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A Collaborative Online Project

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Medical Authority and Queer Health Disparities

Over the last few decades, lesbian, gay, bisexual, and transgender (LGBT) people have become increasingly visible in many parts of the world. In North America in particular, this greater visibility has illuminated the many problems faced by queer [1] people. From homophobic bullying at all levels of education to disturbingly regular acts of physical violence to higher rates of suicide, many queer people live in a constant state of alert, keenly aware of the increased likelihood that they will face some sort of prejudice, discrimination, or violence.

An often-overlooked aspect of queer people's daily lives health care. Queer people have distinct health care issues and needs, but these needs are not well understood by the biomedical establishment (Institute of Medicine 2011). There is anecdotal (e.g., Schuster 2012) and empirical (e.g., Eliason et al. 2011; Risdon et al. 2000) evidence of the ways that heteronormativity [2] has been institutionalized in biomedical practice in North America as a form of authoritative knowledge (Jordan 1997). The ways that these biases are silently infused with biomedical practice negatively affects the health-care-seeking behaviors of LGBT people, which can have deleterious effects on their overall health.

Medical Authority and The Hidden Curriculum

Health and illness are always already political. Biomedicine, the dominant medical theory and practice in Euroamerican societies (sometimes called Western medicine or modern medicine), has both greatly improved overall health and simultaneously been utilized in the oppression of marginalized peoples, sometimes in the quest to improve the health of dominant social groups (for examples, see Washington 2006; Skloot 2010). As a biopolitical practice, biomedicine is closely linked with the production of sociocultural norms. Social workers, for example, depend upon biomedical definitions of sex and gender (rather than the expressed identities of individuals) in their work helping the state categorize and manage persons (Monro & Warren 2004).

To be a useful biopolitical tool, biomedicine must serve as a source of authoritative knowledge. Authoritative knowledge refers to the knowledge that members of a community agree is important enough to inform decision-making and justify actions resulting from those decisions (Jordan 1997). Authoritative knowledge is considered by the community to be legitimate, consensual, and meaningful to such an extent that it becomes hegemonic, is naturalized, and renders other ways of knowing unthinkable. As such, authoritative knowledge is actively, regularly, and unreflexively (re)produced. The education and training of biomedical practitioners clearly evidences the role of authoritative knowledge in biomedical practice.

One way that biomedical physicians take up and reproduce authoritative knowledge is through the hidden curriculum of medical education. Frederic Hafferty (1998) discerns three kinds of curriculum in medicine: the formal curriculum (the official coursework and explicit training), the informal curriculum (the unscripted teaching/learning moments between students and faculty), and the hidden curriculum, which refers to the implicit ways that medical education is structured that routinely and systematically exposes physicians-in-training to biomedical objectification of patients to such an extent that the physicians become alienated from their patients as persons.

Robbie Davis-Floyd (1992) describes this hidden curriculum as a biomedical rite of passage that has the effect of re-organizing the cognitive patterns of physicians so they learn to detach information about bodies and diseases from actual persons. This cognitive reorganization has traditionally occurred in the first two years of medical school, where physicians-in-training receive an “intellectual overload” (Davis-Floyd 1992: 264) of information about bodies and diseases, much of which is forgotten by the time they reach hands-on clinical training in the third year of medical school. [3]

One result of the hidden curriculum is what Foucault (1994) called the medical gaze. The medical gaze refers to the separation of body from identity that leads biomedical practitioners to see a patient not as a whole person, but as a set of biological problems to be solved through the examination of pathological etiologies. This kind of patient-provider relationship is a key site where authoritative knowledge is (re)produced in biomedical societies: The patient’s body becomes a site of scientific and biomedical discovery, and thus cultural knowledge production. Privileging physicians as objective sources of (authoritative) knowledge can strip patients of agency and give them less space to address their own health concerns that may have little or nothing to do with disease. Based on the view that understanding one’s body requires years of dedicated and specialized training, patients may over-depend on physicians to make decisions about their own health care. Thankfully, there are on-going efforts in biomedicine to take more seriously the patient-provider relationship.

One of the factors illuminated by research on the patient-provider relationship is the importance of trust between the patient and the provider. Improved levels of trust in the patient-provider relationship have been linked to more efficacious healing and treatment regimens (Mead & Bower 2000; Wechsler et al. 2011). Trust between biomedical providers and patients is greatly enhanced when patients can raise culturally stigmatized issues (such as gender variance or sexual orientation) without facing censure (Herek et al. 2007; Platzer 2006), when providers receive education and training on issues important to people from diverse backgrounds (Sanchez et al. 2006), and when providers themselves come from non-normative backgrounds (Beagan 2003).

One possible way to alleviate the first two of these shortcomings is through cultural competence training, though this approach is not without problems. The intended goal of cultural competence training is to eliminate health disparities, which are morbidity, mortality, and health-care access differences among various populations (Dressler et al. 2005). However, the ways that cultural competency training is designed often does not work towards that goal (Gregg & Saha 2006). For example, assuming that these goals can be accomplished through physician education and training alone may leave out other ways of addressing health disparities such as policy changes and social welfare programs. Unfortunately, such assumptions often have the effect of reinforcing health disparities rather than eliminating them because they can ignore non-biomedical (i.e., sociocultural) influences on health disparities.

Queer Health Disparities

Despite the growing visibility of queer people, biomedical practice largely remains heteronormative, homophobic, and transphobic. There is a distinct lack of knowledge about (and sometimes outright hostility towards) sexual minorities among biomedical practitioners (Institute of Medicine 2011; Risdon et al. 2000; Smith & Mathews 2007; Hatzenbuehler et al. 2012; Eliason et al. 2011). This lack of understanding inevitably opens the door for unexamined heteronormative assumptions to seep into biomedical education, become internalized as authoritative knowledge, and then institutionalized in biomedical practice. This in turn reinforces the heteronormativity in public understandings of and policy decisions about queer people that informed such assumptions in the first place.

Among the research that has been done on queer health disparities, the current favored explanation is the minority stress model (Meyer 1995), which argues that a mismatch between minority status and hegemonic social values creates a hostile social environment that stigmatizes members of minority groups, leading to chronic stress that generates worse health outcomes. Empirical evidence supporting the minority stress model is slowly being generated. Sexual minority status has been linked to a number of health disparities, including increased risk of substance abuse (Halkitis et al., 2007; Kashubeck-West & Szymanski 2008), increased risk for sexually transmitted infections (Halkitis et al., 2004), and psychological distress and mental illness (Cochran et al., 2003). [4]

Mark Hatzenbuehler and colleagues (2012) provide an interesting empirical example of the correlation between discrimination against sexual minorities and health. The researchers analyzed the health-care-seeking behaviors of 1200 gay men for 12 months before and 12 months after the enactment of marriage equality in Massachusetts in 2004. They found a 13 percent decrease in healthcare visits in the 12 months after marriage equality was enacted in both partnered and non-partnered gay men. This indicates that the improved social status of marginalized groups may lead to improvements in health as fewer physician visits is correlated with fewer health problems.

If the minority stress model explains why queer health disparities exist, the question becomes how do we eliminate them? Most broadly, advocacy for the equal and fair treatment of queer people in society writ large will help to alleviate queer health disparities by lessening stigmatization and discrimination faced by queer people. However, even if queer health disparities were completely eliminated, there will still be unique health care needs and issues for queer people, so improving education and training for physicians on queer health is vital.

As additional research is conducted and new knowledge is generated on the particular health needs of queer peoples, medical education curricula will need to incorporate these findings in order to better prepare future physicians to recognize and deal with these needs. Further, educating biomedical providers on how to engage with queer patients in sensitive ways will decrease the incidents of heterosexism, homophobia, and transphobia experienced by queer patients in biomedical settings—incidents which contribute to poor health outcomes. At the very least, health care providers should be made more aware of the ways that their words and actions can be harmful towards the patients they are charged with helping.

As it stands now, the ways that biomedicine incorporates heteronormative cultural biases into its theory and practice leads to a binary of either no recognition of queer peoples and their specific needs or a focus on only one set of health risks/needs (typically this focus for queer patients is on HIV/AIDS, substance abuse, and mental health). Better knowledge of, attention to, and concern for the specific health needs of queer people will improve the health and lives of queer people. Isn't that what health care is supposed to be about?

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Notes

1. The term “queer” is used here as an umbrella term to refer to all gender-variant and non-heterosexual people.

2. Heteronormativity refers to the cultural logic that values binary gender roles as natural, normal, and complementary.

3. Fortunately, this pattern of education and training has recently begun changing to include clinical training early on in medical education.

4. It should be noted that much of the literature generated on queer health disparities comes from examinations of gay and bisexual men. There remains a dearth of research on lesbian and bisexual women and transgender people.

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