Manuscript Title: The Irrelevance Narrative: Queer (In)Visibility in Medical Education and Practice

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Abstract

How might heteronormativity be reproduced and become internalized through biomedical practices? Based on in-depth, person-centered interviews, this paper explores the ways heteronormativity works into medical education through the hidden curriculum. As experienced by my informants, case studies often reinforce unconscious heteronormative orientations and heterosexist/homophobic stereotypes about queer patients among straight and queer medical students alike. I introduce the concept of the irrelevance narrative to make sense of how queer medical students take up a heteronormative medical gaze. Despite recognizing that being queer affects how they interact with patients, my informants describe being queer as irrelevant to their delivery of care. I conclude with a discussion of how these preliminary findings can inform research on knowledge production in biomedical education

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and practice with an eye toward the tensions between personal and professional identity among biomedical practitioners.

Keywords

Medical education, heteronormativity, hidden curriculum, professional identity

"A specter is haunting medicine—the specter of homosexuality."
Anne Fausto-Sterling, *Sexing the Body* (2000)

Introduction

It is uncontroversial to say that queer people in the United States are more visible than ever. Social institutions such as marriage and family are rapidly being reframed in increasingly inclusive ways. New laws, such as the Matthew Shepard Act that extends federal hate-crimes protections to queer citizens (Library of Congress 2009), are legally codifying human and civil rights of sexual minorities. While increased visibility often leads to more social inclusion, it also sheds light on areas of concern, including homophobic bullying directed at children and teens by their peers, physical violence towards queer people, and heteronormativity, heterosexism, and homophobia[1], which can all negatively impact the everyday lives of queer individuals. In biomedical settings, the result of an institutionalized heteronormativity[2] is that many health care providers remain unaware of the unique health needs of queer people, and they often lack the vocabulary to start conversations with or about

[1] In this paper, I distinguish between *heteronormativity*, *heterosexism*, and *homophobia*. Heteronormativity refers to the implicit treatment of reproductive heterosexuality as natural and normal to the extent that it is the assumed default subject position of all people until a non-heterosexual identity is disclosed. In contrast, heterosexism refers to the explicit belief that heterosexuality is not only natural/normal but morally superior to non-heterosexuality. These terms may be differentiated from homophobia, which is disgust or hatred for queer people. Heteronormativity and/or heterosexism may or may not be homophobic—one can believe in the naturalness and moral superiority of heterosexuality without hating or being disgusted by gay and lesbian people (Boellstorff 2004), though this distinction is often difficult to notice in discourse and practice. Like any other social environment, all three may be present in medical settings. This paper focuses on heteronormativity because I am interested in the implicit assumptions and productions of normative gender/sexuality rather than the intentional moral elevation of heterosexuality or the fear/disgust towards queer people.

[2] The institutionalization of heteronormativity in biomedical settings is evident in everyday practices that normalize heterosexuality, such as clinic staff inquiring about a person's opposite-sex partner without knowing their relationship status or sexual orientation, as well as in the pervasive lack of education and training on queer health issues.

them (Baker & Beagan 2014). A 2011 report by the Institute of Medicine (2011a) concluded "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). We know queer people have unique health issues and experiences with medical care, but the solutions to those issues remain elusive and require more research.

In this paper, I focus on how the hidden curriculum of medical education works to invisibilize queerness in patient-provider interactions. Based on person-centered interviews with medical students and faculty at a medical school in South Texas, I analyze one aspect of this enculturation process in which future queer providers begin to employ a heteronormative gaze on their patients. After reviewing the relevant literature, I discuss the findings of this research, which is divided into three themes: Visibility and the heteronormative gaze, lack of training and education on queer health issues, and the irrelevance narrative, a concept I introduce to discuss how the medical students and faculty I talked to describe their queerness as being irrelevant to their delivery of health care despite it being an otherwise important aspect of their experiences and identities. The irrelevance narrative helps highlight the tension between queer personal identities and socially neutral professional identities. I conclude the paper with a discussion of the findings and suggestions for potential future research on this topic.

Background

Trust between patients and their health care providers is an important factor in the effectiveness of treatment regimens (Wechsler et al., 2011; Mead & Bower 2000). Patients must feel they can bring up culturally stigmatized issues, including non-normative sexual or gender identities, with their providers without being condemned (Herek et al. 2007; Platzer 2006). Biomedical settings are often viewed by queer patients as heteronormative and

homophobic (Baker & Beagan 2014; Murphy 2014; Obedin-Maliver et al. 2011; Schuster 2012; Eliason et al. 2011; Sanchez et al. 2006; Diaz et al. 2001; Eliason & Schope 2001; Beehler 2001; Ridson et al. 2000; Scherzer 2000). Many queer people avoid going to the doctor, often citing fear of discrimination or previous bad experiences as reasons for delaying or avoiding seeking health care (Moyer 2011; Institute of Medicine 2011a; Beehler 2001; Eliason & Schope 2001). Such views tend to degrade queer patients' trust in providers, who often receive little-to-no training on queer health issues (Murphy 2014; Obedin-Maliver et al. 2011; AAMC 2014). The scant training on queer health issues that does exist in medical education curricula is usually attached to "cultural competence" training, which is the most common approach medical education has utilized to sensitize physicians to patient diversity (Baker & Beagan 2014; Murphy 2014; Shaw & Armin 2011; Gregg & Saha 2006; Shaw 2005; Beagan 2003; Taylor 2003a; Tervalon & Murray-Garcia 1998). By framing cultural competence training and education as an issue of patient diversity, providers' own cultural biases and assumptions go unexamined and are therefore able to creep into education and training through the hidden curriculum of medical education. Since the types of knowledge that are most highly valued by biomedical educators and practitioners tend to exclude psychosociocultural data because it is not viewed as an important aspect of case reports or clinical presentations (Good et al. 2007), educators and providers often ignore the sociocultural aspects of biomedicine, thereby reinforcing the "culture of no culture" (Taylor 2003b) in biomedicine and further obfuscating the important, though mostly invisible, role of culture in biomedical education and practice.

Frederic Hafferty (1998; see also Hafferty & Castellani 2009; O'Donnell 2014) identified three kinds of curriculum in medical education: *the formal curriculum*, indicating official and explicit coursework and training; *the informal curriculum*, denoting the unscripted and interpersonal teaching/learning moments among faculty and students; and *the*

hidden curriculum, referring to the implicit, unintended transmission of cultural norms and beliefs in educational settings. Anthropological examinations of the hidden curriculum of medical education have uncovered some common themes, namely "the loss of idealism, the prominence of hierarchy, the adoption of a ritualized professional identity, and emotional neutralization" (Gaufberg et al. 2010: 1709; see also Davenport 2000). Little work has been done on how gender and sexuality norms work into medical education through the hidden curriculum (Murphy 2014). It is important to note that focusing on the hidden curriculum, as I do in this article, should not be taken to imply there are no significant problems in the formal curriculum, and it is imperative to keep in mind these different forms of curriculum are only one aspect of the broader system of medical education and practice through which cultural norms are (re)produced (Hafferty & Castellani 2009; O'Donnell 2014; Hafferty & O'Donnell 2014).

All three forms of curriculum work together to instill in medical students and physicians the belief that disease and illness are reducible to biophysiological etiologies, enabling inattention to psychosociocultural aspects of disease and illness. Thus, physicians-in-training are systematically exposed to the objectification of patient bodies to the extent that physicians can become alienated from patients as persons. This medical gaze (Foucault 1994) relies on an epistemological separation of body from identity, leading physicians to see patients not as whole persons, but as medical objects with particular sets of pathophysiological etiologies that can be diagnosed and treated through individual therapeutic intervention. The medical gaze also allows physicians to incorporate bodies back into the existing body of knowledge, permitting the medical system to further regulate bodies by establishing what kinds of bodies or conditions are considered normal or pathological (Canguilhem 1978). In this way, the medical system comes to do the work of the cultural system by regulating and enforcing norms, and patient disclosure of their queerness exposes

them to a medical gaze that can then normalize or pathologize queerness in various ways (Foucault 1990).

The work of Byron Good and Mary-Jo DelVecchio Good (Good & Good 1989; Good 1995; Good 1994), helps illuminate how the medical gaze has manifested in the patient-provider relationship. Good & Good (1989) describe how students at Harvard Medical School learned to reconstruct patients into cases, focusing on physical and physiological characteristics while ignoring sociocultural and individual personality characteristics, thus objectifying the patient. Students talked about how they began to see people differently after spending long spans of time learning the anatomy of human bodies by exploring inside cadavers. Yet, despite the potentially negative outcomes of this process, Good & Good argue the medical gaze is a necessary component of the development of a professional physician-self because it allows providers to re-define patients' and their own personal boundaries in ways that enable providers 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. Thus, the medical gaze instilled in biomedical practitioners through the hidden curriculum poses a practical challenge as physicians must learn how and when to treat patients as persons in some contexts and objectify patient bodies in others.

It is important to note that, like any social practice or institution, medical education and practice change over time, and there are movements to address structural problems in medical education. Over the last couple of decades, many medical education programs have shifted from didactic to problem-based learning models (MacLeod 2011; Kenny & Beagan 2004) that begin hands-on training earlier and seek to better incorporate psychosociocultural issues into medical education. These shifts are becoming institutionalized in the broader biomedical educational structure as organizations like the Association of American Medical Colleges push for new medical school admissions requirements that encourage applicants

from diverse backgrounds (AAMC 2013). There are also calls for programs to implement curricular as well as cultural changes with regard to queer health (AAMC 2014), and some medical schools are beginning to pay closer attention to queer health needs. It is worth mentioning that I collected the data for this research during the final academic year before the institution transitioned to a problem-based learning model. As far as I am aware, there were no plans to incorporate queer health issues into the new curriculum.

Despite these changes, American biomedical education still tends to frame disease and illness in biologically reductive ways. As such, these values are transmitted through the hidden curriculum, continuing the deep intellectual history and heritage that predisposes practitioners to objectify patients.

Methods

This research came out of a larger project with the original aim of collecting information about the experiences of LGBT medical providers. Unfortunately, the project discontinued after this data was collected, partially due to difficulty recruiting participants but also due to changes in life and professional circumstances for some of the project members. The data used here is from the part of the project that focused on medical students, which developed after learning from a colleague who worked at the medical school in South Texas where this research was conducted that there was no education dedicated to queer health issues in the curriculum.

In the spring of 2012, with IRB approval from the medical school, I sought out informants who self-identified as queer—typically, but not only lesbian, gay, or bisexual—and/or transgender. To recruit informants, I attended meetings of the campus' queer student group, which included students from medicine, dentistry, nursing, and the physician's assistant (PA) programs, posted flyers around campus, and emailed flyers via the queer students' listserv. At the meetings and in the announcements, I described the research project

and asked anyone who was interested in participating to contact me. I was also given names of potential informants who were not present at these meetings and reached out to them via e-mail, but the majority of these contacts did not reply or declined participation.

I conducted semi-structured, in-depth, person-centered interviews with a total of eleven people, including eight medical students ranging from first year to fourth year, one physician-assistant student, and two practicing physicians who regularly interacted with students at the medical school. My informants included one queer woman, one bisexual woman, two lesbian women, and seven gay men, all given pseudonyms. I failed to locate any trans medical students. The small sample size is the result of both difficulty locating willing participants in a small "hidden" population within small medical school as well as the extremely busy schedules of the medical students, many of whom expressed an interest in participating but either did not follow-up on requests for appointments or simply stated they did not have the time to spare.

Informants were asked about their experiences during medical school, both in general and as queer-identified people. Prompts and topics included experiences of "coming out" both in their everyday lives and in medical settings, how their sexual orientation and/or gender variance impacts their everyday lives and their experiences as medical students, providers, and patients. Informants were also asked about case studies in order to gain an understanding of their perceptions of the use of case studies in their education. Interviews were recorded and transcribed, and the transcripts were uploaded into Dedoose, a qualitative data analysis program. The transcripts were analyzed using grounded theory, an inductive analytical methodology that identifies emergent themes in a text to generate explanatory frameworks to address the research problem (Bernard & Ryan 1998; Birks & Mills 2011). While a few codes were applied deductively, such as "heteronormativity," "homophobia," and "coming out," most of the codes emerged inductively during the coding process, and

included terms such as "visibility," "professional," "patient-provider relationship," "marginalization," and "medical specialization."

Findings

The findings of this research are divided into three main themes. The first theme, visibility and the heteronormative gaze, examines informants' perceptions of queer (in)visibility in medical settings from the perspectives of students, providers, and patients. The second theme discusses the lack of education and training on queer health issues as experienced by my informants. In the third theme, I introduce the concept of the irrelevance narrative to explain how my informants talked about their queerness as irrelevant to the delivery of care despite recognizing the ways being queer affects how patient-provider interactions.

Visibility and the Heteronormative Gaze

When I asked whether or not they assume strangers in public places are heterosexual until shown otherwise, my informants gave a variety of answers. Those who felt they did not make assumptions about strangers' heterosexuality often included language such as "not really" and "not necessarily" to avoid an absolute answer. Those who said they did make assumptions about strangers' heterosexuality often included similar non-absolute language, such as "usually" and "for the most part," except for both of the practicing physicians I interviewed, who unequivocally stated they have heteronormative perceptions of strangers. In contrast to this diversity of answers given to the question about heteronormativity in their everyday lives, every single informant stated they *do* assume that patients are heterosexual unless told otherwise.

In fact, Brandon, a second-year medical student who identifies as a gay man, went as far as claiming the assumption that patients in case studies are heterosexual is at "the core of our academics." This statement is supported by other informants who said the only times

patients in case studies were not assumed heterosexual was when they were explicitly identified, and this always took the form of a homosexual man with HIV (discussed below). As far as my informants could recall, patients in case studies were never explicitly identified as heterosexual. Many of my informants speculated that case-study writers were making assumptions about case-study patients' sexualities, and thus the students were adopting the same stance as the writers in order to answer questions correctly. This is indicative of a medical gaze that is both heteronormative *and* desexualizes patients, which enables physicians to physically engage with patient bodies while retaining a sense of professionalism and medical objectivity (Good & Good 1989). Yet, it simultaneously instills the belief that a patient's sexuality is only relevant when it concerns pathology because the medical gaze inculcates a view of bodies as pathological objects rather than persons, much less persons with sexual subjectivities. When the medical gaze is turned to sexual behavior, it is often focused on maintaining heterosexual reproductive functionality or treating sexually-transmitted infections rather than sexual subjectivity (as indicative of good overall 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 of the means by which the hidden curriculum operates. Case studies make patient heterosexuality the invisible default, and queerness is only brought up in relation to stigmatized health issues for a specific subset of queer patients. Students 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 certain medical pathologies are present.

My conversation with Alex, a fourth-year medical student who identifies as a gay man, illuminates this biologically reductive perspective. Alex claimed he does not need to come out to his health care provider because his health issues have nothing to do with his

sexuality; yet, based on our discussion, it became clear that being in the closet to his parents and during his residency search process was 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 (Meyer 1995; Dressler et al. 2005), and it is ironic—though unsurprising given the biologically reductive enculturation he has experienced over the course of his medical education—that Alex seems unaware of how the stresses of being a sexual minority may be adversely affecting his health even as he argues it has no bearing on his health issues.

Many of my informants recognized how disclosing queerness can affect both patients and providers comfort in medical settings and influence patient-provider interactions. They expressed frustrations with navigating medical environments both as queer patients and providers. Interestingly, my informants described the patient-provider relationship differently depending upon whether they were taking the provider or the patient subject position. When taking the provider subject position, many informants denied the importance of their queerness on their practice of medicine, and when it did come up as affecting their work, it was often due to the ways patients reacted to their queerness. For instance, Brandon, a second-year medical student, told a story about correcting a patient who assumed his wedding ring meant he was married to a woman:

> [The patient] 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 did I. I had to leave and get somebody else to come in and basically do my job for me because he was uncomfortable with it.

This encounter made Brandon more cautious about disclosing his orientation to patients because he wanted to avoid similar uncomfortable encounters in the future.

On the other hand, when informants took the patient subject position, they had a different perspective on patient-provider interactions. Danny, a first-year medical student,

said being gay would have no bearing on his professional identity and how he would treat patients but acknowledged 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 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." Both Brandon's and Danny's experiences exemplify how visibilizing queerness in a patient-provider interaction can lead to awkward and uncomfortable encounters (Baker & Beagan 2014; Harbin et al. 2012). Once their queerness was visibilized in those settings, the physician-patient relationship became uncomfortable or even hostile. Danny attributed this discomfort on the part of physicians to a lack of experience and training with queer patients, which can be interpreted as the logical outcome of a heteronormative medical education system that incorporates the broader society's heteronormative cultural biases and prejudices through the hidden curriculum.

When I asked if they were out to their providers, many of my informants said they were not for various reasons. Ingrid, a first-year medical student who identifies as a queer woman, said she was afraid to come out to her provider in her small home town for fear of being outed. Grace, a first-year medical student who identifies as a lesbian woman, told me she was not out to her provider for the simple reason that she had not been asked. Hector, a fourth-year medical student who identifies as a gay man, said he only sometimes comes out

to his health care providers when he feels it is relevant to his health issue. These sentiments demonstrate an understanding that, despite the biomedical ideal of an objective, unbiased provider who is unaffected by culture (Taylor 2003b), in reality providers and patients always come to the relationship with their own sociocultural baggage, which both subtly and noticeably influence how those relationships unfold. While my informants more readily recognized how being queer affects their experiences as patients, they were reticent to acknowledge how being queer might affect their practicing of medicine. Before addressing this point in more detail, it is necessary to discuss the lack of attention to queer health issues in medical education as experienced by my informants.

Lack of Quality Education/Training on Queer Health Issues

The hidden curriculum of heteronormativity results in a dearth of quality education and training on queer health issues, and this absence was true for the training at this school as in many other medical schools (Coleman 2012; Baker & Beagan 2014; Obedin-Maliver et al. 2011). Informants expressed concern at the inadequate training on queer health issues and desired more curricular attention to queer health issues. The only explicit education they received was limited to small pieces of information scattered across their curriculum, with the most concentrated information relegated to a single lecture on sexuality in a behavioral health class. When queer health issues did come up in the formal curriculum, it appeared in one of two ways: the social history and the HIV-positive homosexual male in case studies.

By far my informants' most talked-about aspect of their education was being trained to ask about sexual behavior as part of the patient's social history using a specific refrain: "do you have sex with men, women, or both?" This catchphrase was mentioned by nearly all of my informants. Dr. Finn, a cardiologist and faculty member who identifies as a gay man, explained, "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 if this meant that sexuality in clinical presentations and case studies is based on behavior rather than identity, he said, "Yeah. It's more, sort of—yeah. Not how they define themselves." Taking a patient's social history shapes the physician's medical gaze by allowing the collection of information about sexual practices, which are used to make assumptions about identity and potentially aid the perpetuation of stereotypes such as the conflation of homosexual men with HIV/AIDS. Thus, the social history is one avenue through which the hidden curriculum can work to incorporate cultural norms and biases about gender and sexuality into medical practice.

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 a person's sexual behavior is not necessarily indicative of sexual identity (Boellstorff 2011; Beagan et al. 2014), and such a conflation is indicative of risk-based, behavioral understandings of identity prevalent in contemporary medicine (Aronowitz 2009). My informants believe this question gets at sexual orientation because the common medical practice is to inquire about behavior (in order to assess risk) and then infer identity rather than to ask about patients' identities as separate from practices. As some of my informants noted, this question, when answered honestly by queer people, often changes how providers interact with queer patients. Hector, a fourth-year medical student, associated this change with the level of comfort (Baker & Beagan 2014; Harbin et al. 2012) the provider might have with queer people: "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." Brandon shared a story about his husband going to the doctor for painful eye problems and, upon disclosing his sexual identity, the physician "stopped and went all the way back and started testing him for STDs." Brandon's story is indicative of the pervasive stereotype associating gay men with STDs, and HIV in particular, but also a more fundamental problem of the automatic

association of queer identity itself with sex to the extent that even non-sexual health issues such as eye problems are immediately reduced to sexual pathology upon a patient's disclosure of queerness.

The other way queer health issues came up in their education was the example of "homosexual men with HIV" in case studies, which also arises from a risk-behavior 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.

Other informants shared similar experiences and concerns that the only examples of queer patients in their education were HIV-positive homosexual men, making it *the* queer topic in their education. Dr. Finn, a cardiologist and faculty member, summed this up in 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.

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.

While it is certainly important that medical students are educated about HIV/AIDS, including that it disproportionately affects queer people, it is unfortunate and vexing how HIV/AIDS

awareness is almost exclusively associated with homosexual men. "Homosexual men with HIV/AIDS" in case studies serves as one of the only means by which queer people are visibilized to these medical students, perhaps to the extent that HIV becomes synonymous with male homosexuality. The fact that people other than homosexual men are never explicitly labeled in case studies influences students to view patients heteronormatively because it insidiously sets up an expectation that non-heterosexual patients will be disclosed as such, and any case study that deals with sexuality but does not explicitly label the patient's sexuality can safely be assumed to be heterosexual by the student.

For example, when I asked Brandon, a second-year medical student, whether or not heterosexual patients were explicitly labeled in case studies, he said he could not recall any questions that did, but did recall one question he had not realized was heteronormative until our discussion:

> A specific question just came to mind: "A 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.

Brandon's assumption is a demonstration of how the hidden curriculum can influence a queer person—even one who knows about queer health disparities research and who helped establish the campus's queer student organization—to take a heteronormative perspective of patients.

These case studies, in addition to instilling heteronormativity in future physicians, also perpetuate queer and gender stereotypes. Physicians who do not know anything about queer health disparities may leave medical school believing the only queer-related health problem homosexual men may come to them with is HIV/AIDS-related. Such a view has the potential to reproduce queer health disparities by ignoring other health issues that

disproportionately affect queer people. 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, in addition to being used in problematic ways, *only* HIV-positive gay men are visibilized in case studies. Because the case studies do not visibilize other kinds of queer people and queer health issues are not discussed elsewhere in the curriculum, medical students at this school are completing their education without even a rudimentary understanding of queer health issues, much less queer health disparities and their sociocultural roots. Yet, even having this knowledge is no guarantee against broader sociocultural beliefs and assumptions about normative gender and sexuality working into medical education and practice through the hidden curriculum.

The Irrelevance Narrative

My informants' recognition of the problem of deficient education on queer health issues does not act as a safeguard against taking up and reproducing the very heteronormative cultural mores about which they express discomfort and angst. When asked how much being queer is a part of their professional identities, nearly all of my informants initially indicated it had a small role or no role at all, though some caveated this by noting their queerness might raise their awareness of health issues in ways that non-queer providers do not experience even though they felt it had little or no bearing on how they deliver care. This *irrelevance narrative* is a prevalent way my informants explained that being queer is irrelevant to the delivery of care despite recognizing that being queer affects how they interact with patients.

Danny, a first-year medical student, was the most adamant about his queerness being irrelevant to his practicing of medicine. He said being gay has no part in his professional identity because his professional and personal identities were "just separate things." However, he also said being gay is a big part of his personal identity and shapes how he

interacts with people. This cognitive dissonance works to maintain a strict separation between personal and private identities, and it shows Danny does not recognize how being gay shapes his interactions with patients despite his acknowledgment that it shapes how he interacts with people in general.

Ellie, a second-year medical student who identifies as a bisexual woman, did not see her professional and personal identities as clearly separate, noting:

> 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. 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—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.

Filipe, a first-year medical student who identifies as a gay man, expressed similar sentiments:

> 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.

Hector, a fourth-year medical student, went into even more detail about how being gay was irrelevant 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 norm and thus they do not have to think about how it impacts their treatment of patients—even when they encounter queer patients, cultural competency training does not require them to consider their own heterosexuality but only how to "deal with" their patient's queerness. A physician's heterosexuality can and often does influence how they view and interact with patients.

Danny and Hector were the most insistent that their queer identities are irrelevant to their medical practice, and while Ellie and Filipe agreed that queerness does not affect the quality of care provided, they offered that a provider's queer identity could impact their practice because it produces a kind of sensitizing awareness that inspires them to ask different kinds of questions than their non-queer counterparts. All of my informants seemed to struggle with reconciling their personal and professional identities, viewing their queerness as relevant or irrelevant to varying degrees.

Discussion

It appears the experiences of these queer medical students vary depending upon how visible they are or choose to be and what kinds of medical environments they are in. From these discussions, I see tensions between visibilizing queerness and status as professional 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 remain mostly uninfluenced by their queerness. My informants expressed concern and anger over the lack of meaningful education on queer health issues at their school, but do not recognize this is an expected result of the same heteronormative system into which they are being socialized.

These irrelevance narratives also demonstrate the belief that being queer is irrelevant to the delivery of quality care by competent providers as cultural competency training

emphasizes patient culture over physician culture, which is the outcome of an approach to medical education that emphasizes the culturally neutral objectivity of members of the profession (Taylor 2003a; Baker & Beagan 2014; Murphy 2014; Shaw & Armin 2011; Gregg & Saha 2006; Shaw 2005; Beagan 2003). The tension between queer and professional identities results in contradictory statements that appear to be an effort to reconcile these identities. The nuanced differences in my informants' irrelevance narratives result from variations in whether they view the professional and personal as more or less integrated. This struggle is fueled by the hegemonic "culture of no culture" (Taylor 2003b) perspective, which is instilled into biomedical praxis and teaches through the hidden curriculum that physician background and culture is irrelevant to the practice of medicine. This friction is likely compounded by informant understandings of how their own queerness shapes their worldviews and engagements with biomedical providers as patients, as well as their recognition of and frustration with the absence of queer health issues in their curriculum.

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, an irrelevance narrative helps maintain the cognitive dissonance necessary for the hidden curriculum to instill the heteronormative medical gaze into students as they come to view their queerness as irrelevant to practicing medicine. Once medical students take up this gaze, with its concomitant narrative of social neutrality, objectivity, and culturelessness, it becomes more difficult to reconcile those beliefs with the reality that their queerness is inseparable from and always already informs their worldview, including their own practice of medicine.

So, when is queerness relevant in clinical encounters? As discussed above, many of my informants claim it is mostly irrelevant both as a patient and a provider, and what makes

it relevant is if the disease or illness being presented in the clinic is obviously related to sexual behavior. If we think of clinical encounters as only concerning the treatment of disease, this makes sense; however, if we treat clinics as social environments, where physicians seek to build rapport with patients in pursuit of a productive patient-provider relationship, especially under more recent moves toward patient-centered holistic health care, queerness becomes relevant even when patients are seeking care for seemingly irrelevant diseases or illnesses. Thus, the reduction of the relevance of queerness to sexual practice can be highly problematic because it can disrupt the patient-provider relationship in ways that negatively impact queer people's health care experiences, which is shown to potentially decrease care-seeking behaviors.

Building on past scholarship indicating widespread belief among biomedical providers that sexual orientation is irrelevant to health care (Beagan et al. 2015; Beagan et al. 2012; Baker & Beagan 2014; McNair & Hegarty 2010), the findings discussed in this article demonstrate that being queer is no guarantee against taking up a heteronormative medical gaze, even for those who may otherwise not operate under such assumptions in their everyday non-clinical encounters. The queer-identified medical students and physicians I spoke with take up a heteronormative medical gaze despite their own experiences as queer patients shaping their perceptions of medical settings as heteronormative and sometimes homophobic. Even recognizing the importance of sexual orientation disclosure in patient-provider relationships does not seem to shake the heteronormative medical gaze instilled in these medical providers.

The arguments in this article about the dissonant relationship between personal and professional identities raise further questions: how and at what point in the educational process do students begin taking up a heteronormative medical gaze? What specific aspects of medical education might inculcate this perspective? How might queer and non-queer

people differ in the taking up of a heteronormative gaze? Future research can more deeply explore the heteronormative gaze among medical students by including queer *and* non-queer medical students and faculty, examining actual curricular materials in addition to eliciting student experiences with the curriculum, and engaging in participant observation by attending classes and spending time with medical students as they begin their medical education. It could also be fruitful to examine the role of heteronormativity in the development of professional and expert identities, perhaps with an eye toward the gendered nature of various medical environments and specializations.

As medical education curricula continue to ignore issues relevant to the lives of queer patients, it will remain up to queer students and their allies to visibilize queerness in biomedical educational settings and demand systematic attention to queer health issues. Until biomedicine begins attending to physician culture and acknowledging the sociocultural factors of health and illness, medical education will continue to produce students who believe it is actually possible to separate one's self from the biomedical context within which that self operates.

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