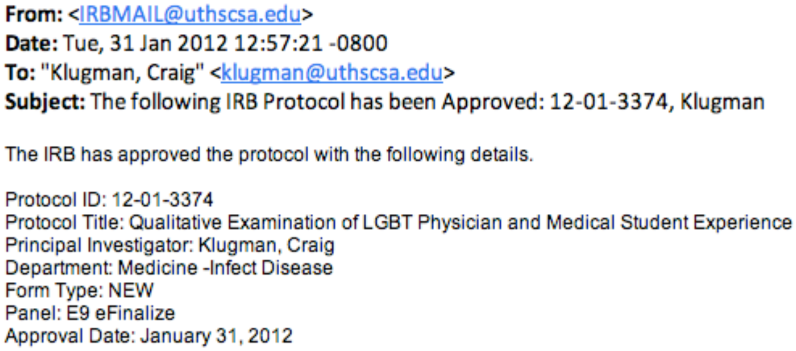
7. Encourage students and faculty alike to participate in ally and safe-space training.
   Members of the queer student group on campus have led an initiative on campus to train allies in how to create safe spaces on campus. Supporting and attending these training events will make the medical school campus—and, by proxy, broader medical environments—more safe and welcoming to people of diverse backgrounds and interests. The visibility of allies and safe spaces on campus will help reduce the psychosocial stress associated with being queer, which has the potential to diminish queer health disparities.

8. Encourage visible queer faculty to volunteer to mentor medical students.
   Many informants expressed a wish to have more mentoring by queer providers. Openly encouraging queer faculty to mentor medical students will help foster a better sense of belonging among queer medical students, which has the potential to improve their experiences of medical school and make them better physicians.

In its current state, American biomedical praxis incorporates unexamined heteronormative cultural biases, leading to a situation where there is either no recognition of the specific health needs of queer people or a focus only on simplistic sets of health risks/needs (typically HIV/AIDS, substance abuse, and mental health). Implementing these best practices will provide medical students and practitioners with better knowledge about queer health issues and thus pay better attention to queer people's health concerns. Only by paying closer attention to queer lives and health needs will medical education and training programs help alleviate queer health disparities as they bring more awareness to queer health issues from a broader and more nuanced perspective. After all, good health *care* is the goal of any provider, and they cannot effectively care for their queer patients if they lack understanding of the unique health issues faced by queer people.

APPENDIX A: IRB APPROVAL LETTER

The data collected for this thesis was done under approval of the Institutional Review Board of the University of Texas Health Science Center San Antonio (UTHSCSA) as the Primary Investigator (PI) for the broader project under which this data collection occurred was housed at UTHSCSA. The protocol, ID number 12-01-3374, was approved on January 31, 2012. Below is a copy of the approval e-mail sent to Dr. Craig Klugman, the PI for the project.



From: <IRBMAIL@uthscsa.edu>
Date: Tue, 31 Jan 2012 12:57:21 -0800
To: "Klugman, Craig" <klugman@uthscsa.edu>
Subject: The following IRB Protocol has been Approved: 12-01-3374, Klugman

The IRB has approved the protocol with the following details.

Protocol ID: 12-01-3374
Protocol Title: Qualitative Examination of LGBT Physician and Medical Student Experience
Principal Investigator: Klugman, Craig
Department: Medicine -Infect Disease
Form Type: NEW
Panel: E9 eFinalize
Approval Date: January 31, 2012

APPENDIX B: SAMPLE INTERVIEW QUESTIONS

- When did you decide you wanted to go to medical school?
- How was your experience at medical school as an LGBTQ student?
- Were you "out" to your peers in medical school? To your faculty? Why or why not?
- Did you feel like an outsider or an insider while you were in medical school? Why?
- Were you "out" when applying to residency programs? Why or why not? Do you think this affected/would have affected your chances of selection?
- How long have you been a practicing physician?
- Are you out at work? To your patients? To your friends? To your family? To your own health care provider?
    - If yes, what were some of your coming out experiences like in these settings?
    - If no, why do you choose to remain in the closet?
- Do you feel you (or other queer people) are treated differently? Why or why not? In what ways?
- If you are in a relationship, do you tell others? How do you refer to your partner?
- How much is being queer a part of your everyday professional life?
- Does being queer affect your everyday professional thoughts or experiences? In what ways?
- On a scale of 1 to 10, with 1 unimportant and 10 being extremely vital, how much is being queer part of your:
    - Professional identity? Why?
    - Personal identity? Why?
- Are you active in queer organizations? If so, what types of things do the organizations do? If not, why not?
- How often do you visit gay establishments (businesses, bars, clubs, etc.)?
    - Which kinds do you visit? How frequently?
- What challenges do you feel that you face that your heterosexual (or cisgender) colleagues do not?
- Do you feel like an outsider or an insider at work? Why?
- What kind of training or education have you received on queer issues in medical school? Since medical school?
    - Do you feel that this training and education is adequate? Why or why not?
- In everyday encounters (e.g., store employees, strangers walking on the street, etc.), do you assume that people you don't know are heterosexual unless told otherwise?
    - Conversely, do you assume that people you don't know are queer unless told otherwise?
    - What sorts of things lead you to these conclusions?
- When presented with cases or case studies, do you assume people are heterosexual unless told otherwise?
    - Why do you think this is?
- Do you feel that you have been treated differently as a patient due to your sexual orientation/gender identity? In what ways? Can you give an example?
- Have you experienced any harassment or discrimination in your life in medicine as a result of being queer? If you would not mind sharing, then what?
- Have you ever seen a physician or medical colleague use derogatory, insulting, or degrading

language when speaking about or to a queer patient?

- Will you be openly “out” when applying for residency? Why or why not?
- Are there disciplines within medicine that you feel are more gay friendly than others?
- What health issues do you think queer patients face more than other groups?
- What ethical issues do queer patients face that are different from or matter to a different degree than those of other patients?
- Do you feel you have more queer patients than other physicians do?
- Is there anything that I did not cover in my questions that you would like to talk about?

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VITA

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