Enactment of LGBTQ Health in Medical Curriculum

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ABSTRACT

This dissertation examined the extent to which medical educational institutions adapt their curriculum to meet the needs of a marginalized patient population, lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities. Because LGBTQ populations experience significant health and health care disparities in comparison to heterosexual and cisgender populations, medical education and medical curriculum about LGBTQ health has been described as a key area of intervention for improving doctor-patient interactions and health system structures to better accommodate these populations. Through a 10-month long ethnography of a medical school, I examined the formal, informal, and hidden curricula surrounding LGBTQ health to explore how medical schools train and thus adequately prepare medical students to provide care to these patients. To investigate these issues, I conducted over 100 hours of participant observation of medical classes and clinical rotations, with particular attention to clinical case studies and online learning modules that are relevant to LGBTQ health, and LGBTQ health initiatives on the academic medical center campus. I also conducted 46 semi-structured interviews with faculty, students, administrators, LGBTQ Health Center employees, and LGBTQ patients about LGBTQ health care at the medical school and about how these groups define and implement LGBTQ health at the institution. Findings suggest that the content, placement, and delivery of LGBTQ health in the curriculum influence how medical students learn to see themselves as capable of providing care to these patients. In particular, the nebulous nature of LGBTQ health makes it difficult for students to learn to enact it in practice. This research asserts that to create medical curriculum about LGBTQ health that will help alleviate health care disparities, medical schools cannot simply add LGBTQ health into their curriculum without fundamentally changing how they teach sex/gender and sexuality to their students as well as centering intersecting inequalities in their teaching. As such, this dissertation calls for a shift to queer health to decentralize sex/gender and sexuality binaries and focus on the practice of learning about LGBTQ health rather than fulfilling a competency. Ultimately, this research theorizes medical education as a space for the enactment of LGBTQ health whereby the complexity of sex, gender, sexuality, and identity gets negotiated by medical faculty, students, administrators, and LGBTQ community members.

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GENERAL AUDIENCE ABSTRACT

This research examined how medical schools change their curriculum to incorporate health topics related to lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities. Because LGBTQ populations experience worse health and in comparison, to heterosexual and cisgender populations, medical education about LGBTQ health has been described as a key area for medical educators to adapt the curriculum to meet the needs of these patients. Medical educators hope to improve doctor-patient interactions and health system structures to provide better care to these populations. Through a 10-month long ethnography of a medical school, I examined the teachings surrounding LGBTQ health to explore how medical schools train and thus adequately prepare medical students to provide care to these patients.

To investigate these issues, I observed over 100 hours of medical classes and clinical rotations, with particular attention to clinical case studies and online learning modules that are relevant to LGBTQ health, and LGBTQ health initiatives on the academic medical center campus. I also interviewed 46 people, including faculty, students, administrators, LGBTQ Health Center employees, and LGBTQ patients, about LGBTQ health care at the medical school and about how these groups define LGBTQ health. Findings suggest that where LGBTQ health is located in the curriculum as well as who teaches the subject influences how medical students learn to see themselves as able to provide care to these patients. In particular, the broadly defined nature of LGBTQ health makes it difficult for students to learn how to provide this care to patients. This research asserts that to create medical curriculum about LGBTQ health that will help alleviate health care disparities, medical schools cannot simply add LGBTQ health into their curriculum without fundamentally changing how they teach sex/gender and sexuality to their students as well as centering intersecting inequalities in their teaching. As such, this dissertation calls for a shift to queer health to focus less on sex/gender and sexuality binaries and to focus more on the practice of learning about LGBTQ health rather than fulfilling a competency. Ultimately, this research states that medical education is a space for the enactment of LGBTQ health whereby the complexity of sex, gender, sexuality, and identity gets negotiated by medical faculty, students, administrators, and LGBTQ community members

DEDICATION

To queer, transgender, and nonbinary people everywhere, we deserve equitable and effective health care. I hope this dissertation helps create that future.

To LGBTQ health educators, it is because of your work leading the charge that this dissertation was possible. I have seen, firsthand, the dedication and real changes you have made to medical education. I hope that this research supports these interventions and helps provide another piece of the puzzle to improving LGBTQ health care.

To Maggie. You have paved the way for me in so many ways. Your love and support fuel me to be a better researcher, friend, and partner. Here is to the beginning of another journey together. I would not want anyone else by my side.

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CHAPTER 1: INTRODUCTION

> Interviewer: What do you define as LGBT [health]?
> Medical Student: Wow, that's a tough question. Um, gosh. I mean, to me. I don't know. I mean, I feel like there has to be a name because it's been ignored for so long. And because it does need to be intentionally taught because clearly otherwise, it's just not happening. But I really wish, and I think that a lot of what we right now call LGBTQ health really just falls under health, like all people, right? And that, just like, I will have the skills to care for two patients who are very different but not based on their sexual or gender identity. I shouldn't have the skills to care for people who have LGBTQ identities. And that shouldn't be like a separate thing.

The above conversation happened between a third-year medical student and myself during our interview at my field site. This student—heavily involved in leading LGBTQ health initiatives at my field site, conducting her own research project on LGBTQ health, and very much knowledgeable about this topic, simultaneously had to stop and think about her definition of LGBTQ health and realize the expansive nature of it. These responses were common from my participants. Even though my participants were eventually able to articulate a variety of skills, health concerns, and structural considerations related to LGBTQ health, they were often brought up short at first, starting with a vague, broad, umbrella definition of LGBTQ health before fleshing out their definitions with particular examples. From a seemingly expansive list of options to choose from, i.e., gender-affirming therapy, HIV/AIDS, cervical cancer screening, psychiatric counseling, among others, LGBTQ health is broad enough to cover a variety of health concerns for LGBTQ populations, which at times causes it to become a nebulous concept. This question—what *is* LGBTQ health—serves as the heart of this dissertation. How and where does LGBTQ health get taken up and implemented if it is such an infinitely malleable object? Who does this work? How do medical students learn about the relevance of this topic to their future careers given its ambiguity? How does this ambiguity impact the delivery of care to LGBTQ patients, who rightfully demand access to quality health care?

These questions are especially important given the patient implications of such training where physicians might not be addressing the specific needs of LGBTQ patients. Given that LGBTQ populations experience health and health care disparities resulting from heteronormative and cisnormative physicians and health care systems, this attention to specific health needs is critical (Graham et al. 2011; Grant et al. 2011; Hollenbach, Eckstrand, and Dreger 2014; James et al. 2015). In particular, LGBQ patients report negative health care experiences resulting from their sexual orientation in terms of outright discrimination, harassment, and awkward and/negative responses to coming out to their providers (Graham et al. 2011; Willes and Allen 2014; Manning 2014; Sharman 2016; Fredericks, Harbin, and Baker 2017). According to the 2015 U.S. Transgender Survey, 33% of the transgender patients who had received care from a physician in the year prior reported a transphobic health care experience, including harassment, assault, refusal of care, and educating the physician about transgender health (James et al. 2015). As one transgender patient reflected

> Multiple medical professionals have misgendered me, denied to me that I was transgender or tried to persuade me that my trans identity was just a misdiagnosis of something else, have made jokes at my expense in front of me and behind my back, and have made me feel physically unsafe. I often do not seek medical attention when it is needed, because I'm afraid of what harassment or discrimination I may experience in a hospital or clinic (James et al. 2015: 96)"

This evidence and this quote in particular highlight the stakes of medical school's implementing effective curriculum about LGBTQ health: LGBTQ patients' health and lives depend on it.

Further, these questions are additionally important given that the American Medical Association (AMA) now includes areas of diversity and inclusion in its accreditation practices, requiring that accredited schools demonstrate that they are creating diverse and inclusive medical school environments. These diversity and inclusion accreditation standards mostly surround racial and ethnic minority health with a focus on cultural competency to address these disparities (Brach and Fraserirector 2000; Betancourt et al. 2003), but there is growing concern about

addressing LGBTQ health and health care disparities and a lack of information about LGBTQ health in medical education (U. S. Department of Health and Human Services 2019; Obedin-Maliver et al 2011; Donald et al. 2017; Solotke 2017). Spurred by this lack of training in LGBTQ health, the Association of American Medical Colleges (AAMC) released guidelines for how to incorporate LGBTQ health into medical school curricula in order to address these health care disparities (Hollenbach, Eckstrand, and Dreger 2014). As such LGBTQ health is becoming established as a medical specialty. With no standardized curriculum for medical schools to draw on pertaining to LGBTQ health, however, administrators and faculty implement and create their own medical curriculum about this topic.

Much of the scholarly literature on LGBTQ health in medical curricula addresses the lack of attention to LGBTQ health in medical schools, student perspectives on LGBTQ health in medical curricula, and whether curricular implementation results in medical students' increased knowledge of LGBTQ health needs (Obedin-Maliver et al 2011; McGarvey et al. 2003; McPhail, Rountree-James, and Whetter 2016; Sanchez et al. 2006). What is missing from the literature is what LGBTQ medical curricula become *in practice,* including where this topic is spatially and disciplinarily located to address LGBTQ health. In other words, how does "LGBTQ health" get defined, in which academic spaces, and in what ways do the social and cultural aspects of medicine shape: 1) how this topic is portrayed by the school administration and medical faculty and; 2) how it is received by medical students. Given that medical schools and scientific knowledge consensus are social and cultural productions, this dissertation seeks to examine the processes that lead to the best practices and evidence-based recommendations upon which these guidelines are based. In particular, given the lack of randomized control studies about LGBTQ

health on which evidence-based medicine (EBM) is based, there is a tendency for EBM to reduce the complexity of gender and sexuality (shuster 2016; 2021).

In line with feminist conceptualizations of sex, gender, and sexuality, this research examines the medical curriculum as a space for the *production* of gender. Rather than understanding gender as solely an identity category, this work recognizes that gender is also a set of cultural, social, and ideological processes. As such, this dissertation seeks to understand not only how medical science contributes to understandings of gender as a social identity but also how gender gets understood as a biological and embodied phenomenon. Through an analysis of medical curricula about LGBTQ health, this research partakes in an interrogation of the medical science epistemes by which sex, gender, and sexuality come to be legible in the curriculum.

A Note on Language: Defining LGBTQ

LGBTQ populations are diverse, often experiencing particular health and health care disparities related to either sexual orientation, gender identity, and intersectional differences based on race, ethnicity, age, religion, socioeconomic status, and ability (Hollenbach, Eckstrand, and Dreger 2014), but the health needs for these populations have been grouped together based on experiences of historical oppression as a result of heterosexism, cissexism, and strong cultural norms related to gender and sexuality (Graham et al. 2011). Still, problems with this term arise. For instance, while LGBTQ is meant to serve as a catchall, in deploying LGBTQ terminology, scholars still focus on gay and lesbians while ignoring bisexual, transgender; in doing so, they ignore all other gender and sexuality minorities that the term is meant to capture (Knisely 2021). While the National Institute of Health (NIH) and AAMC among other academic organizations have pivoted to using sexual and gender minority health as an umbrella term for LGBTQ populations (American Association of Medical Colleges 2021a; University of California San

Francisco 2021; National Institute of Health 2019; American Psychological Association 2017; Mayer et al. 2008), I use the phrase "LGBTQ health" for 2 reasons. First, participants at my field site often defined LGBTQ as "lesbian, gay, bisexual, transgender, and queer." Typically, gay and lesbian refers to same-gender sexual and romantic attraction; bisexual refers to experiencing sexual and romantic attraction to more than one gender; transgender or trans, often an umbrella term, refers to identifying as a gender different from the one assigned at birth; and queer is also an umbrella term for people who do not identify as heterosexual or cisgender. At times some participants shortened the acronym to "LGBT" when talking about this grouping. I include their usage verbatim while continuing to deploy LGBTQ in my own writing. Second, this research investigates the very grouping of LGBTQ including what gets included and excluded and how the term comes to exist as a legible, solitary term. In fact, I seek to understand *how* and *where* these groups—albeit with seemingly different health needs—get condensed together as an "LGBTQ" grouping in the formal, informal, and hidden medical curricula, including in the written text, classroom settings, hospitals, and over coffee. For the purposes of this dissertation, LGBTQ health refers to the health needs of people who do not identify as heterosexual and/or cisgender. I employ this grouping to explore how heteronormativity and cisnormativity structure medical students' learning about non-normative sexual and gender identities.

Research Questions and Rationale

I conducted 10 months of ethnographic research on LGBTQ health curriculum at Southeastern University School of Medicine, a pseudonym for my field site, to explore these nuances related to sex, gender, and sexuality. This medical school has integrated LGBTQ health topics into its curriculum since 2011, and the academic medical center features a LGBTQ Health Center that administers LGBTQ health initiatives. Data from this research comes from three

sources: participant observation of curriculum and health initiatives; semi-structured interviews with medical faculty, students, administrators, LGBTQ Health center employees, and LGBTQ community members; and archival documents about historical diversity and inclusion initiatives at the field site. In this field research, I aimed to investigate how medical students learn to interact with patients in the clinical encounter to avoid providing inferior care and how doctors learn what is *medically relevant* to LGBTQ health. In other words, this dissertation seeks to understand the processes that lead to what is considered 'cultural' *and* 'clinical' competence in LGBTQ health. As such, I ask:

1) (How) do messages about LGBTQ health get delivered vis-à-vis the formal, informal, and hidden curricula? What messages about LGBTQ populations and sex, gender, and sexuality are learned alongside the science and best practices of LGBTQ health? In what ways can this impact how medical students understand and provide care for LGBTQ patients?;

2) How is *medical relevance* determined by medical professionals? Whose group interests determine what is deemed medically relevant to LGBTQ health? (How) does medical authority contribute to this determination? In what ways does medical expertise compete with/contradict and/or merge with experience-based knowledge about LGBTQ health and identity? and;

3) Across various parts of the medical school (community outreach, lectures, practice-based learning, clinical rotations, administrative meetings, and health initiatives), how do LGBTQ health curricula come into existence? (How) do multiple meanings about LGBTQ health exist and what are the mechanisms by which they become a singular entity?

In answering these questions, I show how LGBTQ health has multiple, oftentimes vague, definitions enabling it to be enacted in different settings by multiple groups across the university campus. LGBTQ health straddles medical knowledge, cultural competence, physician advocacy, and patient experience, and it is precisely this multiplicity that allows it to be adapted into so many different aspects of the curriculum and medical practice. Despite these competing definitions, LGBTQ health coalesces into one singular entity through the work of actors from different disciplines across the university. In sum, I argue that not only the content of what is being learned about LGBTQ health, but the placement in the curriculum and recognition of by whom are integral to understanding how LGBTQ health curriculum meets its goal of alleviating LGBTQ health care disparities vis-a-vis medical curriculum aimed at making *all* physicians LGBTQ-competent (Hollenbach, Eckstrand, and Dreger 2014). Moreover, in outlining how these curricula can teach physicians how to provide LGBTQ health care, this attention to how LGBTQ health unfolds within the curriculum ultimately contributes to providing LGBTQ patients with the kinds of respectful, professional, and helpful health care encounters they deserve.

Overview of Dissertation

In chapter 2, I begin by reviewing the literature on LGBTQ health and health care disparities and how medical professionals have attempted to address these issues through cultural competency and other diversity and inclusion models via dedicated curricula. I then situate this study in two literatures: the sociology of medical education literature about the social and cultural aspects of medicine that influence how medical students learn about curriculum topics and feminist science studies insights about the scientific production of sex and gender and its impact on LGBTQ populations, with a particular focus on tensions between medical expertise and experience-based knowledge.

Chapter 3 outlines my research methods of participant observation, interviews, and archival analysis to answer these research questions. I conducted a 10-month long in-person and virtual ethnography of an academic medical center that explicitly incorporates LGBTQ health into its health care system and medical school curriculum. I spent over 100 hours observing the medical center and school and getting to know the curriculum and people who develop and implement LGBTQ health at my field site. I interviewed 46 medical faculty, students, administrators, LGBTQ health center employees, and patients and spent time in the medical center archives to gather how LGBTQ health came to exist at the institution.

I turn to my analytical findings in Chapters 4 and 5, wherein I outline where LGBTQ health is enacted in the medical school's curriculum and how it came to exist at the overall medical center. Chapter 4 defines LGBTQ health at Southeastern and provides an overview of where the topic lives in the curriculum. In doing so, I show how LGBTQ health's broad and nebulous definition allows it to be integrated across a variety of subjects in the medical curriculum. Stemming from this, LGBTQ health is "everywhere and nowhere" at the academic medical center, and I show how this can detract from the curriculum's ability to teach medical students how to adequately provide care for LGBTQ patients. Further, the teachings about sex, gender, and sexuality that accompany LGBTQ health serve to reinforce heteronormativity and cisnormativity, which additionally detracts from health equity goals.

Meanwhile, Chapter 5 explores the institutional context for LGBTQ health as a burgeoning form of expertise. In outlining how LGBTQ health has become a medical specialty treated as similar to other health issues taught in medical school, I describe how LGBTQ health gets integrated into Southeastern's medical center and school by following the institutional pathways of previous diversity, equity, and inclusion (DEI) initiatives. Under this logic of

population-based health, physicians and medical students alike must choose to provide care to these patients. I show how students learn from role models, the physicians who provide care to LGBTQ patients, in their clinic rotations to understand when LGBTQ health is or is not relevant to the health care encounter. I show the difficulty medical faculty and students experience in navigating this emerging specialty in the doctor-patient encounter due to the broad nature of LGBTQ health.

Lastly, Chapter 6 concludes with my contribution to literatures on medical sociology, medical education, and feminist conceptualizations of sex, gender, and sexuality. I show how something as complex as LGBTQ health, an area of health that includes a diverse array of interrelated factors, including health needs, communication skills, and physician advocacy, that cross multiple disciplines—OB-GYN, infectious disease, primary care, among others—hangs together due to its relationship to population-based health. Integrating this nebulous health area requires the work of physicians, students, and patients who opt into this work. Further, it often requires a degree of flexibility and acceptance of the unknown given the complex nature of gender identity and sexual orientation, which themselves challenge the binary thinking embedded in medicine. I conclude that medical education about LGBTQ health has started to grapple with the challenges of integrating such a multifaceted health area and serve as an important first step in this endeavor. Despite this, medical education must also attend to the ethical consequences of teaching students to provide adequate care to LGBTQ patients which requires in some form establishing an expertise inherently tied to someone's personal, LGBTQ identity. Indeed, this research showcases that academic medicine's curriculum often showcases a version of LGBTQ health that intersects with whiteness, leaving queer and transgender people of color's experiences invisible. I underscore how a turn to 'queer health' over 'LGBTQ health'

helps shift this focus and allows for greater structural, intersectional, and long-term change to both the curriculum and community partnerships with medical institutions.

CHAPTER 2: LITERATURE REVIEW

In this chapter, I provide an overview of the literatures that inform this research. I begin by reviewing the LGBTQ health and health care disparities that medical school curriculum on LGBTQ health seeks to address. I discuss how LGBTQ populations experience worse health outcomes than heterosexual and cisgender populations in part because of discrimination and heteronormativity and cisnormativity embedded in health care systems. Following this, I outline the medical school interventions aimed at addressing these disparities and disrupting heteronormative and cisnormative curricula and health care encounters. These diversity and inclusion initiatives have taken the shape of cultural, clinical, and structural competency models intending to provide medical doctors with the skills to provide quality patient care to LGBTQ populations regardless of their sexual orientation and gender identity.

While these initiatives are important steps towards teaching medical students how to provide quality health care to LGBTQ patients, I argue that missing from these literatures is attention to how structural and interpersonal dynamics of medical schools can influence how medical doctors learn to provide care to LGBTQ patients. Of importance, medical sociology frameworks on medical schools as social organizations are integral to understanding how medical schools can address LGBTQ health disparities because they allow for an examination of the organizational and social processes that contribute to medical students learning (or not) about this topic. In particular, I review how formal, informal, and hidden curricula can be vehicles for examining the extent to which medical schools are successful at implementing diversity and inclusion initiatives.

When examining medical curricula on LGBTQ populations, I argue that feminist frameworks on sex, gender, and sexuality are central to understanding how medical students

learn about this topic. Of significance, feminist science studies scholars draw our attention to the ways in which medical science reifies a sex/gender binary legitimizing particularly sexed and gendered bodies at the expense of others, especially with respect to LGBTQ populations. I discuss how insight from feminist enactment theory can help map the complexity and multiplicity of LGBTQ health and the processes by which it comes to exist in medical curricula.

These literatures serve as a foundation for this research to examine how medical education can simultaneously serve as a resource for alleviating LGBTQ health and health care disparities and also reify rather than disrupt heteronormativity and cisnormativity. As this research will discuss, multiple definitions of LGBTQ health circulate in medical school curricula, raising important questions for how medical students navigate learning what is relevant to and who is responsible for providing LGBTQ health care.

LGBTQ Health and Health Care Disparities

Health and health care disparities related to sexual orientation and gender identity persist for LGBTQ populations wherein these groups experience greater negative health outcomes and inferior care as opposed to heterosexual and cisgender populations. Medical professionals have adopted social and structural determinants of health perspectives in the investigation of LGBTQ health disparities to attend to these nuances. For instance, the Institute of Medicine’s report on LGBTQ health adopted multiple frameworks to understand the complexity of LGBTQ populations, including: a life-course approach, focusing on historical context and cohort effects; the minority stress model, which focuses on the effects of stigma on stress levels; intersectionality, which addresses how the interaction of multiple identities affect one’s health status; and social ecology, which focuses on contextual factors that affect one’s health status (Graham et al. 2011).

These health disparities include particular risk behaviors that LGBTQ populations engage in and the negative implications of these risk factors for mental, behavioral, and physical health. For instance, LGB populations[1] participate in risk behaviors such as using tobacco at greater rates than heterosexual populations (Lee, Blosnich, and Melvin 2012; Lee, Griffin, and Melvin 2009; American Lung Association 2010; Blosnich et al. 2014). While research on transgender smoking usage is limited, experiencing structural discrimination has been associated with smoking in trans populations in addition to racial and ethnic minority populations (American Lung Association 2010; Shires and Jaffee 2015a; Lorenzo-Blanco and Unger 2015). Considering how gender and sexuality intersect with racial and ethnic health disparities are especially important given that many people experience discrimination based on their gender, sexuality, and race/ethnicity. Other risk behaviors such as suicide ideation, lack of physical activity, and engaging in unprotected sex have been identified as risk factors for LGBTQ populations (Reisner et al. 2014; Calzo et al. 2013; Thoma, Huebner, and Rullo 2013). For instance, LGB youth are more likely to be suicidal and experience depressive symptoms than heterosexual youth (Marshal et al. 2011).

LGBTQ populations also experience mental, behavioral, and physical health issues related to their sexual orientation and gender identity. Trans populations experience negative mental health outcomes associated with discrimination and victimization related to their gender identity (Hendricks and Testa 2012; Lombardi 2009). For instance, trans men and trans women who experienced sexual and/or physical violence were more likely to have attempted suicide and

[1] In this review of the literature, I use different acronyms depending on which the research study uses. For instance, I use the acronym LGB when the research is reporting on the experiences of gay, lesbian and bisexual people. I use language such as LGBT when the research refers to gay, lesbian, and bisexual people and transgender people. The acronym QLB is used when referring to queer, lesbian, and bisexual people. In the larger text, I use the acronym LGBTQ to refer to lesbian, gay, bisexual, transgender, and queer people because I am interested in how medical curricula include gender and sexual minority groups.

had multiple suicide attempts when compared to trans people who did not have these previous experiences with violence (Testa et al. 2012). In terms of physical health, gay men and trans women have higher risks for contracting HIV/AIDS (Graham et al. 2011); gay men have a greater risk for contracting anal cancer than heterosexual men (Darwich et al. 2013); and gay men, lesbians, and bisexual people are more likely to experience a lifetime of sexual victimization than heterosexuals (Conron, Mimiaga, and Landers 2010; Herek 2009). Additionally, lesbians and bisexual people are more likely to experience cardiovascular disease risk (Conron, Mimiaga, and Landers 2010).

These experiences of violence and discrimination due to minority status can result in added stress to LGBTQ people's lives, negatively impacting their mental and physical health (Meyer 2003; Brooks 1981). For example, in a study of gay men and lesbians' experience with stress, Lewis et al. (2003) found that gay-related stress and stigma consciousness amongst participants were positively associated with experiencing depression (Lewis et al. 2003). These findings are significant given the relationship between stress and negative physical health outcomes (Cohen et al. 1995; Thoits 2010; Hatzenbuehler, Phelan, and Link 2013; Khan Ilcisin, and Saxton 2017). Additional support for the minority stress model comes from an examination of gender-nonconforming trans people's experiences of discrimination and health-harming behavior. Gender nonconforming trans people experience greater discrimination than gender conforming trans people and therefore partake in higher rates of health-harming behavior such as attempted suicide, drug and alcohol abuse, and smoking (Miller and Grollman 2015) and experience worse health outcomes (Grant et al 2011; Reisner et al 2015).

Experiences of stigma during the health care encounter and in health care systems also impact the health of LGBTQ populations at both the interpersonal and structural level. In doctor-

patient interactions, patients report experiencing verbal abuse and refusal of treatment from health care staff as a result of their sexual and gender identity (Rossman, Kinton, Paul Salamanca, and Kathryn Macapagal 2017; Rounds, Burns Mcgrath, and Walsh 2013; Eliason and Schope 2001; Kenagy 2005; Scherzer 2000). Gender expression and identity straying from binary understandings of gender affects the health care encounter. For instance, butch lesbian and bisexual women report experiencing poorer treatment in health care settings than femme lesbian and bisexual women (Hiestand, Horne, and Levitt 2007).

Outright discrimination against trans populations can impact care-seeking practices. Drawing on data from the National Transgender Discrimination Study, Cruz (2013) analyzed how different factors affected trans and gender nonconforming people's decisions to postpone curative care. Decisions to postpone curative care were associated with discrimination from physicians as opposed to affordability. Furthermore, being out as transgender when seeking medical care was associated with postponement as opposed to affordability. Additionally, in a study of trans men's experiences of health care discrimination, 41% of respondents reported verbal harassment, physical assault, and denial of care in a doctor's office or hospital (Shires and Jaffee 2015b). Denial of care to trans populations as a result of their gender identity is also associated with a greater number of suicide attempts (Romanelli, Lu, and Lindsey 2018). Expectations of discrimination from medical professionals also contribute to individual stigma and can deter transgender populations from accessing care and are associated with poor health outcomes (Hughto, Reisner, and Pachankis 2015; Seelman et al. 2017). For instance, in a survey of trans health behaviors, researchers found that trans people who delayed care for fear of discrimination had greater odds of having depression (3.08); of having attempted suicide in the last year (3.81); and of experiencing suicide ideation in the past year (2.93) in comparison to

those respondents who delayed care for other reasons (Seelman et al. 2017). Experiences of discrimination for transgender people of color are often compounded by the intersection of racism with transphobia. According to the 2015 U.S. Transgender Survey, transgender respondents of color reported higher levels of poverty, unemployment, and health disparities in contrast to their white respondents (James et al. 2015). Further, transgender people of color report feeling judged by their providers because of their race and feel they would be treated better if they were white (Howard et al. 2019).

Interpersonal stigma can also occur as a result of unconscious, hetero and cisnormative assumptions that permeate the doctor-patient interaction and can negatively impact LGBTQ populations' experiences of health care. In the context of heteronormativity, queer, lesbian, and bisexual (QLB) women remain invisible unless providers specifically ask about their sexual orientation, something patients report that providers seem unwilling to ask (Fredericks, Harbin, and Baker 2017; Willes and Allen 2014). QLB women themselves actively work to disclose their sexual orientation in their health care encounter, such as using their partner's pronouns, bringing their partners to their appointments, and presenting "queer," to become visible to their providers (Fredericks, Harbin, and Baker 2017). One respondent reported that providers' attempts to use humor to connect with them also led to reinforcing heterosexism by assuming patients were heterosexual (Fredericks, Harbin, and Baker 2017).

Cisnormative assumptions also permeate trans people's experiences of health care. In particular, trans people report sexualization, avoidance by health care practitioners, and misgendering (Nordmarken and Kelly 2014). Additionally, other trans respondents have explained how they interpreted health care workers' discomfort with trans bodies when the workers failed to make eye contact with the patient and assumed a closed-off demeanor

(Nordmarken and Kelly 2014). Trans patients also report unnecessary and excessive questioning by their doctors, i.e., are you really sure you are trans? and treatment of their bodies as spectacles whereby through their excessive curiosity about genitalia doctors ultimately objectify trans people's bodies (Wagner et al. 2016). Physician uncertainty about patients' gender identity can also contribute to inferior health care encounters. Physician authority is often challenged in doctors' interactions with patients because they know less about their patient's health than the patient does (Poteat, German, and Kerrigan 2013). In a study of medical providers and trans patient's experiences in healthcare encounters, Poteat, German, and Kerrigan (2013) underscore that to manage this uncertainty in the clinical encounter and reassert authority, physicians' resort to interpersonal stigma against trans people, belittling trans people's knowledge seeking practices while simultaneously recognizing the discrimination that trans people face. These patients experience cissexism in the healthcare encounter as a result of a cisnormativity where trans bodies are treated as "Other."

At the structural level, marginalization of trans populations occurs through informational and institutional erasure in medical health care systems that perpetuates the assumption that patients are cisgender (Bauer et al 2009). For instance, trans respondents report frustration with the lack of research on transition related care and primary care for trans populations that causes their doctors to be unable to answer questions about the long-term health effects of hormone therapy (Bauer et al. 2009). Trans respondents also felt they had to educate their doctors about their health needs because their doctors were not educated about trans health (Bauer et al. 2009). Inaccurate estimates of the size of trans populations reinforces the assumption that trans patients are isolated cases (Bauer et al. 2009). At the institutional level, trans people are erased through administrative forms, prescriptions, and referral forms that assume that patients are cisgender.

For instance, one trans patient reported having difficulty receiving an ultrasound when their health care forms read male, but they were receiving health care related to body parts normatively associated with female bodies (Bauer et al. 2009). Here billing systems assumed sex-specific procedures must map onto one's sex in the system (Bauer et al. 2009). These cisnormative assumptions embedded in the health care system limited trans people's access to care and contributed to their health care disparities.[2]

Structural stigma, defined as "the societal norms, environmental conditions, and institutional laws and practices that limit the resources, opportunities, and wellbeing of stigmatized people," also limits LGBTQ health and well-being (Hughto, Reisner, and Pachankis 2015: 224). Within the healthcare system, the medicalization of trans identity as deviant and lack of health insurance coverage for trans health care as "medically unnecessary" or "pre-existing" restricts trans patients' access to care (Hughto, Reisner, and Pachankis 2015; Graham et al. 2011). Lack of physicians trained in trans health represents another structural barrier to equitable health care for trans populations (Hughto, Reisner, and Pachankis 2015; Graham et al. 2011), which is unsurprising given that medical education on LGBTQ health is lacking across the U.S. (Solursh et al. 2003; Makadon, Potter, and Goldhammer 2008; Obedin-Maliver et al. 2011). As

[2] When issues or lived experiences become institutionalized, organizations and their documents have the power to reproduce (normative) knowledge about the subject. In this way, normative assumptions embedded in health care practices about what patients "should" be affect LGBTQ and straight and cis populations alike. For instance, with the example of rape victims, Mulla (2014) demonstrates how institutional documents and day-to-day practices can perpetuate certain narratives about rape while simultaneously ignoring survivors' experiences in her research on rape crisis centers. The institutional processes erase the complexities related to rape, such as that men can be victims of rape, because the forms are set up for a female victim and male perpetrator. Additionally, Mulla's study exemplifies those subtleties in the rape crisis center can reproduce knowledge about what rape is. For instance, the forms perpetuate the idea that strangers rape people when their form set-up disallows the survivor to fill out that they were assaulted by a person in their family and not a stranger or when the center automatically offers shelter information to domestic abuse survivors but not rape survivors (when the domestic abuse survivors are always screened for sexual assault). Attending to these normative assumptions embedded in health care contexts can allow for better care for all patients rather than care based on stereotypes that do not capture the realities of everyone's lived experiences.

such, medical education has been suggested as a key proponent in addressing LGBTQ health and health care disparities (Cruz 2013; Hughto, Reisner, and Pachankis 2015).

Diversity and Inclusion: Medical Curricula about LGBTQ Health

Medical professionals working towards reducing health and health care disparities for LGBTQ populations have focused on how doctors and health care systems can provide better care and treatment with a particular emphasis on how to make interventions in the medical curriculum (Eckstrand and Ehrenfeld 2016; Graham et al. 2011). This medical curriculum about LGBTQ health is lacking (Obedin-Maliver et al. 2011; Bonvicini and Perlin 2003; Tesar and Rovi 1998; Solursh et al. 2003; Shindel and Parish 2013). According to a 2011 survey of medical school deans, across all 4 years of medical school, the median number of hours spent on LGBTQ health was 5 hours.[3] Many medical schools taught LGBTQ health through lectures or small groups and this content mostly occurred during preclinical years with only 9 out 132 schools reporting 0 hours in preclinical, which comprise the first 2 years of medical school. Forty-four schools reported 0 hours in clinical years, which comprise the last 2 years of medical school, and faculty development related to LGBTQ health occurred at only 20.5% of the schools. Additionally, no widely accepted formalized curriculum on transgender health has been adopted by medical schools and when LGBTQ health is featured in medical curriculum, dangers persist in reinforcing stereotypes about these populations (Feldman and Goldberg 2006; Snowdon 2010). Lack of training is important given that doctors report this dearth of information as negatively affecting their ability to provide care for transgender patients (Poteat et al 2013; Lurie 2005). Additionally, medical students have reported that they do not receive adequate education

[3] Obedin-Maliver (2011) sent surveys to 176 medical schools in the U.S. and Canada and had an 82.5% response rate.

about LGBTQ health and agree that it is useful to their careers as physicians (Sequeira, Chakraborti, and Panunti 2012; Stryker, Pallerla, and Pickle 2020).

This medical curriculum surrounding diversity and inclusion of marginalized populations in medical education typically uses the language of cultural competency. Cultural competency is defined as, “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross et al. 1989, quoted in Brach and Fraserirector 2010). This training has mostly focused on addressing health care disparities and while many trainings focus on racial/ethnic minorities, others also stress the importance of gender and sexual orientation (Turbes, Krebbs, Axtell 2002). This framework prioritizes attending to the cultural differences amongst minority groups and is opposed to a monolithic view to health care (Brach and Fraserirector 2010). The ultimate goal is to provide better quality health care to minority groups to improve health disparities that result from health care deficiencies (Brach and Fraserirector 2010).

Cultural competency can occur at the organizational, structural, and interpersonal level to improve health outcomes. Betancourt (2006) addresses how cultural competency must be incorporated at the organizational level, with the hiring of racial and ethnic minority health care workers and promoting them to positions of power; at the structural level, helping patients to obtain quality health care, such as having interpreter services; and at the interpersonal level, teaching physicians how to provide cross-cultural health care. Cultural competence interventions hope to change both patient and provider behavior, by encouraging patients to engage in preventative Western medicine and doctors to learn more about cultural differences (Betancourt 2006). Goals of the technique are to improve communication and trust between the patient and

provider and to teach doctors about different racial and ethnic minorities' risk factors and their social context (Brach and Fraserirector 2010). According to the model, improved communication will lead to patient satisfaction, leading to patient adherence and better health outcomes. While cultural competency originally necessitated both a focus on systems-level practices and doctor-patient interaction, the term cultural competency frequently became understood as how to improve the cross-cultural, doctor-patient encounter with the assumption that doctors are mostly white, cisgender, heterosexual, and non-cultural people (Hanssmann, Morrison and Russian 2008; Kumas-Tan et al. 2007; Beagan 2018).

Medical curricula about LGBTQ health have used the cultural competency framework to introduce changes into both doctor-patient interactions and health care systems to facilitate better health outcomes for LGBTQ patients. Medical educators have implemented lectures, large and small group discussions, and case patients featuring LGBTQ patients to familiarize students with LGBTQ health (Braun et al. 2017; Honigberg et al. 2017; Thomas and Safer 2015; Safer and Pearce 2013; Leslie et al. 2017; Ufomata et al. 2018). Provider trainings usually include a mixture of this clinical and cultural information and assume a "knowledge-based" pedagogy where themes of trainings including covering LGBTQ definitions, differentiating between sexual orientation and gender, and providing examples of transgender experiences with health care (Hanssmann, 2012, p.119). This framework has been applied LGBTQ disparities to increase doctors' comfort with providing care to LGBTQ patients and for making changes to the WPATH standards of care to lessen restrictions on access to gender-affirming care for transgender people (Hanssmann, Morrison and Russian 2008; Hanssmann, 2012). Important to note, various definitions of "trans health" exist, including expertise in endocrinology; knowledge about increased risks for HIV; the effects of racist and classist health care systems on transgender

patients; and, as transgender health activists prioritize, the connections between transgender health and the need to dismantle neoliberalism and U.S. imperialism (Hanssmann, 2016).

LGBTQ training sessions have noted short-term changes in students' knowledge about and confidence in providing care for LGBTQ patients (Braun et al. 2017; Honigberg et al. 2017; Thomas and Safer 2015; Safer and Pearce 2013; Leslie et al. 2017; Ufomata et al. 2018). For instance, in a study of first-and second-year medical residents, curricular hours on LGBTQ health in undergraduate medical education was significantly associated with feeling comfortable providing care to LGBTQ patients (Honigberg et al. 2017). Contact with LGBTQ community members in the medical curriculum has also been found to improve medical students' confidence and lessen explicit biases against LGBTQ patients (Burke et al. 2015; Noonan et al. 2018).[4] In particular, attending a panel of transgender speakers where medical students could ask questions reduced transphobia in medical students to a greater extent than attending a lecture from a cisgender expert on trans health (Walch et al. 2012). In a systematic review of LGBTQ bias training in health professions education, three forms of education, including bias-focused, experiential learning, and intergroup contact, increased participants' knowledge, comfort, and tolerance of LGBTQ patients respectively (Morris et al. 2019). Despite this, the authors caution that no study in their review measured a change in respondent bias post intervention.

Beyond just cultural competency training, LGBTQ health care requires that physicians understand the unique health care needs of these populations in addition to serving as advocates on their behalf (Mayer et al., 2008; Eckstrand and Sciolla, 2014; Daniel and Butkus, 2015). In

[4] These studies adopt Intergroup Contact Theory to explain reductions in transphobic views and increased confidence in providing care for trans patients (Noonan et al. 2018; Walch et al 2012) and increased empathy towards gay men and lesbians (Burke et al. 2015). In line with Intergroup Contact Theory, relationships can be between 'out' groups and 'in' groups and can be improved with positive, facilitated contact (Walch et al. 2012). As Walch explains, "Conditions such as equal-status interaction, informal interaction, shared goals, and institutional support (Allport, 1954), as well as opportunities for the development of affective ties (Pettigrew, 1998) have been found to facilitate important change processes" (Walch et al. 2012: 2598).

fact, a Lesbian, Gay, Bisexual, and Transgender Development of Clinical Skills Scale (LGBT-DOCSS) has been developed to capture a variety of skills related to LGBTQ health care, including attitudes, knowledge, and clinical preparedness to address LGBTQ health care provider bias (Bidell 2017). Similarly, an LGBTQ communicative competence model has been proposed that outlines a competent physician as one who understands the health needs of LGBTQ patients; uses appropriate terminology with respect to the patient; neutralizes any personal biases that could affect patient care; and fosters inclusion in health care encounters (Rossi and Lopez 2017). Although LGBTQ health care requires this interdisciplinary collaboration, insights from LGBTQ health care providers often stay within their disciplines rather than transcending these boundaries to others serving LGBTQ populations (Bidell and Stepleman 2017).

As Dean, Victor, and Guide-Grimes (2016) argue, these LGBTQ interpersonal diversity trainings are not addressing heteronormative microaggressions and hospital structures. As such, these interventions must occur at both the level of doctor-patient interaction *and* at the systems-level where structural factors can affect how doctors care for their patients (Hanssmann et al. 2008; Eckstrand, Lunna, and Yehia 2017). Scholars document the need for systems-level changes in health care to acknowledge and provide quality care for gender non-conforming people given that health care delivery for transgender people mostly assumes a binary gender model (Eckstrand, Ng, and Potter 2016; Liszewski et al. 2018). For example, health care institutions can create gender neutral bathrooms for their patients and refer to surgeries as "masculinization" or "feminization" rather than language that assumes a sex/gender binary (Liszewski et al. 2018). Other systems-level barriers need to be addressed to provide quality care

for trans patients, such as intake forms and culturally competent front desk staff to create an environment where trans people can access care (Noonan et al. 2018).

Additionally, scholars warn that learning about definitions can lead to singular understandings of transgender experiences (Hanssmann, Morrison and Russian 2008). While learning definitions is an important first step in doctors understanding transgender experience to provide quality health care for trans patients, doctors should also learn about medicine's role in creating barriers to care for their trans patients and *their own* role in providing accessible care (Hanssmann, Morrison and Russian 2008, emphasis mine). Medical providers indeed do report interest in learning definitions, but scholars suggest focusing transgender health training on highlighting barriers to care over simply learning definitions (Hanssmann, Morrison and Russian 2008).

While cultural competency trainings outlined thus far aim to address health disparities, according to a systematic review of cultural competency training, studies have not proven with methodological rigor that the training is effective (Betancourt et al. 2005; Price et al. 2005). Additionally, in a study of third year medical students' perceptions of cultural awareness after taking a course designed to teach them about cultural competency, Beagan's (2003) respondents described cultural competency as not relating to their clinical studies and was therefore not helpful for their clinical practice. While data thus far has failed to demonstrate that cultural competency training can reduce health disparities, other scholars warn that cultural competency might actually exacerbate health disparities by contributing to stereotypes about marginalized groups (Hester 2016; Kleinman and Benson 2006).

Multiple criticisms of cultural competency exist that point to problems with the model that can impact its effectiveness. First, cultural competency frameworks treat culture as the same

as ethnicity and provide a view of culture as reflecting unchanging ethnic traits (Kleinman and Benson 2006; Carpenter-Song, Nordquest Schwallie, and Longhofer 2007).[5] Treating culture as the same as ethnicity reifies stereotypes about a group and obfuscates the variations that occur within racial and ethnic groups, e.g., ignoring intersectional differences. To combat these deficiencies within the current model, Kleinman and Benson (2006) suggest that physicians should utilize ethnographic methods from anthropology and attempt to understand the life-worlds of the patients, especially paying attention to people's practices, lived experiences, and social contexts. Rather than making assumptions about groups based on their race/ethnicity, such as that certain groups do or do not eat a certain food, a doctor using ethnographic methods would conduct a case study of the individual and understand the patient's framing of the issue, its severity, and what really matters for the patient (Kleinman and Benson 2006).

To incorporate cultural competency in medical school, Kumagai and Lypson (2009) suggest that medical students adopt a critical consciousness where they also evaluate their own positioning in the world and how it affects their patients to avoid othering and stereotyping that can be detrimental to health care. This adoption of a critical consciousness has been defined as cultural humility, whereby medical practitioners embrace uncertainty and recognize their role in continuing systems of inequality in their everyday interactions with their patients (Tervalon and Murray-Garcia 1998; Began 2018). To avoid issues of stereotyping patients that accompany cultural competency, doctors have resorted to avoiding making assumptions and adopting a "colour-bind" approach (Beagan and Kumas-Tan 2009: e21).

This avoidance, however, upholds heteronormative and cisnormative assumptions in health care systems whereby some bodies (and their health needs) are privileged and others that

[5] The language here refers to race/ethnicity because the criticisms stem from cultural competency models focused on addressing racial and ethnic health disparities, but the same danger exists for LGBTQ cultural competency.

transgress these binaries remain invisible (Baker and Began 2014). For example, respondents in Baker and Beagan's (2014) study reported that in doctor-patient interactions, doctors operate under the assumption that their patients are heterosexual and gender normative until told otherwise. When doctors focus on behaviors as opposed to LGBTQ identities, then, doctors reinforce heteronormativity and cisnormativity because health care interactions and systems are infused with normative assumptions about gender, sex, and sexuality. If this normativity is unchallenged, queer and trans patients remain invisible. A gender-blind approach, thus, fails to recognize that LGBTQ specific health problems do exist. As opposed to assuming that LGBTQ identities are static and have definitions that can be mastered, health care systems should recognize and accommodate LGBTQ communities at every dimension of health care delivery (Baker and Beagan 2014).

A second criticism surrounds claiming competency in someone's culture. Biomedicine itself and medical providers have a culture, which cultural competency frameworks ignore (Fox 2005; Beagan 2018). Hester (2016) argues that promoting competence in another's culture assumes that medicine does not already have a historical legacy of oppression against marginalized groups. The argument that more information about marginalized communities will contribute to better health outcomes is at odds with history: more knowledge has led to violence and victimization as in the cases of slavery, the colonies, and prisons (Hester 2016). Scientific progress occurred in the name of torture, such as the cases of Saartjie Baartman and the Tuskegee experiments (Hester 2016). While on the one hand, cultural competency's goals are to provide better medical care to patients, Hester (2016) argues that competency also utilizes patient culture to persuade them to comply with medical regimens according to biomedicine's values, which has negatively impacted groups in the past.

Other training methods, however, avoid these criticisms of cultural competency by focusing on the structural determinants of health paired with the provider's role in confronting inequality. Structural competency models teach medical students about the social determinants of health and provide a structural explanation, including organizational and institutional inequalities, for cultural differences (Petty, Metzel, and Keeys 2017; Metzel and Hansen 2018). The model comprises 5 core competencies: "1) recognizing the structures that shape clinical interactions; 2) developing an extra-clinical language of structure; 3) rearticulating "cultural" formulations in structural terms; 4) observing and imagining structural interventions; and 5) developing structural humility" (Metzel and Hansen 2014: 126). Rather than develop an expertise in complex structural issues, doctors should adopt a perspective of humility and commitment to long-term learning about structure's impact on the medical system that draws on their affective experiences (Burson, Familusi, and Clapp 2021; Metzel and Hansen 2014). This development of structural humility proposes that medical professionals learn that structural problems cannot be solved by one individual but rather must be tackled in multidisciplinary teams (Willging et al. 2017).

To facilitate structural competency changes, medical professionals can partake in advocacy work, such as changing clinical practices and informing the public about the importance of addressing social determinants of health and adopt the structural vulnerability assessment of patients (Kirmayer, Kronick, and Rousseau 2018; Bourgois et al 2017). Interventions can also be made in medical education for students to develop these structural competency skills. For instance, Petty, Metzel, and Keeys (2018) instated a major titled Medicine, Health, and Society (MHS), featuring structural competency training for pre-health students to learn about structural inequalities, and surveyed students in the MHS and pre-health

majors to capture the impact of the course on their understandings of inequality. In comparison to pre-med students from other majors, MHS students were better able to connect structural explanations to cultural differences across racial and ethnic groups, and students who took more MHS classes showed more of these skills. Equally important, MHS students were accepted into medical school at similar rates to the other pre-health students. Proponents of structural competency do not advise the abandonment of cultural competency models, but they do stress the importance of incorporating discussions of culture with structural constraints to avoid stereotyping and victim blaming patients (Metzel, Petty, and Olowojoba 2018; Metzel and Hansen 2014; Hansen and Metzel 2016).

Clinical Competence

While interventions in cultural and structural competence, at both interaction and systems-levels, can help alleviate disparities, clinical competence in caring for LGBTQ patients must also be addressed. Indeed, two types of instruction about sexual and gender minorities have been documented: improving doctor-patient interactions and clinical training for transgender and queer health (Ard and Keuroghlian 2018). For example, patients and providers report a need for providers who are both "transgender-*friendly*" and "transgender-*knowledgeable*" about trans health care (such as gender affirming surgery, hormones, and primary care) (Sanchez, Sanchez, and Danoff 2009: 713, emphasis mine; Noonan et al. 2018). Additionally, patients and providers underscored those changes to the curriculum should include science about LGBTQ health and hormone usage in the basic science courses (Noonan et al. 2018). Responding to the lack of LGBTQ health included in medical curricula, medical educators have utilized this tactic, creating new content and adapting old to include LGBTQ health in the first two years of medical school

to ensure that basic science hours were not cut and to prevent faculty from not wanting to participate in educating about LGBTQ health (Holthouser et al. 2017).

Even with these interventions, opportunities for improvement remain. Despite reporting increases in knowledge, in a study of how medical students provided care for an LGBTQ patient in a group case study activity, medical students' top recommendation was to refer the patient to a doctor specializing in LGBTQ care (Leslie et al. 2017). Additionally, medical providers who attended a workshop on LGBTQ health reported valuing the terminology sections but came away with inaccurate and narrow understandings of trans people, such as defining transgender identity as someone who has gender-affirming surgery (Hanssmann et al. 2008). Without a representation of the variation of trans experience, however, doctors can simply adopt newer yet still reductive understandings of trans experience (Hanssmann, Morrison, and Russian 2008). Insights about medical science and the medical school as a social and cultural organization can help address how even with commitments to addressing LGBTQ health in education, disparities remain.

The Medical Schools as a Social Organization

Tools from the sociology of medical education can help address these LGBTQ health and health care disparities (Giffort and Underman 2016).[6] For instance, at the institutional level, medical schools serve as social organizations that socialize students into particular cultures of medicine and, at the interactional level, actors within the organization also contribute to this socialization. Situated within this context of the medical school as a social organization, medical schools help construct what is perceived as legitimate medical knowledge, especially through formal medical curriculum. At the institutional and interactional level medical schools reproduce

[6] Giffort and Underman (2016) specifically argue that sociologists of medical education can help address trans health disparities, but I situate their work here to address LGBTQ at large because I believe the concepts, they use are applicable to the larger LGBTQ community.

particular ideologies through informal and hidden curriculum. Because of this, these curricula are important to examine to understand how medical schools teach about LGBTQ health.

For instance, sociologists theorize medical education as a social process. The medical school had two functions in its beginning: to teach students' medical knowledge about human health and disease as well as how to treat humans experiencing disease or ill health (Jeffreys and Elston 1989). In addition to these two functions, the medical school also serves to instill social and cultural values into medical students during their time in training. The earliest studies of medical schools date back to Merton, Reader, and Kendall's (1957) functional perspective to medical education and Becker et al.'s (1961) symbolic interactionist analysis of the organization of the medical school and of student culture. Merton, Reader, and Kendall (1957) understood physicians according to Parsons' characterization of the doctor role; this perspective viewed difficulties in medical students' adopting their medical professional roles as resulting from the individual rather than the institution of medicine itself (Jeffreys and Elston 1989). Opposed to this structural functionalist argument in Merton, Reader, and Kendall's (1957) interpretation of the medical school, Becker et al. (1961)'s *Boys in White*, a formative research study on medical student learning, stresses how students make meaning out of their medical school experiences and how student perceptions were often at odds with their medical teachers.

Becker et al. (1961) focused on 3 aspects of the medical school as a social organization which affect how medical students prioritized their learning: shifting group perspectives, a student culture that forms, and the organization of the medical school. Concerning group perspectives, the researchers examined the shifting perspectives of student groups and how their level and direction of effort towards their studies changed throughout their time in medical school. Here students needed to learn how to adapt to the insurmountable workload. With the

initial perspective, students attempted to “learn it all” (Becker et al. 1961). Once realizing this was impossible, students then adopted a provisional perspective where they tried to learn what they thought was important (either focusing on lecture notes, the textbook, or what faculty said was important). Finally, students adopted a learn “what they want us to know” perspective meaning that they attempt to pass the tests by learning what the faculty think is important. This sociological perspective on group perspectives within the medical school can bring attention to how medical students understand or prioritize the complexity of sex/gender and LGBTQ health in their course work.

Student culture also influenced what students learned in medical school. Student culture refers to how the students understood their roles as students within the organization of the medical school as opposed to as medical professionals (Becker et al. 1961). The development of a student culture during the clinical years draws together professional culture with students’ preclinical concerns with what to study to pass medical school (Becker et al. 1961). In particular Becker et al.’s (1961) students were interested in learning medical responsibility and gaining clinical experience in their clinical years. These students learned that faculty serve the role of gatekeepers, and they must do what they say to succeed in their examinations and gain experience in order to be successful in their medical careers (Becker et al. 1961). Further, clerkships serve to socialize students into their roles as physicians who will be providing care to patients and who will need to navigate health care systems to do so (Han, Roberts, and Korte 2015; Krupat, Pelletier, Chernicky 2011; Weaver et al. 2011; Lindberg 2009; O’Brien, Cooke, Irby 2007). This focus on student culture helps pinpoint how students perceive whether their curricula provide clinical experiences for and associates medical responsibility with LGBTQ patients that can help address LGBTQ health disparities.

Lastly, organization refers to the institutional rules of the medical school and the relationships with others in the organization that constrained or influenced students' level and direction of effort in their studies (Becker et al. 1961). Ultimately, medical students are situated within a medical organization that requires that they adopt a cynical day-to-day attitude, whereby they focus on gaining experience and depersonalizing patients in order to graduate (Becker et al. 1961). Despite this pressure, they also retained an idealistic perspective about wanting to help patients (Becker et al. 1961). This sociological focus on organization can highlight how the medical organization itself, with its emphasis on learning the day-to-day clinical tasks, influences how students view diversity and inclusion initiatives, such as those related to sex/gender and LGBTQ health.

The Social Construction of (Legitimate) Medical Knowledge through Medical Curricula

Within this context of the medical school as a social organization, particular types of medical knowledge are considered legitimate. As Bronsan and Turner (2009) pose, medical curricular reform is fundamentally about the state of medical knowledge, drawing boundaries around what is and is not important to providing healthcare: "what types of knowledge distinguishes the medical profession from other groups? What sorts of knowledge are needed to produce a competent but caring doctor?" (9). These social and epistemological struggles over medical knowledge have occurred since the 1950s and Merton, Reader, and Kendall's (1957) study that documented the integration of pre-clinical and clinical knowledge into medical curriculum where students connected health problems to family and community contexts (Brosnan and Turner 2009). More recent medical curricular reforms attempt to blur the boundaries between pre-clinical and clinical knowledge, known as integrated curriculum. An

example of this integrated curriculum is problem-based learning activities where medical students study patient cases (Brosnan and Turner 2009).

"Integrated curriculum," however, can also reify clinical knowledge as more important than pre-clinical knowledge. Atkinson and Delamont (2009) address this political nature of medical curriculum. Drawing on sociologist of education Bernstein's reproduction of educational knowledge, Atkinson and Delamont (2009) explain how curricula have a discursive component – already attached with cultural value, curricula create boundaries around what is considered legitimate knowledge. With the case of the pre-clinical/clinical division in curriculum, cultural values attached to pre-clinical as inferior and clinical as superior become naturalized. Simply adding pre-clinical, social scientific classes to the medical curriculum reifies this binary between pre-clinical/clinical. Disrupting this binary around curriculum allows for changes in what counts as medical knowledge to occur.

This incorporation of pre-clinical to clinical has occurred with the case of bioethics in medical education. Bioethics became integrated into medical school curriculum to address public criticisms of the profession born out of ethical concerns in medicine after the late 20th century when illegal testing on patients without their consent occurred (Keirns, Fetters, and De Vries 2009). Ultimately, while born out of a public critique of medical power and a call for medicine to attend to these ethical issues, bioethics became a pathway for the medical profession to retain medical authority (Keirns, Fetters, and De Vries 2009). By incorporating bioethics into curriculum, and thereby demonstrating a symbolic concern over the issue, the medical profession could deter future public criticisms about not addressing ethical issues and remain in control of how bioethics is taught (Keirns, Fetters, and De Vries 2009). Of importance, bioethics portrays a particularly individualistic framing of ethical issues as opposed to social sciences and has taken

the place of social sciences classes in the curriculum (Keirns, Fetters, and De Vries 2009). For instance, ethical issues such as whether or not to follow a "do not resuscitate" order overshadow thinking critically about how social contexts influence illness, a connection that structural competency model stresses in its curriculum (Keirns, Fetters, and De Vries 2009). As Keirns, Fetters, and De Vries (2009) emphasize, these individualist framings of bioethics are incorporated more easily with clinical training than social science perspectives.

Given the politics of the pre-clinical/clinical divide in medical curricula, how LGBTQ health and sex/gender are incorporated into medical students' coursework could have effects on whether it is taken seriously as an important component of improving patient health outcomes. Additionally, addressing public criticism and making changes to curriculum can also be seen as a strategy to retain medical authority and status over the issue. Important questions are raised, related to what the cultural values attached to LGBTQ health are, how these are solidified in the course curriculum, and how inclusion in the curriculum can shore up medicine's authority over patient experience.

Informal and Hidden Curriculum

In addition to the social processes that prioritize biomedical knowledge over social science knowledge in formal medical curriculum, scholars identify how the organization of medical schools, the social interactions within them, and the design of curriculum can *subtly* influence the messages that students receive about what is legitimate knowledge (Hafferty 1998; Hafferty and Castellani 2009). Labeled informal and hidden curriculum, scholars examine how medical institutions while overtly stating a purported goal, such as a vow to end discrimination, continue to recreate hierarchies that detract from that goal through their curricula. Here informal curriculum refers to the interactional aspects of medical education, such as conversations in

hallways, where medical students learn about the culture of medicine from administrators and faculty (Hafferty 1998). Hidden curriculum, in contrast, has been theorized as the structural aspects of medical education, including organizational policies; how the organization and faculty members are evaluated; and where funding is allocated throughout the organization, that inform how medical students learn and what their priorities should be as doctors (Hafferty 1998). In particular, the hidden curriculum is "more concerned with replicating the culture of medicine than with the teaching of knowledge and techniques" (Hafferty and Franks 1994: 865). These concepts account for the unintended knowledge, information, and skills transmitted to students through curricula and lectures, from faculty and fellow students, and through the physicality of the medical school itself (Turbes, Krebbs, and Axtell 2002).

Examining a school's informal curriculum helps elucidate how marginalized students experience discrimination in their everyday life and how this can support institutional inequalities in medical schools. For instance, medical schools have adopted a goal of diversity and inclusion that condemns overt discrimination. Despite this goal, Beagan (2001) identifies instances of everyday racism, sexism, heterosexism, and classism that medical students experienced through her analysis of surveys and interviews with medical students and interviews with medical faculty. Medical doctors made racist jokes about patients and assumed cultural inferiority of nonwhite patients; women experienced sexual harassment from male physicians; heterosexual patients and classmates would make homophobic comments; and social gatherings alienated low-income students who did not have the social or cultural capital to fit in with their professors or peers (Beagan 2001). The medical school as an organization, then, can be described as a white, masculine, heterosexual, upper class space whose culture reinforces racial and gendered hierarchies (Beagan 2001). Beagan (2001) extends Becker et al.'s (1961) work on

student socialization by addressing the white, masculinity of the medical school and by addressing how micro-aggressions occur amongst interactions of racial/ethnic minorities, women, queer, and low-income medical students. Informal curricula can also produce and perpetuate clinical (mis)understandings that can influence treatment plans and patients' access to types of care (Labuski 2017). For instance, informal remarks made by doctors about how "'Vulvar pain is white. Pelvic pain is black,'" reinforce the racialized notion that only white women experience vulvar pain (Labuski 2017:160). Additionally, these informal interactions contribute to racist discrimination against Black and Latina female patients so that they are underdiagnosed, and their concerns dismissed by providers (Labuski 2017).

Informal curriculum is also a space where medical students learn about sexuality and sexual diversity. Queer medical faculty and queer medical students' informal interactions in medical school teach them that being an out sexual minority would not positively influence their careers. For instance, queer medical faculty were mostly invisible at a top 20 U.S. medical school where Murphy (2019) conducted her fieldwork, and this invisibility sent messages to the students about who did and did not belong. Similarly, Fallin-Bennett (2015) explains how LGBTQ medical professionals' choice to remain closeted indicates the hidden curriculum surrounding sexual orientation and gender identity. They review how in a study of general surgery residents, more than 1/3 of the LGBTQ respondents were not out at work. Queer medical students had difficulty finding queer faculty mentors, and Murphy (2019) reported greater visibility of heterosexual medical faculty whom in lectures would reference their opposite-gender spouse whereas no queer faculty shared this information with their classes. In this environment of queer invisibility, queer medical students felt the pressure and responsibility to correct inaccurate information about queer sexuality or condemn outright homophobia, causing

stress for these students, replicating and overlapping with the mental health burdens borne by their LGBTQ patients. On the one hand, some heterosexual students in interviews with Murphy (2019) reported that sexuality did not matter in medical school, and in doing so ignored the burdens that queer students face in a heteronormative educational space. On the other hand, heterosexual students reported learning more about sexual diversity from their queer colleagues through their informal interactions rather than from the formal curriculum.

While informal interactions within the medical school can influence medical students' knowledge and feelings of belonging, the hidden curriculum can also influence what students learn is important and who belongs. For instance, in the case of professionalism, Michalec and Hafferty (2013) underscore how students are taught in the formal curriculum that professionalism and connecting with patients is important, but these ideals are at odds with ceremonies, such as the White Coat Ceremony, that stress how medical students are important, bolstering their authority. Lempp (2009) investigated whether Black men and women and white women believed their race/ethnicity and/or gender inhibit them from succeeding in medical school. Focusing on a hidden curriculum within the culture of the medical school, Lempp (2009) finds that students learn to avoid challenging medical faculty and accept humiliation to be able to graduate medical school and join the medical profession. These unwritten rules become normalized, and medical students do not question this hierarchy (Lempp 2009). These students learned that they must keep their complaints about discriminatory remarks to themselves (Lempp 2009). A lack of racial/ethnic mentors sends a message about the type of medical professional (i.e., white) who will succeed (Lempp 2009).

Hidden curriculum also conveys subtle messages about minority groups that can contribute to social inequalities. For instance, in an analysis of over 900 case studies used in

first- and second-year medical curriculum, Turbes, Krebbs, and Axtell (2002) discovered pervasive misinformation related to gender, sexuality, and race/ethnicity and disease. Cases of women were underrepresented in diseases prevalent in women, such as hypertension; cases about sexually transmitted diseases and having multiple sexual partners were associated with queer sexuality; and when case studies used racial/ethnic language, it was always associated with a racial and ethnic minority in relationship to diet, genetic diseases, and where they lived (Turbes, Krebbs, and Axtell 2002). Turbes, Krebbs, and Axtell (2002) address how these case studies conflated identity with behavior as a risk factor for disease, and thereby reinforced stereotypes about marginalized groups within the curriculum.

The hidden curriculum also upholds heteronormativity and contributes to the marginalization of non-normative sexual and gender identities. For instance, Murphy (2016) explains how heteronormative assumptions about penetrative sex are embedded in faculty presentations about male reproductive anatomy, where a faculty member used language that implies men have sex with only women and only in vaginas. When queried about the assumptions about heterosexual sexual intercourse that the faculty member integrated into his lecture, the faculty member did not think the example was important, claiming it was not relevant to teaching how to conduct a physical exam (the point of the lecture) and was simply a humorous device (Murphy 2016). This exam not only taught students about male anatomy, but also reinforced heterosexual privilege and conveys messages about "normal" sexuality (Murphy 2016). Additionally, Murphy (2016) found that separating LGBTQ experiences outside of the formal curriculum, such as a transgender guest panel, not only exoticized trans experience but also "reinforce[d] heteronormativity by implying that those who disrupt normative arrangements

of sex-gender-sexuality cannot be integrated into the realm of normal life experience, but rather must be treated as a separate category of persons or experiences" (276).

Despite diversity and inclusion initiatives to incorporate of LGBTQ health into medical school curriculum, the sociological concepts of informal and hidden curriculum draw attention to the ways in which institutions and the interactions within them recreate social inequalities through their instruction. These concepts can be helpful for understanding how despite the inclusion of LGBTQ health in medical schools, homophobic and transphobic inequalities might persist. Crucial to my dissertation, this sociological attention to the social organization of medicine, the social construction of medical knowledge, and how micro-inequalities create an institutional environment that condones oppression can help me to describe how social inequality can be reproduced within the school despite commitments to diversity and inclusion. Given the social and cultural changes surrounding sex, gender, and sexual orientation taking place in the U.S. today and scientists' increasing criticisms of the sex/gender binary as too simple, I am interested in how these changing ideologies influence (or not) the production of the next round of physicians who will provide care to LGBTQ patients of the future. Building off of this previous work of the social organization of the medical school, this research is attuned to the institutional and interactional aspects of the medical school that influence how students understand sex, gender, and sexuality vis-a-vis LGBTQ health.

Feminist Conceptualizations of Sex, Gender, and Sexuality

Feminists understand sex, gender and sexuality as complex, intersectional, and embodied aspects of human existence that cannot be relegated to a sex/gender binary. This section outlines feminist articulations of this complexity and its relationship to systems of inequality; how, in contrast, medical science produced particular understandings of sex, gender, and sexuality that

have naturalized and been mapped onto bodies; and lastly how medical science helped produce a normative way to be transgender through the medicalization of transgender identity and experience.

Sex is typically understood as a person's biological characteristics including their chromosomes, hormones, gonads, genitalia, and secondary sex characteristics. Gender is typically understood as the social characteristics normatively associated with someone's sex, related to one's identity and expression. Lastly, sexuality is typically understood as a person's sexual and/or romantic attraction to others, including someone's behavior and identity. Feminists deconstruct these categories to show how they are socially constructed and performative and interrogate naturalized assumptions embedded in these popular understandings that limit sex, gender, and sexuality to binaries.[7]

A social constructionist perspective to sex, gender, and sexuality challenges essentialist, binary assumptions and demonstrates that the meanings we attach to sex, gender, and sexuality are context dependent (Davis and Preeves 2017; Lorber 2016; Seidman, Fischer, and Meeks 2016). For instance, the categorization of essential sex has changed over time: in some cases, genitalia are taken to dictate a person's essential sex, whereas in others, such as the guidelines for sex testing for women athletes, rely on hormones as the true indicator (Davis and Preeves 2017). With the case of intersex infants, multidisciplinary teams of endocrinologists, urologists, geneticists and pediatricians are assembled to disentangle one's "true" sex (Kessler 1990; Davis 2015). These various criteria for sex and perspectives on what counts as a "true" sex underscore

[7] While sex, gender, and sexuality have been defined as separate phenomena by the general public, scientists, and feminists alike, not all feminist scholars agree with this easy division. For instance, Valentine's (2003) research participant did not divide her gender identity as a trans woman to her sexuality. In fact, the division of sexuality versus gender and the language that feminists use to distinguish between the two limited the participants' ability to share her experience.

that defining sex is fundamentally a social negotiation, instead of a natural, biological event, which cannot be detached from the social and cultural context (Davis and Preeves 2017).

In a similar vein, gender and sexuality scholars demonstrate that meanings associated with gender and sexuality have changed over time. For instance, while Western societies typically assume a gender binary of men versus women, other societies recognize third genders, such as Indian hijra identity[8] (Lorber 2016; Reddy 2005; Nanda 1986). Here gender is enmeshed with racial categories. Gender influences how people act in their everyday life, including parenting expectations, dating norms, and the types of work people do in ways that appear to naturalize sex/gender (Lorber 2016). In terms of sexuality, meanings about sexuality are also context dependent, such as homosexuality once being labeled as a disease whereas today this association does not necessarily persist (Seidman, Fischer, and Meeks 2016). Despite the variety and complexity inherent to sex, gender, and sexuality, these categories have been paired together and assumed to be natural under the rubric of heteronormativity. Heteronormativity assumes a gender binary where sex is the biological referent of gender and refers to "practices that derive from and reinforce a set of taken-for-granted assumptions relating to sex and gender…includ[ing] the presumptions that there are only two sexes; that it is 'normal' or 'natural' for people of different sexes to be attracted to one another"[9] (Kitzinger 2005: 478).

In addition to understanding gender as a social construction, feminist examinations of gender also understand gender as an interaction (West and Zimmerman 1984), a structure

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[8] While hijra identity has been positioned to challenge the Western gender/sex binary, this identity cannot be reduced to a third gender category as it continues a legacy of colonial violence against Global Southern countries. Reddy (2005) addresses the colonial history that informs research on hijras living in India. Some research refers to these people as a 3rd sex, understanding their lived realities of gender, sexuality, kinship, religion, and class solely through this lens (32-33). Rather than understanding the historical, cultural, and structural influences of hijra identity, and how hijras understand their identities, Western scholarship has used hijras to deny sexual dimorphism (32).

[9] Heteronormativity also refers to "the myriad ways in which heterosexuality is produced as a natural, unproblematic, taken-for-granted, ordinary phenomenon" (Kitzinger 2005: 478)

(Lorber 2016), and a discursive phenomenon (Butler 2002). These feminist conceptualizations of gender challenge gender essentialism, which assumes gender is a fixed essence. For instance, Judith Butler theorizes performativity in *Gender Trouble* (2002), explaining that there is no essential gender but rather posits that gender is a sort of embodied narrative that we actively create:

> [s]uch acts, gestures, enactments generally construed [that a person does], are *performative* in the sense that the essence or identity that they otherwise purport to express are fabrications manufactured and sustained through corporeal signs and other discursive means. That the gendered body is performative suggests that it has no ontological status apart from the various acts which constitutes its reality" (2002:185)

Because people act and behave in gendered ways with their bodies, we think that gender is inherent and natural/biological to our selves (Butler 2002). However, these enactments hide that there is no true gender. This constant repetition of gendered behavior creates the falsehood that gender is natural and controls people's gendered expressions to act according to normative standards (Butler 2002). Even though gender is not inherent to bodies, bodies still enact gender on a daily basis and embodiment is crucial to understanding how the idea of gender becomes naturalized (Butler 2002). We use our bodies to act in certain gendered ways as we imitate normative gendered ideologies. Drag performances, wherein people take on another gender, reveal that gender itself is a performance because the actors are exaggerating gendered acts; to behave in a gendered way (as a woman or a drag queen) is to perform in a gendered way (Butler 2002).

Performativity has also been theorized in the pharmacopornographic era, with special attention to the body, gender, and technology. A pharmacopornographic era "refers to the processes of a biomolecular (pharmaco) and semiotic-technical (pornographic) government of sexual subjectivity – of which 'the Pill' and Playboy are two paradigmatic offspring" (Preciado 2013:33-34). Within this era, bodies are fictions and Preciado (2013) theorizes a lived

performativity as a means of politicizing the body and exploring gender variation. Drag king workshops demonstrate the fictional status of gender. For instance

> [a]ll of them [referring to genders] are performative products to which different frames of cultural intelligibility confer various degrees of legitimacy. The difference is found in the degree of self-reflection, of consciousness, of compulsion, of the performative dimension of these roles. Becoming a drag king is seeing through the matrix of gender, noticing that men and women are performative and somatic fictions, convinced of their natural reality (374).

All genders – not only traditional gender categories of women and men – are performances. By adopting different gendered behaviors, one can become aware that gendered behavior is a performance with material dimensions and repercussions and can shift these power relations. Further, gender—for all people—become enmeshed with technologies, whether that be testosterone patches for someone transitioning to a masculine gender, birth control pills taken by cisgender women, or erectile dysfunction medication taken by cisgender men. Here all genders interact with technology in some capacity. These cases are all instances of technology producing gender, rather than simply interacting with it. Indeed, even cis genders are produced. Performativity here has been used to demonstrate that gender expression is not inherent to a person, and even more, that gender is a narrative that is reproduced through our repetition of gendered acts.

Here feminists challenge sex and gender essentialism and its connection to heteronormativity under the assumption that sex, gender, and sexuality are socially constructed, performative, and complex phenomenon. These understandings are in stark contrast to endocrinologists' assertions that gender is rigid (Safer and Pearce 2013; Thomas and Safer 2015). In fact, feminists identify medical science as a site of gender production whereby health care systems and medical professionals contribute to socially constructed ideologies of gender.

Medical Science as a Site of Gender Production

Medical science has been a key site for the production of gender and has recently been critiqued by feminism for its role in creating binary understandings of gender. Feminists, focusing their attention on critiquing gender that withheld women's progress, prioritized social studies of gender over studies of the body, leaving biology to the biological sciences where essentialist ideologies about femaleness and maleness remained (Oudshoorn 1994). A resurgence in feminist theorizing has occurred where feminists have reinserted themselves into conversations about the body to question and complicate essentialist thinking (Grosz 1994). These feminists underscore how scientists can project cultural ideologies onto studies of the body.

For example, medical scientists have (re)produced traditional gender ideologies in their work. Fausto-Sterling's (2000) research demonstrates that "[w]hat bodily signals and functions we define as male or female come already entangled in our ideas about gender" (4). In the case of determining the sex of babies based on penis size, ideas about masculinity inform doctor's decisions. Doctors have judged male sex based on if the person will be able to use the penis to penetrate (presumably a vagina) during sex and if the penis will be large enough to be socially accepted among male peers (and urinate standing up) (Fausto-Sterling 2000: 58-59). Challenging and transcending these binaries around sex helps us to better capture lived, embodied experiences of human variation, such as intersexuality, and depathologize gender and sexed realities outside the norm.

Similarly, Nelly Oudshoorn's (1994) study of sex hormones also exemplifies continuing to situate feminist biomedical studies back into discourses about the body. She questions what we think of as natural in terms of sex hormones, and her work exemplifies that "there does not exist an unmediated natural truth of the body" because scientists do not conduct studies in a

vacuum but rather draw on other professionals, such as pharmacists, to create knowledge about the body and hormones (Oudshoorn 1994: 3). Oudshoorn (1994) questions how often scientists incorporate culture into their studies and draws on Ludwick Fleck's (1979) ideas about "prescientific ideas" which "emphasize the culturally conditioned character of scientific knowledge" to explore how ideas about female sex hormones have become naturalized (1994:11) or what Jordan-Young (2010) labels "assumption containers (54). For instance, scientists conceptualized male and female sex hormones as related to masculinity and femininity respectively, drawing on "prescientific ideas" about femininity's connection to ovaries from Aristotle (Oudshoorn 1994). Ultimately scientists influence what they study and by treating science as if it is "universal, decontextualized knowledge," scientists also erase their part in the creation of knowledge (Oudshoorn 1994: 138). Other feminist scholarship addresses how scientific explanations for sex differences in brains (Jordan-Young 2010) and chromosomes (Richardson 2013) are also intertwined with gender ideologies.

These feminist researchers argue that bodies, sex, and gender cannot be reduced to a binary. Rather, the body exists in "shades of difference," and intersexuality is an example of the body's complexity and of human variation because humans are born with various types of genitalia, levels of hormones, and chromosomes in varying combinations that do not align with the traditional categories of male and female (Fausto-Sterling 2000: 2). In fact, medicine has erased sex and gender variations in humans to support the sex/gender binary. For instance, surgically "fixing" intersex infants to have male or female bodies erases this human variation so that the binary appears normal while intersex appears abnormal (Karkazis 2008). Intersex surgeries performed by medical practitioners perpetuate the idea that we need these surgeries by making it seem as if there are only two forms that bodies can take (Fausto-Sterling 2000).

Rather than reject biology, some feminists adopt developmental systems theory to reject the dualism between nature and nurture (as determining how one develops), showing how the two are interrelated. According to Fausto-Sterling's (2000) explanation of developmental systems theory, "[t]he changes that occur throughout the life cycle all happen as part of a biocultural system in which cells and culture mutually construct each other" (242). As a result, bodies are inextricably connected and interact with the environment and co-construct reality, so bodies (and human sexuality) can change as a result of biology and the environment (Fausto-Sterling 2000). This nuanced depiction of how nature and nurture construct each other better captures lived experiences. The belief that sex is unchanging is false because bodies interact with their environments. For instance, conceiving and giving birth to a child will be different depending on both biological circumstances, such as age, and social aspects, such as one's relationship status, sexual orientation, race/ethnicity, finances, and geopolitical location (Fausto-Sterling 2000). With the case of geopolitical location and its articulation with race/ethnicity, we see that Black women experience higher maternal morbidity rates as opposed to white women. This can be explained because Black women are more likely to give birth in a hospital that has a more severe risk-standardized maternal morbidity rate than white women (Howell et al. 2016). In this instance, biology and culture interact and affect each other to create specific experiences for certain people in certain environments. Feminists continue to grapple with the intertwining of biology and culture and argue that sex and gender are best conceptualized as "entangled" (Springer, Stellman, and Jordan-Young 2012: 1817).

With respect to LGBTQ identity and experiences, essentialist ideologies about sex/gender have informed the practice of transgender medicine and have occurred alongside the medicalization of transgender identity. For example, medical science has actively produced

understandings of gender vis-à-vis transgender medicine and has historically medicalized and pathologized transgender people with medical professionals acting as gatekeepers, controlling access to gender affirming medical care in transgender medicine (Tosh 2016; shuster 2016). Medicalization here broadly refers to the defining of nonmedical issues in medical terms (Conrad 1992; 2005). Stemming from Parsons' sick role, where medicine has been described as a way to control deviance (Conrad 1992), to Szasz's (2007) analysis of psychiatry, medicine has historically been understood in terms of medical social control. For instance, Zola (1972) argues the medical profession contributes to the medicalization of society through expanding medicine's reach to include multiple causal factors; maintaining sole authority to perform medical techniques and to treat taboo issues, such as drug addiction; and finally, increasingly defining everyday practices through medical frameworks (Zola 1972). These pathways solidify the importance of medicine in everyday life, extending the reach of social control. Of particular importance, medical ideology labels certain acts as deviant, then, in collaboration medical providers act as gatekeepers, retaining control over medical technology to fix the deviant problem (Conrad 1992; Conrad and Schneider 2010).

In addition to medical professionals, market forces, pharmaceutical companies, and consumers contribute to medicalization. Within the context of increased corporatization, Light (1993) proposed the countervailing powers thesis where power shifts from being solely in the hands of medical providers to patient consumers, insurance companies paying for services, and corporations who supply health insurance for consumers. Pharmaceutical companies and market interests now greatly influence the process of medicalization, even more so than medical professionals' interests, though these interests can be intertwined (Conrad 2005). For instance, Conrad (2005) emphasizes how managed care has become the "arbiter of what is deemed

medically appropriate or inappropriate treatment" and "in some instances managed care constrains medical care and in other cases provides incentives for more profitable care" (10). Here managed care professionals decide what is covered under insurance, often from a cost-benefit analysis to increase profits gleaned from the delivery of medical care. Further, pharmaceutical companies, with direct-to-consumer marketing, have created new medical markets for medical solutions and serve to profit from an increase in the medicalization of human experiences (Conrad and Leiter 2004).

Medical professionals and patients, therefore, not only contribute to but operate within a profit-oriented and consumer based medical framework. Within this context, the processes that affect whether a condition is medicalized continue stem from both the medical profession and lay interests. After a condition is considered deviant, medical professionals define it in medical terms, both medical professionals and lay people adopt this definition, and then state legitimation and institutionalization of this medical disease follow (Brown 1995). Rather than solely a form of "medical imperialism," however, individuals actively seek out medical solutions to their problems (Conrad 1992: 219). Both medical professionals and transgender patients have contributed to the medicalization of transgender identity and experience.[10]

Transgender medicine emerged in the mid 1900s whereby mental and physical health care providers assisted patients in accessing gender affirming therapies to physical and/or socially transition gender (shuster 2016; shuster 2021). Around this time, The World Professional Association for Transgender Health (WPATH), which was founded in 1979 and originally known as Harry Benjamin International Gender Dysphoria Association, became

[10] With these other forces in mind, I focus on the doctor-patient interaction to underscore how production of gender occurs in this space through medicalization. Pharmaceutical companies and health care systems serve as a backdrop to how doctors provide LGBTQ health care and how LGBTQ patients access this care.

known as the professional organization for mental and physical health care providers who deliver care for transgender patients (shuster 2016). This international multidisciplinary organization prioritizes EBM and releases Standards of Care (SOC) for providing care for transgender patients (shuster 2016). The SOC provides treatment recommendations that require mental health considerations based on current Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses associated with transgender mental health. According to these guidelines, to access gender-affirming care, such as hormone therapy and gender affirmation surgery, trans patients must first receive a diagnosis from the DSM as a prerequisite.[11]

Psychiatric diagnoses associated with transgender identity date back to the 1980 DSM III, with transsexualism and in DSM-IV as gender identity disorder (Drescher 2014). Psychiatric etiologies for queer sexuality once labeled non-heterosexual desire as a disease and as indicating a phase that one would mature out of (Drescher 2015). While the DSM depathologized and removed queer sexuality in the 1973, the DSM still includes a psychiatric diagnosis associated with transgender, labeled gender dysphoria in the DSM-V (Drescher 2015; Drescher 2014). Incorporation of transgender in the DSM has been criticized as pathologizing transgender identity and experience (Tosh 2016). Previous definitions in the DSM labeled transgender identity as a mental illness, but the discursive move to "gender dysphoria" attempts to avoid this conflation. As stated in the DSM V,

> *Gender dysphoria* refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available. The current term is more descriptive than the previous DSM-IV

[11] One of the SOC 7 requirements for accessing hormone therapy is documented gender dysphoria. The SOC states, however, that this diagnosis can be ignored in some cases. As stated, "In selected circumstances, it can be acceptable practice to provide hormones to patients who have not fulfilled these criteria. Examples include facilitating the provision of monitored therapy using hormones of known quality as an alternative to illicit or unsupervised hormone use or to patients who have already established themselves in their affirmed gender and who have a history of prior hormone use" (Coleman et al. 2011: 187)

> term *gender identity disorder* and focuses on dysphoria as the clinical problem, not identity *per se*. (emphases in original, APA 2013, p. 451).

Despite the language changes, associating trans with mental health continues ensuring that medical doctors remain the gatekeepers to accessing gender-affirming care (Dewey and Gesbeck 2017). This association means that the language change is mostly symbolic in that the current processes that trans patients must go through to access gender-affirming surgery remain the same (Dewey and Gesbeck 2017). Rather, gender dysphoria diagnoses can limit access to care because insurance companies often do not cover trans-related care (Dewey and Gesbeck 2017). To provide care for their patients, medical providers have diagnosed their patients with other illnesses, such as depression or a precocious puberty diagnosis, to ensure they can access gender-affirming surgery and hormone treatment (Dewey and Gesbeck 2017). This tactic continues to associate gender as a mental health issue however, contributing to pathologization (Dewey and Gesbeck 2017).

Despite the promise of improved access to health care, the medicalization of a condition can contribute to health disparities and actually impede access to health care. Medicalization individualizes social problems, making the social context for these conditions obsolete and frames the problem as solvable by medical intervention (Conrad 1992; Conrad and Barker 2010; Zola 1972; Barker 2008). This move focuses the source of the problem on the individual as opposed to relating it to systems of inequality (Zola 1972). Through a social determinants of health framework (e.g., Marmot and Wilkinson 2006; LaVeist 2005), sociologists know that social inequality negatively impacts people's health status. By placing the blame on the individual, larger systems of inequality that contribute to health disparities remain intact. Indeed, while a medicalization framework has been used to establish LGBTQ rights, it has also masked the social and structure underpinnings of LGBTQ health disparities that stem from healthcare

systems themselves (Eckhert 2015). A demedicalizing framework for LGBTQ health care strives to examine the heteronormative and cisnormative biases embedded in LGBTQ health care research that contribute to harm against these populations (Eckhert 2016). With respect to transgender medicine, this medicalization of gender identity has contributed to the pathologizing of transgender identity and experience and blames trans people's mental health problems on trans people themselves as opposed to attributing these problems to the cissexism and transphobia that they face (Johnson 2015).

Rather than addressing this cissexism and transphobia, the medicalization that accompanies gender dysphoria upholds a strict gender binary and supports transphobic interventions in children's gender nonconformity. For instance, gender dysphoria "continues to frame gender nonconformity as pathological and enables the continuation of unethical therapies used on trans children with the aim of 'preventing' transsexualism (e.g., Zucker & Bradley, 1995, 2004)" (Tosh: 2016: 62). Through diagnosing patients with gender dysphoria and abiding by the SOC, doctors enforce a medical model that supports a gender binary, with the assumption that every trans person will want to access both hormones and surgery and transition to "the other gender," by labeling transgender as a mental illness that requires medical validation (Johnson 2015; Dewey and Gesbeck 2017). The DSM-5 and WPATH's SOC limits gender expression to a gender binary, creating a normative way to be trans, whereby gendered possibilities outside of this medicalized gender binary are deemed pathological as well (Davis, Dewey, and Murphy 2016; Johnson 2015; Casteñeda 2015). For instance, WPATH prioritizes EBM, but a lack of randomized clinical trials impedes doctors' abilities to rely on this framework when they provide care for their patients (shuster 2016).

To navigate this uncertainty, some doctors relied heavily on the guidelines and believed that their patients needed to be “100% certain” and abide by a strict gender binary to receive care (shuster 2016: 323). Other trans health care providers have imposed traditional gender ideologies on patients seeking their assistance in accessing gender-affirming care whereby patients must demonstrate that their trans identity is “real” (based on traditional gender ideologies) by demonstrating to their practitioners that they will go to any length to transition (Dewey and Gesbeck 2017). In contrast to providers who had strict interpretations of the guidelines, other providers interpreted the guidelines loosely to be able to provide individualized care to their patients (shuster 2016). For example, these providers placed trans patients’ knowledge of their identities and gender fluidity first rather than making them abide by a strict gender binary in line with the clinical guidelines.

In response to gatekeeping in the medical community, patients recognize that they must present themselves in traditionally gendered ways to access care. As one participant in Dewey and Gesbeck’s (2017) study articulated,

> First off you have to have the therapist decide whether you are, yes or no, the real thing. And they do that through talking to you at your visits. In any case, my therapist knew from the second or third meeting session that I was the real thing. I did everything that she wanted me to do (60).

In this way, particular narratives emerge that trans patients use with their medical professionals to access care even if those narratives do not reflect their lived realities (Spade 2006; Johnson 2018; Dewey and Gesbeck 2017). This medical model imposes a transnormativity and actively produces what (trans)gender is and then requires patients to submit to these gendered rules, thereby reinforcing the naturalness of a binary model of gender (Johnson 2015; Dewey and Gesbeck 2017). This model ignores the multiplicity of gender experiences and prioritizes medical intervention as validation for trans identity; through its creation of a

normative way to be trans, it also influences trans people's ability to access legal services and community resources (Johnson 2015).

While medical providers remain gatekeepers of gender-affirming health care for trans people, trans people are not passive recipients in this relationship and play a role in medicalizing transgender identity and experience, as demonstrated in the above examples with trans people's adoption of medical narratives. Rather, trans patients both support and resist these medical discourses (Dewey 2008). For instance, trans patients provide external legitimacy to medical providers and trans medicine when they go to doctors for gender-affirming care; in doing so, they legitimize the current standards of treatment (Dewey 2008). In addition, however, trans patients share information about hormone use in ways that challenge medical authority (Dewey 2008). Trans patients have shared information online outside the medical establishment and network with others, making medical knowledge more accessible to others so that they can advocate for themselves when doctors are unknowledgeable (Dewey 2008). Trans patients, however, do want knowledgeable providers because forcing trans people to educate their providers puts the burden of health care on trans patients themselves (Wagner et al. 2016).

As demonstrated, because gender cannot be reduced to a binary and EBM standards for transgender health care are lacking, medical providers must navigate this uncertainty when providing care for their trans patients and trans patients play an active role in their healthcare encounters. This scenario provides the opportunity for a negotiation of medical expert versus non-expert, experience-based knowledge with relationship to transgender identity and experience. Of importance, scientists conduct boundary work to differentiate science from non-science perspectives whereby they can retain professional status and medical authority over others (Gieryn 1983). As Collins and Evans (2002) have described, on the one hand, a core set of

experts exists while on the other, experience-based experts also contribute to scientific decision-making. With the case of trans medicine, whose knowledge is incorporated into the medical protocols and whose perspectives about gender prevail are important for considering how medical doctors produce knowledge about trans populations.

Transgender medicine, then, is a site of gender production. As Dewey and Gesbeck (2016), explain, "Like the courts in Meadow's study, medicine and psychiatry fail to see ''gender solely as an elective property of individuals'' even while providers may espouse it at times (2010:823) and, in turn, work to *create, rather than merely respond to, what society deems as acceptably gendered and sexed bodies*"[12] (66-67, emphasis mine). Of importance, the difficulty that medical providers experience navigating medical uncertainty in trans medicine shows how EBM does not necessarily provide clear insights into how to care for patients (shuster 2016). EBM does not provide the easy answer for how to provide healthcare for trans patients because 'evidence' takes on the illusion of neutrality to help inform medical decision making (shuster 2016). In practice, complex categories, such as gender or sex, are simplified and standardized through clinical guidelines (shuster 2016; 2021).

Insight from scholarly work on the enactment of phenomena can help to capture the complexity of sex, gender, and sexuality in medical arenas. For instance, Mol's (2002) praxiography of atherosclerosis emphasizes how we *do disease*. From a Mol perspective, various meanings can coexist about a particular phenomenon because they are enacted in practice; in this sense, diseases are always situational. In this sort of framework, an object cannot be separated from its context and its meaning is derived from both the humans who read the charts but also the objects themselves, such as charts and the body parts, that are analyzed. Mol (2002) redefines

[12] Tey Meadow's (2010) research explores how legal systems conceptualized gender through examining the criteria by which court cases determined trans people's legal gender identity.

the word “is" here within her praxiographic analysis to demonstrate how forms of a disease emerge within different environments of the hospital. She argues, “[i]t [referring to atherosclerosis] doesn’t say what it is in and of itself, for nothing ever ‘is’ alone. *To be is to be related.* The new talk about what is done does not bracket the practicalities involved in enacting reality” (54). As Mol (2002) also states, “[i]f we no longer presume ‘disease’ to be a universal object hidden under the body’s skin but make the praxiographic shift to studying bodies and diseases while they are being enacted in daily hospital practices, multiplication follows” (83). In different areas of the medical center and across the patient visit, atherosclerosis is multiple things. It is a piece of artery to be examined under a microscope in the pathology department *and* it is the pain people experience while walking in the outpatient clinic. Here Mol invites us to think about disease as not a sole object. There is no single disease, therefore there is a multiplicity of ways that a disease can be enacted and that medical practitioners can diagnose a body.

Indeed, sex has been described as a multiply enacted and contested biological variable in biomedical research and has often been treated as a singular entity (Pape 2021). In an analysis of the U.S. National Institutes of Health’s policy mandating consideration of Sex as a Biological Variable (SABV) in preclinical research, Pape (2021) demonstrates that policy work aimed at defining sex as a unitary object showcases the various interests that different political groups have in sex-based research. On the one hand scientists aim to correct the “reproducibility crisis” in the pursuit of ‘good science’ whereas on the other, women scientists challenge gender bias and inequality in medicine (Pape 2021: 346). In attempting to define and implement sex variables, the ensuing SABV policy shows the multiple definitions of sex that structure research. As Pape (2021), describes “[sex] is simultaneously enacted as an assigned category, an active biological

force (or influence) in its own right, and an outcome (e.g., ‘sex differences’), constituting what [she] describe[s] as a looping ontological cycle of sex as category, effect, and cause (of itself)” (351-352). Rather than bringing clarity to single definition of sex, these various policy documents show the multiply enacted nature of the object.

Further, within the context of transgender health care, sex is a multiple object, taking on different definitions in different contexts, and yet becomes simplified to a unitary concept that forecloses trans livability (Latham 2017; Latham 2019). Latham (2017) interrogates the enactment of ‘transexuality’ in a gender clinic where surgeons provide gender affirming surgery. In this clinic, sex gets enacted as reported at birth, hormone levels, breast prominence, hair style, height, and feeling, among other enactments. Despite these various components of sex, surgeons sculpt a singular and linear narrative for transgender patients to access this care, one that aligns with a male/female binary, rather than a simply transgender narrative that transcends these categories (Latham 2017). As such, rather than viewing sex, gender, and LGBTQ health as able to be standardized and static, adopting a Mol (2002) framework can account for the ways that these categories can be complex and enacted differently (and possibly embody competing meanings) by various groups in the medical school.

When sex, gender, and sexuality are understood through a binary, static lens, particular gendered experiences are rendered invisible and unlivable (Butler 2004), and LGBTQ people suffer the consequences in medical arenas as well as other legal and social institutions (Spade 2006; Johnson 2015). Moreover, some scholars call for a binary sex categorization in medicine to be abandoned because it simplifies the known complexity of binary sex and pathologizes difference (Freeman and López 2018). As the complexity of sex, gender, and sexuality become better understood by medical scientists, questions remain about how medical doctors grapple

with these insights and incorporate them into their teaching to address health and health care disparities. These questions are especially relevant given that biology is often referenced to prove some underlying truth about gender. Feminist analyses critique this assumption and demonstrate that what we understand as biology is always already informed by our understandings of gender (Vidal 2012). As such this dissertation research seeks to understand how, if at all, medical faculty through their definitions of what counts as "LGBTQ health," (re)produce normative gender, sex, and sexuality ideologies in their teaching.

CHAPTER 3: ETHNOGRAPHY OF CURRICULUM

Previous research on LGBTQ health curricular initiatives focus on conducting the LGBTQ health intervention wherein the researchers explain the intervention in question and often collect feedback from health professional students in the form of surveys and writing reflections post-intervention to justify its effectiveness (Morris et al. 2019). This research complements existing assessments of medical student respondents' self-reports about increased comfort and knowledge about LGBTQ health by demonstrating how LGBTQ health is understood and implemented. With this in mind, this research departs from this previous literature in terms of aim and methodology. The purpose of this dissertation is not to evaluate LGBTQ health curricula. In contrast, this dissertation is exploratory in nature and utilizes qualitative ethnography, including participant observation, interviews, and archival research to provide an analysis of the interpersonal, organizational, and structural underpinnings of medical schools that support or act as barriers to such initiatives. As such the following research questions guide this study:

1) (How) do messages about LGBTQ health get delivered vis-à-vis the formal, informal, and hidden curricula? What messages about LGBTQ populations and sex, gender, and sexuality are learned alongside the science and best practices of LGBTQ health? In what ways can this impact how medical students understand and provide care for LGBTQ patients?;

2) How is *medical relevance* determined by medical professionals? Whose group interests determine what is deemed medically relevant to LGBTQ health? (How) does medical authority contribute to this determination? In what ways does medical expertise

compete with/contradict and/or merge with experience-based knowledge about LGBTQ health and identity? and;

3) Across various parts of the medical school (community outreach, lectures, practice-based learning, clinical rotations, administrative meetings, and health initiatives), how do LGBTQ health curricula come into existence? (How) do multiple meanings about LGBTQ health exist and what are the mechanisms by which they become a singular entity?

To respond to these questions, ethnographic methods allowed me to capture the quality of the information portrayed to students and the various institutional and interactional components of the medical school that influence the delivery of LGBTQ health curriculum.

Given the valid critiques of medicalization, it is important to highlight that in examining and supporting the inclusion of LGBTQ populations within a medical framework, this research contributes to the medicalization of these populations. In this process, however, I outline both the importance and limitations of current LGBTQ health curricular initiatives. Further, I suggest that future queer and transgender health curricular initiatives are needed to challenge heteronormativity and cisnormativity embedded in health care systems and to grapple with the interaction between gender identity and sexual orientation for all populations. This research seeks to identify strategies to simultaneously challenge and work within the medicalized system to connect patients with the quality health care they deserve. As outlined thus far, the stakes of LGBTQ heath care are great in that improving LGBTQ health care directly influences the health and well-being of these populations.

In line with ethnographic methods, then, I examined the everyday workings of medical curricula about LGBTQ health. With Institutional Review Board (IRB) approval from Virginia

Tech, I conducted a 10-month long ethnography of LGBTQ health curriculum at Southeastern University School of Medicine and the associated academic medical center which features an LGBTQ Health Center. Southeastern University incorporated LGBTQ health into its curriculum beginning in 2011 at the request of a queer medical student who found the LGBTQ health content lacking. This student collaborated with a medical school dean to incorporate sexual history taking lessons and gender affirming care for transgender youth into the curriculum and surveyed medical faculty about their ability to provide this instruction to their students. Over the past decade, the LGBTQ Health Center and actors within the medical school developed and implemented LGBTQ health initiatives and curricula on a diverse array of topics to serve the needs of LGBTQ patients. As such, the institution provides ample opportunity for examining the structural and social processes that enabled the implementation of LGBTQ health curricula and initiatives and the impact of these curricula and initiatives on medical faculty, administrators, and students.

While conducting my field research on Southeastern's campus, I paid attention to institutional and organizational practices related to LGBTQ health curricula and initiatives; the norms surrounding these curricula and health initiatives; administrator, LGBTQ Health Center employee, community member, medical faculty, and medical student understandings and experiences of the curriculum and health initiatives; and the functions and impact of the curricula and health initiatives (Bailey 2018). Through participant observation, interviews, and archival analysis of the LGBTQ Health Center initiatives and LGBTQ health curricula, I examined the birth and implementation of LGBTQ health curricula; the formal, hidden, informal curricula surrounding LGBTQ health; and various group perspectives on LGBTQ health on Southeastern's campus.

I focused on both the Southeastern School of Medicine and the Southeastern Medical Center, where the LGBTQ Health Center is located. The Southeastern School of Medicine and the Southeastern Medical Center were once the same entity but have split. Despite being two separate entities, they still have crossover, i.e., the LGBTQ Health Center leads presentations in medical classes, and is located in the same area of campus. Observing the Southeastern School of Medicine and the LGBTQ Health Center allowed me access to the formal, hidden, and informal curricula and cultural and clinical training in LGBTQ health in multiple arenas on campus. The LGBTQ Health Center not only provides educational training for medical faculty, medical students, and staff, but also addresses other core components: patient care, policies, community outreach, institutional climate, and visibility of the LGBTQ community. These core components allow me to explore how LGBTQ health is understood across campus and provide context for the curriculum found at the Southeastern School of Medicine.

Focusing on one medical campus allowed me to capture in-depth data about the day-to-day workings of medical curricula about LGBTQ health and to explore the relationships across campus that bring the curricula to life. LGBTQ health at Southeastern University, while not generalizable to other medical schools, has been informed by medical faculty who had major roles in developing guidelines around LGBTQ health. For instance, one of the students who helped start the LGBTQ health center, who is now a medical doctor, also supported national guidelines for implementing LGBTQ health curricula. Additionally, another medical dean involved in implementing LGBTQ health into Southeastern's curricula has also served in a leadership position in the American Medicine Association. These connections allow me to make broader statements about how medical authorities contribute to the cultural and clinical

competence related to LGBTQ health and how these key actors influence the implementation of LGBTQ health curriculum.

In the remaining portions of this chapter, I provide a fuller description of my research design, including a description of my ethnographic participant observations, interviews, and archival data and my data collection and analysis process, including an explanation of site entrée, the field site, participant recruitment, and analysis.

Research Design

Data from this research comes from three sources: participant observation of curricula and health initiatives; semi-structured interviews with medical faculty, students, administrators, LGBTQ Health Center employees, and LGBTQ community members; and archival documents about historical diversity and inclusion initiatives at the field site.

Ethnographic Participant Observation

From September 2019 until early March 2020, I conducted the following participant observations, interviews, and archival research in person. Following the Coronavirus pandemic shutdown in the U.S. in the early spring of 2020, the medical school and center closed in-person learning and pivoted to virtual learning and telehealth for non-essential healthcare. Because of this, my observations and interviews from March 2020 until July 2020 occurred online. The in-person data collection included participant observation of classes focusing on LGBTQ health, LGBTQ health initiatives on campus, and administrative and community member outreach meetings where the content of medical curriculum about LGBTQ health is developed and LGBTQ health on campus is discussed. Participant observation focused on activities and interactions across the university's campus in addition to inside the classroom to capture data about what LGBTQ health means across various dimensions of the medical school.

First, I attended the courses and clinical rotations that both feature and/or serve as a backdrop for LGBTQ health content across all 4 years of the medical curriculum. To understand the larger structure of the medical curriculum, I investigated the course curriculum on Southeastern University's website and set up meetings with medical school deans and curriculum leaders to glean the content in and reasoning behind the medical curriculum structure. Upon establishing whether the course included LGBTQ health I received permission from course instructors to observe how the medical faculty teach the content and how the medical students responded to the material in the classroom as well as outside the classroom during break times. I sought out standardized patient-interactions, clinical case studies, and online learning modules that are relevant to LGBTQ health. In particular, I observed sexual history taking of LGBTQ patients for first year students; a clinical case study on a gender dysphoria patient for first year students; health and healthcare disparities lecture and discussion for sexual health students; and a clinical rotation in the transgender health clinic.

To gain a wider sense of the context for this LGBTQ curriculum, I observed lectures in Obstetrics and Gynecology (Ob/Gyn) and neurology for second year students in their clinical rotations and lectures in a physical diagnosis course wherein students learn to examine patients' bodies and provide a diagnosis. I additionally attended the lecture portions of a longitudinal professional development course that occur over all four years of the medical curriculum. While I was unable to observe the small group discussions due to medical student privacy, these spaces were described as areas where students could talk about interpersonal problems without judgment amongst their peers. Lastly, I shadowed clerkship rotations wherein medical students provide care to patients under the guidance of medical faculty and attended grand rounds

lectures, large scale lectures that anyone in the medical center can attend, featuring both LGBTQ health and/or diversity and inclusion topics.

Second, to understand the larger context and structure of medical education, I attended LGBTQ Health Center meetings and initiatives on campus. Examples of these health initiatives include a Transgender Day of Remembrance event and LGBTQ advisory board meetings. The Southeastern Medical Center also houses a transgender health clinic, where patients receive gender-affirming care from a physician, and a transgender youth health clinic, which comprised a multidisciplinary team of doctors who met once a month to intake new transgender and nonbinary youth patients. I observed the workings of both of these clinics after making contact with the medical faculty who lead them.

Third, I attended the medical student social justice organization's meetings to understand the student context, initiative, and impetus in implementing social justice related content, which included LGBTQ health, in the curriculum. Medical students originally requested more information about LGBTQ health be available to students, leading to the creation of the LGBTQ Health Center. Since medical students historically demanded more LGBTQ health content, the perspectives of current students were an important area to examine to understand how well the medical school has responded and continues to respond to calls for more inclusion and diversity.

Lastly, I observed and met with people at my field site campus and at the medical center, spent time amongst the students and health care workers in shared communal spaces, and would hold informal conversations with people at my field site to get a better sense of the overall curriculum and medical center. In between meetings during my time on campus, I would find an empty table in the library—the lower level of the medical school—and be surrounded by medical students studying for their courses. I would take meetings with participants in the open study

rooms to learn more about the medical curriculum and where they saw LGBTQ health in it. Additionally, I would often meet with faculty, students, and patients in the cafeteria spaces of the hospitals over coffee so that they could learn more about my interest in LGBTQ health and in turn they could share their experiences and connect me with others who were doing LGBTQ health work at the institution. Conversations would focus on overall diversity and inclusion initiatives at Southeastern; an LGBTQ health curriculum mapping initiative; strategies for making the medical center more LGBTQ friendly; the origin and development of the transgender health clinics; and people's (non)involvement in these LGBTQ health initiatives. Working amongst these spaces not only allowed me the chance to establish rapport with participants but also allowed me the opportunity to further gather the tenor and pace of the medical school and center which serves as context for LGBTQ health initiatives.

Drawing on guidelines from Emerson, Fretz, and Shaw (2011) and Bailey (2018), I took detailed field notes of both formal and informal interactions with participants and my own personal reflections about conducting research to capture the formal, hidden, and informal curriculum about LGBTQ health. I focused on the course material medical faculty presented; questions students raised; conversations amongst students about the course content; the content LGBTQ Health Center employees presented about LGBTQ health in meetings and lectures; and the comments and questions LGBTQ community members raised about LGBTQ health initiatives at Southeastern. During and/or after every interaction and observation I took quick jottings and or recorded myself recalling details from the event. Following these initial jottings and recordings, I fleshed out these themes to full-length field notes, elaborating on small details and providing context for my observations.

Of importance, I conducted this research during the middle of a pandemic, which impacted the curriculum and health initiatives that I could observe. Because of the pandemic, I was effectively shut off from these spaces, due to rules from not only my IRB and the permission I had received from my field site, but purely from the nature of remote learning and being an outsider of the institution even though I had maintained physical access. For instance, the morning my field site went completely virtual, I was scheduled to observe medical students in the cadaver lab for the first time, and in March 2020, I had multiple observations planned at the transgender health clinic. Because of the pandemic, I lost access to these spaces and could not observe doctor-patient interactions in-person or virtually. This impacted what I could observe at my field site. LGBTQ health undoubtedly existed in other spaces that I did not access at this time.

The connections I had with medical administrators, faculty, students, and patients at my field site, however, gave me strategies and opportunities to pivot my observations and observe as much as I could in the now truncated time I had left in the field. For instance, medical faculty allowed me to observe the clinical case study for gender dysphoria in the first year, as well as all of the clinical case studies in the reproduction and endocrine curriculum. The medical school administrators gave me access to the online learning portal for this block as well so that I could access course materials. The medical students I had met shared their course documents with me and kept me in the loop about changes that were happening at the university due to COVID, such as a pandemic course medical educators planned for students. Additionally, a medical dean who originally helped me receive access to Southeastern, invited me to a virtual LGBTQ health discussion that medical students led.

I outline COVID-19's impact on my research to contextualize my findings. In some ways, COVID-19 limited what I could observe and therefore say about LGBTQ health at Southeastern. Despite these disruptions, I was able to conduct 6 months of in-person observations of LGBTQ health and the overall curriculum prior to COVID-19, and throughout this time I developed and maintained relationships with my participants that helped me navigate remote learning and maintain some kind of connection once Southeastern closed its physical doors. This field work, therefore, offers a snapshot of LGBTQ health during one moment in time—prior to and then amidst a pandemic.

Interviews

I conducted 46 semi-structured interviews with people involved in implementing LGBTQ health initiatives across campus and developing LGBTQ health curriculum, including 17 medical faculty, including one neurologist, three pediatric/adolescent health physicians, one anesthesiologist, two endocrinologists, one internal medicine physician, two family medicine physicians, one infectious disease physician, four OB/Gyn physicians; and two plastic surgeons; 10 medical students; 8 administrators; 4 LGBTQ Health Center employees; and 7 community members (see Table 1). Most of my participants (40) identified as white, with only 3 Black participants, 1 Indian American participant, 1 Asian participant, and 1 participant of South Asian ancestry. Over half of my sample identified as heterosexual and cisgender (31), with 15 participants identifying as part of the LGBTQ community. Of these 15, 13 participants identified as gay, lesbian, bisexual, or queer and 7 participants identifying under the umbrella of transgender or nonbinary. Five of these participants identified as both queer and transgender.

This research unintentionally oversampled white participants and therefore mirrors the white framing of queer and transgender rights frameworks more broadly. Even though gender

identity and sexual orientation have always been racialized, queerness has come to be understood as a white issue where queer and transgender people of color's experiences have been overshadowed (Howard et al. 2019; Logie and Rwigema 2014; Carter 2007; Harper and Jernewall 2004; Somerville 2000). For instance, white gay men's interests dominated LGBQ and emerging transgender rights frameworks in prioritizing marriage equality and anti-hate crime legislation, as opposed to dismantling the carceral state and its impact on people of color (Spade 2015). This prioritization of white LGBTQ patients' health seems to be especially the case in this research that examines the intersection of LGBTQ topics and academic medicine as academic medicine has also been historically white and has struggled to increase the representation of racial and ethnic minorities in the profession (Odei et al. 2021; Let et al. 2018; Merchant and Omary 2010). This intersection of queerness and academic medicine resulted in providing a limited sampling of participants of color in general as well as an even smaller number of queer and transgender participants of color.

As will soon be presented, LGBTQ health is dispersed across the medical center and school, in different offices, classrooms, buildings, and parts of the city. Because of this, I used snowball sampling to connect with the individuals who were involved in LGBTQ health, often being referred to me by others doing similar work. Additionally, participants responded to my recruitment survey to participate in an interview. In both of these cases, individuals self-selected into my research study and thereby self-identified as being involved in LGBTQ health initiatives. Participants form the medical center and school either taught about, learned about, and/or helped design and implement curricula and initiatives about LGBTQ health. LGBTQ community members involved in the study either served on an advisory board for the medical center or received care at Southeastern.

Interviews lasted anywhere from 30 minutes to over 2 hours long depending on the participants. In these interviews, I focused on how medical faculty and medical students understand sex, gender, and sexuality and LGBTQ health and its importance; the relationship between cultural and clinical competency; health and health care disparities for LGBTQ populations and the importance of diversity and inclusion in medical curriculum; and their opinions on the success of LGBTQ health curriculum in preparing future physicians for providing care for LGBTQ patients. In interviews with administrators, and LGBTQ Health Center employees, I focused on how these actors contribute to understandings of LGBTQ health across campus and their understanding of the purpose and utility of diversity and inclusion initiatives. Lastly, in interviews with community members, I focused on patients' experiences with LGBTQ health curriculum, LGBTQ health initiatives on campus and at the medical center, and health care experiences on the Southeastern campus.

Archival Data

Lastly, data for this study comes from archival analysis of documents outlining the history, implementation, and future revisions of the LGBTQ Health Center and LGBTQ health curriculum. These data allowed me to chart how sex, gender, and sexuality have been embedded in the LGBTQ health curriculum. Additionally, I accessed the Southeastern University Medical School Archives to examine documents about the history of diversity and inclusion initiatives at Southeastern related to race/ethnicity, gender, sexual orientation, and ability. These documents allowed me to analyze the context for how LGBTQ health gets incorporated into existing diversity and inclusion initiatives on-campus.

Data Collection and Analysis

I conducted my fieldwork at Southeastern School of Medicine and the Southeastern Medical Center from September 2019-July 2020. I spent over 100 hours over the course of 10 months developing relationships with medical faculty, students, administrators, LGBTQ Health Center employees, and LGBTQ patients to gain access to and learn about how Southeastern University both taught students how to provide care for LGBTQ patients and how the medical center facilitated quality health care for LGBTQ patients. In the following section, I outline how I gained access to my field site, a description of my field site, how I recruited participants, and my analytical framework.

Site Entrée

In the spring of 2019, I began contacting potential field sites for my dissertation. These medical schools featured LGBTQ health in some capacity, either offering LGBTQ health concentrations or featuring LGBTQ health centers. In my research, a mutual colleague suggested that I reach out to a contact, a physician, at my field site because this academic medical center conducted LGBTQ health initiatives and this contact facilitated many of the LGBTQ health initiatives at this academic medical center. As such, I started preparations for accessing the site in February 2019 by emailing him. This physician and I coordinated a pre-fieldwork visit where I would meet with him, sit in on an LGBTQ health lesson conducted by the LGBTQ Health Center at the medical school, and meet their colleagues at the center. This visit introduced me to central players at my field site—my contact (who I would find out later was leaving the site for another position); a coordinator for the LGBTQ Health Center; and a medical faculty member who is an adolescent health physician who provides care to LGBTQ youth and teaches the sexual health course for upper-level medical students.

Upon moving to my field site in the summer of 2019 and gaining IRB approval in the fall of 2019, these initial introductions served useful in my time at Southeastern as I asked to observe classes, clinic visits, and LGBTQ health initiatives. To identify classes that feature LGBTQ health and actors who work on LGBTQ health at Southeastern, I continued these and developed new relationships with participants at my field site through snowball methods. For instance, I scheduled meetings with the LGBTQ Health Center coordinator; medical school deans; and medical school curriculum leaders in charge of different sections of the curriculum to understand what events and curriculum I might be able to attend in the coming months and to get in contact with medical faculty, students, LGBTQ Health Center employees, and LGBTQ patients. Upon referral from my contacts at the field site, I identified key aspects of the curriculum and key actors who implement these curricula and initiatives.

Description of Field Site

Through these discussions and further research on the university website, I gleaned that undergraduate medical education as this site was broken down into 3 phases: pre-clinical coursework for first year students; clinical coursework for second year students; and a hybrid curriculum with clinical and classroom learning for third- and fourth-year students. The academic years for all medical students begin and end in the summer. For instance, courses first year medical students take include: a professionalization class; biological science courses that focus on topics such as homeostasis and reproduction, and the brain; and a diagnosis course. During their second year, medical students take clerkships in various disciplines: surgery, medicine, pediatrics, obstetrics-gynecology, neurology, and psychiatry and elective courses. Third- and fourth-year medical students' schedules are individualized where they attend multiple one-month courses electives. Throughout their entire tenure at Southeastern, students take

longitudinal courses on professional development and healthcare delivery systems. In sum, the curriculum features pre-clinical, clinical, and blended learning opportunities for medical students and features a variety of topics from the biological sciences and diagnosis to health care systems and professionalization.

Many of these courses take place in a few central hubs on campus—the library, and two neighboring medical center buildings with classrooms. In recent years, the medical school had moved into and become centralized in a newly renovated building on campus. The medical school building housed a library on the ground floor and the school of medicine classrooms and administrative offices on the upper levels. I familiarized myself with this space by walking the aisles of bookshelves, using the computers to print consent forms, sitting on sofas while I waited for meetings, and working at the tables in between my interviews and observations. This building is where I spent most of the down time during my field work as it was the heart of the medical school and a convenient location for sitting in on lectures and meeting with faculty and students.

While the medical school was mostly housed in the two educational buildings on the medical campus, the medical center was dispersed across a variety of buildings on the main campus as well as separate satellite locations. Southeastern also has multiple clinics dispersed across the city and surrounding towns. For instance, the main hospital, the children's hospital, and psychiatric hospital, were located on the main campus, while adolescent health was located at a separate medical center, the transgender health clinic was located off-site at a clinic in a strip mall, and the plastic surgery offices were located on both the main campus and in a neighboring town. The LGBTQ Health Center, while centrally housed in a building on the main campus that also featured classrooms, similarly existed across multiple sites. For instance, LGBTQ Health Center employees worked in an office space during some parts of the day, such as in the case of

answering the LGBTQ health hotline where they referred patients to LGBTQ-friendly doctors, but also conducted trainings and meetings on LGBTQ health initiatives at Southeastern across these different areas of the medical centers and neighboring town, sometimes being asked to provide lectures to neighboring health professional schools.

As such, the Southeastern Medical Center and within it the School of Medicine was scattered unevenly not only across Southeastern's campus in different buildings but also in the surrounding city and in various clinics and hospitals. Faculty, administrators, students, staff, and patients traversed these spaces, and depending on their roles, some might spend more time in certain spaces than others, but to a certain degree Southeastern was a fluid space across the city and surrounding area. To give an example of a possible trajectory, a medical student could go to class at the library on the main campus in the morning; meet with a faculty member in their office in another building across the street; then traverse, either by car or bus, to a clinic in a separate part of town to shadow and/or provide care for the remainder of the afternoon. I found myself following similar routines, where depending on who and where I was meeting, I would travel amongst these buildings and parts of town, sometimes all in one day, to complete my field work.

Additionally, the medical center archive, housed in the library, held records for the medical school. I accessed these archives to examine the presence of LGBTQ health in the historical record as well as the precedence set at this school by other diversity and inclusion initiatives. Because records created within the last 25 years are restricted, I received written permission from the dean of the medical school to review these records. I contacted the librarians who work with these collections, and they pulled curriculum records, departmental records, and

meeting minutes related LGBTQ health. I relayed that I was interested in the following broad themes

1. LGBTQ Health Curriculum and Health Initiatives at Southeastern University Medical School/Medical Center
2. Origin and Implementation of LGBTQ Health Center (unsure of the start date, possibly around 2010)
3. Diversity and Inclusion Initiatives (Related to race, gender, class, sexual orientation)
4. AAMC Accreditation related to Diversity and Inclusion

And I requested the following:

1. records of speeches and lectures
2. lecture notes
3. audio-visual materials and photographs
4. observational research data
5. reports of accreditation visits
6. department minutes, memos, reports, and syllabi

As such the librarians pulled curriculum documents for me but as one librarian explained, they had documents about "minorities in medical education from before 1994, although [he didn't] see anything specifically about LGBT issues" but that I was welcome to look (quotation from personal email correspondence). I made a few appointments to sit in the library and review stacks of documents. Because you cannot take the documents outside of this space, I took photographs and uploaded them to my computer. I reviewed AAMC accreditation files and curriculum meeting minutes.

Participant Recruitment

To be included in the study, medical faculty had to have: incorporated LGBTQ health in their curriculum; taught medical curriculum related to sex, gender, and sexuality; and/or served on a curriculum committee. Medical students had to have been currently or previously enrolled in courses that featured LGBTQ health. Interviewed administrators were those that had been involved in the development of LGBTQ health initiatives across the university, including

educational, research, and/or outreach. LGBTQ Health Center employees were currently or formerly employed by or affiliated with the office. Community members received health care or informational services from Southeastern Medical Center and/or served on the advisory board. To recruit participants in this research, I primarily used snowball sampling methods in addition to sharing my recruitment flyer via email and in-person spaces. For instance, for the former, the LGBTQ Health Center and my research sponsors at the institution, in acclimating me to LGBTQ health at Southeastern, served as resource to connect me to those on campus who worked on LGBTQ health initiatives. From here, I would be put in contact with others involved in LGBTQ health and my contact list snowballed. For the latter, I shared a recruitment flyer for my study to medical faculty and they shared it to their classes via email. Further I distributed my recruitment flyer around the medical center and campus, posting it on bulletin boards and hallways of these shared spaces. To compensate participants for their time, medical students and LGBTQ patients received a $25 Amazon gift card for their participation in this study. I limited gift card compensation to these groups because they are often either overburdened, underpaid, and/or marginalized.

Data Analysis

To understand how messages about LGBTQ health get embedded in the medical curriculum, I conducted qualitative content analyses of my field notes, interview transcripts, and archival work throughout the entire data collection process to pursue emerging themes in the data. Verbally taken field notes and interviews were transcribed via Otter, a computer-generated transcription service, and/or Rev, a paid transcription service. Upon receiving the transcriptions, I reviewed and edited them for clarity. All data was stored in a password protected computer and a locked office desk. I analyzed transcripts of field notes, interviews, and archival data

documents using Atlas.ti, a password protected coding software. I compiled a list of master codes focused on sex, gender, sexuality, LGBTQ health, diversity and inclusion, clinical and cultural competence, structural competency, and health and health care disparities. In line with grounded theory, I refined my codes as they emerged from the data, including focusing on LGBTQ health expertise, where LGBTQ health was located in the data, and who implemented this material (Charmaz 2014). I then organized my codes into themes and wrote memos throughout the coding process to guide my focused and axial coding.

CHAPTER 4: LGBTQ HEALTH AS EVERYWHERE AND NOWHERE

"How many people have had sexuality or gender identity concerns come up with their patients and/or families that were difficult to navigate?" An LGBTQ Health Center employee posed this question to several medical students in a sexual health elective course that I attended at my field site. On this particular day, representatives from the LGBTQ Health Center provided a guest lecture on LGBTQ health after coordinating with the faculty instructor, an adolescent and young adult health physician who also has "Adolescent LGBT Health" listed as an area of expertise on the academic medical center's website. This question opened the presentation, allowing medical students to draw on their personal experiences with LGBTQ health in their clinical rotations. The audience, myself amongst them, sat gathered around a table in a semicircle, while the LGBTQ Health Center employees stood in the front next to their slideshow presentation displayed on the wall. As I sat amidst the medical students, faculty instructor, and other LGBTQ Health Center employees in this small, intimate classroom, I could almost hear the wheels turning in the students' heads. *When had they encountered LGBTQ patients? What issues arose?*

After a few minutes of reflection, the lead LGBTQ Health Center employee asked for volunteers to share their experiences. A couple of hands raised, and one medical student explained that they had provided care for an adolescent patient who was a transgender man, but the parents misgendered him and used his deadname. While the medical team providing this patient's care used his correct name and pronouns, the parents expressed disapproval and frustration, rolling their eyes when the doctors said the transgender son's name and pronouns. In response, the faculty member, who I sat next to, validated this experience by commenting on how navigating unsupportive parents often happened when providing care in adolescent

medicine. Next a woman medical student, seated across from me, who I had talked with previously and knew to be a member of the LGBTQ community, shared a troubling experience she had while caring for a transgender woman on a clinical rotation. While she, along with the resident and the attending physician, used the correct pronouns, the medical staff who did not have access to the electronic medical record (EMR) with the updated pronouns, kept misgendering the patient. She asked about strategies to avoid misgendering the patient when medical assistants do not have access to the EMR. An LGBTQ Health Center employee suggested that they first ask the patient if the patient is open to everyone knowing their pronouns. If so, the medical team could post a sign on the door that directs anyone entering the patients' room to check in at the nurses' station to be told the patients' pronouns. Second, in the case that staff consistently misgender the patient, he suggested the medical student to "go up the chain of command" and enlist the attending to correct anyone who was misgendering the patient.

These two examples show two skills related to LGBTQ health—avoiding misgendering and physician advocacy—that focus primarily on the interpersonal aspects of providing care to LGBTQ patients. And yet, LGBTQ health also spans a variety of areas that relate to the course. For instance, as described in the syllabus, the course in question

> provide[s] students with a comprehensive understanding of the *anatomy, physiology, and psychiatric considerations of genital development, puberty, menstruation, sexual identity and function and reproduction.* At the completion of this course, students will have a knowledge base about *sexual and reproductive medicine* far exceeding that gained in clinical clerkships. Students should be able to *appropriately care* for patients at all stages of life in these areas. They should be able to evaluate for *disorder or dysfunction and develop an appropriate and sensitive plan for evaluation and treatment* (emphasis mine).

As will be demonstrated, LGBTQ health spans across these various areas, having connections to topics such as anatomy, physiology, and psychiatry, among others, and relates to many of the skills listed in the course description of providing appropriate care and evaluating dysfunction. I observed that LGBTQ health is a nebulous concept and takes a variety of forms scattered

throughout the curriculum, of which the above examples in the sexual health course are just two. Further, students often self-select into this work, again like in the above examples, by taking a sexual health elective course in their third and fourth years of medical school. As such, LGBTQ health is becoming a growing area of expertise, whether it is designed to be or not.

With the context that this field work occurred both prior and amidst a pandemic that limited my research access, these findings focus on where LGBTQ health became visible in the curriculum, where in some cases I was able to observe and in others, where my participants recalled teaching and learning about this topic. Based on these insights, in this chapter I provide the context for and demonstrate the boundaries of this growing specialization. First, I define the varying aspects of LGBTQ health as I observed them; second, I provide an overview of where it is enacted at the academic medical center and in its accompanying curriculum, and third, I outline how sex, gender, and sexuality become integral to this nebulous web surrounding LGBTQ health in ways that reinforce heteronormativity and cisnormativity. In doing so, I showcase the *blurriness* of LGBTQ health wherein it shows up in everything and nothing simultaneously and becomes adapted throughout the curriculum and in medical practice. To use the language of Murphy (2019) LGBTQ health can be "everywhere and nowhere" (p. 203), which I argue can have negative consequences for its goals of educating all physicians to be able to provide quality care to LGBTQ patients (Hollenbach, Eckstrand, and Dreger 2014).

Defining LGBTQ Health

As outlined in the introduction, the LGBTQ Health Center at my field site defines the acronym LGBTQ as "lesbian, gay, bisexual, transgender, and queer." A lecturer teaching about how to take a sexual history lesson from LGBTQ patients to first year medical students used a more expansive definition, "LGBTQIA," in her presentation. Here she stated, "Traditionally L is

for lesbian, G is for gay, B is for bisexual, Q is queer or questioning, T is for trans; I is for intersex; and A for asexual. Sometimes they say the A is for ally – but it's not. If you're an ally you don't get to be an acronym, that's a fact" [She and the room of medical students laughed]. Both definitions highlight LGBTQ as referring to groups of people—not necessarily allies—who identify as a part of a community based on their non-normative gender identity, sexual orientation, or sex assigned at birth. As such, one unifying definition for "LGBTQ health" adopts a population-based health perspective: "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (Kindig and Stoddart 2003: 380). As one medical student described, "it's important to think about how our patients' identities interact with their health needs, and for LGBTQ health I think that that is specifically thinking about someone's sexual orientation and gender identity and how that interacts with their health needs." Here LGBTQ health focuses on the intersection of health and identity, specifically how one's identity might influence their health and health needs. This medical student had described that in medical school they learn about a person's health needs, and so LGBTQ health simply adds the lens of LGBTQ people to this concept. Important to note in this definition is that while everyone has a sexual orientation and a gender identity, a point that gets outlined in the LGBTQ Health Center's presentations on LGBTQ health given to medical faculty, students, and employees across the university, here sexual orientation and gender identity get coded specifically as *non-normative* sexual orientations and gender identities, i.e., LGBTQ identities.

This point will be addressed further in this chapter, but here I want to further connect how LGBTQ health gets enacted as the health needs of LGBTQ populations. In the presentation that LGBTQ Health Center employees provide to the academic medical center, referenced above,

they also draw loose boundaries around LGBTQ health. Indeed, one of the more standardized definitions available at my field site focuses on the following:

> - Describ[ing] the health problems that occur more commonly in the LGBT population
> - Describ[ing] theories of the etiology of sexual orientation and gender identity.
> - Explor[ing] unique aspects of LGBT relationships and how these can affect both physical and mental health
> - Understand[ing] health treatment issues that are specific to the LGBT community.

Health problems, definitions of sexual orientation and gender identity, LGBTQ people's physical and mental health, and treatment issues all fall under the purview of LGBTQ health. As one medical faculty member, specializing in anesthesiology and heavily involved in leading the integration of LGBTQ into the academic medical center and school curriculum, succinctly described

> LGBTQ health is simply understanding and caring for patients in the LGBTQ community and their families, and it involves the growing recognition that there are unique needs of LGBTQ patients and their families that have often been overlooked and poorly understood. We know that as care recommendations are different as the sort of psychosocial profile may be different for how those patients interact with the healthcare system. There are opportunities to optimize outcomes—that really is the focus of this growing field.

In this definition, LGBTQ health not only refers to the health needs of LGBTQ people, but to family members additionally involved in their care and the impetus for care lies in their "psychosocial profile" and "interaction[ion] with the healthcare system." These definitions are broad and vague, allowing for a wide variety of health needs to be covered under the concept of LGBTQ health. Unearthing what specific health needs and skills relate to LGBTQ health required further questioning.

These diverse health needs become additionally apparent as I asked follow-up questions of my interview participants, asking that they provide examples of what LGBTQ health looks like. For instance, a plastics faculty member had described that LGBTQ health can look different from non-LGBTQ health. I probed, asking how LGBTQ health might look differently, and he described the following

> Number one is if we're looking, for example, like an example in the transgender community and you're talking about a very low socioeconomic community, a higher rate of some sexually transmitted diseases and things like that, so you have to factor those into it. So, you have to be accommodating to them from a socioeconomic standpoint. And also, more than that is, I think, to accommodate them in terms of making them feel comfortable in that space. I think, as a whole, the LGBTQ population is a population that's also undergone a lot of basically, have trauma recently to them, and abuse to them. And it's some simple things like the way you examine a transgender patient is very different than how you turn you examine a cisgendered patient. Patients are often, they have a lot of dysphoria towards parts of their body, and it can be very traumatic, the medical exam for them. So, a simple thing like examining a trans males' chest, that they haven't had surgery yet, they can have a lot of dysphoria and they can have a very negative experience. So, I think it's just it's different in terms of catering towards the population.

While on the one hand, high socioeconomic status patients seek out and secure gender affirming procedures, such as facial feminization surgeries (Plemons 2017), this medical faculty member also recognized that transgender health disparities often result from low socioeconomic status. Here, a diverse health need for transgender patients relates to multiple perceived factors—socioeconomic status, higher rates of sexually transmitted infections (STIs), historical and contemporary discrimination and abuse from the medical establishment, medical exams, and gender dysphoria—and thus requires an intersectional lens. This became apparent once my participants started untangling what LGBTQ health care looks like to them.

Another participant, a gay man who receives health care from Southeastern Medical Center provided an example from personal experience when asked about clarifying what health concerns relate to LGBTQ people. He stated, "I guess it's not shocking to me when they talk about anal issues and that kind of thing as a man.... I think that one thing that comes to mind is something I've run into several times is that I have a disease." Interpreting his LGBTQ identity as being viewed as a disease, he clarified that having doctors who are comfortable around LGBTQ patients improves LGBTQ patient health care. While the health needs of men who have sex with men might differ from transgender patients receiving a "culturally competent" physical exam, these both fall under the rubric of LGBTQ health because they relate to this diverse patient population, and they are aimed at improving the health care of these patients. These types

of examples become apparent once medical faculty, students, administrators, LGBTQ Health Center employees, and community members alike expand upon what skills are relevant for providing LGBTQ health care, why medical students and physicians should know about LGBTQ health care, and what physicians' roles are in alleviating LGBTQ health disparities.

Elsewhere, I have discussed how LGBTQ health expertise mirrors AAMC recommendations that unique health needs, cultural competency, and physician advocacy should be included under the rubric of LGBTQ health (Herling 2021; see also Eckstrand and Sciolla, 2014; Daniel and Butkus, 2015). Here I showcase examples of these various definitions that were thematic across my interview participants to demonstrate the multiplicity of LGBTQ health. First, as partly described by participants above, LGBTQ health gets enacted as a patient's unique health needs as a result of being a part of the LGBTQ community. These are, at times, explicitly connected to the health and health care disparities that LGBTQ communities experience. For instance, the adolescent and young adult health physician who led the sexual health course described the following about what medical students should learn about LGBTQ health:

> I guess I feel like it's important for students to know how to ask the questions to make sure that you don't offend somebody or box somebody out by making an assumption that they can't then undo they mean or misgender somebody and then scar that person and they never come back to the doctor. Um, understanding health disparities, right? So, like, why does it matter? Because we know that typically, LGBT folks have higher rates of mental illness, higher rates of substance use, not everybody but if you find out that somebody is not supported bullied or you know, then you're clearly going to be more careful and more attentive to checking in with that foundation. You know, so if you're getting bullied in school and I see you for a sore throat, I might ask you a few extra questions that I might not ask somebody else because I'm like, hey, how's school going? Are you going? Are you feeling, are you, you know, because I know that I should be perhaps a slightly more worried about you.

She connects LGBTQ health care to being aware of health disparities that leads to unique health needs for these populations. Further, in doing so, this physician is careful to avoid stereotyping the whole LGBTQ community as having higher rates of mental illness and substance abuse. Rather she compares it to an example of bullying—if you know that someone has a higher risk of

getting hurt, then you would adapt your health care encounter to make sure that you ask questions around and ultimately address this issue so that it is not missed.

Additionally, in her definition of understanding health risks, she draws on a second enactment of LGBTQ health, "culturally competent" medical care, aimed at improving communication and trust between the patient and provider. Here she stressed the importance of physicians not offending their patients by misgendering them or making assumptions about their health needs. This second theme of cultural competency becomes even more apparent in the following example. When asked about what competent care would look like for LGBTQ patients, a trans guy who receives care at Southeastern and who serves on the advisory board for the medical center states,

> I would say like keeping some gender neutral, do- are you married? Versus do you have a husband? You know, what are the gender identities or sex of the people that you sleep with or have relationships with? You know, what type of people do you live with in your household? Just keeping it—you're not putting a direct gender on things so that people can and allowing the space for people to self-identify. So not necessarily, you know, being like, okay, if you see me and my partner, most people would assume that we're a straight couple. But I'm a trans man, she's more or less a nonbinary person. And so, and we don't call either one of us -we're not, we don't call ourselves gay. So, we're like in a spectrum. So, it's just kind of like let people self-identify versus just thinking of you see my wife with me at an appointment, we must be straight because that's not necessarily what we want to be known as. So, I think it's just taken a lot of the assumptions out of it and making it more neutral.

Here he stresses that he appreciates when physicians use gender neutral language and questions that do not align with a sex, gender, and sexuality binaries. As he stated, he and his wife could appear to be a straight cisgender couple, when in actuality they are not. This sentiment was shared in the LGBTQ Health Center presentation where providers "can't make assumptions about patients. [They] need to be in conversation with them."

I use the language of cultural competency here because it serves as a catchall for the interpersonal skills physicians should utilize when providing care to LGBTQ patients. I do so because cultural competency dominates medical frameworks and remains a popular medical education tool for teaching about identity and difference, despite its criticisms (Sorensen et al.

2017; Jernigan et al. 2016). Interpersonal skills, such as improving communication between the physician and patient, become legible as cultural competency to improve doctor-patient communication and therefore improve patient outcomes (Brach and Fraserirector 2010). Indeed, if interviewees did not use the language of cultural competency at first when first asked to define LGBTQ health, they discussed skills such as respecting patients and avoiding making assumptions. Further in the interview, when I would ask about their opinions on the importance of cultural competency frameworks, most of my participants would say that what they had said earlier about communication and respect was relevant.

And yet, I recognize that cultural competency presumes that there is a cohesive LGBTQ "culture" to be learned. In contrast, I have shown that LGBTQ health is amorphous and not something that can be defined as a singular "LGBTQ culture" that can be mastered by non-LGBTQ and LGBTQ physicians and students alike. Moreover, LGBTQ Health Center employees recognized the diversity of LGBTQ health concerns and recommended that physicians always individualize their care to their patients and ask the patient about their gender identity and sexual orientation. And yet, cultural competency was underscored as a best practice for patient care. I continue to use this language within the dissertation and recognize that the cultural competency framework is fraught to show that cultural competency is itself an enactment of LGBTQ health. It is one to which I also contribute. As I will show, cultural competency does not necessarily capture an LGBTQ culture, nor does it ensure that physicians are 'competent' in LGBTQ health.

With these criticisms of cultural competency in mind, when physicians make heteronormative and cisnormative assumptions about their patients, LGBTQ communities (and their health needs) become invisible. One of the central tenets of LGBTQ health then, is to make

visible LGBTQ communities to physicians so that they can provide health care attuned to their health needs. For instance, as the quote from the youth and adolescent health physician above noted with her discussion of unique health needs, LGBTQ populations experience health disparities and risks at greater rates than other populations. If physicians do not know they have LGBTQ patients, then they cannot address their unique health needs. Further, if doctors do not ask about gender identity and sexual orientation in the clinical visit and otherwise assume they have heterosexual and cisgender patients, then heteronormativity and cisnormativity do not get disrupted and patients report feeling invisible (Baker and Beagan 2014). The construct of "LGBTQ health," then, facilitates the disruption of heteronormative and cisnormative assumptions about patients.

This emphasis on physician role segues into another enactment of LGBTQ health—physician advocacy on behalf of their patients. An upper-level administrator of the medical school who teaches a course aimed at physicians' understanding of their role in the health disparities of patients says that when teaching this topic, he stresses

> how can we better advocate for [patients].... It's really disheartening to think about whole groups of patients that are systematically disadvantaged because of something like that—And so as a clinician, I think that that is really important just for us to know. So that when there are opportunities for us to advocate when there are opportunities for us to find resources and address those issues that were able to do that.

Recognizing that physicians have power to influence their patients' health outside the clinical visit, some participants posit that physicians are uniquely situated to advocate on either personal or structural levels for their patients. This is apparent especially in adolescent medicine and in providing gender-affirming care to transgender youth. For instance, at the end of a pediatrics clerkship presentation on transgender youth health care, one medical faculty member includes the following template for providers to use when writing letters to schools for bathroom access corresponding to a students' gender:

> Please be advised that Tyler H. is a transgender person in my care. She is participating in a program of gender affirmation.
> As part of this process, Tyler is expected to live as a female at all times. I request that you provide her with your understanding and assistance. Should you require further information, please feel free to contact me.

Here a physician can use their medical status to affirm students' gender in school contexts that might otherwise misgender them and cause further harm. The level of physician advocacy fluctuated between participants, some stating that physicians could advocate on an interpersonal basis, as seen in the previous example, or at a structural basis, interfering at the level of state legislatures that aim to make transgender youth health care illegal. During the time of my field work, anti-LGBTQ legislation was on the rise, with bills proposed in multiple states to make transgender youth's access to gender affirming therapy illegal and physicians who provide this health care liable for child abuse (Lam 2020). In these cases, physicians from my field site overtly stated they would gladly testify that this health care is necessary for transgender youth and is not child abuse. Regardless of the level of advocacy, a link between LGBTQ health care and the social and cultural context of homophobia and transphobia existed for my participants.

These examples demonstrate that something as straightforward as LGBTQ health gets complicated once you start unpacking this content area. A first step at defining LGBTQ health requires defining who is LGBTQ. As demonstrated, different actors use different umbrella terms, but often it is used as shorthand for people with non-normative gender identities and sexual orientations as outlined above. Once limited to this purview, LGBTQ health then gets taken up as a population-based health that has biological, interpersonal, and structural considerations. But even these examples of LGBTQ health raise further questions: what health issues are covered under this rubric? When do these health issues apply? What should physicians know and as a consequence be able to provide for their LGBTQ patients? As demonstrated by my participants, the LGBTQ acronym and LGBTQ health by association is an umbrella term that includes a

variety of people whose gender identities and sexual orientations contradict heteronormativity and cisnormativity, and these people often have diverse health needs (Graham et al 2011). If not necessarily everyone in the LGBTQ community needs every single health care option covered under LGBTQ health, how do physicians go about providing care to "LGBTQ" people? LGBTQ health then necessitates a breaking down of categories and attention to intersectionality to understand where the health needs overlap and diverge. I have demonstrated here that LGBTQ health gets simplified into a broad, overarching view of health to include all of this complexity. In the remaining sections of this chapter, I outline the consequences of this definition for curriculum development and medical student learning. While on the one hand, this vague definition allows for the content to be integrated into various aspects of the curriculum, the broad nature of LGBTQ health allows it to simultaneously become a medical specialty that exists both everywhere and nowhere.

Locating LGBTQ Health

Informed by enactment theory, I set out to document the enactment of LGBTQ health and the practices that led to its perceived homogeneity. Due to a confluence of factors, including the COVID-19 pandemic, the sensitive nature of LGBTQ health, and HIPAA, what I describe in this chapter is what I was able to do given these constraints. I went looking for this topic in spaces where it would be enacted at least discursively. In doing so, I document the enactment of LGBTQ health by flagging where it shows up in the curriculum in these different spaces. After reviewing Southeastern's list of courses, it quickly became clear that LGBTQ health was not simply siloed into one course at my field site. As I soon realized, LGBTQ medical curricula and health initiatives lived throughout the curriculum and resulted in part from the labor of LGBTQ

health educators who worked to integrate this content. As such, I set out to investigate where this topic was enacted in the curriculum.

One infectious disease faculty member had started mapping LGBTQ health in the curriculum by running searches through their system and using keywords, and he described how even he had trouble with how to define LGBTQ health. When we met over coffee one day in the cafe at the academic medical center, he outlined his dilemma—many people teaching do not have an educational assessment background, and thus might not include LGBTQ health in their educational objectives. In explaining his search terms (i.e., “gender identity,” “LGBTQ,” among others but not “bias” as this could bring up all forms of bias) he mentioned that asking the question, “do you have sex with men, women, or both?” as might be found in a sexual history taking lesson does not count as LGBTQ health. Rather he referenced LGBTQ identity, risk factors, and health disparities as being salient to LGBTQ health. As demonstrated above, this fits with the broad nature of LGBTQ health at my field site as vague and tied to population health, but here also serves to show the difficulty in mapping this topic in the curriculum—if the topic is so broad, how does one go about mapping it? With some classes and lessons in mind from his search of the curriculum, I moved forward meeting with anyone who claimed to be knowledgeable about LGBTQ health (in any capacity) to get started.

During my time in the field, I met with over a hundred people who in some way had a relationship to LGBTQ health and thereby helped inform my exploration of LGBTQ health at this institution. These meetings ranged from physicians who provide healthcare to transgender patients to deans of the medical school involved in diversity and inclusion initiatives at large and medical students of all years who have made their way through the curriculum. Through formal interviews and informal conversations with medical faculty, students, administrators, curriculum

coordinators, LGBTQ Health Center employees, and community members, and observations of courses and clinical rotations, I sought to map out LGBTQ health enactment in the curriculum. Initial meetings with my field site contact, who was heavily involved in integrating LGBTQ health into the academic medical center and school, snowballed into further people to contact about LGBTQ health at Southeastern.

These meetings rarely led to just *one* person who was involved in LGBTQ health at the institution. While at times, some names repeated due to their roles at Southeastern, such as physicians who worked in the transgender health clinics, I was also referred to multiple people, indicating the sprawling reach of LGBTQ health. As I have discussed previously, I often heard the phrase "Oh you should talk to…" so and so, during my journey, where my networks of individuals involved in LGBTQ health saw themselves on the periphery of expertise on the topic while their colleagues viewed them as central (Herling 2021). Despite my participants retaining potential loose ties to LGBTQ health, I was able to map where in the curriculum topics about LGBTQ health was enacted due to their recommendations and my exploration and observations (see Table 1).[13]

LGBTQ health topics lived amongst multiple topics and disciplines and ranged in the depth they were covered by different instructors, indicating multiple enactments of LGBTQ health at this field site. For instance, in year 1, the professional development course includes LGBTQ populations amongst the list of marginalized groups that experience health care disparities, and the epidemiology unit references LGBTQ populations during a discussion about

[13] As stated in this chapter, I used snowball techniques to find LGBTQ health in the curriculum. As such, some aspects of LGBTQ health may have been discussed in places that I did not have access to or heard about and so this is not an exhaustive list but a starting point. In line with the thesis of my dissertation, I set out to explore what LGBTQ was and where it was located to start to map this expansive topic. In doing so, I realize that because LGBTQ health is broad, some topics could be missed.

STIs. Guest lectures on the mental health concerns related to gender identity and sexual orientation and LGBTQ sexual history taking are featured in the psychiatry unit and diagnosis course respectively. Here LGBTQ health gets enacted as a professional development milestone, risks of increased mental health illness, and sexual history taking. Lastly, students in the endocrine and reproduction block learned about gender dysphoria vis-a-vis a case-based learning educational activity. In developing the sexual history taking lesson and the gender dysphoria case specifically, medical faculty and students intended for these lessons to reach all students. As one medical student, involved in the planning and writing of the gender dysphoria case described

> I think if you have a case, the CBL [case-based learning], it sends a message that that topic, understanding that topic, is something that every physician needs to know. So, my thoughts were, literally almost no physicians today are trained on how to take care of a transgender patient. They will claim that they don't know how to do it, because they feel like they don't, you know, they don't understand, it's going to be complicated [they think].

Educators aimed this CBL at providing all students with a foundation of knowledge in transgender health because it was integrated into a core component of the curriculum and their grades, the CBLs. Further, this medical student outlines that with every physician learning this transgender health curriculum, fewer physicians could hide behind the excuse that they do not understand transgender health care.

Indeed, physicians' refusal to care for transgender patients, which transgender patients have reported experiencing and which therefore has negatively impacted their health, echoes physicians' homophobia in their resistance to treating some of the earliest cases of HIV infection and AIDS (Sherman and Ouelette 2000; Sherman and Ouelette 1999; Merril and Thornby 1998). Because I did not interview medical faculty and students who did *not* have expertise in LGBTQ health, this research cannot state that non-LGBTQ experts at Southeastern claimed this lack of knowledge as an excuse to then refuse care to LGBTQ patients. With this response from early HIV physicians and transgender patients' reports of refusal of care in mind, however, physicians

and students who refuse care to LGBTQ patients in this way could be euphemizing homophobia and transphobia. As such, unless students missed classes on these specific dates, it is safe to assume that all first-year medical students received instruction on LGBTQ health from a variety of disciplines, ranging from professional development and diagnosis to more science-focused courses of psychiatry, endocrine and reproduction, and epidemiology.

After the first year, LGBTQ health enactment in the curriculum decreases as the courses that feature this topic become mostly elective. In year 2, a youth and adolescent health physician, who specializes in LGBTQ health, provides a lecture on gender affirming care for transgender youth that all students attend. After this example, however, almost all opportunities for learning how to provide care to LGBTQ patients are student-driven or up to chance. For example, accompanying the guest lecture on LGBTQ health, students have the opportunity to listen to a transgender youth panel discussion about their experiences of health care. Medical students historically organize and facilitate this learning experience for their peers. Further, because physicians in both OB-GYN and pediatrics provide care to LGBTQ patients at Southeastern, students who rotate through particular clinics or alongside particular providers, such as physicians who work in the transgender health clinics, have the chance of providing care to LGBTQ patients while on these services.

In years 3 and 4, LGBTQ health enactments continue but remain elective and therefore student driven. The sexual health course, previously referenced, is an elective course that upper-level students can take where they receive a guest lecture on LGBTQ health cultural competency training from the LGBTQ Health Center. While this class does not focus solely on LGBTQ health, students have the opportunity to shadow physicians who provide primary care to transgender and nonbinary patients. Students can also shadow physicians who provide gender-

affirming surgery to transgender and nonbinary patients in a plastics clinical course and can opt into designing and conducting a research project on an LGBTQ health related topic during their mandatory research project spanning years 3 and 4.

Across all years of medical school, LGBTQ health is being enacted in different clinical and educational spaces, but students must seek these out. Students can shadow in different clinics providing care to LGBTQ patients, attend LGBTQ health grand rounds lectures, participate in LGBTQ health equity discussions, and attend LGBTQ Health Center lectures and community engagement events. For instance, students can contact and shadow physicians who provide primary care, gender-affirming surgery, and HIV care to LGBTQ patients in the transgender clinic, transgender youth clinic, the plastics gender clinic, pediatrics, and the HIV clinic. During my field work at Southeastern, multiple grand round lectures featured LGBTQ health, ranging from the ethics of gender affirming surgeries, to Differences in Sex Development (DSD) diagnoses. Further, medical students organized health equity discussions for their peers to learn about how physicians can intervene in health disparities for marginalized populations, one of which focused on LGBTQ health care. Lastly, LGBTQ Health Center events are often open to medical students, such as an LGBTQ Health symposium and Transgender Day of Remembrance, among others. During my time at Southeastern, when I attended clinics, grand rounds lectures, health equity discussions, and LGBTQ Health Center events, I often saw medical students, sometimes the same group, in attendance as well. Across many of these educational opportunities outlined above, most are elective and student-driven and range in activity type. For instance, students learned from didactics from physicians who provide care for LGBTQ patients, patient-led panels, LGBTQ Health Center lectures, case-based learning, shadowing in clinics, and research opportunities to learn about LGBTQ health.

Regardless of who initiated the curriculum, the logics of inclusion underlying these initiatives are almost competing. On the one hand, educators argue for adopting LGBTQ people into the medical frameworks that previously existed, while on the other hand, simultaneously questioning medicine's role in health care disparities. For instance, LGBTQ Health Center employees and guest lecturers alike at my field site describe LGBTQ health as "health like everybody else" and describe LGBTQ health care in non-threatening, potentially nondisruptive terms. As demonstrated in the examples above, LGBTQ health in some ways can simply be included in discussions that are already being taught, i.e., physician's roles in disrupting health disparities, or cultural competency training. These tactics can be beneficial when assuming an audience that is hostile and discriminatory and can serve to diffuse anti-LGBTQ sentiments and support the goal of integration. Despite this tactic of simply adding LGBTQ health care to medicine, some of my participants, an LGBTQ Health Center employee and a medical student, equally questioned medicine's role in LGBTQ health disparities, arguing that health care needs to be transformed to accommodate these populations. For instance, the LGBTQ Health Center highlights cultural competency training as an avenue for neutralizing hostile healthcare environments. Additionally, one medical student stated the following in response to a question about a medical school's role in addressing disparities

> So, I think it's really important, from a kind of humanistic perspective, to talk about the differences, because obviously, this population, among many others, especially minority populations have been disenfranchised, and have been treated poorly by the community at large, and by the healthcare community. So, it's important to know kind of the history behind what has happened and why some of these individuals may be, you know, may be wary of seeking medical attention. So, I think that's an important element of it, like the history behind it.

Here both examples indicate that simply adding and stirring LGBTQ health into the mix of an academic medical center is not sufficient to meet this population's health needs. Rather, a change in physician behavior, such as an avoiding making assumptions about patients' gender identities and sexual orientation is necessary. Further being aware of the marginalization that

these populations experience resulting from discriminatory health care environments and enacting structural changes to these same environments, such as changing the electronic health record to capture one's sex assigned at birth, gender identity, and sexual orientation, a change being led by the LGBTQ Health Center, is also necessary.

Along with the variety of LGBTQ health topics, educational activities, and logics of inclusion, I additionally learned that the goal of LGBTQ health curriculum at Southeastern was integration, and in tandem, that physicians need to be learning about this topic. At first glance then, these enactments of LGBTQ health across the institution meet the goals of not only the AAMC but also participants at my field site who led key roles in designing and delivering LGBTQ health curricula and stressed to their fellow physicians and students that they would need to be prepared to provide care for LGBTQ patients. For instance, when asked "where do you think LGBT health should be included in curriculum?", the anesthesiology medical faculty member who has led many LGBTQ initiatives at Southeastern explained the following:

> LGBTQ health should be infused and integrated throughout training programs, whether it's at the UME [undergraduate medical education] or the GME [graduate medical education] level. Because it applies and has relevance to so many different areas, whether it's physical diagnosis, basic embryology, endocrinology, pharmacology. There are so many different places where the broad topic of LGBT health is relevant. And so, I believe that from the educational design perspective, having content integration is important and probably the most effective way to teach these things rather than having it as standalone content. That being said, there probably are some aspects of LGBT health that require some standalone approach

When I inquired about what standalone topics might look like, he elaborated that he believes transgender standardized patients, where actors pretend to be transgender, are inappropriate, and the logistics of this activity might be more challenging. Here he described how LGBTQ health is related to topics that medical students already study—even beyond cultural competency training of avoiding making assumptions about patients—and that for them to best learn how to apply their skills to LGBTQ patient care, they should learn about them alongside their usual curriculum. As I describe in Chapter 5, how medical students learn to draw these connections

between what they are learning in the classroom to providing care to LGBTQ patients in their clinics highlights a discrepancy, but the goal of integration remains the same: connect LGBTQ health to the educational foundation rather than silo it from their medical careers. An unintended (or intended) consequence of this decision communicates that LGBTQ health is relevant to every physician's future.

Indeed, others describe the sheer numbers of LGBTQ patients in the U.S. and at Southeastern itself and how Southeastern physicians and medical students would interact with them during their time here as reasons for needing LGTBQ competent physicians. This insinuates they *need or should* be prepared to provide care for them. For instance, in delivering the sexual history taking lesson to first-year medical students, the instructor stated, "You will meet patients who are queer." and "You will also treat trans patients." She referenced a study indicating that 3% of youth identify as TGNC [trans and gender non-conforming] in Minnesota. She expanded "3% is a ton; if you think about how many people you are going to see in clinic – 20 a day" then you would see "a couple a week then. There are probably higher percentages in other places." This referencing the sheer number of LGBTQ populations in the U.S. and the likelihood that these patients would interact with Southeastern physicians was common in my fieldwork, drawn on by other medical faculty, students, and LGBTQ health center employees when discussing the importance of LGBTQ health.

Further, because Southeastern provided gender-affirming surgeries to transgender and nonbinary patients, the medical center was seeing an increase in transgender patients every day. I attended a grand rounds lecture featuring a panel of experts on the ethics of providing gender-affirming surgeries to transgender patients that discussed this topic. A plastic surgeon who specializes in this gender affirming surgery outlined the growing popularity of this care and the

need for physicians to be ready to be a part of the medical team to care for these patients. He showed a graph of Southeastern with numbers of clinic visits and operating rooms from previous years showing that the numbers are increasing. For the upcoming year, they were projecting 700 clinic visits and 150 operating rooms (almost doubling the previous year). Upon discussing the grand rounds with one of medical faculty members on the board afterwards, he and others coordinated the panel in response to backlash from other physicians about providing gender affirming surgeries to transgender patients. I had sat in a large, yet packed, lecture hall amongst the attendings, residents, medical students, and medical center employees that early Friday morning, and felt the tension in the air. As the panel of experts outlined that this type of care was *ethical* and *necessary*, one faculty member brusquely stated, "if you don't want to do this kind of work, don't work here – think about whether you want to work here – this is what we are, and this is what we do." Here the message was clear: you need to be prepared to provide population specific healthcare to LGBTQ patients.

As such, these enactments of LGBTQ health across the curriculum follow the rubric of preparing all physicians to be able to provide some kind of care to LGBTQ patients but as demonstrated, many of the educational opportunities listed above were elective and student driven. In the case of the transgender patient panels, shadowing opportunities in clinics that provide care for LGBTQ patients, LGBTQ health research projects, LGBTQ health equity discussions, students were at the forefront of these activities, planning and executing these educational opportunities in conjunction with supportive faculty. Even in the case of some of the mandatory LGBTQ curricula aimed at all students, such as the sexual history taking lesson and gender dysphoria case, medical students either initiated these conversations and/or were central to designing and implementing them. These goals of integration and providing all physicians

with a basis in LGBTQ health (in some form, given that I have outlined how broad this topic is) then are worthwhile first steps in achieving a goal of health equity for these populations. Indeed, LGBTQ health educators worked diligently over the past decade to improve sexual and gender minority health care and ensure that this topic was integrated and highlighted in the curriculum. The messages that surround these topics are also worthy of interrogation to examine what accompanies these teachings, particularly as they surround sex/gender/sexuality as combatting LGBTQ health disparities is intimately tied to rejecting sex/gender binaries and dismantling heteronormativity and cisnormativity (Murphy 2016).

Locating Sex, Gender, and Sexuality vis-a-vis LGBTQ Health

In pinpointing where LGBTQ health gets enacted in the curricula, I discovered that LGBTQ health spans a variety of subject areas and lives in curricula such as infectious disease, psychological distress, endocrine and reproduction, and professional development. Students can shadow clinicians who provide gender-affirming care or primary care and additionally conduct optional medical research projects about a range of topics. In addition to the expansive nature of LGBTQ demonstrated thus far in how broadly the term is defined and where it is located in the curriculum, there is a tendency for LGBTQ health, especially introductions to this topic, to live alongside the concepts of sex, gender, and sexuality. Of importance, I am not arguing that LGBTQ health is only *solely* located alongside sex, gender, sexuality. For instance, in a presentation in the OB-GYN clinical rotations on interpersonal violence, educators included transgender populations because of their increased risk of experiencing this violence without defining these topics. Indeed, I am not insinuating that every time someone discussed LGBTQ health with me at this institution that they immediately defined these terms. I, instead, draw attention to the ways that sex, gender, sexuality become legible alongside LGBTQ health in ways

that strengthen their connection to LGBTQ health but make invisible their relevance to normative gender and sexual orientations.

In what I refer to as 'LGBTQ 101' trainings, or introductory presentations aimed at audiences unfamiliar with LGBTQ health, the basic instruction related to LGBTQ health always defined sex, gender, and sexuality before moving on to discuss nuances of LGBTQ health care. At my field site, the LGBTQ cultural competency training delivered by the LGBTQ Health Center, the adolescent and young adult physician-led lecture on LGBTQ youth health care in the pediatrics clerkship, and the sexual history taking lesson in the diagnostics course all serve as introductions to LGBTQ health and to provide audiences with a basic understanding of the topic. In all of these presentations, defining sex, gender, and sexuality served as icebreakers to discuss non-normative gender identities and sexual orientations and were often introduced in the beginning of presentations. For instance, in the LGBTQ Health Center training in the sexual health class, the employees reviewed a terminology section and "some common language" by discussing the "ABCs of LGBTQI," which focused on, as one employee emphasized, cultural competency. The medical center employee noted that with this group of medical students, who had demonstrated that they have more than a basic level of LGBTQ health understanding, "might have a good grasp of things." Here the LGBTQ Health Center employees positioned the definitions for sex, gender, and sexuality as introductory.

As noted previously, the LGBTQ Health Center presents their slide deck to multiple offices on campus and additionally allows other LGBTQ health educators to adopt their slides when instructing on the topic. The youth and adolescent health physician who leads the pediatrics lecture on LGBTQ youth health care incorporated these slides in her presentation, including the slides focused on sex, gender, and sexual orientation. When defining sex, gender,

and sexuality in these presentations, educators provide definitions that encompass both cisgender and heterosexual identities alongside LGBTQ identities. For instance, as an overview of terminology, the youth and adolescent physician not only differentiates sexual orientation from gender identity, gender expression, and sex development but provides examples of each term (see Figure 1). Here straight gets defined as a sexual orientation alongside lesbian/gay, bisexual, queer, straight, pansexual, and asexual and cisgender gets defined as a gender identity alongside transgender, genderqueer, and nonbinary.

Further, the pediatrics presentation defined sex as "a medically assigned identity based on physical packaging – our chromosomes, hormones, and genitalia" and including "male, female, intersex"; gender identity as "our innate sense of being a man, woman, or something else; how the mind and heart regard the body. For transgender teens, their gender identity may differ from their sex assigned at birth" which included "woman, man, transwoman, transman, genderqueer"; and gender expression as "the ways in which we externally communicate our gender identity to others, such as through mannerisms, clothing, body language, roles, hairstyles, etc" and including "feminine, masculine, and androgynous." Lastly, the presentation included the following definition for sexual identity

> An enduring emotional, romantic, sexual, affectional, & relational attraction to other people. Often used synonymously with romantic identity, but these do not always align. Determined by the personally significant sexual or romantic attractions one has, and the way in which someone self-identifies.

Examples of sexual identity consisted of "lesbian, gay, bisexual, MSM, WSW, queer, asexual, pansexual, straight." These definitions clearly differentiate between sex—a medically defined aspect of one's identity comprised of multiple factors versus gender identity—a person's inner sense of who they are, versus sexual identity another self-defined part of one's identity focusing on their attraction and to others. Of importance, sex, gender, and sexuality are not specific to LGBTQ populations. As stated, non-LGBTQ people too have a sex assigned at birth, an inner

sense of who they are, and attractions to others. And yet, these terms get defined and made visible and relevant alongside providing care to LGBTQ patients. Here heterosexuality and cisgender identity function similarly to whiteness, where whiteness tends to function as a non-race (Rothernberg 2008; Dyer 2005; Applebaum 2003).

This theme of defining the terms persists in the sexual history taking lesson that utilizes the "Gender Unicorn" to define gender identity, gender expression, sex assigned at birth, physical attraction, and emotional attraction and replaces the "Genderbread Man" with more expansive sex, gender, and sexuality options (See Figure 2). The instructor situated an explanation of these terms within her larger discussion of the appropriate language to use when talking with LGBTQ patients and the discriminatory experiences that these patients have faced in health care all while answering students' questions about LGBTQ topics. In her use of the Gender Unicorn, she explained that "gender identity" meant "what your brain thinks you are" and went on to say, "my brain tells me that I identify as a woman. Other people might identify as other things – genderqueer, gender fluid, other gender categories." She outlined the other differences between the Gender Unicorn and the Genderbread man: "the gender unicorn has switched so that there are circles on the end" which means "you don't have to be on the spectrum, [you] can identify as anything." Again, here sex, gender, and sexuality were defined as inclusive for all gender identities and sexual orientations and yet, were still included in the LGBTQ health unit.

A final "LGBTQ 101" example is the gender dysphoria case-based learning (CBL) activity in the endocrine and reproduction first year curriculum. CBL activities represent a core component of the curriculum at Southeastern, allowing students to learn about topics through their own research and investigation, application of unit concepts to the case at hand, and

teamwork. As a course document explains, CBLs provide students the opportunity to "focus on conceptual understanding, rather than rote memorization." CBLs also represent an additional effort to simultaneously center patients in the medical school curriculum and give medical students a strategy for recalling the scientific information more easily. One mid-level administrator who leads the first-year curriculum discussed how the CBLs were

> trying to bring the patient in, more the idea of patient centered, in that the problem we always had is- we taught a lot of science… And if you didn't relate it to the patient, when the students saw those patients in the ward, they couldn't go backwards to retrieve their science nearly as easily. Now, if you're talking about oh, and this is why a patient with this disease shows these symptoms. Now, when they see that patient, they trigger back really quickly, especially with the case groups in the small groups we do. So, from that perspective, I think if they've had less science when they get to the word, they can retrieve it much more easily.

Patients and their vignettes additionally connect medical students to the scientific underpinnings of patient care. The gender dysphoria case became a way for transgender patients to be built into the curriculum and for medical students to learn about scientific basis of sex and the social understandings of gender.

The inclusion of gender dysphoria in the CBL additionally represents an intentional effort to include the topic in curriculum, as described previously by the medical student who helped plan the activity when she responded that all medical students would get exposure to transgender patients in their first year via the CBL. Southeastern curriculum coordinators built this sentiment into the facilitator's guide they provide each medical faculty member who leads each small group:

> An additional aim of this case is to introduce students to a population of patients that many physicians are currently unprepared to treat and care for and who experience significant social disparity. We hope that through this case, students will develop a *foundational competence* in issues related to transgender health. One of the main goals of this case is to produce 100+ more future physicians every year who are prepared to care for trans/LGBTQ+ patients, no matter what specialty they are in (emphasis mine)

As stated here, the learning objectives students investigate and research will provide them with a basis of what to know about for transgender health, and from a patient's perspective. This facilitator's guide additionally includes "Sex and Gender Terminology," including many of the

terms and definitions previously described as being central to LGBTQ 101 trainings (sex assigned at birth, gender identity, transgender, transgender woman, transgender man, nonbinary, cisgender, gender expression, sexual orientation, and differences in sex development). Medical faculty use the facilitator's guide as a roadmap for the small group discussion. While facilitators could interject in the medical students' discussion to define these terms (the facilitator's guide instructed facilitators to interject when students used outdated language, for example), it was not explicitly stated in the guide. Rather, these terms may have been included to ensure that every facilitator and medical students, if needed, understood the basic terms needed for the case.

Regardless, sex and gender became central concepts relevant to this transgender patient and to the science needed for students to complete the assignment and the case. For instance, vis-a-vis the learning objectives, students learned about hormone effects on the body, embryonic development of urogenital tracts, and epidemiology of U.S. transgender populations among others to make sense of the current standards of transgender health care. Further, transgender patients, themselves, become an avenue for students to learn about the science and social nature of sex and gender, respectively. For instance, one of the official learning objectives for the case was to "Compare and contrast Gender Identity vs. Gender expression." Here students were *required* to learn about gender in their medical school curriculum. Concepts about sex, gender, and gender expression became integral to the differential diagnosis vis-a-vis a gender dysphoria diagnosis. In the student write up, one group wrote their differential diagnosis as follows

> In summary, [the patient] is a 12-year-old boy who presents to the Pediatric Endocrinology clinic with a strong desire to be treated as the other gender.
>
> Gender dysphoria—meets the DSM-5 criteria including a marked incongruence between his expressed gender and his sex characteristics, strong desire to get rid of his secondary sex characteristics, and strong desire to be of the other gender.
>
> > A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
> > A strong desire to be rid of one's primary and/or secondary sex characteristics
> > A strong desire for the primary and/or secondary sex characteristics of the other gender

> A strong desire to be of the other gender
> A strong desire to be treated as the other gender
>
> Gender non-conformity—would be ruled out because [the patient] does not fit the definition of gender conformity, which is having behaviors/conditions that don't match society's gender expectations. [The patient] is experiencing discomfort or distress due to this discrepancy between his gender identity and assigned sex at birth.

To be able to establish a plan for how to care for this transgender patient, students must differentiate between the sex characteristics, gender identity, and gender expression of the transgender youth in addition to differentiating between dysphoria and non-conformity. Students must follow the logic of gender dysphoria and disentangle that sex refers to the body, gender refers to the mind, and expression refers to how the patient presents themselves to be able navigate this case. Otherwise, students would be unable to provide a care plan for the patient and fail the lesson.

In contrast, sex, gender and sexuality do not become a part of the diagnosis for cisgender patients. For instance, there is no case where a cisgender woman accesses birth control pills and sex, gender, and sexuality get defined vis-a-vis the case. A cisgender woman using birth control pills demonstrates the relevance of all these categories of experience for cisgender and transgender people alike and showcases the intersection of gender, bodies, and technology (Preciado 2013). Of importance, even with this attention to sex and gender in the curriculum for transgender patients, the sex/gender binary remains as the students in the above example conclude that the patient wants “to be treated as the other gender.” Given multiple factors, including the complex and social natures of both sex and gender, the critiques from trans scholars and activists against gender dysphoria, and the time limitations of curriculum, the CBL provides a brief (and limited analysis) of sex and gender to medical students.

Sex, gender, and sexuality become seen as integral to understanding LGBTQ health in ways that highlight LGBTQ populations while also making invisible, and normalizing that

cisgender and heterosexual have gender identities and sexual orientations as well. Indeed, as one medical student, already quoted above stated, "for *LGBTQ health* I think that that is *specifically thinking about someone's sexual orientation and gender identity and how that interacts with their health needs*" (emphasis mine). While everyone has a gender identity and sexual orientation, these concepts become highlighted vis-a-vis LGBTQ populations. Further, during the endocrine and reproduction block, it was not until the gender dysphoria case that defining the terminology of sex, gender, and sexuality became relevant to the learning objectives and differential diagnosis for a case. Topics discussed in these units included pregnancy, contraception, STIs, and the female and male reproductive tract, which are all lived as sex, gender, and sexuality (Preciado 2013). While the impetus at my field site to include LGBTQ patients in the curriculum stemmed from their exclusion from the sexual history lessons, now this lesson almost exclusively focuses on LGBTQ patients. In these examples, sex, gender, and sexuality become marked as relevant to LGBTQ populations and their health needs.

This dissertation set out to learn about sex and gender and sexuality vis a vis LGBTQ health. Indeed, LGBTQ health makes sex/gender/sexuality visible in classroom and clinical spaces. While LGBTQ health does not exclusively reside next to sex/gender/sexuality in the curriculum, in my fieldwork it became clear that sex, gender, and sexuality often lived alongside LGBTQ health and sex, gender, and sexuality become legible in relationship to LGBTQ health. It is true that sex, gender, and sexuality exist in medicine outside LGBTQ patients (i.e., people fill out their paperwork and share their sex and/or gender depending on the medical system and in OB-GYN, they discuss their sexual history whether it is queer or not) but these concepts get *defined* when talking about LGBTQ patients and when the binary gets disrupted. I note that *when* people decide to define these terms is important because certain bodies get marked as 'other'

while others remain normative and thereby reify binary understandings of sex/gender and sexuality. Indeed, sex, gender, and sexuality seem to “stick” to LGBTQ populations in ways that do not happen for cisgender and heterosexual people, like what Ahmed describes as happening for diversity, equity, inclusion (DEI) initiatives and people of color (2012: 62).

Rather than a more disruptive understanding of bodies where how we connect sex, gender, and sexuality to biology gets challenged, nonnormative bodies get positioned against a normative standard. For instance, gender is embedded in reproductive care in the case of labeling women’s health as a catchall phrase for reproductive health care associated with female sexed bodies. And yet, not even all cisgender women retain (or are born with) their reproductive body parts, but cisgender women’s reproductive health care often gets defined as such until proven otherwise as dysfunction, i.e., infertility, hysterectomy (Center for Disease Control and Prevention 2020; National Library of Medicine 2018.). Under this rubric of explaining sex, gender, and sexuality in relationship to LGBTQ people, the fact that not all bodies align within a sex/gender binary and indeed that many bodies do transgress a normatively sex/gendered body becomes invisible. This is important for LGBTQ populations because overall normative ideologies about how bodies are sexed/gendered does not get challenged. As a result, LGBTQ populations instead become ‘othered’ rather than understanding bodies as “shades of difference” (Fausto-Sterling 2000:2). A more disruptive understanding of sex, gender, and sexuality would challenge assumptions based on how identity interacts with lived experience and the body to provide care that is attuned to any differences. Here normativity gets disrupted when LGBTQ patients enter the curriculum and clinical encounter but rather than challenging a sex/gender based medical system, these bodies become marked as different from the norm.

LGBTQ Health as Everywhere and Nowhere

As discussed previously, COVID-19 impacted my ability to observe LGBTQ health in the curriculum and in addition to the cases outlined in this chapter, LGBTQ health undoubtedly occurred elsewhere beyond the walls of Southeastern and virtually through remote learning and tele-health visits. Therefore, further enactments of LGBTQ health may exist. With this in mind, this chapter focuses on what became visible during my time in the field. Further because this research oversamples white participants, it cannot speak to the experiences of queer and transgender physicians and students of color or queer and transgender patients of color. Due to the intersection of the whiteness that populates LGBTQ rights frameworks and of academic medicine itself, this chapter describes LGBTQ health as mostly enacted from a white perspective (Spade 2015; Odei et al. 2021; Let et al. 2018; Merchant and Omary 2010). There are dimensions and therefore further enactments of 'LGBTQ health' that might exist if there was a greater diversity of people involved. Because this sample is mostly white, this is not present in this dissertation.

From the research outlined thus far, LGBTQ health has been established as a multiple object and it refers to the unique health needs of LGBTQ populations, the culturally competent skill sets providers should adopt when providing care for these patients, and a level of advocacy that physicians should engage in to help these patients navigate heteronormativity and cisnormativity embedded in health care systems and beyond (Herling 2021). These skills become relevant in multiple enactments of LGBTQ health in the curriculum—psychiatry, diagnosis, endocrine and reproduction, primary care, and infectious disease as featured at Southeastern. Further, given the recommendations of my participants and the AAMC, LGBTQ health in some form is relevant to every physician's practice of medicine, and therefore would be relevant to any

specialty in medicine, not just the ones where it was featured in my fieldwork. LGBTQ health, in its multiplicity, becomes sprawling and potentially relevant whenever and wherever a medical educator wants to highlight the health care needs of LGBTQ patients.

I argue that because LGBTQ health is so expansive, allowing it to be enacted in many healthcare situations and medical curricula, it becomes nebulous and is at times difficult to pinpoint. In fact, one infectious disease specialist, who provides care to transgender patients, responded to the question: "In your opinion, what is LGBTQ health?" with "I guess, gosh I've never been asked to define that before. I guess it would be providing health care to folks who identify as LGBTQ." Another OB-GYN infertility specialist replied "Well, I mean, it's kind of hard to put into words I think, I think of it as a very broad definition." An LGBTQ Health Center employee responded similarly, "Gosh, I haven't really defined it in the past. But it's certainly a concerted effort to provide copious education and tools and to engage in research that brings the medical industrial complex to parity for sexual gender minorities, who have long undergone bias and discrimination in healthcare settings." He proceeded to connect LGBTQ health to population-based health focus and discrimination in his definition. And yet at first, people who either provide or facilitate health care to LGBTQ patients get thrown off by this question. Something as seemingly straightforward and obvious as "LGBTQ health" becomes nebulous as you ask what is this *thing*? And how does it come to *exist*?

The consequence of this broad nature of LGBTQ health is that it can get dispersed and enacted across different areas of the medical school and have many different people involved, as highlighted by the 46 interview participants and many others I encountered in my field work. I argue that when LGBTQ health becomes broad and nebulous, it becomes difficult to see and therefore exist unless it is explicitly named as such, which is done in many of the examples

named above but could potentially be taken for granted. Indeed, the dangers of *too much* integration in medical curriculum are that students and faculty do not realize that they are learning a topic without specific attention being drawn to it (O'Donnell 2014.) O'Donnell (2014) described, "by embedding educational initiatives within larger curricular settings, but without the labels, we unknowingly had created an invisible curriculum...the topics had become unintentionally invisible (18-19)." In this case, ethics curriculum was integrated into the curriculum without being titled "ethics," and therefore, unfortunately, students did not realize they were in fact being taught ethics. The integration of LGBTQ health across the medical school similarly raises these concerns and risks reifying heteronormativity and cisnormativity if LGBTQ health is unmarked. Here LGBTQ health becomes the avenue for disrupting assumptions that physicians have about sex, gender, and sexuality, even though such disruptions could also benefit all patients.

Indeed, LGBTQ health at Southeastern became "everywhere and nowhere" similar to Murphy's (2019) analysis of sex education (p. 203). At Southeastern, sex and gender and sexuality are "everywhere and nowhere" too (Murphy 2019), meaning they are normalized, and heterosexual, cisgender, and LGBTQ people alike receive care related to their gender identities and sexual orientations, i.e., OB-GYN related care, STI screenings, among others, and share their identities while completing Southeastern paperwork. Despite this, at Southeastern sex, gender, and sexuality are additionally *made* relevant in relationship to LGBTQ health when medical educators highlight and define them in LGBTQ health trainings and not others related to heterosexual and cisgender health care. Indeed, these terms become relevant in relationship to LGBTQ populations because these populations disrupt and deviate from heteronormativity and

cisnormativity. Meanwhile, sex, gender, and sexuality do not get defined alongside cisgender and heterosexual people's sexed/gendered body parts as they do not challenge these normativities.

And yet, all patients have a sex assigned at birth, a gender, and a sexual orientation that impacts their health. For instance, a person assigned the sex of female and the gender of woman at birth who identifies as a woman as an adult, who receives a hysterectomy, is a patient whose health needs diverge from the normative woman assigned female at birth. I use this example not to detract from LGBTQ health by any means. Instead, I draw attention to the ways that we continue to categorize people's health into a sex/gender binary of female/woman and male/man, with assumptions about what body parts and health needs they experience, without critical reflection that bodies change and transgress these boundaries all the time. And yet, this binary system persists in medicine. Here we only connect sex, gender, and sexuality to particular bodies in ways that reify heteronormativity and cisnormativity by assuming these concepts are only relevant to LGBTQ patients. Because of this, a queer perspective on health—one that prioritizes conversations of intersecting power inequalities that inform health care and how physicians and providers contribute to these—allows us to think about bodies and identities in more complex ways. Indeed, embracing queer health as an alternative can help us prioritize the intersection of LGBTQ health with other aspects of identity—race/ethnicity, ability, and socioeconomic status—and center the health needs of queer and transgender people of color.

Positioning sex, gender, and sexuality next to LGBTQ health in the curriculum raises concern given the history of pathologization and eugenicist research on the etiology of queerness. For instance, medical institutions have long pathologized LGBTQ identities, and movements to remove homosexuality and transgender identity from the DSM attempt to sever this connection (Tosh 2016; Drescher 2008). Conversion therapy for both queer and transgender

stemmed from disapproval of queerness and transness and a desire to correct these deviations from the norm (Graham 2018). Further, medical scientists actively search for the ‘origin’ of queerness and transness as deviations and thereby assume heterosexuality and cisgender to be natural and normal. Searching for the biological basis for queerness stems from a eugenicist research agenda aimed at preventing people of color and ‘sexual inverts’ from reproducing (Ryan 2019; Stein 2015). Much scientific literature still searches for the biological basis of sexuality and gender identity (Ganna et al. 2019; Ngun and Vilain 2014; Garcia-Falgueras and Swaab 2008). While ‘born this way’ arguments can be used to gain legal protections, they have (and could be used again) to bolster eugenics arguments against queer and transgender lives, rather than in support of them (Sheldon et al. 2007). While the LGBTQ initiatives at Southeastern state that all people have sexes, genders, and sexualities, this history of pathologization serves as context for LGBTQ health curricula everywhere and must be highlighted when discussing how medical physicians of the future learn about these populations.

With regards to placement in the curriculum, even though LGBTQ health was integrated across different topics and years of medical school training, many of these opportunities remained elective. While integrating and funding LGBTQ health curriculum and initiatives conveys that the academic medical center cares about this initiative, this elective curriculum shows how a medical school can both fund LGBTQ health opportunities but simultaneously remain apolitical. I propose elective curriculum as related to and yet a deviation from hidden curriculum. Here the institution supports this work but also acts almost laissez-faire, leaving it up to students to choose to opt into this curriculum.

Ultimately, because LGBTQ health is not just one “thing,” and it requires multiple ‘experts’ embodying different skills and working in different disciplines working together to

provide care for these patients, physicians and medical students must also learn how to navigate when LGBTQ health becomes relevant to their day-to-day realities. It is an emerging specialty that is everywhere and nowhere and oftentimes requires expertise from more than one person. As such, LGBTQ health is an area of population health with a variety of unique health needs related to health and health care disparities, interpersonal skill sets, and physician advocacy aspects, and the onus can be on those physicians to figure out how it is relevant to them and their overlapping specialties of expertise. Here didactics and discussion-based training can only do so much to teach physicians about LGBTQ health. The following chapter focuses on how LGBTQ health—a newly established (nebulous) medical specialty, intended for everyone—gets navigated by physicians and students in the health care encounter. Students and physicians learn how to provide care to LGBTQ patients and therefore adopt LGBTQ health expertise through trial and error when providing care to these patients.

CHAPTER 5: THE DEVELOPMENT OF LGBTQ HEALTH EXPERTISE

When asked if medical students should learn about diversity and inclusion in medical curricula, a medical faculty member at my field site responded with the following:

> I think that everybody in the universe encounters people who are different from them every day of their life. And I think that the more that we can equip students to be able to not make a big deal about those differences but also make a big deal when it needs to be made a big deal when someone, you know, when someone can't afford their medication, or you know, when someone is homeless and they need a follow up appointment or when someone can't get married to their partner and whatever, I think that those, those sort of unique issues facing, again, patients but anybody in the universe, I think it's important for students to understand the challenges that their patients will inevitably have, whether that's insurance status or housing status or marital status or sexual orientation or what have you.

This medical faculty member highlights being able to communicate with patients across aspects of patient-provider difference that are tied to identity, a central feature of cultural competency frameworks, as necessary for patient care (Betancourt et al. 2005). Medical professionals have made a concerted effort to introduce cultural competency frameworks into common-based practice, suggesting that doctors must be aware of and communicate appropriately with their patients of different backgrounds and life experiences to be able to provide them quality care (Betancourt et al. 2005). It should come as no surprise that after nearly 50 years, this kind of framework has made its way into physicians' thinking as an appropriate treatment plan around identity, especially as it relates to differences between provider and patient populations (DeAngelis 2015).

Indeed, this medical faculty outlines that patients will have unique issues and these could be based on a multitude of factors—socioeconomic status, homelessness, insurance status, marital status, and/or sexual orientation—that physicians must understand. Of importance, he outlined the importance of medical students knowing to both *attend* to and *not attend* to differences in patient care stemming from identity in their interactions with patients when he refers to knowing when to 'make a big deal' about 'difference.' Embedded in his response is that

medical students need to elevate identity, with an assumption of difference, to a certain level of importance when it impacts the care that physicians will be able to provide. These assumptions of difference are political and posit the provider as either belonging to the dominant group and/or as receiving an education that focuses on white, able-bodied, cisgender, male, and heterosexual as the norm and people or color, feminine, disabled, and queer as difference. Indeed, cultural competency frameworks focus on the patient's 'culture' as different from that of biomedicine culture and thereby normalize and assume medical providers are white, able-bodied, cisgender, masculine, and heterosexual (Fox 2005; Beagan 2018). Furthermore, in medical care and thereby in medical education, white, able-bodied, cisgender, masculine, and heterosexual patients are assumed to be the norm (Nolen 2020; Barral Morán 2010; Epstein 2008). 'Difference' then gets coded as marginalized patients' health needs.

From this logic, special attention should be given to marginalized populations' health needs *because* the curriculum focuses on white, able-bodied, cisgender, male, and heterosexual patients, and therefore, students, regardless of their identity, may or may not know how identity informs healthcare from this instruction. For instance, it cannot be expected that students of color or queer and transgender medical students know *all* about how marginalized racial/ethnic identities, gender identities, or sexual orientations affect patients' care and how this might differ from white, cisgender, and heterosexual patient care because they receive the same instruction as their white, cisgender, and heterosexual peers. There is a case, however, that marginalized doctors know more about how identity can impact patient care stemming from their personal experiences. For instance, physicians of color and LGBTQ physicians can know more about how identity informs health care, and this can benefit patient care as in the case of the impact of racial concordance on doctor-patient communication and queer medical students serving to informally

educate their peers about LGBTQ health (Murphy 2019; LaVeist and Nuru-Jeter 2002). This raises an important question for medical education—how do you teach students when 'difference,' or the identity of the patient, are important for the health care encounter, especially when tied to systems of inequality and privilege? How do students navigate knowing when 'difference' should not be "a big deal" or when it is essential to being able to provide quality care for their patients?

The answer from this faculty member shows that this is not an easy answer for him, if not for his students too. This faculty member, who is white and gay, went on to explain that he was a part of a discussion amongst other faculty about the importance of recognizing differences in medical treatment for Black patients and when to highlight a patient's race in the presentation of the patient on rounds. For instance, he recalled, when do you say "Mr. Jones, a 55-year-old man…. or Mr. Jones, a 55-year-old African American man….?" Here the faculty agreed that because the ideal blood pressure medications for white people and people or color differed, highlighting someone's race was important for medical care. After giving this example, however, he stated he could not think of other examples of when to ignore difference and did not have any examples for when LGBTQ health was important in his area of neurology. He explained, as a neurologist, he did not see a lot of health concerns that interact with LGBTQ health except for a small percentage of hormone replacement cases, which in his experience was usually for women in their 70s, even though these women are sexed and gendered as well, and not LGBTQ patients. He could list other areas that he imagined LGBTQ health would be important—OB-GYN, urology, plastic surgery, primary care, endocrinology—but these were not his specialties, and he again did not know any specific examples of how LGBTQ health intersects with these disciplines. For instance, he mentioned how he could not imagine colonoscopies would be

different. I highlight his response because it lays the groundwork for showing how the multiplicity of LGBTQ health gets taken up differently in different specialties.

Knowing that identity—again as tied to 'difference'—in medicine *is* and *is not* important serves as a backdrop for learning about LGBTQ health. How might students understand so-called difference as it relates to LGBTQ health? The multiplicity of LGBTQ health serves to further complicate this question for students. As an area of population health, LGBTQ health spans multiple disciplinary backgrounds and can even require a multidisciplinary approach to medicine in the case of medical care teams for transgender patients seeking gender affirming care. Because the multiplicity of LGBTQ health gets taken up differently in different specialties, medical schools need to pay attention to this complexity. Here a one-size-fits-all model, where everyone learns a baseline of LGBTQ health cultural competency frameworks, will have its challenges in alleviating health care disparities if students cannot tell when LGBTQ health is relevant to their future medical practice. Students may or may not know when LGBTQ health is relevant to them, especially as LGBTQ health becomes its own sort of specialty.

In this chapter, I first outline how LGBTQ health gets enacted as a type of specialty health issue and area of expertise. I then show how LGBTQ health becomes established at Southeastern by following the trajectory of previous diversity, equity, and inclusion (DEI) initiatives aimed at alleviating health disparities for marginalized populations. Through this DEI framework, LGBTQ patients have a place to contribute to LGBTQ health expertise through their own patient experiences, but these are often in ways that bolster medical expertise. Lastly, I explain how students start to navigate a tension surrounding when LGBTQ 'difference' is or is not important to providing health care when learning to become LGBTQ health experts. Here medical students seek out experts and role models, and/or conduct outside research on their own

to understand when LGBTQ health is medically relevant and important to their health care encounters, and yet some still do not know how to navigate this tension. I argue that role models are a start to helping students navigate these challenges but that again, the nebulous area of LGBTQ health expertise—which straddles the domains of increased health risks, being culturally competent, acting as a patient advocate, and LGBTQ patients' own forms of expertise—is difficult to standardize.

LGBTQ Health as an Emerging Specialty

Alongside the core integration of LGBTQ health into Southeastern's medical curriculum, the topic gets enacted as a specialty that people opt into and have varying levels of knowledge and expertise in depending on their disciplines. Recalling the nebulous definition established in Chapter 4, where LGBTQ health refers to the health needs and experiences of LGBTQ populations which spans a variety of risks and skills that students should understand and be competent in, this topic remains cohesive as medical students compare it to other health issues and skills they have learned thus far in medical school. Because LGBTQ health is learned alongside other health issues in the medical school curriculum, LGBTQ health fundamentally becomes an object to be learned and gets treated as such by students. Here I discuss LGBTQ health as a burgeoning area of expertise—one that crosses disciplines to provide whole patient care, including primary care, infectious disease, OB-GYN, and psychology—and fundamentally is becoming learned as a cohesive object. Recalling the medical faculty member from Chapter 4 who stated that LGBTQ health is a "growing field," I argue that LGBTQ health is becoming an emerging specialty because of its comparison to other health specialties, health issues and associated medical treatments as topics.

For example, as discussed in Chapter 4, Southeastern medical faculty and students purposefully included gender dysphoria case-based-learning (CBL) in the first-year curriculum so that all students would have exposure to gender affirming care. Because of this placement in the curriculum alongside other critical areas of health that medical students should learn about, LGBTQ health is positioned alongside other health topics that should be learned. For instance, in explaining the CBL assignments, the medical student who helped lead the gender dysphoria case explained the following:

> And the cases are based, are all around a patient. So, we have a case on like heart failure. You have a case on diabetes. You have a case on like, sickle cell. And they're basically some of the most common, like, problems, I guess medical problems that all doctors should be really, should really understand. And students use this patient case, which is all about like from the patient's very first presentation to the physician. And then like, their work up, their physical exam, their labs, their treatment, the complications, their return visit, like etc, etc, etc. And they're supposed to learn about the disease through the lens of an actual patient. And remember that disease by that patient story.

Heart failure, diabetes, sickle cell anemia, and now gender dysphoria are not only health issues that medical students should be aware of and understand from a patient perspective but the placement of LGBTQ health in this part of the curriculum signifies that it is like these other health issues. Just like how all medical students should learn about heart failure, they all should also learn about LGBTQ health because it accompanies a variety of knowledge and skills that must be learned to provide quality care to patients.

This comparison to other health issues persisted in other student responses. For instance, another student compared diabetes to LGBTQ health because both health issues require physicians to understand the social needs of their patients. As she said, “I think it's important for physicians to read the whole context of a patient when they're treating them because that will allow the doctor to tailor the treatment to the patient.” In her comparison to diabetes, she outlined how socioeconomic status and education impact how well someone can manage their diabetes. She signaled to larger barriers outside of the patient’s control, such as the price of a McDonald’s

burger versus a bell pepper and which constitutes a full meal, that influence a patient's diet. Attending to the whole context of the patient and tailoring a treatment plan based on social aspects of care would allow for the patient to get the most benefit out of their care. Through this comparison, LGBTQ health is another area of health where physicians can apply whole patient care and social determinants of health frameworks to their patients. Again, the comparison to these other health issues positions it as a growing field where students can learn knowledge and skills to be applied to these patients. Further, when asked about what would facilitate her learning on LGBTQ health, she compared LGBTQ patients to geriatric and gynecologic patients when she highlighted how students learn via simulations for these patients to understand their different health needs. As she said, "I think it would be nice to have a simulation with a patient with LGBT health needs just to be able to put those skills in practice before we see real patients." Similar to other patients, LGBTQ patients can require different medical care (at times, which will be discussed further in this Chapter), that require students to learn about and even practice to be able to provide that care to real patients.

Indeed, physicians gain certain skills when working with particular patient groups, LGBTQ included. Another medical student highlighted how physicians learn to navigate medical care systems to help their patients access the care that they need. When asked about what specialists would have an in-depth understanding of LGBTQ patients and who would be able to provide care for LGBTQ patients, he responded with the following:

> By being able to deal with more of those patients, they're able to be focused on their problems a little bit better. So, I think like in my mind, these, how I frame a lot of those, it's still very consistent with like, if you have patients with cystic fibrosis, you want a medical provider that sees a lot of cystic fibrosis patients, so they know like, it's hard to get Medicaid to pay for this equipment, try this equipment.

He explained that certain specialists who work with LGBTQ patients—like how it works in medicine with cystic fibrosis patients—would be able to focus their time better and therefore

provide better care for these patients. He raises the point that certain physicians understand how to navigate medical systems, as in the case of which equipment Medicaid would pay for, to be able to provide quality care for their patients. Not only do these examples fall under the definition of LGBTQ health—as relating to different unique health needs and physician advocacy—but they also still require specific knowledge and skills to be learned that certain physicians have, and others may not despite LGBTQ health being integrated into the curriculum.

Another medical student's example further supports this argument that LGBTQ health is a burgeoning specialty—in fact, his response insinuates it already is a specialized area of medicine. This student, who was heavily involved in LGBTQ health initiatives at Southeastern, compared transgender health to cystic fibrosis during the LGBTQ health training lesson in the sexual health course. For instance, he talked about how even though he has an interest in and believes LGBTQ health is important, he was afraid to say to attending physicians that he was interested in transgender health because he did not want to be 'pigeonholed' into transgender healthcare work. He believed that transgender health should be treated similarly to cystic fibrosis, where students who communicated interest in the topic were not pigeonholed by attendings. Here he implied that transgender healthcare has already been established as a medical specialty and wished that it would be viewed as a topic of interest that physicians devote their time to.

I highlight these examples to demonstrate that LGBTQ health is a burgeoning area, still being established and the boundaries around it are still in flux. With this transition comes different examples of what it should become in medical practice. On the one hand, LGBTQ health has become a specialty, where if medical students express interest in it, they will be pigeonholed, whereas on the other, LGBTQ health at least requires a certain level of expertise

where physicians can learn through experience to provide quality care to their patients. In both examples, LGBTQ health is an object to be learned, the depths of which are still changing, and becomes a medical specialty to opt into. When physicians can opt to include 'LGBTQ health' in their areas of expertise, as is the case on the Southeastern website, this signifies that these physicians specialize in this area like specializing in cardiology. As these medical students' examples highlight, this specialization shows up in the curriculum when LGBTQ health becomes an area of expertise to be learned and relevant to their future careers as physicians providing this care to patients. Despite this cohesion as a medical specialty for LGBTQ populations, LGBTQ health remains a nebulous concept, requiring students to navigate which aspects of this health area are relevant to their delivery of care. In the following section, I outline how this emerging specialty came to exist in the academic medical center and how medical students learn when LGBTQ health is medically relevant to their patients.

Institutional Context for LGBTQ Health Expertise

Alongside the medical profession's impetus to include LGBTQ health in the medical curriculum to alleviate health care disparities for LGBTQ populations, LGBTQ patients *want* to have LGBTQ competent physicians. As participants in my study noted, LGBTQ patients seek out physicians who will be knowledgeable and nonjudgmental about LGBTQ health, just as members of other minoritized groups do when they can (Sanchez, Sanchez, and Danoff 2009; Noonan et al. 2018). Given that patients want LGBTQ experts, how do health care systems, including medical education, shift to accommodate LGBTQ patient populations? I show that the LGBTQ health integration follows the logic of integration outlined in Chapter 4 where the goal of LGBTQ health initiatives is to adapt what is already at the medical center to make it workable for LGBTQ populations given the dire need to provide quality LGBTQ health care. In reality,

integration is a complicated process because LGBTQ health involves a variety of specialties. As a result, LGBTQ health experts—physicians, medical students, and medical center employees—from a variety of disciplines navigate structural barriers to provide care to LGBTQ patients. To navigate these difficulties, LGBTQ health remains in the hands of those currently deemed 'LGBTQ health experts,' a status determined with some patient input, so that they can provide quality care to patients and follow the logic of previous Southeastern DEI initiatives.

Previous DEI initiatives at Southeastern provide the institutional context for the development of LGBTQ health initiatives. For instance, the Liaison Committee on Medical Education (LCME) provides accreditation to U.S. medical colleges and originates from a joint effort from the AAMC and American Medical Association (AMA) to monitor U.S. medical education (Kassebaum 1992). The LCME includes a list of areas where medical schools self-report their own performance metrics. The list covers and evaluates medical schools on a broad range of topics, including the medical school's mission and goals, academic learning environments, faculty preparation, educational infrastructure, curricular design, and curricular content. Under this latter section, medical schools must teach about the biomedical, behavioral, and social sciences; the organ systems and human life cycle; the scientific method; problem-solving skills; societal problems, cultural competence and health care disparities; medical ethics; communication skills; and interprofessional collaborative skills.

When I set out to locate LGBTQ health in the curriculum, one of my mentors mentioned that it was an accreditation year for the LCME at Southeastern. This meant that the school would be implementing or documenting their initiatives and curriculum that met the LCME requirements. She suggested there might be some developments related to LGBTQ health as Southeastern prepared for accreditation. Other medical faculty and administrators conveyed

similar sentiments, but upon connecting with the survey site coordinator, she disclosed that the LCME did not include any LGBTQ health-focused competencies. Despite this, medical schools provide their own documentation to demonstrate how their curriculum meets accreditation's standards. She and other medical faculty explained that under the LCME accreditation, LGBTQ health could be included under the "Cultural Competence and Health Care Disparities" section. This section outlines the following:

> The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction regarding the following:
>
> - The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments
> - The basic principles of culturally competent health care
> - Recognition of the impact of disparities in health care on medically underserved populations and potential solutions to eliminate health care disparities
> - The knowledge, skills, and core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society

The survey site coordinator explicitly drew attention to how this section cites "gender and cultural biases" and highlighted that this could relate to LGBTQ health. Indeed, as outlined in Chapter 4, Southeastern did include LGBTQ health alongside other health care disparities, such as in the first-year professional development class. In an interview with one of the upper-level administrators who led these class discussions on health disparities, she explained the language of health disparities or health systems science already existed in this course, and that medical faculty included LGBTQ health alongside these other disparities. She described the process as follows:

> At that point, [we] introduced sessions on health disparities and a couple of different races. And LGBT health was, you know, again, that group LGBT was one of the, you know, underserved or, you know, group suffering from disparities. And so that was, I don't think we went into a lot of depth, but we did want to make sure that the students received that information

She went on to explain that this curriculum was important for students to be able to see themselves of larger systems issues, including policies and offices—that impact patients' health

care. This disparities curriculum already existed and because LGBTQ populations experience similar disparities, LGBTQ health could be included, even if briefly.

Alongside changes in the curriculum, the academic medical center additionally adapted to include the LGBTQ Health Center. The LGBTQ Health Center also exists in relationship to the Southeastern DEI office and organization, whose mission is to alleviate health disparities for marginalized populations. The DEI institutional presence at the institution—such as the DEI office, events, committees, and portions of the Southeastern budget devoted to DEI work—serve as a resource that LGBTQ health educators and administrators draw on to address LGBTQ health disparities in their work. For instance, while funding for the LGBTQ Health Center comes from a variety of sources, when the LGBTQ Health Center experienced unexpected budget problems, the director contacted the Chief Diversity Officer at the medical center, who also served as the Senior Associate Dean for Diversity Affairs at the medical school, for help. This physician, who had worked at Southeastern for over 30 years and worked heavily in leading the DEI work, transferred the money into their budget so that they could stay afloat.

Upon realizing that the LGBTQ health center operated under a limited amount of funds, he communicated that he would advocate on their behalf in budget negotiations. The LGBTQ Health Center survived through its connection to DEI work at the university medical center. Indeed, this same Chief Diversity Officer, in an interview outlining the history of DEI work at Southeastern, grouped the erasure of LGBTQ scientists and clinicians alongside Black people and women who have been made invisible at the institution. He described the importance of valuing people's work and transforming the vision of who is or is not a clinician or scientist at the institution. One of these early initiatives was to incorporate more portraits of people other than white men in the medical center and school buildings. Indeed, during my time at

Southeastern, portraits of physicians, who were not just white men, hung in classroom buildings and hallways.

The “Southeastern Diversity Timeline” represents another avenue for highlighting diversity at the academic medical center. The Office for Diversity Affairs sponsors this timeline, and it takes up residence alongside a corridor that leads to classrooms in one of the Southeastern medical school buildings that receives a lot of foot traffic. A staircase next to the timeline leads to the ground level where the medical school central building, a hospital cafe, and the main medical center are all within a short walk nearby. I passed this timeline several times throughout my fieldwork, stopping to read the different portions of the timeline as I made my way to grand rounds lectures and to attend medical school didactics. The sign that accompanies the timeline describes it as “an organic creation…. created almost entirely by word-of-mouth” and instructs passersby that “If [they] see someone missing in the timeline that should be present, please fill out the card in the folder...and [the office] will research to see if they can be posted.” The timeline begins in 1904 and documents the first people of color, women, and LGBTQ people to hold positions of power at Southeastern and those who started organizations for marginalized communities at the university and medical center through the year 2018. The timeline featured over 50 DEI milestones at Southeastern, of which the creation of the LGBTQ Health Center joins this legacy.

While the original impetus to integrate LGBTQ health topics into the curriculum began with a medical student objection to the lack of LGBTQ health content at Southeastern, the development of an LGBTQ health center and the focus on health disparities in the LCME accreditation follows the logic of previous institutional DEI work. Here, making space at Southeastern for marginalized communities to hold positions of power and advocate against

health disparities becomes another enactment of LGBTQ health. Not all physicians, however, believe that health disparities and corresponding social aspects of health fall under their expertise, as evidenced by an op-ed written by a professor of medicine from the Perelman School of Medicine at University of Pennsylvania (Goldfarb 2019). An upper-level administrator at Southeastern explicitly referenced this article and the backlash it received from the medical community in her interview with me while discussing the importance of including social justice in the curriculum. She noted how social health needs become politicized as something outside of medicine's purview and that some physicians believe they "should just stay out of it and focus on, you know, the things we do, like take care of disease." This tension of what medical students should know was also reflected at my field site in an interview with another medical school administrator who surveyed Southeastern medical students about their opinions on medical education including social issues in the curriculum. Based on the Southeastern data, she relayed the following:

> Most of the students who come here, and I think most students who go into medicine have a more kind of social orientation to what healthcare medicine is. And they think that it's a more collective kind of enterprise and we're trying to bring up the health population or in this project together, etc. There's a small group of people, and it's relatively consistent, I'm gonna say, I gotta look back at it, but like 10 to 15% of the students who just don't think that they don't think that medicine is a group project. They don't think that healthcare is a collective sport…. They want to learn how to fix people's brains when they come in … want to spend the next 20 years of their life just digging down that very small technical question.

These administrators highlight a changing tide in the medical curriculum, one where social aspects of medicine have a place, but medical faculty and students still must *choose* to take on health disparities as a part of their purview. Ultimately, it is up to the individual physician to label social aspects of health within their expertise, which a growing number of Southeastern students were in fact doing.

Even with a concerted effort to include social aspects of medicine in the curriculum at Southeastern, medical students self-selected into social justice topics by creating a social justice

club and hosting their own events, some related to LGBTQ health as outlined in Chapter 4. Under these conditions, *some* LGBTQ health advocates at Southeastern recognize the impact of healthcare systems on patient disparities and actively work to mitigate these. As a result, some LGBTQ advocates take ownership over LGBTQ patients to provide them quality health care. For instance, one of the services the LGBTQ Health Center offers is patient referral, either via phone or email. The LGBTQ Health Center updates and maintains a private list of LGBTQ-friendly providers to connect LGBTQ patients to vetted LGBTQ physicians at Southeastern. An LGBTQ Health Center employee explained that this vetted list, in addition to saving time and energy, allowed him to send patients to the same providers to keep those patients "*safe*." As he described, he saw it as his job to help patients safely navigate Southeastern's medical center. A queer medical student also took on this role of protecting LGBTQ patients when she was on rounds in the clinics. She described that "when you're LGBTQ, you take ownership of a patient. Basically, you want to protect that patient or any type of situation where you feel like the patient is going to be negatively affected, you will go to bat for that patient." Here she described that protection meant trying to interfere in homophobic or transphobic interactions, and a tactic could be to politely ask questions to the medical team about the correct pronouns a patient uses.

While physicians, students, and LGBTQ Health Center employees leverage their own medical expertise and institutional power to provide quality care to LGBTQ patients, these groups also highlighted the importance of a lay community perspective to LGBTQ health (Epstein 1996). Within this institutional context of learning how to provide patient care from an expert provider perspective, community perspectives have an important place and often take the form of patient panels or advisory boards. The involvement of the community's perspectives represents more enactments of LGBTQ health, such as when LGBTQ youth patients speak to

medical students in the pediatrics curriculum, a mother of a transgender patient speaks to first-year medical students in the neurology curriculum, and the LGBTQ Health Center holds a LGBTQ advisory board comprised of 10-12 members who offer feedback on LGBTQ health initiatives at Southeastern. The intent behind the advisory board is to discuss community impact and provide guidance for LGBTQ Health Center procedures, clinical services, policies, and community outreach.

In this scope, patients have a place. And yet, physicians with experience providing care to LGBTQ patients get deferred to when providing care to LGBTQ patients. Indeed, medical faculty and curriculum coordinators rely on LGBTQ health-affiliated providers to lead LGBTQ health guest lectures. LGBTQ-identified or LGBTQ-serving physicians deliver the LGBTQ health guest lectures in pediatrics, grand rounds lectures, and have students shadow them as they provide care to LGBTQ patients. In the LGBTQ health 101 training in the diagnosis course, one student asked the instructor about the maturity level of minors and their ability to choose gender affirming surgery. In response, the instructor deferred to transgender youth clinics who provide this kind of care. She said that they would be better able to answer 'those types' of questions. Upon talking with a first-year medical student after this lecture, she relayed to me that students wanted more instruction from physicians who are providing this kind of care to patients. Here wanting exposure from physicians and patients alike makes sense as students may have different questions for different groups and may hope to gain different kinds of information from both.

Even with these insertions of LGBTQ community perspectives into the curriculum and at the medical center, questions about how community expertise disrupts or maintains medical expertise remain (Epstein 1996). For instance, at the close of an advisory board meeting, members stated they wanted an increased role at the medical center which created space for a

discussion about the role of the advisory board at Southeastern. Members spoke about advising more policies at the medical center and the ability to serve as LGBTQ health liaisons. This role would allow them to access and share resources with LGBTQ community members in their towns. One transgender woman stated they should "*actively*" be influencing policy. The decision to increase members' roles on the board and expand their responsibilities was not settled at this meeting and was not settled during my field work, but in closing the meeting, this same transgender woman brought up the sentiment that nobody would listen to her because she was not a physician and physicians just want to listen to physicians. In her interview, I followed up about this comment and LGBTQ community members' role with the advisory board and at Southeastern medical center. She explained:

> And it was [an LGBTQ Health Center employee] talking about the board and what they would be doing and that sort of stuff. And one of the things he made very clear was the board will not be involved in setting policy. And he was specifically referring to actual patient care and all that sort of stuff. And I mean, I'm in almost constant contact with [a previous LGBTQ Health Center employee] And I was telling [him] about it when all this was going on. I sent him a text saying... they don't really want our involvement in the operation of the gender clinic and stuff. He emailed me back, he said, and what's the point in having an advisory board?

The advisory board's role might be to provide feedback on clinical policies and services, but what form that feedback takes and how much weight that feedback has to influence any of the Southeastern's policies was up for debate. Domains such as policies for patient care at a gender clinic where the intent is to serve transgender and nonbinary patients were out of the community's scope of expertise from this physician's perspective outlined in her response.

Another transgender woman, who does not serve on the advisory board for the medical center but does attend grand rounds public lectures, voiced similar concerns about community members' place in discussions about LGBTQ health care at Southeastern. She and I both attended the grand rounds lecture on the ethics of providing gender affirming care to transgender patients, and she had asked a question about gender affirming care expansion during the

discussion portion of the event. She prefaced her question by disclosing that she is a transgender patient at Southeastern and claimed the right to be a part of this space. In a follow up interview to this event, she explained her reasons for attending these events:

> I'm there because this affects me personally and it's something that I can very well attend. It was like a Grand Round sort of thing and I went to it and when it came to the question and answer section, after hearing a lot of these questions, I was able to have my question answered and I basically said a lot of what I've said to you, saying that you don't understand that there are people in this room who you are talking about and that it could very well be the difference between life and death, the ability of care and the amount of discrimination that you have against it.

She referred to a conversation taking place about “conscience clauses" that allow physicians to withhold treatment to patients based on religious or personal beliefs. While the panel of speakers criticized these clauses, no one on the panel was a patient. She purposefully attended and spoke to the room about the severe impact these types of clauses can have on transgender and nonbinary patients to infuse community perspectives into the discussion.

Medical students interviewed for this study supported this sentiment of infusing community perspectives into the medical curriculum. One queer medical student recommended the following for LGBTQ health curriculum development:

> So, when you talk about, let's say health disparities, it's great to cover the literature on what those are. I've mentioned previously that I think you need to talk about the structural systemic stuff that contributes to that. I think it then makes sense to bring in folks or have folks from the community to help you develop that talk, to weigh in on the way that you are talking about them. And say, "Here's a nuance that maybe you're missing. Here is something that I need my provider to understand." *Literature is valuable, but it's not good enough. Necessary, but not sufficient.* So have your students actually talk to queer people and when you're producing educational materials involve queer people in the process of developing them (emphasis mine).

This student moves beyond simply listening to patients tell their health care stories but actively including them in the process of curriculum development. Indeed, students interviewed for this research valued patient experience about their health care. One student framed patients' experience as “powerful” while another highlighted the importance of “learning[ing] from people.” Like the advisory board, when LGBTQ community members actively participate in the policies and practices that directly affect their health becomes an important issue for LGBTQ

health initiatives. And yet, as already discussed, students want to learn from medical experts, too, to understand the nuances of providing this care. These somewhat competing forms of expertise—medical prestige and expertise from physicians and lay, embodied, community perspectives from patients—co-exist with the perpetual danger that community perspectives will be overshadowed or overlooked. Even following the legacy of DEI work at the institution, how this work gets implemented and at whose expense remain important questions for whose expertise becomes important to LGBTQ health. Community perspectives at Southeastern do have a place, but this place often aligns with the order and operations of the medical care system where physician expertise overrules community experience. Even in cases where patients challenge this notion, such as when the advisory board asks for more input on procedures and policies at the institution, the decision-making remains in the hands of physicians who work at the institution.

With these tensions concerning who should be informing this work—LGBTQ-identified, patients or medical experts—LGBTQ health is becoming a complex, emerging specialty institutionalized as a population health area. Multiple skill sets, disciplines, and experts are often needed to provide "LGBTQ health care." With this complexity in mind, how do students learn if an LGBTQ identity is important to a health care encounter (or not)? In the following section, I outline how this emerging, broadly defined area of expertise becomes difficult for students to navigate. I show how LGBTQ experts draw the boundaries (knowingly or not) around LGBTQ health in their teaching and learning about this topic.

Developing LGBTQ Health Expertise

The Southeastern LGBTQ Health Center communicates that, at times, LGBTQ health is fundamentally the same as health care for non-LGBTQ patients. This disclaimer: "The mental

health assessment of LGBT patients is not fundamentally different from that of non-LGBT patients" even appears in their LGBTQ Health 101 presentation. They specify that because LGBTQ people face greater mental health risks, health care workers should treat patients differently by bringing this up with patients to address these issues. In the sexual health course, one LGBTQ Health Center employee told a story of a transgender woman who could not find a doctor willing to provide her care in her town. This patient needed medical care for her face. This employee suspected that the providers might have been transphobic and withheld care or realized the patient was transgender and decided their medical training went out the window. For this latter point, the employee commented how this was "funny because trans care is fundamentally the same." Here, this patient sought care for her face—a non-LGBTQ-specific health issue—and yet because the patient was transgender, her face care became an LGBTQ-specific health issue, though the treatment is the same. Physicians should know that their medical training allows them to provide quality care to all patients. A medical student shared similar concerns in her interview when she cautioned against LGBTQ health being relevant to all medical encounters. Describing the "trans broken arm syndrome," she explained:

> It's like a phenomenon and basically, is the idea that if a person comes into the emergency room with a broken arm, and they're trans [and] suddenly thought of [as a] more complicated issue, that it requires some sort of different care. And that's a very good example of a time when it really does not and should not [matter].

There are times when LGBTQ health, with its specialized knowledge, is not relevant to patient encounters. In the case of broken arms or facial issues, LGBTQ patients are the same. The gender dysphoria CBL case prescribed similar sentiments in that educators wanted students to feel prepared to provide appropriate care to transgender patients. The aim of the CBL as previously referenced was to teach students to be knowledgeable about transgender health,

especially given the statistics that many physicians feel unprepared to provide care to these patients.

Not only must students learn when LGBTQ health *is not* relevant, but by contrast, they must also learn when LGBTQ health *is* relevant to their delivery of care, and this interacts with their medical specialty. One medical faculty member frames the issue of the depth of knowledge that medical physicians must have as follows:

> There are certainly a very small number of clinicians that have a deep interest and expertise in LGBTQ health. And that's fine. Just as there are clinicians who have a deep interest and expertise in heart failure. But I would expect that every physician should have some basic understanding of what it means to be an LGBTQ person, so that even if they don't have that deep expertise or understanding or interest, they know an appropriate way to interact with the patient and can help them seek out the medical resources that they might need.

Not every physician will need a deep level of LGBTQ health expertise or will need to know where LGBTQ health interacts with their specific specialty. Where this line is drawn, however, is up for debate. Despite this, there is a baseline level of knowledge and respect communicated to physicians that they should have when interacting with patients. Further, as a part of the baseline curriculum for LGBTQ 101 training, LGBTQ Health Center employees advise health care staff to be comfortable *not* knowing everything about LGBTQ health. For instance, in navigating providing health care to LGBTQ patients, the LGBTQ Health Center provides the following recommendation in their PowerPoint Presentation:

- Providers should not feel daunted by the specialized mental health needs of LGBT patients!
- Patients are our best teachers
    - We've all had the uncomfortable experience of feeling "caught" in our own ignorance about a situation
    - (lack of knowledge around nuances of an HIV regimen)
    - (which pronouns with a gender non-conforming spouse)

- We're all more comfortable feeling like an "expert"
- Given our diverse communities and the explosion of specialized medical knowledge, achieving "expertise" an ideal not reality
- What to do when feeling "caught?"
    - acknowledge the gap in our knowledge base
    - enlist the patient's experience
    - seek available medical resources in a transparent and timely manner
    - patients don't expect us to be perfect

They acknowledge that LGBTQ health can require specialized knowledge. Given the diversity of LGBTQ communities and the constant changing of best practices for LGBTQ healthcare, they suggest it is nearly impossible to expect physicians to be experts. They empathize with physicians, recognizing physicians might feel more comfortable being the 'experts.' At times, physicians will need to enlist the knowledge of their patients, who will know more than the physician about LGBTQ health. LGBTQ health center employees conclude that patients do not expect physicians to be perfect. Further, they suggest that physicians lean into the ambiguity of LGBTQ health care and partner with their patients.

With an influx of knowledge on LGBTQ communities, as outlined in the presentation, physicians and medical students must learn how to both be an expert in LGBTQ health (knowing when LGBTQ health is or is not relevant to a patient encounter) but also be comfortable with not being an expert and instead embrace an openness to learning—representing yet another enactment of LGBTQ health. And yet, LGBTQ health does require experts to exist. Otherwise, LGBTQ curriculum, health centers, and physicians who provide this care to LGBTQ patients would be irrelevant to providing quality care to these patients. As such, medical students must learn how to navigate becoming an expert in LGBTQ health and in doing so, learn what and when aspects of LGBTQ health are relevant to their individual patients.

In doing so, lines are drawn around whether health issues are relevant to LGBTQ health or not, but who draws these lines? Certainly, the medical literature, the LGBTQ Health Center, and medical faculty in the classroom enact LGBTQ health and draw these lines when they connect LGBTQ health to certain health issues in their didactics and discussions. And yet, learning how to apply these skills to clinical encounters happens in clinics when medical students are parts of teams providing care to LGBTQ patients. One way this gets integrated is through the

differential diagnosis, as outlined in the gender dysphoria CBL when students included DSM recommendations in their final writeup of their patient. One student expressed that knowing something exists and giving it a name allows medical practitioners to avoid forgetting it in the future. I asked for an example of this, to which he described the differential diagnosis as key to knowing what is relevant to a patient encounter:

> I mean, like, the biggest way is like, how do you form a differential diagnosis and exclude some ideology. I think for this, you know, at one point, LGBTQ health, like a lot of things are pretty much the same, except for things that aren't, and then how like, be able to recognize, hopefully recognize some of those things that aren't the same, that may predispose them to more dangers, one way or another to see them, maybe not to, like know the entire list of them. I think that would be reserved for a lot of specialists who would be consulted in those situations. But I think the exposure and the exposure diversity is important.

This medical student reiterated that much of LGBTQ health is the same and that he formed a differential diagnosis around the health issue to remember and recall the list of health risks. Even after forming the differential diagnosis, he was unsure of which health issues might be relevant and suggested physicians can refer to a specialist when needed.

Data from my field work suggest that despite the singular entity of LGBTQ health, it is complex, varied, and unevenly distributed across medical specialties. How, then, do medical students navigate what is baseline knowledge they should know versus what is reserved for specialists? At what point, does a physician become an LGBTQ Health expert? To investigate these questions, I asked medical students how they learned to navigate when LGBTQ health is important or unimportant to providing care to LGBTQ patients during their time at Southeastern. Some relayed they learned it in didactics, others described that they have not learned this at all, and still others said they learned through role modeling in clinics from medical faculty and residents who provide care to these patients.

For example, when asked about this learning process, one medical student outlined areas of the curriculum where it is addressed:

> So some of that is actually addressed in some of the curriculum that we have, like in the OB-GYN, kind of reproductive health section, we talked about that. We talked about that in like our psychiatry blocks. And then it's kind of just addressed on an individual basis like on certain clerkships. So yes, I think it depends on the clerkship or the specialty and how they decide to address that if at all. So like for the OB-GYN, for example, we would, you know, they were like, here are some questions that you might want to ask to understand like their habits and their activities and know what to be looking out for if there's increased risk of like certain diseases or if they, you know, you need to be on the closer lookout for anxiety or depression or something like that. So, I think they talked about it, kind of those contexts but there's no dedicated like, here are the things that you need to worry about or be thinking about more like, here's when it would be relevant, it kind of just comes down to the individual specialty and like, how they address it.

Depending on the specialty, in this case OB-GYN and psychiatry, she learned through her formal curriculum that there are appropriate questions to ask or health risks to keep in mind when providing care to LGBTQ patients, and individual interactions on clerkships solidified this understanding for her. In her interview, she also highlighted the stakes of learning when to address LGBTQ health with LGBTQ patients. She highlighted how treating LGBTQ health as important to the health care encounter *when it is not medically relevant* could be negatively interpreted by the patient. In some instances, highlighting identity could even be alienating. As she described:

> I think identity is important. I think it depends on what kind of care you're providing. So, you know, I think it's inappropriate in some settings to focus on that identity, if it's not really relevant to the care that you need to give. But then, you know, some aspects like, especially for women's health, if your women's health or primary care, anything where like that would be relevant, potentially, to what kind of things you might need to look out for things to counsel your patient on. Definitely important, but I think, you know, it's not appropriate to like ask every single one of your patients if you're, I don't know what example to give, but like certain kind of specialties or certain kind of visits like that doesn't necessarily need to like, be like a spotlight that you shine on your patient or something if they feel uncomfortable.

She did not provide specific examples of when LGBTQ health would not be relevant but realized the gravity of getting LGBTQ health care wrong, or in other words, addressing LGBTQ health when it was not medically relevant. Given the impact providing medically relevant LGBTQ health care has on the patient encounter, ensuring medical students know how to provide that care becomes especially important.

And yet, some medical students expressed that the curriculum does not explicitly state how to navigate when LGBTQ health is important or unimportant. For instance, in response to a

question about learning when LGBTQ health is important or unimportant to the health care encounter, one medical student stated the following:

> No. I feel we don't really learn that at all. I feel like the examples I'm drawing on are just from personal experience, but not necessarily because someone told us when it is or when it isn't, I feel there are standard questions in encounters that you ask. So, for OB-GYN, there's important questions related to sexual history that you have to ask, just to, so you know, your patients better. So, I feel that's obviously a time where you would ask him where it would be important, and then otherwise, I don't know if necessarily, I don't know. I don't, I feel it's, I don't have that fully understood at this time.

This student could pinpoint some areas where LGBTQ health would be important—in the case of OB-GYN, but ultimately felt she did not learn this in medical school nor was she comfortable deciding when LGBTQ health was important to health care encounters. Another student who was involved in developing the CBL case and had a depth of knowledge on the subject also concluded, "I don't know if I've actually had that happen myself. Um, yeah. So, I don't know what I would say." She could not think of an instance, saying there was not a time where this was explicitly outlined. Another medical student, differentiating between the structured medical curriculum from what she learned on rounds, stated, "That's something that we didn't necessarily talk about in our curriculum. I think it just came from... My understanding of that just came from seeing attendings and residents give importance to it." Role modeling, already outlined in medical literature as important for medical student learning, served as an important resource for learning about how LGBTQ health gets enacted in the day-to-day workings of the medical center (Passi, Vimmi, and Johnson 2016; Cruess, Cruess, and Steinert 2008).

Indeed, when asked the same question, others similarly referenced and pinpointed interactions in clinical spaces where they learned from their attendings and residents how to enact LGBTQ health. For instance, another medical student stated clinical environments solidified what she learned in the classroom about LGBTQ health:

> I think what I'm learning right now is just honestly baseline experience in what I see residents and attendings do and when they ask special health questions and when they don't. And so, I've just learned by example that they set. I think we're taught formally in our first year that we should always be asking special

> health questions and identity questions, but I think that's kind of unlearned or relearned when I spend a lot of time in the clinical environment, and kind of catch onto the trends of when providers are asking those questions and when they aren't asking those questions.

This student learned from the examples of her superiors in the clinics. Others provided specific examples of residents correcting medical staff when they misgendered patients. One example, quoted at length, represents how students learn when LGBTQ health is relevant to the health care encounter and how physicians can use their institutional power to create transgender affirming health care spaces. When asked when LGBTQ health came up in their learning, one medical student relayed the following learning opportunity she had on rounds:

> Yeah. I don't know ... I'll share this one other experience with you, though I'm not sure if it's super useful or relevant, because here in our demographics, we don't have a ton of patients who are openly identified as LGBTQ, so it hasn't always come up in a lot of my clinical experiences. Though we did, on my surgery rotation, I did a colorectal surgery elective, or that was just part of my surgery rotation as a second-year medical student, and I did colorectal surgery, and we had one day where we were removing anal polyps, and so that population of patients that day was the most LGBTQ patients I've ever had and most of them were gay men.
>
> The removal of anal polyps is because some of them can be precancerous, and it's just a quick procedure. You put them under light anesthesia and chop off the little polyp. My surgical resident that day was awesome. She was very affirming in people's identities and very deliberate about using the language and everything, and you can tell the patients' response to that. I don't think that was necessarily the case for all of the OR staff and the anesthesiologist, who didn't necessarily directly interact with the patients quite as much, but on that day, we did have one trans man patient, and the attending surgeon expressed some somewhat derogatory confusion of like, "What is the technical term here? Do I say 'his' vagina? That sounds so weird."
>
> And a resident just totally shut him down and was like, "Yes, you say 'his' vagina. That is absolutely the correct language." That totally set the tone, and he was like, "Okay, yes. His vagina. There we go," and proceeded with whatever point he was making. But I just remember the OR staff were ridiculously confused about what the patient's gender was and what that meant for the anesthesia… But I was really glad to have had a resident that day who just shut that stuff down.

Noting that because of Southeastern's location, the LGBTQ population may not openly identify in clinics, and therefore LGBTQ health learning experiences were infrequent. Still, she could remember a time on a surgery service where an LGBTQ patient came to receive care for anal polyps. Uncertain if her example counted as a time when LGBTQ health was relevant, she still recalled this as a time when she learned how to interact with medical care teams to provide gender affirming care. In this story, the resident, using her authority resulting from the hierarchy

of medical teams, corrected the medical team and, as this medical student stated, set the tone around the gender-affirming care they were providing. First, surgery for anal polyps connects to LGBTQ health, presumably through the assumption that gay men are having anal sex. This health issue became relevant to LGBTQ health through the increased risks associated with anal sex. Second, this patient happened to be transgender, which provided another opportunity for students to learn how to disconnect binary understandings of sex/gender from gender identity. Because gay men access care based on their sexual orientation, and because this OR staff member made transphobic and cisnormative comments, LGBTQ health became medically relevant to the care for this patient.

Medical students described that role modeling from physicians who provide care to LGBTQ patients became important for them to understand how and when LGBTQ health is relevant to the patient encounter. While these students are by no means experts—some acknowledge they still do not know how to recognize when LGBTQ health is relevant or how LGBTQ health interacts with certain specialties—they often looked to role models, LGBTQ health experts, who have had exposure to and experience with providing care to LGBTQ patients. During my time in the field, students would seek out the transgender health clinics and LGBTQ health discussions led by LGBTQ health care providers to learn from the physicians who provided this care. In discussing and drafting a care plan for the patient in the gender dysphoria CBL, students asked questions of and deferred to the one student in the group who shadowed a physician from the transgender health clinic. They expressed they wanted a physician's standpoint on navigating parents who do not want to pay for gender-affirming care for trans children rather than just reading the medical literature on the subject. One student asked, "Does [the physician you shadow] – would they have exposure to these kinds of

questions? We can look up articles [on the topic] but "I'm curious about a physician's standpoint on it." The student with experience shadowing the transgender health clinic often provided input from her work with the physician who provides transgender health care throughout the lesson.

These medical faculty who provide LGBTQ health care, knowingly or not, serve as LGBTQ health experts that help delineate what is or is not LGBTQ health care. In particular, their exposure to and experience working with LGBTQ patients is in and of itself another enactment of LGBTQ health, influencing students to seek them out and learn from them. In my interviews with medical faculty, while some had formal training in LGBTQ health, many learned on the job and through their doctor-patient interactions with their LGBTQ patients. In one case from my research, LGBTQ students can also serve as this expert. From previous research, we know that medical students do seek insight from their LGBTQ classmates on LGBTQ health topics (Murphy 2019). In this research, one of my queer medical students mentioned that she and other queer medical students mention LGBTQ people in peer-to-peer learning groups to call attention to the group. As she said:

> When we're talking about health system science and health disparities, or the skills of being a physician, sometimes when you're talking about the physical exam elements of that, people might be like, "Remember that for this population, you have XYZ considerations.

In this capacity, both medical faculty and students can serve as LGBTQ health experts educating on this topic. As I established previously, many LGBTQ health experts, faculty included, do not always see themselves as experts even though others see them as such (Herling 2021). As a consequence, they often unintentionally or intentionally establish the boundary around and write the rules of LGBTQ health in their clinics and serve as resources for students to learn about this topic. Through their formal didactics curriculum and informal learning on clinical rotations with attendings and residents, students learn to balance becoming knowledgeable about LGBTQ health relevance with not being an expert and knowing all the answers.

In learning to navigate this tension, students learn strategies to maintain positive relationships with their LGBTQ patients. One strategy is to explain the reasoning behind any questions asked to communicate medical relevance. For instance, in the sexual health class, the LGBTQ health center advises that medical students contextualize why they are asking things. A student asked, "Let's say you are aware of what a binder is, but you might struggle with asking how to auscultate. How would you want to navigate that?" The LGBTQ Health Center employee replied with the following strategy, "Work with the patient and say that you are trying to make them feel comfortable. The more that you could do, the better. Explain what you need to do, be fast and thorough, and be meeting them where they're at." Similarly, another medical student highlighted the importance of valuing a patient's identity to provide them quality care. As she stated,

> I would like for my patients to always trust me with their identities, so I understand more of where they're coming from, in different ways. Not that if you're queer that's the only important thing about your identity and I need to think about that every time I'm checking your blood pressure. But I think it's important to know your patients.

Navigating when identity is medically relevant to health care is not straightforward, but as this student highlighted, recognizing and valuing the patient and establishing trust can help to provide good patient care. With the case of LGBTQ health, it is nebulous and loosely defined and therefore difficult to apply in health care. To navigate this uncertainty, these medical students not only communicated the need to value and understand their individual patients' perspectives but also sought out the experience and expertise of physicians who provide care to these patients.

Navigating LGBTQ Health Expertise

Because LGBTQ health is everywhere and nowhere for physicians and students to learn, LGBTQ health expertise becomes complex when enacted in practice, as established in Chapter 4. Despite this, in this chapter I have outlined how LGBTQ health is singular enough to become a

medical specialty that physicians and students can opt into adding to their repertoire of expertise. This can be baseline—meaning that physicians understand the needs of these patients and can at least be welcoming and professional, and at best provide resources for the patient if the health need is outside of their expertise. Additionally, physicians can dedicate their careers and practice of medicine to serving these populations, like what one medical faculty member referred to as a physician having expertise in heart failure. This topic gets taken up unevenly, however, by physicians and students alike, who must opt into and decide their level of expertise on the topic. This area of expertise exists in part due to previous DEI initiatives at Southeastern that paved the way for medical students to learn about identity and 'difference' and for marginalized populations to access resources at Southeastern to fund initiatives to alleviate health care disparities. This population-based health perspective to LGBTQ health, shift in medicine to focus on social aspects of medicine, and patient demand for LGBTQ health experts creates opportunities in the medical curriculum for medical students to learn about LGBTQ health care as a part of their scope of expertise.

In the development and implementation of LGBTQ health initiatives and curriculum, patients have a space here to contribute to LGBTQ health expertise. For instance, they can serve on advisory boards and patient panels to infuse patient perspectives into Southeastern's enactments and deployments of LGBTQ health. Despite this, tension surrounds how lay expertise influences LGBTQ policy at Southeastern, as was the case with the advisory board's impact on the gender clinic planning. Southeastern LGBTQ patient care still gets subsumed under the lens of medical experts where providing patient care is still the responsibility of the physician. LGBTQ health thereby gets understood through this lens of medical expertise. As a result, physicians who provide care to LGBTQ patients and who have some level of expertise,

knowledge, and relationships with these patients serve as liaisons for student learning. Indeed, medical students look to LGBTQ health experts in various disciplines to help them navigate when to elevate LGBTQ health difference to the level of imperative for patient care versus ‘not a big deal.’

Further, because LGBTQ health follows the logic of previous DEI initiatives, in highlighting disparities and difference across populations, white, able-bodied, masculine, cisgender, and heterosexual remain the norm, where these marginalized identities are added to the existing framework of medical education. In this way, these identities can serve as hegemonic frames for understanding the human body through difference and reifying what medical curriculum and medicine are at large. Indeed, much of this sample identifies as white, heterosexual, and/or cisgender. As such, these participants could view normalized and privileged identities—white, able-bodied, masculine, cisgender, and heterosexual—as already integral to patient care. In this way, privileged identities can recede from view “into the background” (Ahmed 2012: 38). Thus far navigating how one identity—LGBTQ—impacts care has been difficult for students. How students might learn to navigate applying how multiple marginalized identities impact individual patients remains an important question for medical education.

Significantly, even though I interviewed LGBTQ-identified medical faculty, students, and Health Center employees, their own LGBTQ identity did not provide all the answers to questions about providing LGBTQ health care to patients and sometimes framing patients as ‘other.’ This is evidenced by one queer medical student, quoted previously, when she recommended having medical students talk to queer people but did not include herself is this latter grouping. This could be for a variety of reasons—intersectional aspects of identity, such as race/ethnicity, class, ability, impact patient experiences in ways that might differ from LGBTQ

physicians' and Health Center employees' experiences as patients. The heterogeneity of the LGBTQ grouping itself means that, for instance, a gay physician will not have the same experience as a transgender patient; and/or my interviewees may have been separating their occupational roles as physicians in the delivery of care and Health Center employees in their facilitation of this care versus their personal experiences of receiving care as LGBTQ patients. Regardless, these LGBTQ-identified participants did also serve as experts in this area by leading or collaborating on LGBTQ health initiatives, whether they drew on personal experience as LGBTQ-identified people or not.

Even when looking to LGBTQ-identified or heterosexual and cisgender role models, students get confused about when LGBTQ identity is relevant or not to their delivery of patient care. It is important to note the possibility that medical students who interviewed for this research self-selected into the study because they care about LGBTQ health. Many of the medical students were a part of the social justice club at Southeastern, identified as LGBTQ, and/or led LGBTQ health curricular initiatives. Even with students who believe LGBTQ health is important and who are knowledgeable about this topic, learning when LGBTQ health is or is not relevant to patient encounters was not always straightforward. Here because LGBTQ health is expansive—encompassing aspects beyond medical expertise—it is difficult to standardize and therefore guarantee that students will be able to learn how to navigate when LGBTQ health is medically relevant in every situation. These initiatives remain important and are wanted and needed by physicians, students, and LGBTQ patients alike, to improve LGBTQ patient outcomes. LGBTQ health medical education and initiatives become important first steps in alleviating health care disparities for LGBTQ populations, but future curricular initiatives must attend to teaching about the politics of difference, especially as it relates to such a diverse

community as LGBTQ populations. To help medical educators navigate difference, a shift from LGBTQ health to queer health, which I take up in Chapter 6, is necessary to decenter identity and refocus the conversation on relationships among the physician, patient, and the health care system.

CHAPTER 6: ENACTMENT OF LGBTQ HEALTH

> Health care disparities continue to be experienced by people who are LGBT, gender nonconforming, and/or are born with differences in sex development (DSD). To reduce these disparities, all health care providers must learn to address the specific health care needs of these populations, and health care institutions must promote a climate that supports, values, and includes individuals in these populations (American Association of Medical Colleges. 2021b).

Southeastern, among other medical colleges, are responding to this AAMC call to action for LGBTQ health integration into medical school curriculum as an avenue for alleviating health care disparities (Morris et al. 2019). The AAMC published their "Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who are LGBT, Gender Nonconforming, or Born with DSD: A Resource for Medical Educators" in 2014. At the national level, the AAMC recommends that *all* healthcare providers become competent in LGBTQ health, including understanding unique health needs and transforming healthcare environments. Through this lens of attending to health disparities, LGBTQ health curricular initiatives get coded with the language of diversity and inclusion, as indicated on the AAMC website whereby articles on LGBTQ health feature the tag "Diversity and Inclusion" (American Association of Medical Colleges 2021a). This study examined how these kinds of diversity and inclusion initiatives pertaining to LGBTQ health get enacted in the everyday workings of a medical school and addressed the complications to and resources for learning about LGBTQ health.

In this chapter, I situate this study's findings with the sociology of medical education and feminist enactment theory and focus on the implications of this research for future developments of LGBTQ health curriculum. I first provide an overview of the study findings, focusing on the objectives of my research. I then outline the processes by which the diffuse area of LGBTQ health gets enacted across the differing parts of the medical center and school and the consequences of this enactment. I suggest a move away from LGBTQ health and outline queer health to address some of the shortcomings associated with an LGBTQ health-focused agenda

and to challenge normativities embedded in medical education. Following this discussion, I highlight the contributions this research makes to the fields of medical sociology, LGBTQ health in medical education, and feminist conceptualizations of sex, gender, and sexuality. I conclude with a discussion of the limitations of this study and future directions of research on queer and transgender health.

Overview of Study Findings

This research sought to examine the day-to-day workings of medical curricula and the *process* of teaching students about LGBTQ health. Now that medical education has established a need for this instruction, it is important to ask: how do medical schools adapt to respond to this need? With particular attention to the interactional and institutional components of curriculum, this research complements existing literature on student knowledge and shows where LGBTQ health gets integrated, by who, and what ideologies about sex/gender/sexuality accompany these teachings. Employing ethnographic methods, including 10 months of participant observation, 46 interviews, and archival research of medical school archives, I illustrated 2 main themes: 1) that LGBTQ health can be enacted and made relevant across the curriculum in a wide variety of disciplines and yet still remain relatively invisible to medical students; and 2) resulting from the oftentimes broad and nebulous definition of LGBTQ health at this field site, medical students experience difficulty navigating when LGBTQ health is medically relevant to their delivery of health care.

First, LGBTQ health gets broadly defined as the health needs of LGBTQ populations and serves as a sort of black box/container for the health needs of sexual and gender minority populations. Indeed, when I asked my participants to define this concept, some stumbled at first, unsure how to define it. Nevertheless, it served as a grouping where, after some additional

prompting, participants named unique health needs and risk factors, cultural competency and interpersonal skills, and physician advocacy as relevant to LGBTQ health. With this broad definition in mind, I sought out where in the curriculum this topic gets enacted. Table 1 outlines the more than dozen portions of the curriculum—including first year lectures, clinical rotations, and independent research projects—where students can learn about LGBTQ health. As shown, this topic exists across multiple disciplines, including OB-GYN, pediatrics, neuroscience and psychiatry, infectious disease, and across all years of medical school. Southeastern provides various learning opportunities for LGBTQ health too, including didactics from LGBTQ health care providers and LGBTQ health center employees, CBLs, patient panels, student research projects, shadowing opportunities, and grand rounds lectures. While clearly medical educators formally integrated this topic into the curriculum, it remains elective, and more than half of the learning opportunities listed in Table 1 requires that students seek out this material.

Further, a portion of these LGBTQ health learning opportunities, specifically what I term LGBTQ 101 trainings, are placed next to discussions of sex, gender, and sexuality. In the LGBTQ Health Center trainings, pediatrics didactics on LGBTQ youth health care, the sexual history taking lesson, and the gender dysphoria CBL, educators define sex, gender, and sexuality as medically assigned identities, inner identity, and sexual and romantic attraction, respectively, and highlight that these concepts refer to cisgender and heterosexual populations as well as LGBTQ populations. And yet, sex, gender, and sexuality become integral to learning about LGBTQ health when they are positioned next to learning about the distinct health needs of LGBTQ populations. This process reifies heteronormativity and cisnormativity whereby sex, gender, and sexuality become medically relevant to non-normative genders and sexuality while sex, gender, and sexuality's impact on cisgender and heterosexual people's health needs remains

invisible and normalized. Further, the pathologization and a eugenicist history of research on the etiology of queerness raises caution for positioning sex, gender, and sexuality next to LGBTQ health given the search for the biological basis and explanation of these populations but not for heterosexual and cisgender populations. Due to this broad definition as an area of population-based health, the multiple skills relevant to providing health care to these populations, and its associations with sex, gender, and sexuality, LGBTQ health gets defined and integrated as a nebulous concept that can be simultaneously everywhere and nowhere. While solidifying into a singular entity, LGBTQ health is multiply defined and gets incorporated in various aspects of the medical school and portions of this work reify heteronormativity and cisnormativity.

Second, LGBTQ health emerges as a burgeoning medical specialty at Southeastern despite its disparate and sprawling nature. LGBTQ health becomes incorporated into the medical curriculum like any other health issue to be learned, such as heart failure, diabetes, and sickle cell anemia. LGBTQ health, while crossing disciplines to provide whole patient care, including primary care, infectious disease, OB-GYN, and psychology among others, fundamentally becomes learned as a cohesive object. And yet, as an area of population health, LGBTQ health's integration into the curriculum follows the logic of previous diversity, equity, and inclusion (DEI) initiatives that strive to alleviate health care disparities, which is different from the treatment of heart failure and diabetes. It is not only an object of medical knowledge to be learned by medical students but relates to combating institutional inequality at the academic medical center.

Medical educators and LGBTQ health center employees draw on established DEI work at the institution to structure and fund LGBTQ health curriculum and initiatives, such as in the case of the AAMC's cultural competency requirements and DEI funding respectively. Within this

institutional context, LGBTQ Health Center employees, physicians, and medical students choose to take on this work of alleviating LGBTQ health care disparities. Indeed, these groups oftentimes take ownership over LGBTQ patients to ensure that they receive quality care. Further, patients *want* LGBTQ health experts to provide them quality care. These demands, by physicians, students, and patients alike, contextualize the deployment of LGBTQ health curriculum. In this current configuration, however, patients have a limited voice over their health care. As demonstrated, the academic medical center often controls the input they want to hear from the community board members, outlining what is and is not within their purview to advise on, and patients feel that they need to point out the patient's perspective in discussions about LGBTQ health care. LGBTQ patient perspectives often align with the order of operations within the medical care system where physician expertise overrules community expertise.

Combined with the sprawling nature of LGBTQ health and the elective nature of many of the LGBTQ health learning opportunities, knowing when this topic *is and is not* important becomes complicated for students to navigate. While some students expressed the didactics in formal curriculum helped them navigate this tension, others expressed that they learned this from attendings and residents in their clinical rotations. This role modeling allowed medical students to see how LGBTQ health experts decided when LGBTQ health was important to address or when it was not relevant to the health care encounter. Students shared that attendings and residents correcting others on the medical team when they misgendered patients served as important instances where they learned to address LGBTQ health in health care. Despite this, not all students in medical school will be able to shadow and learn from LGBTQ health experts during their time in medical school, especially across a variety of specialties. The one-size-fits-all model, where everyone learns a baseline of LGBTQ health cultural competency frameworks,

is insufficient to alleviate health care disparities if students cannot tell when LGBTQ health is relevant both to their future careers and to their delivery of care, especially as LGBTQ health becomes its own sort of specialty.

This development of expertise becomes difficult to navigate even as LGBTQ health gets incorporated into the infrastructure of the medical center and school to alleviate healthcare disparities through population-based frameworks and previous DEI initiatives. Certain LGBTQ health experts, who have experience with providing care to these patients, emerge and students seek them out to learn from them. Implementing LGBTQ health in patient care becomes complex, and these LGBTQ health experts serve as liaisons who help students navigate LGBTQ health relevance. And yet, student learning about LGBTQ health is still imperfect because LGBTQ health is a complex topic that straddles medical knowledge, cultural competence, physician advocacy, and patient experience. Given these overlapping and multiple definitions—how does LGBTQ health hang together? In the following section, I outline how these multiple dimensions of LGBTQ health often hang together through population-based health frameworks to form a cohesive concept.

Enacting LGBTQ Health

Participants in this research suggest that LGBTQ health should just be 'health' in that it is not much different from all people's health, and yet LGBTQ health is emerging as a medical specialty that people opt into. While the AAMC hopes that all physicians will be competent in LGBTQ health, as I have described, there are multiple reasons this goal is difficult to achieve in practice: this topic can require varying levels of expertise, spans multiple disciplines, and requires a multitude of skills which depend on the physician's specialty and interest. Indeed, definitions of LGBTQ provided thus far are flexible (and vague enough) to encompass a wide

variety of health aspects. For example, as described by one medical student, a broken arm is just an arm and not relevant to transgender health even though some physicians might *make* it relevant through their transphobia. Further, LGBTQ health may or may not be relevant to a health care visit depending on whether sexual health or partners comes up. Additionally, LGBTQ health might not be relevant for transgender patients except for the doctor not misgendering or deadnaming the patient or it might be relevant if the patient is seeking gender-affirming care. LGBTQ can be all these things at once—or none of them—depending on where the patient enters the healthcare system and for what health issue.

And yet, LGBTQ hangs together in the curriculum. All of these seemingly disparate entities—an LGBTQ Health Center whose purpose is to facilitate LGBTQ health initiatives at the medical center; transgender health clinics who serve transgender and nonbinary patients; LGBTQ health trainings, courses, and certificates which immerse students in this topic; and LGBTQ health being an option for physicians to list in their areas of expertise on a patient facing website—communicate a semblance of a cohesive object. When asked about defining LGBTQ health, at first participants stumbled to find words to describe this topic, but they eventually listed a variety of health issues, skills, and specialties relevant to LGBTQ populations. It is exactly *because* LGBTQ health is so vague and fluid that it can be adapted into so many different aspects of the curriculum and medical practice. LGBTQ health might not always be relevant to every single health care encounter for LGBTQ patients, but it still coheres into a singular unit even though it is difficult to pinpoint in the curricula and how it is relevant to health care encounters.

I argue that this cohesion happens because LGBTQ health is tethered by population-based health disparities and gets linked to combating heterosexism and cissexism for these

populations. As previously outlined, the reason for including LGBTQ health in the curriculum stems from health disparities, and all LGBTQ medical curricula at Southeastern in some way reference LGBTQ health disparities as reasons for learning this material in medical school (Hollenbach, Eckstrand, and Dreger 2014). Indeed, LGBTQ health initiatives receive support from Southeastern DEI offices to improve LGBTQ health care encounters. Even though the acronym LGBTQ itself is blurry and nebulous (who is LGBTQ? Are agender, asexual, demisexual people included? Further, is a man who has sex with men but identifies as straight a part of this community? In other words, is LGBTQ health only relevant to people who identify as a part of this community?) LGBTQ health stands freely in the curriculum. Certainly, aspects of LGBTQ health are relevant to all health—and even other marginalized communities—such as cultural competency and trauma-informed exams. Despite this, following the logic of previous diversity, equity, and inclusion initiatives, LGBTQ health becomes an object that ties these definitions together into a cohesive unit and therefore allows an insertion into the medical curriculum with the purpose of alleviating healthcare disparities for these populations.

Some best practices, such as not making assumptions about patients and asking the patient how they identify, insinuate that LGBTQ becomes a catchall for sexual and gender minorities. Here agender, asexual, demisexual people, among others not listed, can be included under this acronym even though they are not explicitly named. And yet, much of the curriculum focuses on LGBTQ-identified people, such as when the adolescent and young adult health physician explained health risks for LGBTQ populations or when the LGBTQ health center outlined health disparities for LGBTQ populations in their training. The reliance on health disparities statistics that inform evidence-based practice makes sense given that the medical

profession often relies on evidence-based literature that prioritizes large sample sizes in clinical research (Gupta et al. 2016; Goldman and Shih 2011).

As shuster (2021; 2016) outlines, transgender medicine guidelines prioritize evidence-based medicine (EBM), but a lack of randomized clinical trials impedes doctors' abilities to rely on this framework when they provide care for their patients. Medical providers' difficulty in navigating medical uncertainty in trans medicine shows how EBM does not necessarily provide clear insights into how to care for patients (shuster 2016). 'Evidence' in EBM takes on the illusion of neutrality to help inform medical decision making and does not provide the easy answer for how to provide healthcare for trans patients (shuster 2016). Here, complex categories, such as gender or sex, are simplified and standardized through clinical guidelines (shuster 2016, 2021). Similar to shuster's findings, the gender dysphoria CBL in this research shows how sex, gender, and sexuality become components to be learned through this medial framework, devoid of any critical perspectives of medicalization, pathologization, and medicine's role in co-producing these categories. The enactment of LGBTQ medical curriculum relies on EBM practices that elide such critical, feminist perspectives on these categories (Springer, Stellman, and Jordan-Young 2012).

This enactment of LGBTQ health raises important questions for future directions of medical education. On the one hand, under the rubric of LGBTQ health care, medical curriculum has adapted to feature sexual and gender minority health care and many of these practices can be applied to a broad range of the populations who experience homophobic and transphobic health care encounters. Indeed, the fact that there were so many LGBTQ medical curricula and health initiatives to observe is in part a testament to the hard work that LGBTQ health educators have done over the past decade to improve sexual and gender minority health care outcomes. If not for

the work of medical administrators, faculty, students, LGBTQ health center employees, and LGBTQ patients, both on a national level and at Southeastern, who have demanded that medical school curriculum and academic medical centers change their policies and procedures related to LGBTQ care delivery, these changes would likely not happen.

On the other hand, curricular change is by no means easy, and even the best intended efforts cannot provide a perfect solution to alleviating LGBTQ health disparities. In this case, the broad, nebulous nature of LGBTQ health, albeit enacted across different aspects of the medical school, including in classrooms, transgender health clinics, HIV clinics, public lectures, and others, becomes difficult to learn in a medical framework. Students had trouble navigating this in practice when providing care to actual LGBTQ patients. Indeed, how sex, gender, and sexuality—for *all* patients—intersects not only with medical care but with other dimensions of identity, becomes complicated to enact because critical perspectives on sex, gender, and sexuality are often illegible in medical frameworks. Because of this, larger curricular changes related to sex, gender, sexuality are needed to enact a version of queer health that destabilizes both sex/gender and sexuality binaries and the power dynamics and politics of difference between providers and patients.

From LGBTQ Health to Queer Health

If LGBTQ health has become a nebulous, catchall phrase for non-normative gender and sexual minority health, which I observed can be complicated when enacted, should we still use the term? LGBTQ health educators and activists employ this term to better the health needs of these populations. Because of this, I argue that the word can and should be used in particular instances to achieve this goal. For instance, if medical educators can adopt a population-based framework to adopt LGBTQ health into current DEI work that will directly impact the lives of

LGBTQ people, then of course, I would not argue against such use. I do not, however, believe in a one-size-fits-all approach to alleviating health care disparities, and ultimately believe that critique can strengthen these initiatives. In doing so, I believe medical educators should simultaneously adopt a queer health framework of sorts, a call to constantly challenge what we know and how we know it, to decenter normativity, and to not only challenge medical authority's control of LGBTQ health but also the sex, gender, and sexuality binaries that currently pervade health care (Zeeman, Aranda, and Grant 2014). Rather than provide an exhaustive definition of queer health, I instead draw attention to ways that current frameworks can be of service toward the goal of health equity for queer and trans people.

First, medical educators are shifting a focus of cultural competency training to more self-critical, reflective consciousness that ask doctors to question their role in disparities. Cultural humility is one such approach, whereby physicians embrace uncertainty in medical encounters and recognize their role in furthering systems of inequality in their everyday interactions with their patients (Tervalon and Murray-Garcia 1998; Began 2018). This cultural humility approach has been applied to LGBTQ populations as a way to queer health:

> This queering involves changing the structure of how we understand LGBTQ+ individuals' health both by centering and privileging the voices of LBGTQ+ patients and examining how the provider-patient interaction is shaped by sociocultural context, including cultural mechanisms of homophobia, sexism, racism, transphobia, and ableism (Sarkin 2019:12).

This cultural humility approach centers community perspectives and a physician's self-reflection. It still, however, centers culture, albeit absent physicians' own identities, in its approach to improving doctor-patient interactions, which can limit how we understand the role of structural inequality in affecting health outcomes (Petty, Metzel, and Keeys 2017; Metzel and Hansen 2018). Structural competency models suggest that physicians remain humble in their pursuit of long-term learning about how medical systems structure health outcomes. Medical

professionals would learn that structural problems cannot be solved by one individual physician but rather are larger problems that must be tackled by multidisciplinary teams and must center physicians' affective experiences (Burson, Familusi, and Clapp 2021; Willging et al. 2017). Vestiges of this type of structural thinking are apparent in my field work, for instance, in Chapter 4 when the plastics physician discusses socioeconomic status as a barrier for transgender people accessing health care or when the LGBTQ Health Center situates LGBTQ health within a disparities framework in their LGBTQ Health 101 trainings. As a queer and feminist framework, these types of skills should be at the forefront of LGBTQ health care because they center and interrogate the power relations of institutional medicine.

Structural humility, a concept that stems from structural competency is a critical consciousness of medicine's role in health inequity and is central to my understanding of queer health because it situates physicians in a relationship with patients where the power imbalance is apparent. Similarly, medical schools teach a social determinants of health framework and focus on differences along racial, gendered, and sexuality-based lines, but rarely do medical schools teach about the systems of inequality that structure these differences or how to interfere in them (Sharma, Pinto, and Kumagai 2018). Combining structural humility with social determinants of health shifts the focus from identity as a source of difference to focusing on how the politics of difference are embedded in structures of power. As such, medical educators similarly call for refocusing on developing a 'critical consciousness' that centers systems of power and inequality (Sharma, Pinto, and Kumagai 2018). Further, these educators recognize that this call to action is not a minor curriculum change, but rather requires systems-wide changes focusing not on whether something was taught but the continuous monitoring of how topics are taught. Similarly, a queer health framework would adopt these principles and focus on the process by which people

learn about queer and trans health rather than how many trainings one attends that makes them 'competent.'

My second theme for queering health is to reckon with the embedded nature of sex/gender-based medicine in health care systems and medical education, which is a shortcoming of cultural humility perspectives. I have outlined how attaching sex, gender, and sexuality to LGBTQ populations reifies heteronormativity and cisnormativity and does not challenge sex/gender-based medicine. Lowik (2020) simultaneously recognizes the historical context for the emergence of gender-based medicine, as in the case of women's health care, and critiques its current existence for its impact on transgender and nonbinary health care. As they proclaim:

> Cisgender women have bodies, and those bodies have health-care needs, and the creation of women-centered health-care services emerged from this reality. Challenging androcentrism in medicine has been and continues to be incredibly vital work. *At the same time, however, the resulting gendered silos of health, including reproductive health specifically (and reproductive life, more generally) don't necessarily work for trans people.* Not only women menstruate, have cervixes, get pregnant, lactate— some men do. Not only men produce sperm, have testicles and prostates—some women do. Trans people have (or ought to have access to) rich, reproductive lives, too. But the cis-normatively gendered silos we've created, a door marked women's health and another marked men's, don't work for trans people" (Lowik 2020:6).

Cisnormativity assumes that men and women's bodies naturally feature particular body parts and health care needs, and as Lowik (2020) states, transgender people's health care needs transcend these boundaries. Quality health care for transgender and nonbinary people necessitates that we challenge sex/gender-based medicine. I additionally argue that to queer health care, we must also challenge the sex/gender system for all populations lest we risk assuming that the sex/gender system currently serves the interests of all people, when it in fact, does not.

As demonstrated in Chapter 4, the sex/gender binary remains unchallenged and deeply embedded in medical education when the concepts of sex, gender, and sexuality "stick" to certain (LGBTQ) bodies over others (Ahmed 2012: 62). In this case, simply focusing on LGBTQ patients does not challenge the sex/gender binary that pervades medicine. LGBTQ health becomes a third category that represents all nonnormative sexed/gendered variations that bolsters

a binary. Rather than grappling with how sex, gender, and sexuality are far more complex than just an either/or category of male/female, man/woman, LGBTQ health needs become 'othered,' much in the way the needs of racial minorities and disabled people are othered. This framework does not adequately represent the complexity of bodies, and though medical educators at Southeastern include that sex, gender, and sexuality are not simply binaries in their LGBTQ health 101 trainings, this is only the first step in challenging binaries in medicine.

Beyond binaries then, queer health should not only complicate binary thinking but recognize and center the complexity of sex, gender, and sexuality. In decentering LGBTQ identity from the framework, and instead focusing on queering practices to account for power and inequality, physicians should work with patients to provide quality health care (Zeeman, Aranda, and Grant 2014). As an iterative process, queering health necessitates an adoption of a critical consciousness that centers structural humility and challenges sex, gender, and sexuality normativities embedded in medicine. As such, queer health might look like changing health care systems (such as the EHR) to de-sex and de-gender health care needs. It might look like discussing sex, gender, and sexuality with all patients. It might look like recognizing the socially constructed nature of sex, the inability to separate sex from gender, and the validation of intersex realities (Springer, Stellman, and Jordan-Young 2012; Davis 2011; Karkazis 2006). It might look like understanding that sex and gender are always lived in intersections with other dimensions of identity, such as race/ethnicity and disability, and therefore highlighting a need to avoid reducing the complexity of patients' experiences. Regardless of the example, however, as a framework for approaching health, it should be informed by queer liberation frameworks and be open to adapting to the needs of queer and transgender people (Shanker 2020; Sharman 2016; Spade 2015; Zeeman, Aranda, and Grant 2014). In doing so, it *must* focus on expanding health care

access to queer and trans patients and employing trans and queer people to do this work (Hanssmann 2012; Spade 2015).

Implications for Medical Sociology

With insight from the sociology of medical education literature that the implementation of curricula cannot be separated from the structural and social pathways by which these curricula come to exist, I set out to examine the messages constructed, embedded, and communicated in the formal, informal, and hidden curricula at Southeastern (Hafferty 1998; Hafferty and Castellani 2009). By focusing on the formal didactics, presentations, course documents, Southeastern medical school website, and public lectures, I situated where LGBTQ health was located and what messages about this topic were featured in the overt curriculum. I sought out, observed, and talked to faculty, students, administrators, LGBTQ Health Center employees, and LGBTQ patients about their experiences with developing and implementing this work. Participants expressed the informal ways they both taught and learned about this topic at Southeastern, such as in the case of medical students who asked questions about this topic with their LGBTQ classmates both inside and outside of classes. Further, I investigated how LGBTQ health fits into the overall mission of Southeastern's medical school and medical center through examining LGBTQ health's placement in DEI initiatives and how these initiatives receive funding from the institution.

Through this fieldwork, I observed that even though LGBTQ health was integrated into the medical school curriculum, and in ways to prepare all first-year medical students with the skills to provide care to transgender patients, such as gender dysphoria CBL, most of the LGBTQ health initiatives were elective. From a hidden curriculum perspective, on the one hand, the fact that LGBTQ health was included throughout the curriculum and LGBTQ health

initiatives took place at this medical center, conveys that the academic medical center cares about this initiative. On the other hand, the fact that many of these initiatives are elective cannot be ignored. Indeed, this elective curriculum conveys a hands-off approach from medical educators that while students can choose to learn about this topic, they cannot be forced to. An underlying feature of the hidden curriculum then, is that the university does fund and devote energy to LGBTQ health curriculum. And yet, medical students often lead these curricula, as in the case of the first introduction of LGBTQ health into Southeastern's curriculum, the social justice club at Southeastern, and the gender dysphoria CBL. Building off hidden curriculum, then, I propose that the LGBTQ health initiatives at Southeastern are a more elective form of curriculum that straddles these two domains—one where the institution supports this work but also another where it acts almost laissez-faire, leaving it up to students to choose to opt into this curriculum.

This elective curriculum shows the determination of groups of educators, including faculty, students, and administrators who want to change curriculum and is a start to LGBTQ health curricular reform. The fact that any of this exists is due to their efforts to change the curriculum. With regards to politics of curriculum, not *everything* will fit, and these battles have occurred and most likely always will (Brosnan and Turner 2009). Further, while there is a push in medicine for physicians to address social determinants of health, this topic is complicated and has been politicized, receiving some pushback that this is not under the purview of medicine (Maani and Galea 2020; Goldfarb 2019; Sharma, Pinto, and Kumagai 2018). And yet, elective curriculum becomes a way that institutions circumvent the politics of curricular reform. On the one hand, for educators who want LGBTQ health, schools can show their multitude of opportunities that exist for students. On the other, they can show detractors of social

determinants of health that they can opt into these initiatives. Focusing on the elective curriculum, allows for an examination of how medical schools both attend to health care inequalities but remain flexible enough to appear apolitical.

Implications for Medication Education

Southeastern medical educators have started to change their curriculum in response to the complex nature of LGBTQ health. One aspect of the curriculum that solidified learning the most is role modeling whereby students learn hands-on from the physicians who provide care to these patients. The finding that role modeling has an important influence on student learning should come as no surprise given that doctor role modeling, from attendings and residents alike, has been found to be a powerful teaching tool for medical students' development as a physician and future career pathways (Passi and Johnson 2016; Cruess, Cruess, and Steinert 2008). In the case of students learning to navigate when LGBTQ health is relevant to the health care encounter or not and how to navigate ethical issues, such as process of facilitating transgender youth's access to gender affirming care, students both named that they learned from physicians doing this work in clinics and sought out the experience and knowledge of these physicians when questions arose during their learning. Further, students in this research expressed that standardized patients, like geriatric patients and OB-GYN patients, and case-based learning can facilitate student learning about LGBTQ health.

Building off this work, future directions of LGBTQ health curriculum must grapple with how to provide on-hands training with medical students because aspects of teaching and learning expertise might be difficult to change. For instance, it is recognized that students learn best through hands-on learning and that expertise in medicine is a part of the job description for doctors. These become complicated when LGBTQ health is the subject to be taught because this

topic is tied to a marginalized identity. This research raises questions about the consequences of teaching students to provide adequate care to LGBTQ patients that requires in some form establishing a form of expertise inherently tied to someone's personal, LGBTQ identity. Indeed, this issue is intimately connected to the medicalization (and pathologization) of LGBTQ health (Tosh 2016; Drescher 2008). Patients already participate in a medicalization framework to access care, such as in the case of gender dysphoria for transgender patients, and negotiations of expertise require discussions of what aspects of LGBTQ health should or should not be under medical domain.[14]

Further, medical education must grapple with the criticisms leveraged at cultural competency trainings for all groups, but especially the case of LGBTQ populations, that pinpoint how this this training ignores how medicine not only has a culture but actively contributes to the inequalities patients face (Kleinman and Benson 2006; Carpenter-Song, Nordquest Schwallie, and Longhofer 2007; Fox 2005; Hanssmann 2012; Hester 2016; Beagan 2018). Hanssmann (2012), a women's and gender studies scholar and previous LGBTQ cultural competency training leader, outlines the shortcomings of LGBTQ cultural competency training and provides recommendations for future practice. Of importance, even though some transgender and nonbinary people have become the leaders of these trainings, allowing for their expertise to dictate the training rather than just medical practitioners, health care equity for all transgender and nonbinary populations has not been achieved. Medical education has integrated and

[14] Again, I focus on the doctor-patient interaction wherein physicians and patients negotiate LGBTQ health care, but as outlined previously, pharmaceutical companies and health care systems serve as a backdrop to this interaction. What insurance will pay (or not pay) for in terms of transgender medicine (Dewey and Gesbeck 2017) is an example of how these forces contribute to the medicalization of transgender identity. While this was not evident in this research, it is a force of medicalization relevant to future research on transgender and queer health.

prioritized a limited view of LGBTQ health rather that does not require that it transforms how it educates students.

Further*, who is* doing this cultural competency training matters. As outlined in this dissertation, LGBTQ health experts were often physicians and LGBTQ health center employees who worked at the academic medical center, and not LGBTQ patients. Hanssmann (2012) expresses that the marginalized transgender people should be hired to develop and lead these trainings. Not only would they inform on the matters that affect the most marginalized to ensure that these perspectives are included, but it would provide career opportunities as well. These types of initiatives not only integrate LGBTQ health, but ultimately address simultaneous systems of inequality based on race/ethnicity and income and push medical education frameworks to grapple with transformation rather than inclusion. Coincidentally, "teaching from the margins," a feminist and queer technique that centers those health needs of the most vulnerable and builds off bell hooks' centering the margins, would assist in accomplishing this task (Hanssmann 2012: 130). This research demonstrates how these types of critical interventions have not yet taken shape in the curriculum, and even further, that patients' perspectives are often used to bolster medical authority rather than inform curricular development. Rather than continue cultural competency trainings, based on this research I suggest that medical schools integrate structural humility training and focus on queer and trans health by employing and partnering with queer and trans communities.

Hanssmann (2012) additionally outlines community-based participatory research (CBPR) as an avenue to partner with transgender and nonbinary people outside of academy to develop models that reflect and prioritize lived experience. CBPR approaches are partnerships between various stakeholders, often including a research team and, in this case, queer and transgender

community organizations, to plan, execute, and disseminate research findings in a way that not only involves community members but ensure their perspectives are treated as equal to those who are conducting the research (Minkler and Wallerstein 2011; Wallerstein and Duran 2006). As such, CBPR approaches can infuse queer and transgender people's perspectives into the practice of medicine and medical education. While these approaches can transform power relations in research, they are largely underutilized, especially as non-political cultural competency training gets prioritized over it (Hanssmann 2012).

This dissertation furthers this call to action for CBPR approaches to be incorporated into medical education. CBPR requires researchers develop trusting relationships with communities, especially those that have been harmed by medicine, but the reward would be to truly make an impact in these communities. Research is already happening in medical education, and medical students themselves conduct their own research as a part of their degree. They often work with physicians, such as the case of the transgender health clinic, to conduct research in those clinics. Coordinating CBPR training and hiring and supporting faculty who employ these approaches would be a step towards investing in communities-based knowledge. This kind of change requires that medical systems put time, energy, and money into the communities they serve. Rather than just including patients in the curriculum to speak about their experiences, this approach prioritizes their health concerns and actively supports patient-informed remedies to health care disparities.

A last recommendation from this research is to attend to grouping together health needs based on gender and sexual minority health under the rubric of LGBTQ health. Much of the curriculum focuses on health risks for LGBTQ populations, and yet, gender and sexual identity categories are fluid and identity and behavior do not always map onto one another. As already

expressed, care must be taken to implement EBM frameworks for populations who transcend these categories. Rather, medical schools should adopt a queer health framework to assist them in teaching medical students about the fluidity of all gender identities and sexual orientations. Further, these curricular initiatives must address the tension between primary care and specialty care for all patients. While a baseline recommendation for all physicians to be welcoming and affirming is important, medical education needs to simultaneously address how queer and transgender health intersects with specialties. Otherwise, medical education is again leaving it up to the individual physician to understand the nuances of queer heath without providing them a framework for incorporating this topic into delivery of care.

Implications for Feminist Conceptualizations of Sex, Gender, and Sexuality

Resulting from a lack of feminist attention to the body, feminist scholars re-popularized critical scholarship on the intersections between sex, gender, sexuality, and the body, inserting themselves into a mostly scientific dominated literature (Springer, Stellman, and Jordan-Young 2012; Jordan-Young 2010; Karkazis 2008; Fausto-Sterling 2000; Grosz 1994; Oudshoorn 1994). This scholarship shows how bodies, including sex, are just as much socially constructed as gender roles. Now, these critical reflections, informed by feminist ideology, are included in the medical curriculum, and this research attends to *how* and the impact of these concepts on patient care. Sex, gender, and sexuality became relevant to—and stick to—what is considered non-normative, which in this case are LGBTQ populations' health care and bodies. And yet, these concepts are not only also relevant to cisgender and heterosexual people's health care but are also not always relevant to LGBTQ patients. For instance, sex, gender, and sexuality inform LGBTQ health care in a variety of ways, such as in the cases of sexual health care and gender affirming care, but in some instances, not at all. As some of my participants claimed, at the end

of the day, LGBTQ health is really just health. From this assumption, sex, gender, and sexuality would not always be relevant to LGBTQ health care, but the association persists, and sex, gender, and sexuality get defined in relationship to and become a part of the medical care surrounding LGBTQ patients.

Further, they get taken up, integrated, and solidified in the medical frameworks as pertinent to LGBTQ health care. These concepts neatly fit into the medicine's bureaucracy, curricular structure, and diagnosis and patient care. As seen in the gender dysphoria case, sex and gender become integral to the differential diagnosis. Here critical reflections on these topics, including how everyone's lived experience is informed by sex, gender, and sexuality, get sidestepped because the point of the lesson is to diagnose LGBTQ patients. Sex, gender, and sexuality get packaged to support this goal. I caution that these feminist concepts and critical analyses get taken up in ways that support heteronormativity and cisnormativity where these concepts only become relevant to LGBTQ health. Sex, gender, and sexuality are relevant to health care—and inserting these conversations in the curriculum vis-a-vis LGBTQ health is a first step in doing so. Beyond integrating these concepts into curriculum with respect to LGBTQ health, sex, gender, and sexuality binaries in medicine at large—health care systems EMRs and overreliance on EBM frameworks for LGBTQ health, need to be challenged. While connecting LGBTQ health to sex, gender, and sexuality has been necessary to insert these topics into the curriculum, a wider lens of queer and trans health that complicates binary thinking is needed. In delineating difference, feminist scholars invested in LGBTQ health need to be additionally cautious about how concepts that stem from feminist critical ideologies get used to support normativity. A need for feminist led medical initiatives, rooted in queer and transgender health, paired with queer and transgender community led CBPR can help attend to this gap in medicine.

Limitations

This research provides insight into how medical schools adapt their curriculum to include LGBTQ populations with the intent to alleviate health care disparities for these populations. While this research analyzed the day-to-day workings of one medical school to attend to the various forms of curricula that influence this delivery, it also has several limitations. First, this research used snowball sampling to determine courses and clinics to observe and participants to interview. LGBTQ health curricula was not siloed into one course at Southeastern. To identify courses, I met with administrators, faculty, students, LGBTQ health center employees, and LGBTQ patients and discussed in what classes and clinics LGBTQ health topics came up. Through this method, I pieced together parts of the curriculum where LGBTQ health was discussed. Moreover, from March 2020 to July 2020, COVID-19 impacted my ability to connect with and observe LGBTQ health at my field site. As such, other LGBTQ health curricula and initiatives could have occurred, but I did not have access and therefore could not observe or there were more areas of curriculum not coded as LGBTQ health that are relevant to this topic that were missed. Additionally, many of my research participants suggested that others at the field site participate in my research and connected me to other potential interviewees. As a result, conclusions drawn from this research must recognize the potential for self-selection bias.

Second, most of my participants identified as white, cisgender, and/or heterosexual, meaning that the findings from this research provide a limited understanding of LGBTQ health. While 15 of my participants identified as LGBTQ, only 1 of these participants was a transgender person of color. Given this limited sample size and the fact LGBTQ people of colors' health needs are intersecting, conclusions drawn from this research speak to LGBTQ health as it

intersects with whiteness but does not speak to the experiences of LGBTQ people of color (Howard et al. 2019).

Third, faculty and students who were not interested in LGBTQ health did not participate in this research. All of my participants expressed an interest in LGBTQ health and/or the intersection of medicine with health equity and alleviating social inequality.

Fourth, this research mainly draws on classroom training and interviews with medical faculty and students reflecting about their experience in clinics as opposed to observations of clinic-based learning for LGBTQ health. One reason for this is that LGBTQ patients are difficult to pinpoint in the medical system as one may not out themselves as LGBTQ in their medical visit. Additionally, physicians expressed the need to protect their LGBTQ patients, who have expressed feeling like they were in a 'zoo' if too many people were in their clinical visit.

Lastly, like all qualitative, ethnographic research, these findings are not generalizable because they address the structural and social context at Southeastern that impacts LGBTQ health. Other medical schools will have different factors that can affect the delivery of LGBTQ health curriculum.

Future Directions

This research demonstrates how one undergraduate medical education institution enacts LGBTQ health, highlighting the structural and social processes that allow students to learn about this topic. To continue to focus on how queer and transgender health gets understood and implemented across various medical institutions, future research should attend to six different areas: 1) faculty and students who do not participate in elective LGBTQ health events, or in other words, those who do not opt in; 2) patients receiving care from students at academic medical institutions where LGBTQ health is an area of specialty; 3) resident knowledge and

experience with LGBTQ health and graduate medical education enactments of LGBTQ health; 4) national initiatives and medical education groups dedicated to LGBTQ health, including the AMA and AAMC initiatives for LGBTQ health; 5) whether concordance between LGBTQ providers and LGBTQ patients impacts patient care; and 6) the experiences of LGBTQ faculty, students, and patients of color and how this intersects with ability and income.

First, much can be learned from interviewing what physicians and students know about LGBTQ health and how they learn about it if they do not have an investment in the topic. All participants in this research sought out LGBTQ health information and often *elected* into educational initiatives for it. Talking to people who do not care about this topic can help us understand exactly how initiatives for alleviating disparities are taking shape. This is especially relevant since the AAMC wants all physicians to understand LGBTQ health, examining what and where physicians and students learn (if at all) about this topic can be integral for future curricular initiatives.

Second, patients receiving care from medical teams, including attendings, residents, and medical students, at academic medical centers who specialize in LGBTQ health would allow for a greater exploration of patient experiences and how these health care initiatives impact their care.

Third, as a part of the medical team delivering care to patients, residents contributed to medical student learning about LGBTQ health in clinical spaces. As such, interviewing this group not only about how they teach this topic to others but what they know and how they learned it can be a part of the missing puzzle of implementing LGBTQ health curriculum. Much attention has focused on undergraduate medical education as the foundation of knowledge for physicians to then continue to learn from but graduate medical education (GME) for residents

solidifies that learning (Pregnall, Churchwell, Ehrenfeld 2021). Interviews with GME educators and ethnographic observations of LGBTQ health GME would highlight how this knowledge gets solidified or not in future training, especially as it relates to medical specialty.

Fourth, future research should expand to interview leading physicians and community health centers that provide LGBTQ health care across the U.S. to examine how LGBTQ health as a medical specialty extends to the wider medical profession and how healthcare systems and pharmaceutical companies impact the medicalization of LGBTQ health. These interviews can place this ethnographic research in conversation with the wider U.S. medical industrial complex, and therefore the constraints of U.S. healthcare and medical education systems in which LGBTQ training is situated.

Fifth, given that racial concordance between patients and providers positively impacts patient care and LGBTQ patients seek out LGBTQ friendly and knowledgeable doctors, future research should investigate whether LGBTQ concordance between patients and providers benefits patients' health care.

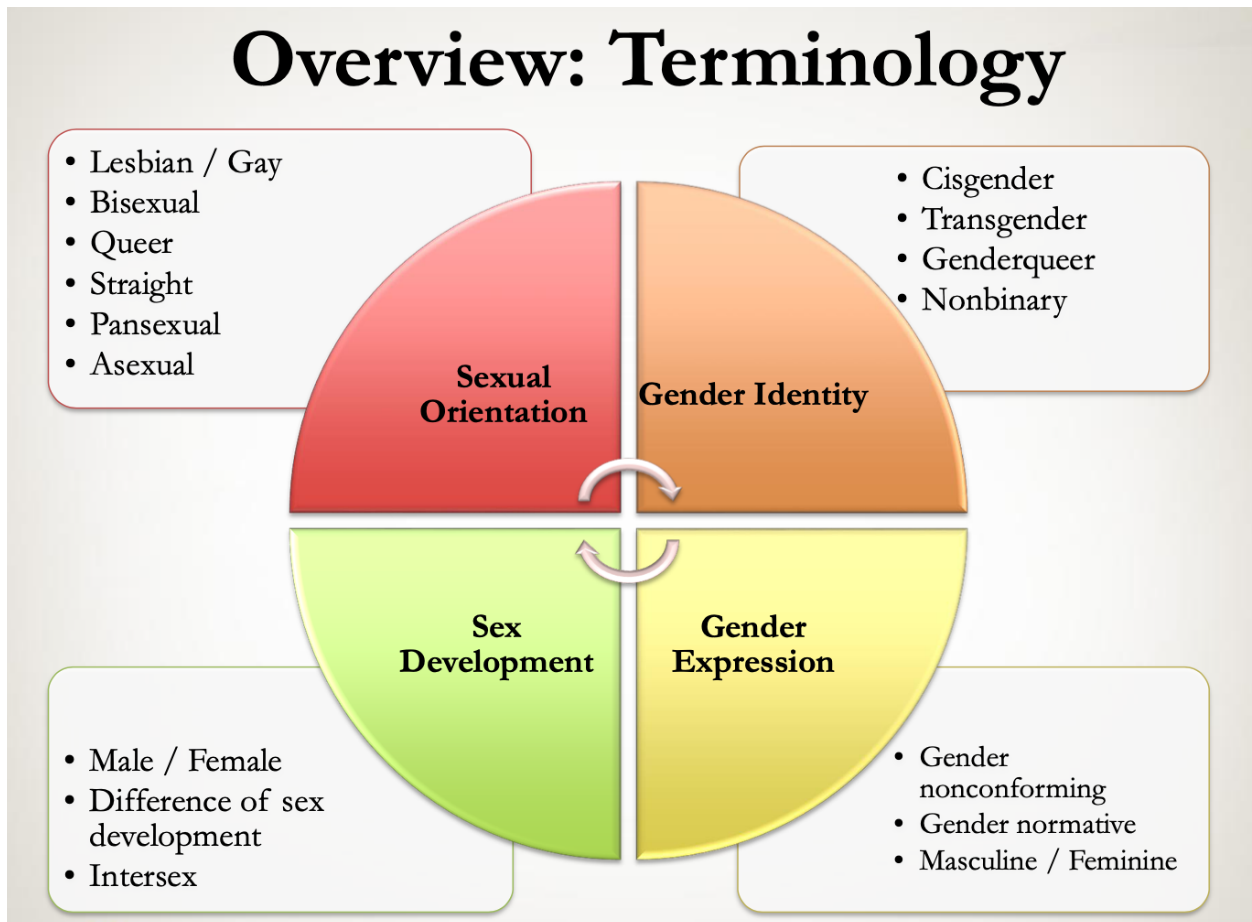
Lastly, future research should examine how LGBTQ physicians, students, and patients of color, understand LGBTQ health as intersecting with race/ethnicity, class, and ability. Findings from this research suggest that LGBTQ health gets packaged in the medical curriculum following the logic of previous DEI initiatives, which focused on race, and educators explain that LGBTQ health is intersectional, but these topics were often kept separate. Highlighting the intersectional perspectives of physicians, students, and patients would allow for a fuller understanding of how enactments of LGBTQ health are racialized, class, and able-bodied.

Conclusion

This research examined the formal, informal, and hidden curricula surrounding LGBTQ health to explore how medical schools train and thus attempt to prepare medical students to provide care to these patients. In doing so, I charted the enactment of LGBTQ health in the curriculum. Findings suggest that the content, placement, and delivery of LGBTQ health in the curriculum influence how medical students learn to see themselves as capable of providing care to these patients. This research asserts that to create medical curriculum about LGBTQ health that will help alleviate health care disparities, medical schools cannot simply add LGBTQ health into their curriculum without fundamentally changing how they teach sex, gender, and sexuality to their students. Proponents of LGBTQ health at Southeastern, including medical faculty, students, administrators, LGBTQ health center employees, and LGBTQ patients have started LGBTQ health initiatives that are undoubtedly doing important work to extend and improve health care access for LGBTQ patients. The LGBTQ health center initiatives, transgender health clinics, grand rounds lectures, social justice clubs' events, and LGBTQ health focused curricula represent the importance that LGBTQ health at Southeastern. In doing so, these educators work to integrate LGBTQ health into the current workings of the academic medical center. This research recognizes not only the importance but the difficulties that this kind of work experiences, especially for something as nebulous and complex as LGBTQ health. As such, future medical education efforts must grapple with the complexity of queer health, as opposed to LGBTQ health, and reconcile with a transformative approach to health equity, one that requires attention to power dynamics, systems of inequality, and the embeddedness of sex, gender, and sexuality binaries in medicine. A move to queer health will help medical educators focus on new ways to partner with queer and trans populations to transform health care.

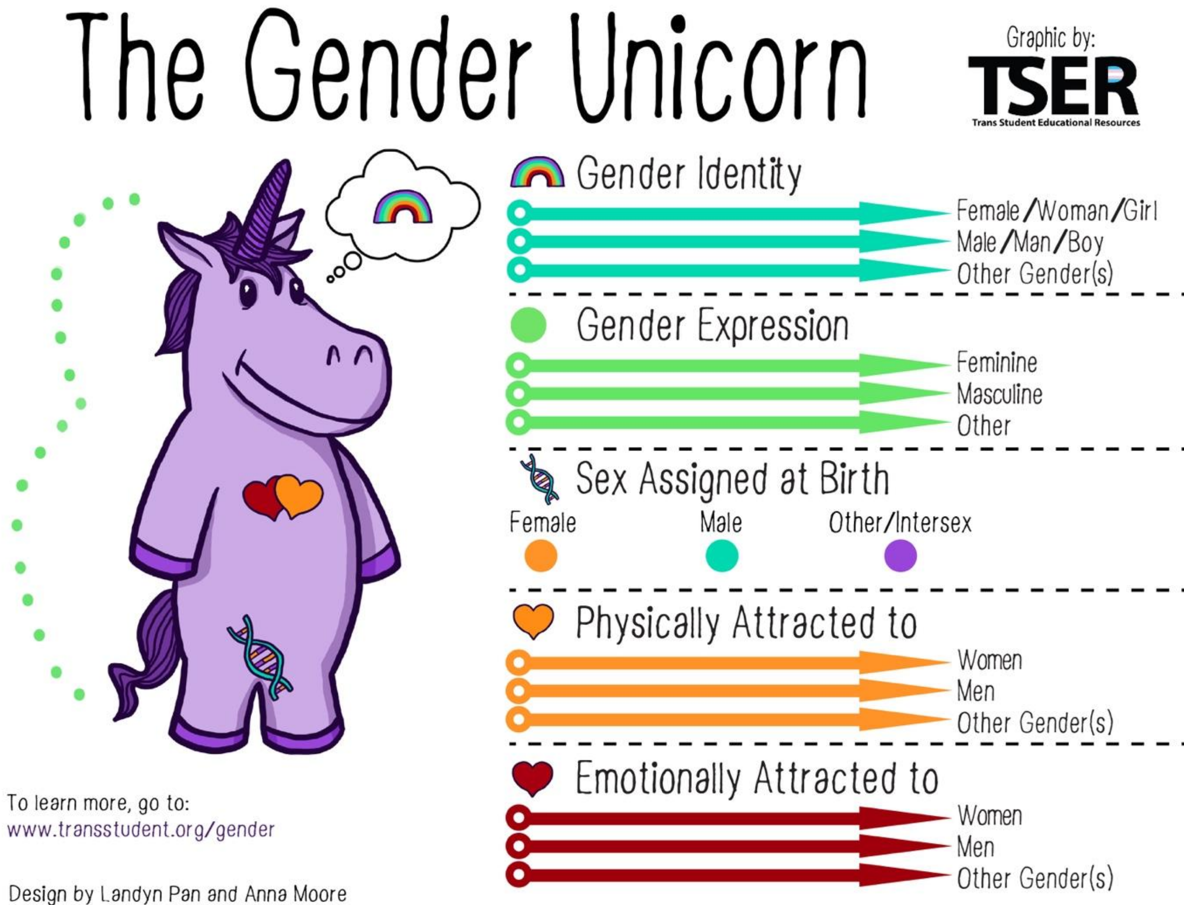
FIGURES

Figure 1. LGBTQ Terminology



Source: Jessica Herling

Figure 2. The Gender Unicorn



Source: Trans Student Educational Resources (2015), used with permission of author under Creative Commons License

TABLES

Table 1. Study Participants

ID#	Affiliation	Description	Race	Gender Identity	Sexual Orientation
1	Administration	Upper-level administrator	White	Cisgender woman	Heterosexual
2	Medical Student	3rd year	White	Cisgender man	Gay
3	LGBTQ Health Center Employee/Affiliate	Affiliate	White	Genderqueer	Gay
4	Administration	Staff member	White	Cisgender woman	Heterosexual
5	Medical Faculty	Neurology	White	Cisgender man	Gay
6	LGBTQ Health Center Employee/Affiliate	Employee	White	Cisgender man	Gay/Queer
7	Medical Faculty	Youth and Adolescent Health	White	Cisgender woman	Heterosexual
8	Administration	Upper-level administrator	White	Cisgender woman	Heterosexual
9	LGBTQ Health Center Employee/Affiliate	Employee	White	Cisgender man	Gay
10	Medical Faculty	Anesthesiology	White	Cisgender man	Gay
11	LGBTQ Health Center Employee/Affiliate	Affiliate	White	Cisgender woman	Heterosexual
12	Community Member	Patient/Board member	African American	Trans guy	Pansexual
13	Medical Faculty	Endocrinology	White	Cisgender woman	Heterosexual
14	Community Member	Board member	White	Cisgender woman	Heterosexual

15	Community Member	Board member	White	Woman, trans woman	Heterosexual
16	Medical Faculty	Pediatrics	Asian American, Indian American	Cisgender man	Heterosexual
17	Medical Faculty	Youth and Adolescent Health	White	Cisgender woman	Heterosexual
18	Medical Student	3rd year	White	Cisgender woman	Heterosexual
19	Medical Faculty	Endocrinology	White	Cisgender man	Heterosexual
20	Community Member	Patient	White	Nonbinary, Genderfluid, Between Transfeminine and Not really a Gender, Androgynous	Pansexual, Bisexual
21	Medical Faculty	Family Medicine	White	Cisgender woman	Bisexual
22	Administration	Upper-level administrator	White	Cisgender woman	Heterosexual
23	Medical Faculty	Internal Medicine	White	Cisgender woman	Heterosexual
24	Medical Faculty	Infectious Disease	White	Cisgender woman	Heterosexual
25	Administration	Upper-level administrator	White	Cisgender man	Heterosexual
26	Medical Faculty	OB-GYN	White	Cisgender man	Heterosexual
27	Administration	Mid-level administrator	White	Cisgender man	Heterosexual
28	Medical Faculty	Family Medicine	White	Cisgender woman	Heterosexual
29	Administration	Upper-level administrator	African American	Woman	Heterosexual
30	Administration	Upper-level	African	Woman	Heterosexual

		administrator	American		
31	Medical Student	Recent graduate	White	Cisgender woman	Heterosexual
32	Medical Faculty	OB-GYN	White	Cisgender woman	Heterosexual
34	Medical Faculty	OB-GYN	White	Cisgender woman	Heterosexual
35	Medical Faculty	OB-GYN	White	Cisgender woman	Heterosexual
36	Medical Faculty	Plastics	White	Nonbinary, gender fluid	Heterosexual
37	Medical Faculty	Plastics	White	Cisgender man	Heterosexual
38	Community Member	Patient	White	Trans masculine, nonbinary	Queer
39	Community Member	Patient	White	Cisgender man	Gay
42	Medical Student	MD/PhD student	Asian	Cisgender man	Heterosexual
43	Medical Student	3rd year	White	Cisgender woman	Queer
44	Medical Student	2nd year	White	Cisgender woman	Heterosexual
45	Medical Student	MD/PhD student	White	Cisgender woman	Heterosexual
46	Community Member	Patient	White	Trans woman	Bisexual, poly
47	Medical Student	2nd year	White	Cisgender woman	Heterosexual
48	Medical Student	MD/PhD student	Asian, South Asian	Cisgender woman	Heterosexual
49	Medical Student	4th year	White	Cisgender woman	Heterosexual

Table 2. LGBTQ Health in the Medical Curriculum

Year of Medical School	Integration in the curriculum	Topics
First year	Professionalism	LGBTQ health care disparities
	Diagnosis	LGBTQ sexual history taking
	Epidemiology and Microbial and Immune Diseases	Risk factors for Sexual Transmitted Infection (STIs)
	Endocrine and Reproduction	Gender dysphoria case
	Neuroscience and Psychiatry	Mental health concerns related to gender identity and sexual orientation
Second year	Ob/Gyn*	Shadowing physicians who provide Ob/Gyn care to LGBTQ patients
	Pediatrics	Didactics on LGBTQ health; transgender youth panel discussion;* shadowing physicians who provide primary care to LGBTQ patients*
Third/Fourth year	Sexual Health science course*	LGBTQ health cultural competency training; shadowing physicians who provide primary care to transgender and nonbinary patients
	Plastics clinical course*	Shadowing physicians who provide gender-affirming surgery to transgender and nonbinary patients

	Student Research Projects*	Design and conduct a research project focusing on LGBTQ health
All years of medical school	Transgender clinic*; Transgender youth clinic*; Plastics gender clinic*; Pediatrics; HIV clinic*	Shadowing physicians who provide primary care, gender-affirming surgery, and HIV care to LGBTQ patients
	Grand round public lectures*	Attending department grand rounds on LGBTQ health and DSD diagnoses
	LGBTQ Health Center lectures and community engagement events*	Attending LGBTQ Health symposium, Transgender Day of Remembrance, or related events

Source: Adapted from Herling (2021)

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