ABSTRACT

Investigating the Origin of Discrimination Toward Pregnant Transgender Men with Proposed Methods of Medical Education Reform

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Throughout history, the LGBTQ+ community has faced monumental obstacles in its journey of seeking inclusion and acceptance. Those who identify as transgender have faced some of the hardest obstacles, such as gaining support and acceptance from family and peers and pursuing gender-affirming healthcare from their doctors. In recent years, this gender-affirming healthcare has come under fire and is at risk of being banned in multiple states, proving that the attack on transgender people has only increased despite ongoing increases in acceptance and support for the LGBTQ+ community. One barrier to healthcare access that female-to-male (FTM) transgender people face is the prospect of pregnancy. Pregnant transgender men often face discrimination and prejudice by their healthcare providers when they seek obstetrics care, and in this thesis, I seek to understand and find the origin of this discrimination as well as address ways of improving undergraduate and graduate medical education to help facilitate better LGBTQ+ healthcare. I begin with an overview of LGBTQ+ history and then proceed into a detailed analysis of experiences of transgender discrimination in healthcare. From there, I investigate the origins of this discrimination and provide proposals to address and eliminate this discrimination.

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INVESTIGATING THE ORIGIN OF DISCRIMINATION TOWARD PREGNANT TRANSGENDER MEN WITH PROPOSED METHODS OF MEDICAL EDUCATION REFORM

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INTRODUCTION

It might be easy to think that LGBTQ+ history began with the Stonewall riots in 1969, and while this marked a significant moment in LGBTQ+ history, it was neither the starting or stopping point in the LGBTQ+ rights movement. The LGBTQ+ community has been fighting for inclusion and rights since the beginning of time, and they are still fighting for the same inclusion and rights today. There have been improvements for LGBTQ+ rights, such as the monumental *Obergefell v. Hodges* case that gave way for the United States Supreme Court to strike down state bans on same-sex marriage. However, when it seems steps are made in the positive direction for LGBTQ+ rights, there will always be steps made in the opposite direction. As of now, the American Civil Liberties Union is tracking 484 anti-LGBTQ+ bills in the United States, which demonstrates that while we have made steps in the positive direction of LGBTQ+ rights, there are still attacks being made on these rights every day.[1] LGBTQ+ history is made every day that the community continues to fight for their rights, and it is important to understand this history and the role that this history has on the gay rights movement.

The LGBTQ+ community has been very fortunate in the past few decades as more attention has been brought to their suffering and rights. Still, one community that has remained in the dark as the community has gained this attention is the community of transgender men who are pregnant or have given birth. The inspiration for pursuing this subject matter not only stems from an overall lack of information on this subject but also

[1] "Mapping Attacks on LGBTQ Rights in U.S. State Legislatures in 2024."

from personal interest sparked by discovering transgender father content creators who blog about their experiences being pregnant and giving birth post-transition. I learned much from these content creators about this niche community that does not receive much attention from both the media and the medical community. Because of this lack of attention, there is an overall lack of knowledge and education on how to properly provide care to these communities. These content creators, as well as participants in the studies that I have included in later chapters of this thesis, speak about their experiences in healthcare and how these experiences are not always positive. They speak about the stigmatization they face as well as discrimination because they are pregnant men. I chose this subject to write about because it is a topic that I think deserves more attention than it is getting, and I think that this discrimination could be easily fixed if society made the effort to understand its origins and what it takes to fix it. In this thesis, I aim to bring attention to this issue, shed light on the possible origins, and propose methods of reform to aid in the elimination of this discrimination.

Chapter One of this thesis provides a brief, yet detailed description of LGBTQ+ history beginning with the Stonewall Riots. It is important to note that LGBTQ+ history did not start with the Stonewall Riots, but this event catapulted the community into the limelight and can be attributed to the beginning of the gay rights movement. While I do not include every historical event involving the LGBTQ+ community, I have included events that I perceived to be the most important to my subject matter as having roles in the increased stigmatization of the LGBTQ+ community or as having roles in breaking through this stigmatization. LGBTQ+ history continues to be made every day, and there have been important events that have taken place since I began to write this thesis.

LGBTQ+ history is a robust subject matter that could have an entire thesis dedicated to it, but because I have sought to condense this history into a singular thesis chapter, I have inevitably left out some events that are undoubtedly important to recognize. I would like to mention that just because I have left out certain events does not mean I think these events are unimportant to LGBTQ+ history, but rather I had to choose certain events to include that I thought best exemplified the points and arguments I make in this thesis.

Chapter Two of this thesis narrows into an analysis of discrimination and prejudice towards the community of pregnant transgender men or transgender men who have already given birth. This chapter utilizes studies on the experiences of transgender men who were pregnant or have given birth to understand the scope of the discrimination and prejudice they receive on behalf of their medical providers and the medical community as a whole. One of the examples I provide does not stem from a particular study but is rather a famous example of a transgender man who rose to popularity because of his pregnancy. Thomas Beatie, also known as "the pregnant man," is one of the most popular examples of how society perceives transgender men who are pregnant as he received both positive and negative attention from his pregnancy. Other studies included in this chapter look at the overall experiences of transgender men during their pregnancies and report a common thread of rude treatment from their medical providers or being turned away from treatment altogether. This chapter is used to provide specific examples of discrimination and prejudice that these transgender men experience in healthcare so that more people can understand the dire need for education on how to properly care for and treat this community.

Chapter Three moves into an investigation of the origins of LGBTQ+ discrimination in healthcare, with a focus on transgender discrimination. The origin that I focus on in this chapter is the lack of adequate medical education on LGBTQ+ care in both undergraduate and graduate medical education. There is an overall lack of knowledge and education on how to treat LGBTQ+ patients, specifically transgender patients. Because of this lack of education, it can be understood why medical providers cannot give their LGBTQ+ patients the standard of care that they deserve. Besides the overall lack of medical education on LGBTQ+ health topics, I also bring attention to institutionalized heteronormativity in medical education as well as implicit biases taught through the hidden curriculum in medical education. While some may argue that the origins of LGBTQ+ discrimination have a theological basis, theology is not the focus of this thesis and I have avoided delving into theological implications on sexuality and gender orientation at this time. Rather, I solely focus on undergraduate and graduate medical education and its lack of LGBTQ+ curriculum, its institutionalized heteronormativity, and the presence of the hidden curriculum in this education.

Lastly, Chapter Four is a section on proposed methods of medical education reform. Throughout this chapter, I mostly reference two articles because of their incredible proposed methods of reform and their empirical evidence of how the reformed curriculum works. The first article is more of a speculative idea of what medical education reform should look like, while the second article is a review of an actual curriculum implementation that brought about an increase in knowledge and comfort regarding LGBTQ+ health topics. This chapter includes a lengthy analysis of what a proper curriculum that includes a proper amount of time dedicated to LGBTQ+ health

topics would look like and the overall positive results that come from implementing this curriculum. This chapter provides a glimpse into a medical community that is comfortable treating LGBTQ+ patients and in which there is virtually no discrimination or prejudice that stems from a lack of knowledge and education about LGBTQ+ care.

This thesis has been incredibly enlightening to write as I have learned much about a niche subject and community that already does not have much information published on them. I am grateful for the support I have received throughout the process of writing this thesis from my thesis advisor as well as my family and peers. I could not have written this thesis without the help and support of my thesis advisor, Dr. Katelyn Jaynes of Baylor University, who has been with me every step of the way. My peers at Baylor University have also served to be an incredible resource and source of support as I dedicated long hours to writing this thesis. Lastly, I am truly grateful to my family who have been by my side every day and have always pushed me to pursue topics of which I am passionate. This thesis was not written and completed by myself alone, and I would like to dedicate this thesis to everyone who has had some part in helping me throughout the past few years that I have worked on this thesis. There is not a day that goes by that I am not thankful for the support and encouragement I have received.

CHAPTER ONE

A History of Queer Discrimination in the United States

Despite the recent uptick in conversations regarding the LGBTQ+ community, the LGBTQ+ identity has been around for decades. While it may seem that those in the LGBTQ have garnered profound improvements in terms of acceptance and inclusivity, it was a long and arduous road to get here. The community continues to face obstacles, and it does not seem that the road to full inclusivity will be an easy one, especially with recent attacks on laws permitting gender-affirming care for minors. In this chapter, I will briefly cover the history of challenges and discrimination the LGBTQ+ community has faced, and then delve specifically into the barriers that transgender people have faced in healthcare. It is vital to understand the history of the LGBTQ+ community in order to understand the full scope of the discrimination that the community has faced and continues to face today. Throughout my paper, I will use LGBTQ+ and queer interchangeably, as I think of them as synonymous terms because "queer" can be used as a blanket term to encompass every sexual identity. To be properly equipped to fight against this discrimination, a knowledge of the community's history will provide the appropriate background knowledge to understand the need for change. This will provide a gateway into the discussion of the origin of discrimination and prejudice towards transgender men who are pregnant and seeking obstetrics care.

To simply say that the LGBTQ+ community has faced obstacles throughout history would be an understatement to the true nature of the hatred and attacks they have had to withstand. It is a common misconception that it was harder for those in

the LGBTQ+ community to exist in the previous centuries, but recent targeted attacks such as the shootings at the Pulse club in Orlando, Florida and at Club Q in Colorado Springs, Colorado show that just existing as a LGBTQ+ person in today's time is still a dangerous act. It is without a doubt that those in the LGBTQ+ community live more proudly than they did a hundred years ago, but this is due to the sacrifices and work of those who came before. One such sacrifice occurred at the Stonewall Inn, which was a gay bar, on June 27th, 1969, in which people who only wished to dance and have fun had their night ruined when the New York Police Department (NYPD) raided the inn and became violent towards those who went against what was perceived as the standard gender norms.

Being a member of the LGBTQ+ community meant constantly seeking a place in which you fit in and could also unwind without the fear of being harassed. To most, the Stonewall Inn was that place of acceptance and comfort where LGBTQ+ youth could be confident in their identities. Besides the presence of LGBTQ+ youth that dominated the Stonewall atmosphere, there was also the blend of other cultures as African-Americans and Latinos also frequented the inn alongside working- and middle-class whites.[1] William Eskridge is quoted saying that Stonewall was "a place where queer was normal, and society's prejudice could be forgotten," so it is easy to see why Stonewall was a place of comfort for a variety of people.[2] The night of the Stonewall riots, the patrons were more uncooperative than normal, leading to unrest and disgruntlement as police began arresting

[1] Ibid, 32.

[2] Ibid, 32.

some of the party-goers.[3] A rock was thrown into a police car, which set in motion the violent events of the night. The riots did not stop that night, and the crowds continued to gather the following evening and began demanding the end of harassment.[4] Looking at how quickly the riots progressed from the first rock thrown to the Molotov cocktails, it can be understood that the patrons of the inn saw this as an opportunity to air out their frustrations and that it was a combination of activism from the previous years. This was an open gate for the LGBTQ+ community to take care of their grievances and it acted as motivation for the gay rights movement that took over the United States and the world.

Four years prior to the Stonewall riots, John Lindsay had been elected as mayor of New York City, and upon his election, he "ended the brutal program of repression and entrapment of gays carried out under the administration of Mayor Robert Wagner."[5] This was, without a doubt, a catalyst for the attacks that would occur within the next four years. During the month of June in 1969, numerous gay bars experienced raids and attacks, with the attack on Stonewall occurring on June 24th. Compared to the other bars, Stonewall piqued the interest of police due to the rumor that "it appeared Wall Street employees who frequented the bar were being blackmailed for information facilitating the theft of negotiable bonds," and because of this, the police intended to raid the bar and close it for good.[6] This blackmail was reportedly being done by the Mafia towards

[3] Ibid, 33.

[4] Ibid, 33.

[5] Frank, *Law and the Gay Rights Story*, 32.

[6] Ibid, 32.

wealthier patrons of the Stonewall Inn who wanted to keep their sexuality a secret.[7] It would be reasonable to wonder why Stonewall was the bar that received so much publicity in the wake of attacks on the other bars. The attention came from the fact that the Stonewall riots were one of the rare times that rioters gained the upper hand on the police, including the anti-Vietnam War and civil rights protests.[8]

Three years after the Stonewall Riots, the term "homosexuality" was removed from the *DSM-II's* official list of psychiatric disorders by a vote of 13-0 by the American Psychiatric Association. On February 8, 1973, the Nomenclature Committee of the American Psychiatric Association (APA) met with a committee of gay activists who were representing New York City's *Gay Activist Alliance*.[9] The committee acknowledged how defining homosexuality as a psychiatric disorder invited negative attitudes towards the queer community, saying that "Because the psychiatric profession was one of the 'gate-keepers' of society's attitudes, we believed that this change would have profound effects on the lives of gay people; it would hasten the elimination of sodomy laws and 'moral turpitude' clauses in state regulations that prohibited the licensing of otherwise qualified professionals."[10] Ten months later, in December of 1973, the committee of gay activists' wishes came true. On December 15, 1973, the Board of Directors of the APA made the executive decision and declassified homosexuality per se as a mental disorder from the

[7] "1969 Stonewall Riots - Origins, Timeline & Leaders."

[8] Ibid, 33.

[9] Silverstein, "The Implications of Removing Homosexuality from the DSM as a Mental Disorder."

[10] Ibid.

DSM-II.[11] This decision marked a step in the positive direction for the gay rights movement because declassifying homosexuality as a psychiatric disorder helped to remove some of the negative stigmatization that stemmed from that classification.

While this action may seem like a monumental step forward in the Gay Rights Movement, it is important to know that this decision was conditional. The Nomenclature Committee recommended to the Board of Directors that only *some* homosexuals suffered from Sexual Orientation Disorder and were in need of treatment, meaning that while the Board of Directors declassified homosexuality as a psychiatric disorder from the *DSM-II,* it was still considered a psychiatric disorder based on certain qualifications.[12] According to the *DSM-III,* which was released in 1980, "homosexuals were classified as either ego-syntonic toward their sexual orientation, and not in need of treatment, or ego-alien, and therefore, suffering from a mental disorder," and the *DSM-III* did not specify whether the treatment would be directed toward sexual orientation change or working toward an ego-syntonic homosexuality.[13] The *DSM-III* removed the diagnosis of "Egodystonic Homosexuality", but it left the residual diagnosis "Sexual Disorder Not Otherwise Specified" which could apply to "any" sexual orientation.[14] The long-range goal of the activist committee was that the entire group of sexual disorders would be dropped from the *DSM.*[15] While the short-range goal of the committee was accomplished, it has been

[11] Ibid.

[12] Ibid.

[13] Ibid.

[14] Ibid.

[15] Ibid.

thirty-five years since the Board of Directors declassified homosexuality and the committee's long-range goal has yet to be achieved. As I argue in my thesis, proper medical education on sexual orientations and gender identities would aid in the overall discrimination towards the LGBTQ+ community in healthcare, and with this medical education reform, achieving the long-range goal of dropping all sexual disorders from the *DSM* may be achieved after all.

In 1977, four years after the declassification of homosexuality as a psychiatric disorder, Harvey Milk made history when he became the first openly gay person to be elected to public office in California when he won a seat on the San Francisco Board of Supervisors.[16] Milk did not initially have any desire to go into politics or be a gay rights symbol, as he only entered politics when he was forty-three and kept his gay identity a secret for most of his life.[17] Milk grew up in the New York City suburbs, went to college at the University of Albany, joined the Navy, and then became a high school teacher.[18] He was dissatisfied with his teaching job, and when his partner took a job as a stage manager in San Francisco, Milk moved with him and became a financial analyst.[19] Milk was fired from his job as a financial analyst for burning his BankAmerica card during a protest against the Vietnam War and moved back to New York, but he resettled in San Francisco in 1973 where he and his new partner, Scott Smith, opened a store called Castro

[16] Foss, "The Logic of Folly in the Political Campaigns of Harvey Milk."

[17] Ibid.

[18] Ibid.

[19] Ibid.

Camera.[20] Milk was extremely frustrated with the government's failure to meet people's needs, and this served as his catapult into politics. Between 1973 and 1977, Milk entered many elections, some of which he won and some he lost. In 1977, Milk was successful when he ran for supervisor for a third time, and he was elected to the California Assembly.[21] Milk only served for eleven months because, on November 27, 1978, he and Mayor George Moscone were assassinated by Supervisor Dan White, who was to learn that he was not being reappointed to the Board of Supervisors on that day.[22] While these events have nothing to do with the discrimination in healthcare, it is important to understand how the events of Stonewall and the *DSM* declassification impacted the queer community as a whole. With the gay rights movement gaining traction and stigmatization around LGBTQ+ people lessening, queer people felt safer expressing their identities in public. As I have mentioned previously in my discussion about the *DSM,* proper education and support can alter how people perceive the LGBTQ+ community. In my thesis, I argue for medical education reform because of how our current medical education has negatively impacted how medical providers treat their LGBTQ+ patients. As we can see from Harvey Milk and his success following Stonewall and the *DSM* changes, proper education and community support can change the lives of LGBTQ+ people.

[20] Ibid.

[21] Ibid.

[22] Ibid.

Three years after Milk was assassinated, AIDS diagnoses began to pick up in the United States. Before the name was changed, Acquired Immune Deficiency Syndrome (AIDS) was known as Gay-Related Immunodeficiency Disorder (GRID). Between June 1, 1981, and September 15, 1982, the Centers for Disease Control and Prevention (CDC) reported 593 cases of AIDS, and death occurred in 243 of those cases.[23] In reference to which populations were most heavily affected by AIDS, the CDC reported that "Approximately 75% of AIDS cases occurred among homosexual or bisexual males, among whom the reported the prevalence of intravenous drug abuse was 12%. Among the 20% of known heterosexual cases (males and females), the prevalence of intravenous drug use was about 60%."[24]

In 1980, Ken Horne, who was a gay sex worker in California, became the first person to be diagnosed with AIDS in the United States, and a year later, the CDC's *Morbidity and Mortality Weekly Report* wrote about five cases of Pneumocystis pneumonia in homosexual men living in Los Angeles, California.[25] The term "gay-related immune deficiency" (GRID) started gaining media attention and healthcare professionals used the term to link homosexuality and what would become known as human immunodeficiency virus (HIV).[26] The use of "gay-related immune deficiency" reflected

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[23] "Current Trends Update on Acquired Immune Deficiency Syndrome (AIDS) -- United States."

[24] Ibid.

[25] Ayala and Spieldenner, "HIV Is a Story First Written on the Bodies of Gay and Bisexual Men."

[26] Ibid.

ignorance toward the queer community and the lack of epidemiological knowledge concerning HIV and AIDS at the time.

The use of GRID coupled with increases in homophobia led to increased frustration in gay men with AIDS, which sparked a need for conversation on the stigmas that arose after the increase in AIDS diagnoses. In 1983, gay men with AIDS attended the Fifth Annual Gay and Lesbian Health Conference and brought forth the Denver Principles, which "catalyzed self-empowerment across health movements for decades to come."[27] Looking at the data from the 1980s to today, "race, class, and sexual orientation continue to shape the HIV epidemic in the United States and around the world, with new infections disproportionately affecting men who have sex with men in Black and Brown communities."[28] Looking at global data, from 2010 to 2019, HIV diagnoses increased by 25% among gay and bisexual men as infections in other groups declined, and in the United States, gay and bisexual men make up almost 70% of new HIV cases each year.[29] While there has been increased conversation and knowledge on the causes of HIV and AIDS, there continues to be a stigma surrounding the diseases and their relation to the queer community. Even today, some people exclusively refer to it as a "gay disease," showing the continued homophobic ignorance and discrimination that the queer community faces. Because of this ignorance surrounding HIV and AIDS, queer people are still subject to stigmatization because the negative beliefs surrounding these diseases.

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[27] Ibid.

[28] Ibid.

[29] Ibid.

Because of this stigmatization, queer people with HIV and AIDS are often subjected to prejudice, discrimination, and/or harassment based on falsely held beliefs.

In the years between 1980 and 2000, there was no absence of homophobic attacks and discrimination toward the queer community. While there were significant advances in queer inclusion, the advances were coupled with numerous setbacks, leading to the question of whether queer people would ever truly be able to fit into American society. However, in 2003, the U.S. Supreme Court made a monumental move in the positive direction of queer rights. Laws prohibiting sodomy existed in numerous states for more than 100 years, which criminalized sexual behavior between same-sex and opposite-sex partners. In 1998, John Lawrence and Tyrone Garner were arrested and charged with violating the Texas sodomy law, which stated that "a person commits an offense if he engages in deviate sexual intercourse with another individual of the same sex," and "deviate sexual intercourse" was defined as being "any contact between any part of the genitals of one person and the mouth or anus of another person."[30] When the case went in front of the Supreme Court, Justice Anthony Kennedy asked the question of whether "the petitioners were free as adults to engage in private conduct in the exercise of their liberty under the Due Process Clause of the Fourteenth Amendment to the Constitution," and then Justice Kennedy turned his attention to how sodomy laws sought to "control a personal relationship that, whether or not entitled to formal recognition in the law, is within the liberty of persons to choose without being punished as criminals."[31] In 2003,

[30] Weinmeyer, "The Decriminalization of Sodomy in the United States."

[31] Ibid.

the case of *Lawrence v. Texas* resulted in the majority of the Supreme Court striking down the Texas sodomy law, and, ultimately, all sodomy laws, which decriminalized the act of homosexual behavior and gave the queer community more freedom to be themselves without the fear of breaking the law. With more freedom to be themselves, members of the LGBTQ+ community felt safer doing several different activities, such as seeking general medical care and gender-affirming care.

Looking more specifically at improvements in healthcare for the queer community, in 2012, the Food and Drug Administration approved Truvada to be taken as a daily preventative for those at risk of acquiring HIV as PrEP (Pre-Exposure Prophylaxis), which marked the first time a drug had been approved to "prevent acquisition of sexually and intravenous transmission of HIV."[32] Two years later, the Human Rights Campaign (HRC) endorsed the use of Truvada for PrEP. After trials and research, the data yielded that Truvada could reduce the risk of obtaining HIV by upwards of 90 percent if it is prescribed by a competent healthcare provider and paired with other safer sex practices.[33] Eleven years after the Food and Drug Administration approved Truvada, there have been two more medications that have been approved for use as PrEP, Descovy (a pill) and Apretude (an injection).[34] While it can be considered an advancement that we now have three medications aimed at helping with HIV contraction, there is still a lack of discourse on the prevalence of HIV within the queer community

[32]"LGBTQ History Timeline Lesson."

[33] "Human Rights Campaign; HRC Endorses PrEP, Calls for Bold Action to Expand Access to Anti-HIV Drug."

[34] "About PrEP | PrEP | HIV Basics | HIV/AIDS | CDC."

and how there needs to be a variety of options for those wishing to take steps to prevent HIV contraction. In order for there to be a discourse on the prevalence of HIV in the queer community, people would need to acknowledge the lack of medical knowledge that we have on the queer community, which is not something our society has mastered.

Another queer milestone reached in 2014 was when the Department of Education issued guidance that clarified that transgender students are protected from discrimination under Title IX, which is a federal civil rights law that prohibits discrimination against students based on their sex and/or gender in federally funded education programs and activities.[35] For most people, it is known that all transgender people are vulnerable to prejudice, discrimination, and harassment, but transgender students are an especially vulnerable population due to their age and proximity to cisgender (gender identity that corresponds to sex assigned at birth) students who may not understand what it means to be transgender. Because of the lack of literature and discourse on transgender people and their struggles, most people are unaware of how dangerous it can be to be transgender in the United States. Transgender students are at higher risk of being victims of bullying and discrimination in schools because of this lack of conversation and acts of discrimination towards these students can come in all forms.

Some of the most common acts of discrimination towards transgender students are prohibiting them from using the bathroom that aligns with the gender they identify with, not letting them participate on sports teams of the gender they identify with, and not letting them dress in clothes that are appropriate for their affirmed gender. There are

[35] "LGBTQ History Timeline Lesson."

countless other forms of discrimination that have occurred towards transgender students. Smith College, an all-woman college, refused to consider the application of a transgender female because there was one male gender marker appearing in a single component of her application.[36] A transgender woman was expelled from California Baptist University after she outed herself when she appeared on a program on MTV.[37] A transgender woman student-athlete was criticized on a nationally-syndicated sports radio program because of her age and natal sex.[38] These examples that I have listed occurred within a three-month period in early 2013, showing just how many acts of discrimination transgender students face on a daily basis. These examples, and the frequency of these acts of discrimination, show the need for literature on transgender people as well as more discourse on transgender life.

One of the biggest obstacles the queer community has faced throughout hundreds of years was the laws prohibiting same-sex marriage. Throughout the years, there have been many efforts to move toward marriage equality, but full marriage equality did not come until June 26, 2015. On that day in 2015, the decision in *Obergefell v. Hodges* was a 5-4 vote that granted same-sex couples in all fifty states the right to full and equal recognition under the law.[39] The Supreme Court held that the "Due Process Clause of the Fourteenth Amendment guarantees the right to marry as one of the fundamental liberties

[36] Buzuvis, "On the Basis of Sex."

[37] Ibid.

[38] Ibid.

[39] "Obergefell v. Hodges."

it protects, and that analysis applies to same-sex couples in the same manner as it does to opposite-sex couples," going further to state that "Judicial precedent has held that the right to marry is a fundamental liberty because it is inherent to the concept of individual autonomy."[40] With full marriage equality finally being achieved in the United States, the queer community celebrated their win. Years of fighting for marriage inclusion and queer rights had given way to a new way of life, a life where queer couples could be recognized under the law. Despite the significant leaps forward in the movement for queer inclusion and rights, queer discrimination still exists.

There are efforts happening today to revoke the decision in *Obergefell v. Hodges and* considering how the Supreme Court overturned the monumental decision in *Roe v. Wade* in June 2022, there is a possibility that we may live again in a world without marriage equality. To tie this event in with the healthcare elements of this thesis, there are many healthcare decisions that are attached to marriage. Unless a person is in a state-recognized marriage, their partner cannot help to enact medical decisions on their behalf unless they have power of attorney, and the partner may not be able to be present during discussions with the physician. With same-sex marriage legalized, same-sex couples do not have to confront these fears, but if *Obergefell v. Hodges* is ever overturned, the LGBTQ+ community will face these obstacles and not have the same rights as heterosexual couples when it comes to medical decision making for their partner. Taking this into consideration, it is clear that the LGBTQ+ community faces many obstacles

[40] Ibid

when it comes to the medical community and healthcare, not just obstacles involving one's own medical care.

In a world filled with homophobia and transphobia, it might not be shocking to know that the queer community faces a significant portion of prejudice and discrimination in healthcare. In a field where the community should feel safe and should not worry about being judged for their sexual or gender orientation by doing the simple act of getting a check-up, the queer community faces the same injustice as they would face anywhere else. Despite the strides and wins for the queer community described in the previous paragraphs, the community still faces tall obstacles in achieving just treatment from healthcare providers (HCPs) and other health professionals. There is a current and ongoing fight for states to approve access to gender-affirming care for LGBTQ+ youth, and as of September 15, 2023, there are twenty-two states that have laws or policies banning gender-affirming care for youths up to the age of eighteen.[41] Compared to the statistic that 35.1% of transgender youth live in these states that have bans on gender-affirming care, it is reasonable to believe that these individuals face an extreme amount of distress over the lack of accessible resources and care for them.[42] Some states, including Oklahoma, Texas, and South Carolina, are considering banning gender-affirming care for transgender people up to the age of twenty-six, and it is likely that with our current political climate, more states will follow. Why is there an attack on gender-affirming care for the transgender community, and why is there such obvious

[41] "Map: Attacks on Gender Affirming Care by State - Human Rights Campaign."

[42] Ibid.

discrimination towards the queer community, specifically the transgender community, in healthcare? This thesis serves to investigate this origin of discrimination, but first, we need to look at some of the barriers the entire LGBTQ+ community has faced in healthcare.

The healthcare community first failed the queer community when they classified homosexuality as a mental disorder and transgender identities as gender identity disorders, completely disregarding how this would affect the queer community. As the queer community health disparities have come into more focus at the national level, the United States Department for Health and Human Services (USDHHS) Health People 2020 initiative recognized the importance in improving health outcomes for those in the queer community, saying that "Globally, members of the LGBTQ community exhibit a number of health disparities related to physical health and wellness, sexually transmitted diseases, mental health, substance use, victimization, bullying, and housing insecurity" and that "Older adults identifying as LGBTQ are susceptible to many health disparities. Age has a direct impact on experiences and quality of life over the lifespan, with many LGBTQ older adults reporting a lifetime of victimization, racism, discrimination, health inequalities, and shame during a time when expression of LGBTQ identity was suppressed due to legal ramifications."[43] There is an obvious need for discourse on the prevalence of queer healthcare inequalities because of the sheer number of people who have faced some sort of disparity, and these experiences of disparities will be evaluated more in the next chapter.

[43] Zanetos and Skipper, "The Effects of Health Care Policies."

Looking specifically at the older queer community, these people have faced a variety of disparities throughout their life span because they have lived through a time when being queer was not as accepted as it is now. These people have faced ridicule and victimization for decades, and despite improvements in inclusion toward the queer community, they still face the same disparities that were present when they were younger. An article that studied physical and mental health-related quality of life among LGBTQ+ older adults examined health disparities in adults fifty and older using information from the 2013 and 2014 NHIS, and the results from their studies suggested there were similarities to global health disparities experienced by all LGBTQ+ individuals and that individuals fifty and older experienced higher rates of chronic conditions, poorer health outcomes, and higher incidence of mental health conditions and disability.[44] Increasing age combined with health disparities has created a dependence on a healthcare system that has supported health inequalities for many years, and even though there are national health policies encouraging non-discrimination towards the queer community, queer older adults continue to face provider bias and negative reactions from their health care providers.[45] Within the entire queer community, there exists the sub-community of older queer adults that face more healthcare inequalities based solely on the fact that they have a dependence on the healthcare system because of their age and because they just happen to not be a part of the cisgender and heterosexual majority.

[44] Ibid.

[45] Ibid.

Another sub-community within the larger queer community that has faced healthcare inequalities would be LGBTQ+ parents that also have a child with developmental disabilities. In an article investigating how queer parents experience healthcare bias and discrimination when seeking healthcare for their children, many parents stated that the forms that they had to fill out for their children did not include inclusive language. Of the sixteen parents that were interviewed, all sixteen parents cited examples of forms not being inclusive toward LGBTQ+-parent families or diverse family structures.[46] One interviewee said that, in terms of family structures, the forms often just include male or female or mother and father and that there is no other option, and she expressed how it is hard to not see yourself reflected in the paperwork and to be considered an afterthought.[47] Another interviewee said that most forms ask for marital status but not the parents' sexual orientation or gender identity, which can prove troublesome if the parents' queer identities were invisible because they presented as single parents of with a partner who appeared to be a different sex.[48] This interviewee is a transman, and he is quoted as saying that "If my genderqueer identity were a little bit more prominent, or if I started using they/them pronouns…I would be up a creek. There's no allowance for those identities on the forms that I've seen…we're always assumed to be straight. Even my wife doesn't identify as straight."[49] If healthcare providers cannot go

[46] Coulter-Thompson et al., "Health Care Bias and Discrimination Experienced by Lesbian, Gay, Bisexual, Transgender, and Queer Parents of Children with Developmental Disabilities."

[47] Ibid.

[48] Ibid.

[49] Ibid.

through the effort to provide inclusive language on forms for parents, how will that reflect their attitudes towards meeting queer parents and talking to them about their children with developmental disabilities? The bias that is shown in the forms will inevitably show itself in the conversation between the HCP and the parent.

According to this article that studied queer parents and their children with developmental disabilities, the queer parents also gave statements explaining interactions they have had with HCPs that blatantly showed uncomfortableness with the parent's gender or sexual identity. Eleven out of the sixteen parents interviewed discussed their challenges with disclosing or discussing their identity with their children's providers, and eight parents described times when providers were noticeably uncomfortable when LGBTQ+ identity came up in the conversation.[50] One parent, a gay man, described how he was assumed to be heterosexual by a pediatric specialist and that when he corrected the provider, the provider visibly displayed discomfort and never apologized for making the mistake.[51] Ten parents described how some providers dismiss the nongestational parent. An provided example was when an HCP asked on lesbian parent what their relation to the child was, and when the parent responded that she was the child's adoptive mother, the parent could tell the provider did not "like" the answer and made sure to continuously ask her if she was authorized to do certain things for the child.[52] In this case, these parents are seeking HCPs for their disabled children, but are still forced to

[50] Ibid.

[51] Ibid.

[52] Ibid.

experience discrimination and bias from the HCP despite not being the patient. Constant experiences of discrimination despite not being the one seeking medical care may lead to parents being more avoidant when it comes to situations which they or their child needs medical care. This could lead to parents not seeking medical care for themselves or their children when it is desperately needed based solely off fears of discrimination and prejudice from prior experiences.

Out of the entire queer community, no one has faced more healthcare inequalities than the transgender community. Access to gender-affirming care as well as doctors willing to provide care to someone transitioning is becoming harder to find, and with more states moving toward banning gender-affirming care, it will be an outright fight to find inclusive and equitable treatment for transgender people in the United States. However, while there is much discourse and conversation on gender-affirming care for transgender people, such as the recent Senate Bill 14 (SB 14) that was passed in Texas that prohibited gender-affirming care for transgender youth, there is less discourse on a specific issue that transgender people, specifically transgender males, face in healthcare.[53] This issue is that of seeking obstetrics care, which is very common among transgender men, but no one talks about the barriers these men face while trying to get the healthcare they want and need. Pregnant transgender men face bias, prejudice, and discrimination from their healthcare providers when seeking obstetrics care because they do not identify as a woman and because they may not appear feminine to their HCPs. The healthcare community could provide safety and solace to a community that experiences

[53] "Transgender Youth Medical Care Ban Subject of Oral Argument in the Supreme Court of Texas."

transphobia and hate in every other part of their lives, but the healthcare community continues to add onto the distress experienced by the transgender community by not respecting their identities and displaying acts of prejudice and discrimination towards those who seek medical help. Being pregnant requires continuous monitoring and checkups, so how can a pregnant transgender man get the required help he needs if he is turned away by every provider he finds or treated negatively by those who are willing to help?

In the following chapters, I will review instances of discrimination and prejudice that pregnant transgender men have faced in healthcare as well as begin to dive into the reasons why there is a prevalence of these inequities. Because of the current lack of literature on this subject, the following chapters aim to provide clarity on this issue, address where this issue stems from, and provide a suggestion on future steps that the healthcare community needs to take to ensure that our society does not continue to fail the queer community. Beginning with a history of LGBTQ+ discrimination and accomplishment allows me to demonstrate how the queer community has faced its obstacles but also has had its triumphs. However, it also shows the queer community is still not free of obstacles even today, despite making such great strides within the last few decades. Achieving equal and fair healthcare is one of the many hurdles the queer community faces, and my thesis will address why this has been such a momentous hurdle for so long and how our society can fix it.

CHAPTER TWO

Discrimination Towards Pregnant Transgender Men in Healthcare

Throughout history, there has been no shortage of discrimination towards the LGBTQ+ community, especially the transgender community. Transgender people have come under attack most recently regarding laws protecting their rights to gender-affirming care as many states are fighting to ban transgender youth from accessing transition-related care. In June 2023, Texas Governor Greg Abbott joined seventeen other states in restricting transgender minors from accessing puberty blockers and hormone therapies.[1] There has been significant focus on how bans on gender-affirming care relate to the mental health of transgender individuals, and because transgender youth are more vulnerable, these bans have created substantial worry about the quality of living for these youth. One area of concern specifically is suicide rates among transgender youth, and multiple studies have yielded that the prevalence of depression among transgender youth is higher than in their cisgender peers. A school-based sample from New Zealand showed that when comparing transgender students to cisgender students, transgender students had a much higher rate of depressive symptoms (41.3% to 11.8%).[2] Looking at the United States, in a study of 96 younger people ages 12-24 years who sought care at a large transgender youth clinic in Los Angeles, California, 20% of the participants had Beck

[1] Melhado, "Gov. Greg Abbott Signs Legislation barring Trans Youth from Accessing Transition-Related Care."

[2] Connolly et al., "The Mental Health of Transgender Youth."

Depression Inventory scores in the moderate to extreme range.[3] This was significantly higher than the scores of the general population of youth, showing the prevalence of depression and suicide ideology in transgender youth and how these bans on gender-affirming care can only negatively contribute further to these rates.

With everything happening regarding transgender youth, there has been no shortage of media coverage on the issue. Most people are aware of the attack on transgender youth, and there have been numerous protests that are fighting for these youth to have access to the care they desire. However, discrimination towards transgender people does not stop exclusively at gender-affirming care. One area of discrimination that receives hardly any media coverage and has a large lack of literature is discrimination toward those who seek obstetrics care. Many, if not most transgender men retain their female reproductive organs and retain the capacity to have children, but there is a lack of education and literature on how to approach these individuals when they seek obstetrics care. Most doctors claim to have received little to no education in treating transgender people, and because of this, there is a gap in clinical skills and the ability to effectively treat these individuals. When there is no information on how to treat certain kinds of people, it leads to an inability to provide the utmost standard of care to someone in that community. An inability to provide a quality standard of care is just a short leap to discrimination and prejudice, which is a common occurrence that the transgender community faces because of the lack of information on how to provide them with care.

[3] Ibid.

In this chapter, I will be reviewing examples of the discrimination and prejudice transgender men face when it comes to obstetrics care, such as pregnancy. While this area has a small amount of literature, that does not mean there is a shortage of discrimination and negative experiences. Despite recent advances in societal acceptance towards transgender people, there remains a major gap between what is taught in professional schools and postgraduate training programs and the transgender individual's needs.[4] This gap leaves many health professionals unprepared to provide quality care to transgender individuals, with many professionals needing to refer to someone else for help when a transgender person presents for care.[5] Medicine has not incorporated gender diversity into routine care, and this presents issues in various areas not just obstetrics. One example is the question of when should transgender men have routine chest (breast) cancer screening after chest reconstruction surgery, or how should people apply breast cancer screening protocols for transgender women?[6] However, despite there being many questions regarding providing care for transgender individuals, one of the biggest questions is regarding how to best care for transgender men who desire to be or are pregnant. Even though there is a lack of literature or media coverage on pregnant transgender men, the struggles of men and other gender-nonconforming individuals going through pregnancy are more common than people might think.

[4] Obedin-Maliver and Makadon, “Transgender Men and Pregnancy.”

[5] Ibid.

[6] Ibid.

One of the widest known examples of pregnant transgender men is Thomas Beatie, who became known as "the pregnant man" as he became a media sensation during his pregnancies. Beatie is not the first pregnant transgender man, but he was the first post-transition transgender man to go public with his decision to keep his female reproductive organs and then use them.[7] Beatie became a visible representative of shifts in the culture around the meaning of "male," "female," "masculinity," and "femininity," and because of this, Beatie's existence brought on important and vital conversations regarding understandings of kinship, belonging, normativity, and gender stability.[8] Much of the publicity about Beatie was positive and showed a preference for loving parents over gender-conforming parents, but Beatie still faced his fair share of negative publicity as well.[9] Beatie was harassed by the press and on news shows such as *FOX News,* and he was called a "mutilated lesbian" among other names by transphobic and homophobic conservative talk show hosts and TV commentators.[10] This harassment and name-calling only prove that pregnant transgender men face discrimination not only in the clinical setting but in the media and their personal lives as well. The lack of literature on these men not only leads to health professionals being unable to provide them with quality care but also leads to society being unable to grasp the concept of what it means to be a pregnant man and how we are supposed to treat them compared to a cisgender pregnant

[7] Halberstam, "The Pregnant Man."

[8] Ibid.

[9] Ibid.

[10] Ibid.

woman. Beatie proved to the world that pregnant men exist and that there needs to be education on how to care for them, and he also showed how a lack of education on the subject can lead to inadequate and harmful medical care. By amassing media attention from his pregnancy, Beatie brought into light the issue of how pregnancy is often solely associated with the female experience. Because of this association, medical providers are often not versed in how to treat their transgender male patients who are considering pregnancy, are pregnant, or who have given birth.

Beatie, as well as other transgender men who have chosen to go public about their pregnancies, provide incredibly insightful glimpses into a topic that has is routinely not on the radar of society. Beatie is just one man who has undergone the process of pregnancy while also navigating his transition from female to male, but the barriers and roadblocks he faced are similar to what every transgender man who has undergone pregnancy or desires to become pregnant face. Because reproductive experiences, such as childbirth and pregnancy, are typically associated with the contemporary cultural constructions of womanhood, motherhood is often treated as an exclusively female experience.[11] Because pregnancy and childbirth are most commonly associated with cisgender women's experiences, transgender and non-binary people with masculine gender expressions face experience fear and trepidation when seeking reproductive care. This fear and anxiety about seeking reproductive care stems from the fact that this vulnerable population tend to experience altered treatment based on how they present to others. Clinicians may treat pregnant transgender men differently then cisgender women

[11] Besse, Lampe, and Mann, "Experiences with Achieving Pregnancy and Giving Birth Among Transgender Men."

based on "pre-existing gender norms and assumptions about who should be able to experience pregnancy in contemporary society- *i.e.* heterosexual, cisgender women."[12] Going further, transgender and non-binary people who were assigned female at birth tend to be misdiagnosed or dismissed by their healthcare providers when seeking reproductive care.[13] Misdiagnoses or dismissals can be extremely detrimental because severe issues that could result in harm or death may be a result. Beatie gave us a glimpse into how society and medicine reacts to transgender men being pregnant or seeking to become pregnant, but his story and experience is felt by a larger population than most people know.

In 2014, Light et al. conducted a cross-sectional study of transgender men who had been pregnant and delivered their child after transitioning from female-to-male.[14] The researchers used a web-based survey that contained multiple choice questions as well as four open-ended questions that asked more specifically about experiences while pregnant.[15] The open-ended questions that were asked were: "Is there anything you would like to medical providers to know about transgender men and pregnancy?" "What was the experience of being pregnant like for you?" "What was the experience of giving birth like for you?" and "What was the postpartum experience like for you?"[16] The responses to

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[12] Ibid.

[13] Ibid.

[14] Light et al., "Transgender Men Who Experienced Pregnancy After Female-to-Male Gender Transitioning."

[15] Ibid.

[16] Ibid.

these open-ended questions were then divided into overarching themes, including 1) effect of pregnancy on concepts of family structure; 2) isolation; 3) gender dysphoria and pregnancy; and 4) interactions with healthcare providers.[17] I am going to mainly focus on this last theme of "interactions with healthcare providers" to give some more insight into the discrimination and prejudice that transgender men experience while pregnant and seeking reproductive care because this is an area that has not had much research done on it and there is often general ignorance about this being an issue at all.

In the Results section of their article, Light et al. states, "In response to queries interactions with health care providers, some participants mentioned positive interactions with their health care teams regarding their gender identity" and that "positive experiences often focused on proper use of gender-related language."[18] On the other hand, other participants noted negative experiences that "ranged from improper pronoun use and rude treatment to being turned away from medical practices and denied treatment."[19] They list a specific example of one participant recalling how Child Protection Services was called on them because "a 'tranny' had a baby."[20] In our modern day health care system, it should be expected that doctors treat their patients, regardless of gender identity or sexuality, with the utmost respect and reverence. To have a health care professional refer to a transgender person using a slur demonstrates

[17] Ibid.

[18] Ibid.

[19] Ibid.

[20] Ibid.

unprofessionalism and a lack of education on how to properly interact and treat with transgender patients. Light et al.'s article is just one of many articles that call for better treatment from the health care system, citing that better treatment would come from "acknowledging the unique identities of pregnant transgender men and grounding health care provider-patient interactions in compassion and respect."[21] If it is to be believed that those who go into the health care profession do so out of the compassion and care they hold for others, then the sheer number of LGBTQ+ individuals who report feelings of prejudice or discrimination from their health care providers disproves that notion. This notion being disproved shows something is contributing to the attitudes that these health care professionals have towards their LGBTQ+ patients, and later in this thesis, I will argue that inadequate medical education on LGBTQ+ health topics is the main contributing factor.

In their article, Light et al. discloses that The American College of Obstetricians and Gynecologists has "highlighted the need for obstetrician-gynecologists to help eliminate barriers to care for transgender men" and that the participants in their study "repeatedly expressed a desire for more information regarding fertility options and access to reproductive health care providers who respect, support, and understand their gender identity."[22] One of the most common expressions of discrimination towards transgender men in health care is the blatant disregard for the potential that they may want to know more about their chances with pregnancy or having a family. Most health care providers

[21] Ibid.

[22] Ibid.

may overlook this issue when caring for a transgender man, likely thinking that since they are transitioning from female to male that they have no desire to become pregnant or bear a child themselves. Assuming this without consulting the patient shows a lack of care for the patient and is just one of the many barriers that transgender men describe when seeking health care. Light et al. use the example of amenorrhea, which is the "absence of menstruation during the reproductive years of a woman's life," to demonstrate one of the various ways that health care providers do not give pertinent information regarding menstruation and fertility to transgender men.[23] Specially, the authors report that studies show that amenorrhea commonly occurs within six months of initiating testosterone therapy, but that the timeframe for resumption of menses after the cessation of testosterone is unclear; some physicians have even gone as far to state that amenorrhea may be irreversible in these cases.[24] Information regarding the ability to menstruate and conceive children after starting testosterone is vital information that should be discussed prior to starting testosterone treatments, and the lack of providing such information can be attributed to forgetfulness regarding how transgender men may want to conceive children in the future or disregarding the fact that transgender men have the right and ability to have children.

Another important point from Light et al.'s article that I would like to highlight is the sentence, "Although most transgender men in this study received prenatal care from a physician and delivered in a hospital, participants used nonphysician providers and

[23] Nawaz and Rogol, "Amenorrhea."

[24] Light et al., "Transgender Men Who Experienced Pregnancy After Female-to-Male Gender Transitioning."

nonhospital birth locations more frequently than the general public," and then they go further to say that "in 2009, 99% of U.S. births occurred in hospitals, compared with 78% of our participants."[25] Looking at this statement and the following statistic, it is alarming to consider how such a large percentage of transgender participants sought care from providers that were not physicians and also went to nonhospital locations for their deliveries. It is a risk to go to other locations for such sensitive services, considering that hospitals are one of the most sterile and best-equipped places for delivering a baby. While there are plenty of other options available besides physician providers, such as nurse practitioners and registered nurses, who are well-educated and informed on obstetrics and gynecologic knowledge, OB-GYNs have received extensive training and education specifically on the topics relevant to transgender men who are seeking information regarding fertility, prenatal care, and pregnancy in general. It is likely that the participants in Light et al.'s study nevertheless received exceptional care from whichever facility or health care professional they chose to go it, but it does not discredit the risks taken to avoid seeing physicians and going to the hospital, which illuminates the issue that transgender parents would rather take the risks of not going to a hospital or physician to avoid any instances of discrimination or prejudice.

The problem at hand here is that fact that the transgender men in this study felt that taking this risk of going elsewhere to receive obstetrics care was a worthy risk to take to avoid whatever prejudice or discrimination they were experiencing, or were to likely experience, at a normal physician's office or hospital. A common thread I found in this

[25] Ibid.

article as well as others that recount transgender men's experiences in health care is the avoidance of seeking health care because of the fear that they will be treated differently because of their identity. Other articles had repeatedly expressed how queer people avoided going seeking health care or waited a long time before seeking care for an ailment that needed immediate attention because of the fear of discrimination by their providers. Light et al. says, "It is possible that health care provider choice and delivery location were responses to actual or anticipated negative experiences as suggested from many qualitative reports of suboptimal interactions with health care providers," but immediately follow this up by saying "health care provider choice and birth location may have resulted from other barriers such as access to health insurance."[26] As Light et al. stated, this choice to forgo treatment at a hospital or by a physician could be attributed to a variety of factors, and some of those factors may not have anything to do with fear of or past experiences of discrimination.

However, there are still too many instances where transgender patients have decided to put their health at risk due to discrimination or anxiety surrounding discrimination from their health care providers. Light et al also makes note of how some participants noted that "although their specific health care provider(s) may have been transgender-friendly, this was not necessarily the case with the office staff, nurses, and other health care workers," showing the graveness of this situation and the depth at which

[26] Ibid.

transgender people face discrimination from a all types of people in a health care setting.[27]

As I shift away from Light et al.'s study, I will begin to look at a study conducted by Hoffkling et al. that also looks at the experiences of transgender men around pregnancy and recommendations for providers. Hoffkling et al.'s article will help to reiterate points made by Light et al.'s article regarding transgender men's experiences with pregnancy. Hoffkling et al. used a "grounded theory approach to explore the experiences of transmasculine individuals' experience with pregnancy through focused, semi-structured interviews with 10 participants," and participants were recruited from a "pool of prior participants of an online convenience sampled survey of transmasculine individuals who had given birth."[28] In their article, Hoffkling et al. mentions the absence of biomedical research and education on transgender people, specifically in the realm of reproduction. As in the Light et al. article, participants in Hoffkling et al.'s study expressed frustrations with the "lack of information on the short-term and long-term effects of testosterone on reproductive organs, ease of conception, pregnancy outcomes, mental health, and lactation," going further to say that "these pervasive questions directly disempowered patients through limiting information useful in informed decision-making."[29] One of the participants in the study expressed the importance of providers

[27] Ibid.

[28] Hoffkling, Obedin-Maliver, and Sevelius, "From Erasure to Opportunity."

[29] Ibid.

"differentiating between 'I don't know' and 'science doesn't know,'" which nevertheless alludes to the overall lack of information regarding transgender health.[30]

Hoffkling et al.'s article provides a robust number of experiences and demonstrations from transgender participants regarding an overall lack of cultural competency and inappropriate medical care. The authors provide a summarized list of some prime examples of medical staff mistreating patients due to lack of cultural competency. This list includes addressing the patient by the wrong title or pronoun, calling the patient by their legal name rather than their preferred name, assuming the patient's genitals by looking at the patient's outward appearance, ignoring patient intake forms that ask the patient's gender, presuming that patients should have, or has, a certain relationship with their body, and discussing gender identity as though it is a sexual orientation.[31] One patient described an experience with a medical provider in which the midwife forced them to reach up inside and touch their babies head, even though the patient clearly stated that they did not want to do that action.[32] Participants in Hoffkling et al's study describe obvious instances of transphobia, such as providers and nurses laughing at them, having providers "make references to…bad fiction…about trans women," and nurses outright refusing to see them.[33] One participant explicitly describes an interaction with a fertility specialist who said that they "thought I was too masculine to

[30] Ibid.

[31] Ibid.

[32] Ibid.

[33] Ibid.

get pregnant," while another describes how they were denied lactation coaching in the hospital.[34] Many participants in the study reference issues with social services, with one participant saying, "Social Services [said] 'we're deeming you as a risk to your child, and we're going to try and get a court order to take her off you on the basis of neglect.'" These examples and testimonies I have provided are just *some* of the experiences referenced in Hoffkling et al.'s article, but the fact that each of these participants have their own stories of transphobia, lack of cultural competency, and inappropriate medical care shows just how big of a problem transphobia and homophobia is in medical care, especially to those who are pregnant.

For those who are not transgender and pregnant, it might be easy to write off these experiences as being uncommon and say that this only happens to a few people, but if we look at the articles written about this issue and look at the number of people that have come forward with their experiences regarding transphobia in medical care, we can see that this is not just a small issue and rather a big one that needs to be addressed. The problem is not with one or two doctors, but rather an entire medical system that does not know how to approach queer health care, especially not when it comes to transgender patients who are pregnant. There is an overall lack of education and knowledge on this topic as well as a lack of cultural competency that leads to outright mistreatment and discrimination. There is also a lack of consequences when it comes to mistreatment and discrimination from medical staff, as most of the time these medical providers face no repercussions for their actions their queer patients. Because there are often no

[34] Ibid.

repercussions for homophobia and transphobia in medical care, queer patients fear going to the doctor or prolong going to the doctor because they know exactly what awaits them when they seek medical care. Looking again at Hoffkling et al.'s article, some patients say that despite living their lives as "out" men, they pretend to be women to avoid barriers at sperm banks and clinics.[35] Another participant describes how they "never really wanted to do a home birth… I was only going to have a home birth just out of fear of how the hospital wouldn't be able to deal with me."[36] The issue when it comes to transphobia in medical care and especially obstetrics care, is not just the transphobic actions themselves, but the fact that a whole set of people actively avoid seeking care or pretend to be someone different just so they do not have to face discrimination from their providers. Transphobia on behalf of medical providers is not just creating an unsafe and uncomfortable environment for queer people in medical settings, but also creating potential health hazards by inciting fear of discrimination in queer people who want and are seeking medical care.

At the end of their article, Hoffkling et al. draw some important conclusions. First and foremost, they acknowledge that the "primary set of findings of this study is the range of experiences and needs of patients" and that the "first, and most central, element is that some of the people who need obstetric care are not women."[37] This simple, yet complex statement, shows the one thing that most medical professionals, especially those

[35] Ibid.

[36] Ibid.

[37] Ibid.

working in obstetric care seem to forget. Obstetrics care is not limited to just women, and men have just as much of a right to outstanding obstetrics care as women. OBGYNs and other medical providers working in obstetrics care may forget about this population of people who still deserve and have every right to receive good medical care because of the common misconception that only women have a right to seek obstetrics care. Hoffkling et al. makes the assertion that their findings "should guide providers on what questions to consider, more than providing definitive information about any given transgender patient."[38] More often than not, the reason for transphobia and discrimination towards transgender patients in medical care is because of the lack of competence on how to treat these patients and ignorance towards the sheer number of negative experiences occurring daily on behalf of transgender and queer patients seeking medical care. Transphobia in obstetrics care is just one of the many types of discrimination that queer people face in medical care, but it one of the types that is often forgotten about because people do not tend to think of men needing obstetrics care. It is this lack of cultural competency and blindness that has contributed to the current state of transphobia and homophobia in medical care.

Regarding this lack of cultural competency, Hoffkling et al. says that "a provider who has never been taught about transgender health may be less likely to see a transgender patient as a normal, reasonable human, and a provider with limited understanding of transgender identities may be less likely to seek out information about

[38] Ibid.

transgender health."[39] The authors further elaborate on this thought by saying "literature on microaggressions suggest that biased behaviors, which, individually, seem of minor significance, can become powerfully aversive in the felt experience of someone who experiences these behaviors repeatedly."[40] To those who are not queer, who have not experienced microaggressions or macroaggressions in healthcare because of their gender identity or sexual orientation may consider transphobia and homophobia to be a "small" problem that does not call for immediate action, but to those who face these aggressions consistently and repeatedly, these problems are not small and provide a consistent barrier to their everyday life. All the articles I have referenced in this chapter have sought to provide guidance and glimpses into these microaggressions and macroaggression that are experienced on a regular basis by transgender patients in healthcare, and as Hoffkling et al. stated, this literature shows how these biased behaviors become "powerfully aversive" to people who experiences these behaviors consistently.[41] One of the common themes throughout all the articles I have referenced is the fear and worry that transgender patients feel whenever they need to seek medical care because of the known fact that they will likely experience some type of bias or discrimination while seeing a medical provider. Repeated biased behaviors has led queer people to have an aversive reaction to the thought of seeking medical care, and this is a problem of major significance that needs to be addressed.

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[39] Ibid.

[40] Ibid.

[41] Ibid.

Because of the presence of discrimination towards transgender people in healthcare and the biased behavior on behalf of medical providers that have led queer people to have an aversive reaction to seeking medical care, it is important to understand where this discrimination and biased behavior stems from. In the next chapter of this thesis, I will investigate the origins of this overall bias on behalf of medical providers towards their queer, specifically transgender, patients. As I mentioned, discrimination and prejudice towards transgender patients in healthcare is no small problem, and to begin the process of correcting these biased behaviors, we must understand where these behaviors stem from. Looking at the various testimonies from transgender and queer patients in this chapter, it is obvious that the medical system has a major problem with medical providers exhibiting biased behaviors towards their queer patients, and if no one recognizes the importance of correcting these behaviors, we will be looking at continued and progressing aversive feelings towards healthcare from the queer population. Queer people are already prolonging seeking medical care or outright refusing to seek care because of the probability of facing discrimination and prejudice from their providers, and this issue does not stand to be fixed, our medical system will face more casualties from cases that could be prevented just because people fear seeking medical attention.

The goal of this thesis is to not only highlight and bring awareness to an issue that is constantly overlooked by both the medical system and the world, but to also take a stand on how to fix this issue. It is not enough to simply acknowledge this issue exists and provide significant evidence of this problem because in that case we are only agreeing this issue exists but not doing anything to correct it and prevent people from experiencing biased behaviors. We must look at these experiences and question what

situations led to these behaviors, and how we can work to ensure that the rate of biased behaviors declines rather than continue to escalate. We cannot erase the negative experiences that have already occurred, but we can learn from them and work to make sure that the future generations of queer people do not face the same experiences. To read these experiences and empathize with these queer patients is to know that we cannot continue to sit back and watch as our medical system continues to marginalize an already vulnerable population. This next chapter will seek to understand where action needs to take place in order to address this marginalization.

CHAPTER THREE

Looking Toward the Origin of LGBTQ+ Discrimination in Healthcare

As the last two chapters have demonstrated, there is no shortage of queer discrimination in our medical sphere. More specifically, there is a large amount of discrimination towards transgender people in healthcare, namely in obstetrics. The previous chapters have looked at the history of queer discrimination while also drawing upon specific examples of discrimination towards pregnant transgender men, but this chapter will begin a dive into the origins of this discrimination. We are not born with the knowledge of how to discriminate against someone or hold certain prejudices as these are learned as we navigate life. Likewise, medical providers do not begin studying medicine with the intention of discriminating against a certain population. Medical providers act on prejudices because they have not been taught how to interact with and treat queer people appropriately, as there is a significant lack of literature and discourse on this subject. There is even less knowledge on how to effectively and appropriately treat transgender patients who are going through pregnancy or want to in the future. This lack of medical education on the subject is one of the major contributing factors to the presence of discrimination and prejudice towards transgender patients today, and in this chapter, I will be reviewing more literature on this lack of medical education as well as drawing conclusions on the overall origin of this issue.

Institutionalized "heteronormativity" in the medical field can be attributed to a wide array of negative effects on the experiences of LGBTQ+ patients. Institutionalized heteronormativity is whenever heterosexuality is deemed as the societal norm, which

creates a sense of othering for those who do not identify as heterosexual. In an article on the effects of heteronormativity in healthcare and education, author Stephanie Enson dives into the implications of "gender." Enson says that gender is a "socially constructed belief system and a major influence on society" that is "often comprising stereotypical roles for men and women and incorporating prescriptions in regards to appropriate behaviour, mannerisms, dress code and even body language."[1] The causes of heteronormativity in society lead to the widely held beliefs that men and women must act in certain ways according to the sex they were born with, which can cause identity issues and mental distress. Heteronormativity is responsible for the dominant idea that heterosexuality is the "normal sexual orientation and dictating that sexual and marital relations are only fitting between two people of the opposite sex," which has negative implications such as how heterosexuality becomes the standard and everything else inevitably gets compared to this standard.[2] It is not a surprise that heteronormativity has influenced the healthcare field as heterosexuality is the dominant sexuality that is presented in medical education. Medical professionals are not exposed to the varying sexualities and gender identities and therefore are not versed in how to approach queer patients. Because heterosexuality is the standard, queer people are constantly compared to this standard, especially in healthcare where there is a significant lack of literature on queer healthcare but an abundance of literature on heterosexual healthcare. This lack of

[1] Enson, "Causes and Consequences of Heteronormativity in Healthcare and Education."

[2] Ibid.

education on queer healthcare but an abundance on heterosexual healthcare further divides our medical system because it is appropriately preparing medical providers to treat heterosexual individuals but inadequately preparing them to treat queer individuals, which inevitably leads to discrimination and prejudice because these providers do not have the proper education on treating these patients.

As Enson notes, the history of the term "homosexuality" is short compared to the term "heterosexuality," and it was not until Karl Friedrich Otto Westphal's article "Contrary sexual sensations" that homosexuality became more widely known and sexual choice because it was known as a psychiatric disorder.[3] Because homosexuality immediately became associated with a psychiatric disorder, the label of homosexuality resulted in an "othering of a section of society who are silenced and invisible" which has led to a society where "heterosexuality is understood as the natural and inevitable state of normal human condition and the 'other,' composed of varying gender identities and sexual orientations, are subject to rejection and the label of deviant."[4] Medical education is at the forefront of heteronormativity solely because of the lack of literature on how to treat queer patients. Because of this lack of literature, medical professionals are not taught to consider the differences that sexual orientation or gender identity may have on a patient's treatment. Medical professionals are unequipped to provide care to queer patients, and because of this, queer patients are more likely to report negative experiences when visiting with their provider or seeking treatment in general. When someone is

[3] Ibid.

[4] Ibid.

"othered" and silenced because of their identity, this can lead to an overall detrimental effect on their health and wellbeing, which can further be worsened when these people seek help and are only further cast away by medical professionals who have no training on how to help and treat queer people.

One of the most predominant examples of the silencing of "othered" people is the invisibility of queer people within sexual health data, such as in HIV risk-taking statistics.[5] Enson describes, "There is not and nor has there ever been a category for HIV positive women who have sex with women in global or national HIV statistics," and that this "implies that either HIV positive women who have sex with women do not exist or that they have been grouped disingenuously within categories such as women who have HIV through sex with men or through injection of drugs."[6] It is noted that "distinguishing lesbians by their sexual identity may be crucial in regard to effectively targeting HIV prevention messages" and that "such omissions lead to lesbian women falling under the health radar in regard to health promotion initiatives and present important questions regarding the validity of categories of high risk groups."[7] Lesbians are one of the many groups of queer people who are practically erased from health literature and the invisibility of HIV-positive women who have sex with women shows how our healthcare system has failed to properly educate healthcare providers on who can get HIV. One of the common misconceptions that has arisen because of false education about HIV is that

[5] Ibid.

[6] Ibid.

[7] Ibid.

women cannot get HIV, which is undoubtedly because of the invisibility of statistics of women with HIV as well as the popularized belief that only gay men can get HIV. These misconceptions and false statistics reports are largely responsible for medical professional's lack of knowledge on how to treat female patients with HIV.

Most of this thesis has focused on how the issue of physician discrimination and prejudice toward the queer community, but it important to know that a variety of medical professionals are responsible for creating negative experiences for queer patients. There have been several studies conducted on how nurses construct ideas of health as well as their experiences dealing with LGBTQ+ patients. One study by Derek Chambers and Aru Narayansamy exposed "a tension between two social 'facts' within the minds of the respondents as it discerned that a 'conflict between the 'Me' (as a locus of social property-the medical practitioner) and the 'I" (the independent thinker) appeared to be held without any feeling of contradiction by the respondents."[8] Chambers and Narayansamy found that this "duality raises important questions on the implementation of health promotion regarding the practitioner's capacity for non-bias practice and/or capacity for absorbing challenging concepts."[9] Gerd Röndahl investigated the experiences of nurses and medical students with LGBTQ+ issues, and this study found that "LGBT people remained a marginalised group and minority within all students' encounters and there was a general lack of awareness regarding LGBT issues by the

[8] Ibid.

[9] Ibid.

teachers and instructors that the students encountered."[10] Röndahl's investigation also revealed that there is "a perception in health care that all patients should be treated equally," yet the "starting point for this equality is heteronormativity, which results in homosexual service users predominantly being treated as heterosexual."[11] These studies conducted by Chambers, Narayansamy, and Röndahl only looked at nurses' and medical student's perceptions of LGBTQ+ issues, but the results reflect a perception held by most medical professionals. Specifically, Röndahl's study reports that the marginalization of LGBTQ+ in healthcare is a result of the lack of awareness of LGBTQ+ issues and heteronormativity, and because part of Röndahl's study was looking at the experience of medical students, it shows that the education medical students are receiving is comprised of heteronormativity and does not expose them to LGBTQ+ issues. If medical students, as well as other students studying to go into the healthcare field, are not educated on how to handle LGBTQ+ issues or how to treat LGBTQ+ patients, this will only further lead to more prejudices and discrimination and the issue will only get worse.

Another study conducted by Chervin et al. in 2003 found that "institutional heterosexism within health and education does not take the form of overtly biased displays of homophobia, but is present in subtle yet equally damaging forms of 'don't ask don't tell," and they "suggest that the argument that everyone should be treated the same translates to everyone being treated as heterosexual, resulting in homosexual people

[10] Ibid.

[11] Ibid.

being rendered invisible."[12] As Enson says, "This study demonstrates that although the intention of equality may be present, lack of awareness of LGBT issues and inherent heteronormativity results in bias experiences for LGBT service users who often feel invisible," which shows that equality can never fully be attained unless there are serious changes made to our education systems regarding LGBTQ+ issues.[13] The issues of heteronormativity and LGBTQ+ invisibility in medical education will go untouched until people begin to include LGBTQ+ issues in the medical textbooks and these issues become a standard part of the education received before entering the healthcare field. Chervin et al.'s study calls for "LGBT competence" among a variety of people to bring society closer to equality, and the easiest way to gain this "LGBT competence" is for textbooks and lesson plans to begin incorporating LGBTQ+ history and issues into the standard curriculum.[14]

The root of all biases can be linked to learning misinformation or not having any knowledge of a subject at all. For someone to form a bias, their brain must make an assessment or judgment based on their personal experiences or learned stereotypes. When medical professionals form a bias towards a patient, it can have drastic results that impact the patient both mentally and physically. As I have mentioned, there is a lack of quality education on human sexuality within medical professional training, which can be seen as the root cause of why medical professionals form biases toward their LGBTQ+ patients

[12] Ibid.

[13] Ibid.

[14] Ibid.

and in turn provide an unsatisfactory standard of care. While medical schools have offered courses on human sexuality, there has been little research into whether this education meets certain standards, such as having accurate information that encompasses topics like puberty, development, sexual and reproductive anatomy, gender identity and expression, sexual orientation and expression, and forming healthy relationships. An article that was written on the production of heteronormativity in medical education states that there "has been very little sociological analysis of the content, delivery, and reception of medical sex education-whether by such education we mean a concerted, self-conscious set of efforts intentionally geared toward educating doctors-in-training about human sexuality or the largely unintentional processes through which messages about and understandings of sexuality may be constructed and transmitted within medical schools."[15] Human sexuality training in medical schools has gone unchecked for too long a time, and this has resulted in a lack of quality education as well as the education not being checked for accuracy. It is unknown whether human sexuality training in medical schools exists solely to meet the requirement that doctors receive such education, or if it exists to truly improve how doctors approach their LGBTQ+ patients.

Most patients have agreed that their sexuality is important to their healthcare experiences, but there is little indication of whether medical professionals put the same importance on sexuality as their patients. The article by Marie Murphy says, "Although empirical research demonstrates that patients consider sexuality to be important to their health and experiences of health care encounters in a broad range of ways, we know little

[15] Murphy, "Hiding in Plain Sight."

of how medical professionals collectively construct their understandings about sexuality and its relevance to their work," and with an education system that is not providing adequate sexuality training, it is harder for these medical professionals to construct these understandings so that they can provide their patients with a comfortable and professional encounter.[16] Murphy continues by saying that "sexuality is not an arcane subject and medical students and doctors alike may develop understandings about sexuality from messages within our ever-more-sexualized culture," meaning that the primary way medical professionals may be learning about sexuality is from the media, which is not always accurate in its depictions of sexuality and gender.[17] If we are not running measures of the quality and content of human sexuality training in medical schools, we cannot be sure that our medical professionals are not receiving false information regarding LGBTQ+ health as well as forming biases toward their LGBTQ+ patients based on popular media depictions of queer people.

Murphy explains how sociologists view sexuality as a historical construction "involving a host of mental and physical capacities, desires, and experiences that gain their meaning with social relations," and because of this definitional ambiguity, it is "particularly important to examine medical understandings of sexuality, which have the potential to impact patients' experiences of health care, and with them, patterned health outcomes including health disparities."[18] Because there is such ambiguity when it comes

[16] Ibid.

[17] Ibid.

[18] Ibid.

to sexuality and gender, the medical schools that do provide human sexuality training may differ in the content of their training. This can only further lead to unsatisfactory experiences for LGBTQ+ patients as they will never know what to expect out of their visit. Patients who fear going to the doctor because of the uncertainty of how they will be treated each time often lead to the ultimate decision to not seek medical help. Suppose there is a large percentage of LGBTQ+ patients who refuse to go to the doctor because of the fear of how they will be treated. In that case, that means that there is a large percentage of our population who would rather put their health at risk than take the chance of being discriminated against by a system that is not taking the proper steps to educate medical professionals on how to approach LGBTQ+ patients.

Sexuality intersects with medical practice in a broad range of ways, such as the diagnosis and treatment of sexually transmissible infections to the seeking of information and counsel about sexuality.[19] Murphy relays how patients experience sexuality's relevance by "encountering sexuality-related stigmatization in the doctor's office."[20] Murphy provides examples of this stigmatization, such as how "transgender patients have experienced hostility, coldness, and outright rejection from health care providers," how "lesbian women have received nonempathetic responses to disclosure of their sexual identity and have felt at risk of harm within health care encounters," and how "gay men have experienced care perceived to be homophobic, heterosexist, or grossly ignorant."[21]

[19] Ibid.

[20] Ibid.

[21] Ibid.

Those who do not experience discrimination and stigmatization when seeking medical aid will not understand the importance of evaluating the medical education on LGBTQ+ issues, but for those who would rather risk dying than see a doctor because of this discrimination and stigmatization understand that there is a dire need for change to our medical system's medical education. Patients who are sick and desperately need to seek medical help do not need the added worry of how they will be treated by their medical provider because of their sexuality or gender identity. A transgender patient who is pregnant does not need any added worries about how their medical provider will treat them as a transgender person, and for a medical provider to be able to adequately treat this patient without stigmatization, there needs to be proper education on how to treat pregnant transgender patients. Proper medical education can not only help to reduce sexual stigmatization towards pregnant transgender patients, but to the queer community as a whole. Murphy's article goes further to analyze the origins of sexual stigma and how this stigma can be attributed to the overall discrimination and prejudice the queer community face in healthcare.

In the section on medical knowledge and sexual stigma, Murphy states, "Sexuality scholarship attributes the historical origins of much of the stigma associated with sexuality in general and nonnormative sexualities in particular to the medical establishment," indicating that much of our modern stigmas and stereotypes about sexuality comes from medical education.[22] One example of this was the classification of homosexuality as a mental disorder in the earlier editions of the DSM, which can be

[22] Ibid.

attributed to the abundance of negative attitudes towards homosexual individuals as well as the creation of certain stereotypes about homosexuality. The breakout of HIV in gay men also led to certain stereotypes about the transmission of HIV and AIDS and the spread of misinformation about the diseases. Murphy draws on the scholars Michel Foucault and Gayle Rubin, who "argued that the medical profession had much to do with the development and maintenance of 'sex negativity,' or the idea that sex, in general, is guilty until proven innocent, and nonnormative sexuality is by definition especially harmful to participants and threatens the stability of society."[23] Murphy continues by saying, "Medical professionals (along with other entities) helped create and maintain a line between normal, natural, healthy sexuality and abnormal, unhealthy, and immoral sexuality," and medical opinion served to legitimate this line between good and bad sexuality.[24] Because medical professionals play a major part in maintaining certain attitudes towards sexuality and gender, giving these professionals proper education on these subjects can help lead to them maintaining and creating a positive attitude towards sexuality in healthcare.

From the provided evidence and statements from LGBTQ+ patients, sexual minority patients are on the receiving end of much of the hostility, discrimination, coldness, and neglect from medical providers based on their sexuality or sexuality-related health condition.[25] The numerous statements I have provided from transgender patients

[23] Ibid.

[24] Ibid.

[25] Ibid.

show that transgender people are one of the most common sexual minorities to receive this discrimination and neglect from medical providers, and we can attribute our existing stereotypes and biases of transgender people to the medical knowledge that exists in this population. Looking at the medical knowledge on HIV and AIDS, people took this information and formed stereotypes about gay men and the spread of HIV. Transgender patients are no different, and there is much misinformation and false medical knowledge about transgender reproductive care as well as media articles condemning transgender people on all accounts of their being, which undoubtedly can be attributed to how the medical system continues to stigmatize transgender people.

A lack of "LGBT cultural competence" is spreading throughout our country and the world, and this lack of cultural competence is leading to an increase in sexuality-related stigma and health disparities.[26] As I mentioned in the first chapter, there have been increased bans on gender-affirming care in several states, alluding to not only a lack of LGBTQ+ cultural competence but a complete disregard for LGBTQ+ rights. Murphy reports that "the *Journal of the American Medical Association (JAMA)* published an article detailing the results of a survey of the LGBT-specific curricula provided in North American medical schools" and that the "median number of hours devoted to LGBT topics by the medical schools who responded to the survey was 5."[27] Many state governments have taken actions to reduce the coverage of LGBTQ+ history and issues in elementary, middle, and high schools throughout the United States, and it would be

[26] Ibid.

[27] Ibid.

reasonable to assume that medical education covering these topics may come under attack soon as well. Five hours attributed to covering LGBTQ+ curricula is already an absurdly small amount compared to the percentage of LGBTQ+ people in North America. If there is an effort made to reduce this number further, then our medical professionals will be receiving little to no education on how to treat LGBTQ+ patients at all. A majority of LGBTQ+ patients have reported experiencing some form of hostility or prejudice when seeking medical aid, and this number will only increase if medical professionals receive even less training on how to treat their LGBTQ+ patients.

Another aspect of education that has come under speculation as the reason for LGBTQ+ discrimination is the hidden curriculum. The hidden curriculum, as quoted by The Glossary of Education Reform, refers to the "unwritten, unofficial, and often unintended lessons, values, and perspectives that students learn in school."[28] Going further, it explains the difference between the formal curriculum and the hidden curriculum, saying, "While the 'formal' curriculum consists of the courses, lessons, and learning activities students participate in, as well as the knowledge and skills educators intentionally teach to students, the hidden curriculum consists of the unspoken or implicit academic, social and cultural messages that are communicated to students while they are in school."[29] Taking this into account, it should be no surprise that LGBTQ+ prejudice and discrimination are direct results of this hidden curriculum. In an article by Keisa Fallin-Bennett, physicians' implicit bias against LGBT people is investigated as a direct

[28] Sabbott, "Hidden Curriculum Definition."

[29] Ibid.

result of the hidden curriculum in academic health centers. Fallin-Bennett notes how the current changing pace of public opinion on the equal rights of LGBTQ+ may falsely allude to more positive attitudes toward LGBTQ+ people and that academic health centers are at the forefront of both explicit and implicit attitudes of medical students toward the LGBTQ+ community.[30] Fallin-Bennett makes the same assumptions about the root of these attitudes as the other authors I have covered, saying, "Providers' lack of training in interacting with diverse patient populations and in LGBT health issues in particular contribute to this perception" and that "Providers may express stigma or discriminate despite having good intentions; they may not be aware of sexual minority health issues and terminology, or they may be lacking communication skills."[31] A study by Kitts et al. found that "75% of physicians surveyed agreed that sexual orientation should be covered more often during training" and that "Almost 40% of physicians responding to the 2010 Gay and Lesbian Medical Association-American Medical Association Collaborative Survey on Physician Experiences Caring for LGBT Patients reported that they had no formal training on LGBT health in medical school or residency, whereas the majority of those who reported some background in LGBT health described that training as 'not very' or 'not at all' useful in preparing them to care for patients."[32] These statistics and findings do not deviate from previous study results I have covered, but they further allude to the origins of LGBTQ+ prejudice and discrimination being the

[30] Fallin-Bennett, "Implicit Bias Against Sexual Minorities in Medicine."

[31] Ibid.

[32] Ibid.

lack of LGBTQ+ education in academic curricula as well as what is taught through the hidden curriculum.

The hidden curriculum is directly linked to the presence of both explicit bias and implicit bias towards LGBTQ+ individuals, as noted by Burke et al. Provider bias inevitably plays a role in the way the provider treats their patient, and if this bias has a negative basis, then the patient's treatment will likely reflect the negativity of the bias. Fallin-Bennett provides an example of this, stating that a study that investigated implicit bias amongst sexual minority individuals found that "heterosexual substance abuse treatment providers, especially those with few LGBT friends, had stronger negative biases toward LGBT individuals than did LGBT providers, and there was considerable variability in outcomes of an attitude scale among the providers on the whole."[33] Implicit, or unconscious, bias plays an important role in how providers discriminate toward their patients because the providers are not actively aware of this bias. The hidden curriculum does an excellent job of instilling these biases without anyone being consciously aware of what it is doing, and it holds a profound effect on individuals throughout life. The hidden curriculum that subtly introduces negative attitudes toward the LGBTQ+ community can be considered a large basis for the discrimination and prejudice towards the LGBTQ+ community in medicine, but it is an issue that is often difficult to address because the hidden curriculum is not always taken seriously. The implicit attitudes and biases that result from the hidden curriculum can have a larger effect than just the way a provider treats a patient; these attitudes and biases can go beyond patient care and affect the

[33] Ibid.

medical field in general. These biases can sway how LGBTQ+ individuals are viewed in medicine and can be a determining factor in the degree to which these individuals are taken seriously by medical providers.

The hidden curriculum not only affects LGBTQ+ patients, but LGBTQ+ medical professionals. Fallin-Bennett discusses this subject as well, saying that the scant literature on LGBTQ+ focuses on the "outness" of LGBTQ+ medical professions students and providers and can be attributed to the general uncomfortable feelings LGBTQ+ providers have about disclosing their identity.[34] Fallin-Bennett states, "The degree to which these persons feel comfortable to disclose their sexual or gender minority status to their colleagues is considered a marker of the 'hidden curriculum' surrounding attitudes toward sexual minorities and could reasonably be equated with the effects of both explicit and implicit bias on the professional climate."[35] A study conducted and published by Lee et al. includes testimonies from general surgery residents on their experiences as being LGBTQ+, saying that "one-third of LGBT residents had not revealed their sexual orientation when applying for residency because of concerns about being rejected for that reason, and over one-half reported actively concealing their sexual orientation from fellow residents and attendings," which demonstrates the extent to which the hidden curriculum effects both LGBTQ+ patients and LGBTQ+ providers.[36] The article continues to say that "LGBT residents were more likely than non-LGBT residents, by a

[34] Ibid.

[35] Ibid.

[36] Ibid.

wide margin, to feel uncomfortable discussing their partner or bringing their partner to events" and that the majority of these residents had witnessed homophobia in their workplace.[37] The hidden curriculum works not only to instill negative biases towards the LGBTQ+ community but also to make those in the LGBTQ+ uncomfortable with their existence because they are aware of the negative attitudes held towards themselves. It is important to notice this discrimination among medical professionals towards themselves and other queer medical professionals because it shows that this is not just an issue affecting patients, but the entire medical community. Queer patients are not the only ones on the receiving end of queer discrimination in healthcare; queer discrimination in healthcare is a wider issue that is affecting individuals at every level in the medical system.

Turning the attention back towards transgender patients, and those specifically who are pregnant or have given birth, the hidden curriculum can be extremely detrimental to the standard of care they receive. As I have already covered, the hidden curriculum unconsciously introduces negative biases toward LGBTQ+ individuals in general, but the transgender community has been the one to suffer the most discrimination and hate throughout the years. In a discussion on the cycle of bias and the hidden curriculum, Fallin-Bennett states, "The compilation of implicit biases, explicit biases, institutional climate, and ingrained behaviors at an academic health center also form the foundation of the institution's hidden curriculum, or what health professions trainees learn from what they observe and experience rather than what they are overtly taught," which

[37] Ibid.

demonstrates how a lack of education of LGBTQ+ patient care combined with the actions of the hidden curriculum exist to perpetuate a constant cycle of LGBTQ+ discrimination and prejudice.[38] There is an even greater lack of literature on how to approach and treat pregnant transgender patients, and combined with the biases instilled by the hidden curriculum, the experiences of those I included in the previous chapter will only grow. The cycle of bias and the hidden curriculum will only continue to be detrimental to the treatment and experience of transgender patients. Fallin-Bennett gives an impactful statement on this cycle, saying, "Learners absorb and emulate what they see and experience; therefore, not only are they likely to take the biases, behaviors, and expectations they learn via the hidden curriculum with them when they move into practice, but they are also likely to recycle them back into the academic environment when they become teachers themselves," which shows the devastating impact the hidden curriculum has had and will continue to have on medical education and the LGBTQ+ community if nothing is done to address this issue.[39]

As I conclude this chapter, I want to ensure that it is understood that while most people may be unaware or hesitant to acknowledge the hidden curriculum, the hidden curriculum undoubtedly exists, and when combined with the inherent lack of medical literature on the LGBTQ+ community it can become a means to the end of LGBTQ+ healthcare. While there is a lack of medical literature on the LGBTQ+ community, there is no shortage of LGBTQ+ people willing to share their experiences when seeking care

[38] Ibid.

[39] Ibid.

and being met with homophobia or transphobia from their providers. These experiences and testimonies provide direct evidence of the implicit and explicit biases of medical providers toward their LGBTQ+ patients, with pregnant transgender patients being one of the specific subsets of the community that has faced tremendous setbacks in receiving the utmost standard of care. In this chapter, I have discussed how the lack of medical literature on LGBTQ+ care and the hidden curriculum work in tandem to create biases within medical providers and how this can be attributed to the decades' worth of LGBTQ+ discrimination in medicine. If we ever want to escape the cycle of biases and the hidden curriculum, the first step we need to take is to address the existence of these biases and the hidden curriculum and acknowledge them as the basis of discrimination. In the last chapter of this thesis, I will discuss the next steps in addressing the origins of LGBTQ+ discrimination and prejudice and how our society can work to correct this ongoing cycle to protect our LGBTQ+ community and ensure that they continue to seek healthcare in a system that has been set up to work against them.

CHAPTER FOUR

The Future of LGBTQ+ Medical Education and Transgender Discrimination

In the past three chapters, I have covered the history of LGBTQ+ discrimination, specifically looking at discrimination toward pregnant transgender men and the origins of this discrimination. The origins of this discrimination can be attributed to a lack of medical education on LGBTQ+ health as well as the instilled implicit and explicit biases from the hidden curriculum. The lack of medical education on LGBTQ+ health can be considered a large contributing factor to the ongoing LGBTQ+ discrimination in healthcare, especially toward transgender patients and those who are pregnant.

In this chapter, I will discuss how our medical education should change to incorporate more LGBTQ+ health education and how our medical education can teach aspiring medical professionals to properly treat LGBTQ+ patients. I will mostly refer to one article throughout this chapter by Pregnall et al. because of their outstanding article on the gaps in undergraduate and graduate medical education regarding LGBTQ+ health topics. There were other wonderful articles that wrote on this subject, but I chose the article by Pregnall et al. because they provided a well-rounded analysis of the lack of queer topics in medical education and how this could be fixed. Their analysis was clear and easy to understand, and it was because of this and the quality of their analysis that I decided to mainly draw from their article compared to other articles. This article provides a lengthy discussion on how a lack of adequate GME education on LGBTQ+ topics can affect LGBTQ+ discrimination and how this education can be reformed to fix the issues of the lack of LGBTQ+ health education. With more knowledge of LGBTQ+ health

disparities and awareness of discrimination in healthcare, we can hope for a future in which the experiences of discrimination and prejudice in healthcare towards the LGBTQ+ decrease significantly or stop altogether.

One aspect of medical education that I have covered briefly is that there have been reforms to undergraduate medical education (UME) regarding LGBTQ+ health issues, but there has been a lack of reforms in graduate-level medical education. To clarify misconceptions on the terms UME and GME, UME refers to medical school education and GME refers to residency training. An article by Pregnall et al. reports that "new literature suggests that didactic education at the UME level is not enough to prepare future physicians to properly and compassionately care for LGBTQ patients," and that recently the "Accreditation Council for Graduate Medical Education (ACGME) implemented a major revision of its Common Program Requirements that requires residents to demonstrate, as a competence, respect and responsiveness to diverse populations."[1] One of these program requirements focuses specifically on respect and responsiveness to diverse populations, saying that residents must demonstrate competence in "diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation."[2] Pregnall et al. point out the major issue I am tackling in this chapter, that there has been a constant failure of graduate medical education (GME) to adequately prepare students to care for LGBTQ+ patients and the authors of this new literature argue for the ACGME to "develop and implement

[1] Pregnall et al.

[2] "Common Program Requirements."

LGBTQ health-related residency requirements."[3] These authors outline a way for the academic medical community to implement these requirements, which I will cover in this chapter. These requirements are an excellent way to start reducing queer discrimination because they are requiring that residents demonstrate a competency in treating queer patients with respect and responsiveness.

Ilan H. Meyer applied the minority stress model to the LGBTQ+ community and found that the "interpersonal and structural experiences of stigma, prejudice, and discrimination" contribute to worse health outcomes throughout the LGBTQ+ community, which demonstrates the overarching need for more LGBTQ+ health education at both the undergraduate and graduate education level.[4] When looking at statistics, around "56% of individuals who are lesbian, gay, or bisexual; 63% of people with HIV; and 70% of transgender and/or gender-nonconforming individuals experienced some type of negative encounter with a physician," and these negative experiences ranged from "excessive precautions to outright denial of care."[5] These are impressively large statistics that show that a majority of LGBTQ+ individuals have experienced some form of discrimination or prejudice on behalf of their medical provider. Furthermore, these statistics show that transgender and gender-nonconforming individuals experience the most negative encounters with physicians, showing the ever-present need to correct these behaviors toward these individuals in medical care. When presented with statistics

[3] Ibid.

[4] Ibid.

[5] Ibid.

like these and qualitative data on the experiences of LGBTQ+ patients, it can be hard to fathom why there have not yet been more reforms to our medical education to include LGBTQ+ health education when the evidence demonstrates a need for reform.

Pregnall et al. say, "Ongoing disparities in care and outcomes of LGBTQ individuals-exposed, in part, by the Lambda Legal report-led organizations like the National Academy of Medicine, The Joint Commission, and the U.S. Department of Health and Human Services to release reports (in the early 2010s) that called for the health care sector to systemically address these issues through research; changes to clinical practice; and improvements in undergraduate medical education (UME), graduate medical education (GME), and continuing professional development."[6] This statement explicitly calls for all levels of education and development to reform their way of educating to include LGBTQ-related content. Over the last ten years, there have been some efforts to address the problems posed by the Lambda Legal report, mainly at the undergraduate level in which they have tried to ingrain LGBTQ+ content into their curriculum. There have been problems associated with these changes to the curriculum, namely high levels of variability across programs, uncertain effectiveness in improving LGBTQ+ patient care, and a lack of "effective mechanisms to evaluate the extent and impact of these changes."[7] This article states that now is the best time to reform the approach to LGBTQ+ education within graduate medical education. To begin this reformation, "The community simply must institute requirements for the inclusion of

[6] Ibid.

[7] Ibid.

LGBTQ-specific topics in GME, as appropriate for each specialty, using the developments and lessons learned at the UME level over the past decade as a framework."[8]

When looking at how UME has incorporated LGBTQ-specific curriculum into its standard curriculum, it is important to note that UME is the first opportunity for future medical professionals to gain an understanding of sexuality and gender. There are vast differences in the students who enter medical schools in the U.S., such as differences in sociocultural backgrounds and educational backgrounds. Taking this into consideration, UME is the "first opportunity for medical educators to ensure that all physician trainees have the same foundational understanding of sexuality and gender- just as they do biochemistry or genetics," demonstrating the need for a good UME curriculum that incorporates accurate depictions of sexuality and gender.[9] While medical students may come from various backgrounds, they are all required to undergo certain curriculum courses before graduating from medical school. This shows the importance of introducing these students to LGBTQ+ issues at the undergraduate level before they interact with patients during residency, especially LGBTQ+ patients. To reference the Obedin-Maliver et al. study again, their study reported that U.S. and Canadian medical schools dedicated a median of five hours to LGBTQ+ health education, which is not an adequate amount of time to properly prepare medical students to care for their LGBTQ+ patients. This lack of education in medical schools on LGBTQ+ health education shows the importance of

[8] Ibid.

[9] Ibid.

reforming the curriculum to introduce sexuality and gender to students at the undergraduate level so that these students go into residency with prior knowledge of LGBTQ+ patient care.

After Obedin-Maliver et al. published their study on LGBTQ+ curriculum, the Association of American Medical Colleges (AAMC) released its first set of guidelines on how to incorporate LGBTQ+ content into undergraduate curriculum.[10] The AAMC guidelines suggested the "multimodal integration of LGBTQ health-related topics through the use of didactic instruction, case-based learning, and clinical rotations" and the guidelines cite different programs as examples of these practices.[11] Pregnall et al. provide an example of how they follow these guidelines, saying that in their basic science course titled "Brain, Behavior, and Movement" they teach first-year medical students about the "neurobiological bases of sexual orientation and gender identity."[12] They go further to explain that their faculty have interviewed LGBTQ+ patients about their experiences in the healthcare setting in Nashville, Tennessee, and they also provide students with the opportunity to ask questions regarding the relationship between sexuality/gender and healthcare.[13] These conscious efforts to make changes to medical school curriculum shows that efforts are being made to address disparities in medical education regarding LGBTQ+ health issues. However, the only way that these disparities

[10] Ibid.

[11] Ibid.

[12] Ibid.

[13] Ibid.

will truly ever be eliminated is if these curriculum changes are instituted at all UME institutions as well as being introduced in GME. It is also reasonable to believe that changes in education for students in universities before matriculating into medical school would also aid in the elimination of disparities because the earlier students are introduced to gender and sexuality issues, the more prepared these students will be when they inevitably care for LGBTQ+ patients.

Other medical schools have made the effort to change their curriculum since the AAMC released their new guidelines. For example, the University of Louisville School of Medicine has piloted a curriculum, the eQuality curriculum, that follows the AAMC guidelines listed in the previous paragraph.[14] Louisville now reports that LGBTQ+ topics have been integrated into "33 hours of existing curricula and that 17.5 hours of LGBTQ-specific information have been added."[15] Examples of other institutions that have taken efforts to follow these guidelines include the University of California, San Francisco; New York Medical College; the Medical College of Wisconsin; and the University of Mississippi.[16] It is without a doubt that these changes as well as the number of institutions incorporating these changes represent exciting progress in the reformation of the undergraduate medical education approach to LGBTQ+ content. However, while it may be easy to only see these changes as exciting progress, it is important to still consider that we do not have any information on how these curriculum changes are spreading and the

[14] Ibid.

[15] Ibid.

[16] Ibid.

effectiveness of these curriculum changes because no researchers have released comprehensive reports on the results of these changes.[17] It is also important to note that solely incorporating more curriculum time to LGBTQ health-related topics is not sufficient enough to prepare physicians to care for LGBTQ+ patients and that if we want to eliminate LGBTQ+ health disparities, we need to expose medical students to LGBTQ+ patients so that they can learn how to best care for them.[18] Clinical exposure is one of the best learning practices for medical students because it allows medical students to not only become familiar with the healthcare setting but also allows them to practice their skills on real patients. Quizzes and exams only test a student's ability to recall information, and while a student may learn about LGBTQ+ topics and ace their exams on these topics, these learning practices do not demonstrate the student's ability to care for LGBTQ+ patients. Clinical exposure to LGBTQ+ patients is a must in the reformation of UME if we want to ensure that these students can adequately care for these patients.

After discussing reforms made to undergraduate medical education, we will now shift focus to integrating LGBTQ+ health issues into the curriculum of graduate medical education. On June 10, 2018, the Accreditation Council for Graduate Medical Education (ACGME) approved a major revision of its Common Program Requirements that later went into effect on July 1, 2019.[19] In these revisions, the ACGME included requirements for "increasing the diversity and inclusion of GME programs and for expanding

[17] Ibid.

[18] Ibid.

[19] Ibid.

professional requirements to include new diverse patient groups," meaning that the ACGME is now shifting to require medical residents to demonstrate competencies in "respect and responsiveness to diverse populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origins, socioeconomic status, and sexual orientation."[20] One discrepancy in these new requirements is that it does not mention a competency in respect and responsiveness to gender identity, which can lead to incompetence regarding treating patients with differing gender identities. Not specifying that residents must demonstrate respect and responsiveness regarding gender identity leads to incompetency in how to treat transgender and gender-nonconforming patients and the discrimination that I have been investigating throughout this thesis. This small discrepancy in not including gender identity in these GME reformations has undoubtedly led to a lack of clinical exposure to transgender and gender-nonconforming patients, which in turn can be attributed to the abundance of negative clinical experiences reported by these patients.

With the changes to the ACGME Common Program Requirements, there has been increased discourse on how LGBTQ-specific health issues need to be addressed within GME.[21] Most medical specialties have unique considerations regarding sexual and gender minority health, and the Pregnall et al. article includes a list of twenty-seven major medical specialties and their clinical considerations for LGBTQ+ individuals, such as cervical cancer screening in transgender men in the field of family medicine and facial

[20] Ibid.

[21] Ibid.

masculinization or feminization in the field of otolaryngology.[22] Looking at the changes to the Common Program Requirements as well as the clinical considerations for LGBTQ+ patients in at least twenty-seven major medical specialties, there is no doubt that efforts are being made to introduce change to GME regarding LGBTQ+ competence.

However, it may seem that there is a positive change being made regarding LGBTQ+ competence in GME, but there is nothing to account for whether these changes are taking place. For example, the GME community "lacks meaningful information on even *whether* residency programs incorporate LGBTQ-specific information in their curricula," meaning that while it shows that these specialties have clinical considerations regarding LGBTQ+ patients, there are no records to account for whether these programs are actively teaching this information to residents.[23] Pregnall et al. report, "Studies surveying program directors on the inclusion of LGBTQ-specific information in curricula exist for only emergency medicine, plastic surgery, psychiatry, and urology-and these studies reveal that, depending the specialty, anywhere between 18% and 70% of programs include no LGBTQ-related training."[24] This statistic shows that while these programs may seem that they are incorporating LGBTQ-related training on paper, they are not putting this training into practice and residents are not receiving training on how to care for their LGBTQ+ patients. This lack of training is then leading to incompetency

[22] Ibid.

[23] Ibid.

[24] Ibid.

regarding treating LGTBQ+ patients, which in turn can lead to discrimination and prejudice.

Another issue with the GME curriculum is that some program directors do not include LGBTQ-specific content unless it is mandated by the ACGME, showing that they are not opting to include these topics in their curriculum unless they are forced to.[25] However, as I mentioned before, there is no evidence of whether medical specialties include LGBTQ+ content in their curriculum. Looking again at the twenty-seven medical specialties mentioned previously, only psychiatry makes "an additional reference to sexual orientation beyond the newly instituted Diverse Populations Requirement" and "no program's requirements make additional references to gender identity."[26] There is an overall lack of acknowledgment of sexuality and gender in the GME curriculum, and unless these programs are under strict guidance to include LGBTQ-specific content in their curriculum, they are not going to make the effort to teach these topics to their residents. If these programs do not take the initiative to include LGBTQ+ topics into their medical education unless they are told to by the ACGME, this suggests that medicine is overtly avoiding the fact that the LGBTQ+ community faces discrimination in healthcare because of the lack of knowledge on LGBTQ+ health issues. Considering the numerous examples of negative encounters provided by transgender patients in the previous chapters, it can be easily seen that LGBTQ+, specifically transgender, discrimination is a major issue in U.S. healthcare. However, despite the abundance of evidence of LGBTQ+

[25] Ibid.

[26] Ibid.

discrimination and prejudice, these GME programs do not see a need to include LGBTQ+ health topics into their curriculum even though studies are demonstrating how important this would be in lessening the ignorance of medical providers toward their LGBTQ+ patients.

Another factor that adds to the discrimination and prejudice that LGBTQ+ patients experience works in tandem with the overall lack of LGBTQ+ topics in GME. This factor is that medical residents do not have the "requisite knowledge and comfortability to care for LGBTQ patients," meaning that aside from the education they are receiving in their GME, these residents do not have the required prior knowledge of LGBTQ+ issues.[27] The literature on GME education shows that medical residents have an overall lack of knowledge on LGBTQ+ topics, and because the GME curriculum is inadequate in terms of LGBTQ+ issues, these residents are not learning the required information that would make them knowledgeable and caring providers for their LGBTQ+ patients. To illustrate this point, a study by Streed and colleagues found that "postgraduate year 1-3 residents scored between 50% and 52% on an exam designed to evaluate their knowledge of basic LGBTQ health-related topics," and another study by Hayes and colleagues found that "residents and fellow, compared with medical students, reported feeling *less* comfortable interacting with LGBTQ patients."[28] This statistical evidence shows that residents do not have the proper knowledge of how to treat LGBTQ+ patients and because of this, they are providing inadequate care to these patients.

[27] Ibid.

[28] Ibid.

Furthermore, because the inclusion of LGBTQ+ topics in the GME curriculum is either barely meeting standards or nonexistent, these residents are not receiving the education to fill in these existing gaps in their knowledge. These gaps lead to the question of how GME educators will address and fix these gaps so that LGBTQ+ discrimination and prejudice will decline rather than continue to climb.

Pregnall et al. provide an argument for how GME educators should address these gaps saying that these educators must consider "the 2 interrelated sides of LGBTQ health," which is cultural competence and clinical competency.[29] Having competency in both the cultural and clinical aspects of queer health would mean that medical professionals are adequately equipped with accurate information on queer health topics as well as being able to properly treat these patients in a clinical setting. Pregnall et al. defines cultural competency as "the ability to provide affirming care to LGBTQ patients," and clinical competency as the "familiarity with specialty-specific LGBTQ considerations," such as those they highlighted in their table of the twenty-seven medical specialties and their LGBTQ+ considerations.[30] Pregnall et al. reviewed studies in internal medicine, psychiatry, and pediatrics that tested "discrete interventions aimed at increasing residents' comfort, knowledge, empathy, and confidence in caring for LGBTQ patients," and this study showed that there was an initial improvement in these metrics, but after ninety days these residents reverted to their preintervention levels in these

[29] Ibid.

[30] Ibid.

metrics.[31] This quick reversion to the previous metric levels shows that the interventions aimed at improving residents' ability to care for LGBTQ+ patients are not long-lasting and that GME educators need to find a way to teach residents about LGBTQ+ patient care that will carry over past the ninety days shown in this study. The education and interventions these residents are receiving are not being integrated into their long-term memory and are not becoming habitual practices, meaning that improvements in LGBTQ+ care are not longitudinal and will decline rather than improve over time. Pregnall et al. propose several possibilities on how to integrate LGBTQ-specific cultural competency topics into a larger longitudinal thread. They quote Siegel and colleagues' six principles for "integrating social determinants of health content into GME and similarly call on the academic medical community to address gaps in teaching about these important factors;" they draw from Aysola and Myers who provide principles for "incorporating quality improvement and health equity into the curriculum;" and they use Donald and colleagues' outline of the benefits of using a "structural competencies approach in medical education to improve care for LGBTQ patients."[32] While many approaches can be used to tackle this issue of longitudinal knowledge of LGBTQ+ care, using any one of these approaches will provide an opportunity to address the issues of how medical professionals provide affirming care to LGTBQ+ patients and the bias in GME towards the LGBTQ+ community. Being able to increase competency in treating LGBTQ+ patients with affirming and proper care through instituted methods of

[31] Ibid.

[32] Ibid.

increasing longitudinal knowledge will eventually lead to an overall decrease in LGTBQ+ discrimination and prejudice because these medical professionals will have the means necessary to provide their patients with the care they need and deserve.

Elaborating further on the importance of cultural competency in LGBTQ+ healthcare, Pregnall et al. say that each specialty "must build upon this preceding cultural competency thread by integrating LGBTQ-specific clinical training."[33] By having residents regularly interact with LGBTQ+ patients, they will not only improve their cultural competency of LGBTQ+ issues but also their clinical competency. Habitual practice as well as constant exposure to LGBTQ+ patients will undoubtedly integrate knowledge of LGBTQ+ patient care so that it becomes part of the longitudinal thread rather than dissipating after a short amount of time. Also, clinical exposure to LGBTQ+ patients is much different than merely reading about how to care for these patients and being exposed to LGBTQ+ patients will allow residents to practice the medical knowledge that they learn from the UME and GME curriculum. Developments at the UME level provide a "useful framework" for approaching the reforms to cultural competency, and academic physicians within each specialty should begin by "defining learning objectives and competencies for LGBTQ-specific learning that are based on the most recent research and current evidence-informed best practices."[34] A combination of UME and GME that draws from recent research on LGBTQ+ issues as well as having medical students and residents undergo continuous clinical exposure to LGBTQ+ patients

[33] Ibid.

[34] Ibid.

will allow these students and residents to gain a cultural and clinical competency that is capable of reducing the high levels of LGBTQ+ discrimination and prejudice in healthcare.

In the concluding section of their article, Pregnall et al. suggest that "after outlining approaches to integrating LGBTQ-related topics into their curricula, select programs trial these reforms so that effectiveness can be measured and adjustments made, if necessary."[35] These trials are pertinent to determining effectiveness because if the curriculum is changed but never checked, there can be no guarantee that anything is changing as a result of the reformation. The authors note this fact by saying, "We suggest this trial-and-reform step to avoid replicating the problem UME incurred: having little knowledge about whether curricular changes have been effective in improving LGBTQ patient care," meaning that it is vital to do these trials and test their effectiveness so that we do not replicate past problems.[36] The last step in implementing and reforming medical education is taking what is learned through these trials and suggesting that the ACGME implement the requirements posed by these trials into medical education. The changes that would be implemented by the ACGME would require continuous monitoring to ensure how effectiveness is maintained over time. By continuous monitoring after implementation, the medical community can ensure that medical students and residents are receiving proper education on LGBTQ+ care and are upholding a standard of care towards these patients that allows for an overall decline in the number of discrimination

[35] Ibid.

[36] Ibid.

and prejudice cases in medicine. By continuous monitoring of effectiveness, the medical community will be able to note if changes need to be made if the education is not achieving the desired results and so they can make the necessary reforms. This plan of action for medical education reform provides an easy yet effective method of ensuring that proper changes are being made and that these changes are producing desired outcomes.

Other authors besides Pregnall et al. have tackled this subject as well, stating similar sentiments about the need for LGBTQ-specific training as well as providing evidence of how impactful changes in medical education curricula can be to the confidence level and knowledge of medical providers on LGBTQ+ topics. A study was conducted by Roth et al. that involved measuring provider knowledge and comfort regarding LGBTQ+ health before and after implementing a curriculum that used "evidence-based and engaging methods of teaching best practices in the care of LGBTQ youth."[37] This study was conducted from 2017 to 2019 at The New York Presbyterian Hospital/Columbia University Irving Medical Center, and the study included all pediatric residents and faculty members of the Division of Child and Adolescent Health, meaning that this study focused primarily on pediatric LGBTQ+ medical education.[38] This study, while only focusing on pediatric LGBTQ+ health, provides evidential support for the findings and statements in Pregnall et al.'s article and demonstrates the overarching benefits that come from implementing a new curriculum for residents and medical staff

[37] Roth et al.

[38] Ibid.

that includes LGBTQ+ health topics. While there are other studies that provided similar results, I will focus on Roth et al.'s study for the remainder of this chapter.

When the study by Roth et al. was initiated, they found that there were "some LGBTQ references in the adolescent medicine rotation, but there were no specific educational sessions dedicated to LGBTQ health," which helped with evaluating the curricular needs of the residency program.[39] The authors of the study utilized a 5-point Likert Scale to ask providers about their levels of knowledge and comfort regarding specific topics such as sexual orientation, gender identity, and specific sexual practices.[40] After conducting this needs assessment, the authors designed a curriculum using Kern's 6-step approach to curriculum development and by using the AAMC and AAP recommendations in addition to topic suggestions from their needs assessment, they developed "formal learning objectives for the curriculum and competencies that residents should meet based on the Accreditation Council for Graduate Medical Education requirements."[41] The authors piloted interactive sessions with "small groups of residents and faculty prior to formally presenting them to the larger pediatric residency program and revised the content and future sessions based on quantitative and qualitative evaluations after each education session," which demonstrates the trial-and-reform method that Pregnall et al. calls for in their article.[42] Roth et al. say that when it came to

[39] Ibid.

[40] Ibid.

[41] Ibid.

[42] Ibid.

evaluating the effectiveness of their curriculum, they performed "voluntary, anonymous pre- and postcurriculum implementation surveys" and that these surveys were completed "before the first session of the curriculum and approximately 1 month after the final session of the year."[43] There were ten sessions in the developed curriculum. The initial needs assessment was completed by 78 providers out of 110 eligible providers; after the curriculum was designed, only 60 providers completed the survey; and approximately one month after the year-long curriculum was completed, 70 providers completed the post-survey.[44]

When looking at the post-curriculum reaction, sixty of the providers that completed the post-survey said that they "felt extremely or somewhat satisfied with the curriculum," sixty-six of the providers "thought it was very or moderately important for the program to have an LGBTQ-specific curriculum," sixty providers believed the curriculum "had a major or moderate impact on their clinical practice," and sixty-two providers "somewhat or strongly agreed that they would change their practice based on what they learned from the curriculum."[45] Regarding comfort levels, mean scores regarding provider comfort with "sensitive history taking and applying LGBTQ-specific guidelines were significantly higher postcurriculum across all domains," and after the curriculum was implemented, the providers reported they were "significantly more likely to report feeling very or somewhat comfortable asking patients about gender identity,

[43] Ibid.

[44] Ibid.

[45] Ibid.

asking LGBTQ patients about sexual practices, screening LGBTQ patients for social/emotional wellbeing, applying screening guidelines for LGBTQ patients, and medically managing transgender patients."[46] As for scores of perceived knowledge, postcurriculum mean scores were "significantly higher for all topics" and providers were "significantly more likely to report 'a great deal' or 'a lot" of knowledge on protecting confidentiality, homelessness and environmental risks, gender dysphoria, electronic medical record logistics, and New York City resources."[47] In assessing changes in clinical practice, providers were "significantly more likely to report asking sensitive history questions after the curriculum was completed" and "the percentage of providers who self-reported asking their patients about sexual identity over 40% of the time increased from 72.0% to 88.4% and the percentage of providers who self-reported asking their patients about gender identity over 40% of the time increased from 23.3% to 43.5%," showing a definite increase in comfortability of discussing sexual and gender identity."[48] These statistics are undoubtedly positive and demonstrate the importance of LGBTQ-specific curriculum to fostering a better physician-patient relationship between the physician and the LGBTQ+ patient. It is important to see this growing relationship because it shows that as providers receive proper education on queer healthcare, they will treat their queer patients better and provide them with better care.

[46] Ibid.

[47] Ibid.

[48] Ibid.

In the discussion section of their article, Roth et al. explicitly state, "Our study demonstrates that LGBTQ-specific training is needed, desired, and effective at improving provider knowledge, comfort, and self-assessed clinical practice," providing evidential support to the claims made in Pregnall et al.'s article. Pregnall et al. emphasized the importance of trial-and-reform when it comes to LGBTQ+ curriculum implementation, and Roth et al.'s study can act as a trial of this curriculum implementation so that the medical community can both learn from the positive outcomes as well as figure out what aspects need to be changed for future implementation. While the curriculum in the Roth et al. study was developed specifically for pediatric GME, this curriculum can be adapted to fit other GME specialties. The authors mention that they believe that their curriculum is the first LGBTQ+ health curriculum to be formally implemented and evaluated, mainly at a pediatric residency program. They go further to note, "Upon literature review, there are few abstracts from academic meetings suggesting that programs across the country have begun to incorporate LGBTQ training, but to our knowledge there is no published data of the efficacy of these curricula or details about the content and learning objectives," which elaborates on a point made by Pregnall et al. about the lack of reported cases of LGBTQ+ curriculum implementation in GME across the United States.[49] Because this may be one of the first LGBTQ+ health curriculums, it can serve as an important starting point for the future of GME and UME curriculum reform to include LGBTQ+ health topics.

[49] Ibid.

Another aspect of the study that was important was the fact that the curriculum was implemented over a year. The authors say, "By providing short, focused, monthly sessions, we allowed learners to gradually build on their knowledge and skills based on the cognitive load theory" and they "aimed to provide learners with the tools to promote lifelong independent learning utilizing situated learning-guided participation techniques."[50] These methods were used to ensure a longitudinal effect of the curriculum so that the knowledge acquired would not quickly dissipate after the period of learning was over. The importance of longitudinal knowledge was emphasized in Pregnall et al.'s article as well because the purpose of implementing an LGBTQ+ health curriculum is not to correct the issue for a short period of time but rather to correct the systemic issue indefinitely. Roth et al.'s study and the points made by Pregnall et al. show that future UME and GME curricula need to ensure that the knowledge taught to students and residents is integrated in a way that stays with the students and residents into the future. It might be easy to focus entirely on the content that is taught and not on the method of teaching, but as evidenced in this study, the method of teaching is incredibly important in the integration of the information so that students and residents do not forget the information as soon as they stop actively learning it or being tested on it.

Roth et al. state that their future efforts will "focus on obtaining long-term data, in terms of both knowledge retention and clinical practice change" and that "by reassessing learners in a future study, we could eliminate any element of recall or recency bias."[51]

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[50] Ibid.

[51] Ibid.

This statement is an elaboration on the idea that knowledge retention is important and that curriculum implementation needs to focus on the long-term aspects of implementation rather than the immediate effects on patient care and physician knowledge. In the method of assessing the long-term effects on clinical practice, the authors suggest that future efforts should focus on "evaluating changes in electronic medical record documentation and overall patient health outcomes, including appropriate screenings, sexually transmitted infection testing, medical management, and adequate referrals when needed."[52] They also mention the importance of "tailoring this curriculum to the needs and time constraints of different institutions" because the twelve sessions that they conducted may not be as easily achieved at every institution, and they even mention the possibility of online modules or educational content that already exist.[53] Some examples of resources that would make this curriculum more adaptable could be The Fenway Institute National LGBT Health Education Center and the Adolescent Reproductive and Sexual Health Education Program, and some methods to help with adaptability could be consolidating curriculum sessions and expanding to subspecialty services.[54] Overall, Roth et al.'s study is incredibly beneficial in providing evidence for the impact LGBTQ+ curriculum is in fostering positive impacts for both the patient and physician as well as providing a model for future curriculum implementation at other institutions.

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[52] Ibid.

[53] Ibid.

[54] Ibid.

In the concluding paragraphs of Roth et al.'s article, they recall what they learned from their study, saying that they learned that "providers believe this content is important for their learning and including LGBTQ-specific training in the existing resident education program can improve provider knowledge, comfort, and self-assessed clinical practice" and that there is an "urgent and substantial need to incorporate formal LGBTQ health training in GME."[55] Most of this thesis chapter has focused on the issues with UME and GME regarding the lack of LGBTQ health education and the effect this has had on the physician-patient relationship and acts of discrimination and prejudice towards LGBTQ+ patients. To tie this back to the overarching point of my thesis in investigating strictly transgender discrimination in healthcare, this discrimination can be attributed to the lack of knowledge that medical providers have toward treating their transgender patients. These providers do not have the knowledge on how to approach conversations regarding sexuality and gender with these patients, and because of this, the efforts made toward facilitating a relationship with these patients are perceived negatively.

When looking at the overarching issue of transgender discrimination in healthcare, I have focused mainly on the specific issue of transgender pregnancy discrimination because this is not a topic that receives nearly enough attention. And, because of assertions made throughout this and the previous chapter, the lack of attention and knowledge on transgender pregnancy can be attributed to the overall medical education that medical students and residents are receiving. While there may be other factors at play that contribute to this discrimination, I have chosen to focus on the lack of

[55] Ibid.

LGBTQ+ curriculum in both undergraduate and graduate medical education as the most important factor. The reason for this decision is because medical education reform is something that can be easily achieved once the importance of the reform is fully understood. Roth et al. supports this notion by saying, "While our curriculum focuses on adolescence LGBTQ health, this material is vital for all specialties and has the potential to meaningful impact the care of all LGBTQ individuals."[56] The curriculum they implemented already led to a positive impact for both provider and patient, and it is easy to see the benefits of curriculum reform on addressing LGBTQ+ discrimination in healthcare as well as how it could impact the experiences of pregnant transgender patients. Proper medical education on transgender pregnancy would undoubtedly lead to reduced stereotypes, prejudice, and discrimination that impacts a patient's life experience and how they perceive the medical system.

[56] Ibid.

CONCLUSION

As I conclude this thesis, I think it is important to reiterate the main reasoning behind why I chose to cover this topic. The LGBTQ+ community has continued to persevere every day since the Stonewall Riots whenever the gay rights movement suddenly garnered media attention that was both positive and negative. Every day, the LGBTQ+ community fights for the ability to live and thrive with their identities, and every day, our society and our government continues to make this a battle. As I mentioned in the introduction of the thesis, the American Civil Liberties Union is tracking 484 anti-LGBTQ+ bills in the United States, which shows the obstacles and roadblocks that the LGBTQ+ community is having to fight in order to live a life of authenticity and peace. This thesis' goal was to shed light on one of the many issues that the LGBTQ+ community face in our society today while also focusing on a specific group within the LGBTQ+ community that has dealt with their fair share of discrimination and prejudice over the years.

The transgender community is a part of the overall LGBTQ+ community that hardly ever gets to live an authentic and peaceful life, and more specifically, the female-to-male transgender community that has either given birth or are pregnant is a much smaller community that is often on the receiving end of scrutiny by both the medical community and the media. This small community deserves to receive good medical care from their medical providers, and they deserve medical providers that are competent on health issues that are pertinent to their situations. My goal in writing this thesis was to bring awareness to the overarching issue of transgender discrimination in healthcare

while also discussing the discrimination and experiences of this smaller community. I sought to understand where this discrimination stems from and how we correct this issue so that the future of the transgender community can safely seek medical care without fear of discrimination, prejudice, and harassment.

My thesis was comprised of four chapters that started with a brief overview of LGBTQ+ history, then moved into examples of transgender discrimination in healthcare, and finished off with both an analysis of the origin of this discrimination and proposed methods of medical education reform that would eliminate this discrimination. In both Chapter One and Chapter Two, I had to decidedly leave out certain events and testimonies for the sake of chapter length, but the examples that I did include were extremely pertinent and relevant to the arguments and topics of the chapters. Any events or examples that were left out were not left out because of their unimportance or irrelevance, but because I could simply not include every single event in LGBTQ+ history as well as every testimony and experience from the transgender community. As far as Chapter Two, which involved examples and experiences of transgender discrimination, I included examples that I thought best exemplified the overarching issue and proved to be a clear example of the discrimination and prejudice I sought to investigate in this thesis. Furthermore, in looking at Chapter One, I did not include every event or aspect of LGBTQ+ history because LGBTQ+ history could have served as a thesis itself, but I chose certain events because of the relevance to my thesis and because of their importance in the stigmatization of the LGBTQ+ community that I seek to analyze and fix in my later chapters.

In my thesis, I sought to understand the origin of transgender discrimination, and I took a route that pointed towards undergraduate and graduate medical education being the most important factor that contributes to this discrimination. While undergraduate and graduate medical education is one of the biggest contributing factors, it is important to say that it is not the sole factor responsible. There are, without a doubt, a number of contributing factors that influence transgender discrimination in healthcare that I could have included in this thesis, but I chose to take the route of medical education as the major contributing factor because it holds much influence on how medical providers treat and care for their LGBTQ+ patients. Medical education is an easily identifiable cause for LGBTQ+ discrimination and prejudice, and it can be easily fixable if medical institutions recognize the importance of reforming their curriculum to include more hours devoted to LGBTQ+ health topics. Overall, the goal is to improve medical provider competency on LGBTQ+ care, and the best way to do this is through medical education reform. In the future, I hope that the numbers of medical institutions that recognize the importance of education reform increases and that they understand how pertinent these changes can be to eliminating discrimination and prejudice towards an already vulnerable community. In the future, I hope that the LGBTQ+ community, specifically the transgender community, feels safe and comfortable seeking medical care and that they will not have to wonder if they will be discriminated against by the people that are supposed to take care of them.

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