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Discussion

Is biomedicine compatible with contemporary understandings of queerness?

DISCUSSION

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ABSTRACT

Medicine is widely considered a site of social power, one that influences, and is influenced by, social and cultural norms. As such, medicine is deeply intertwined with societal powers and has complex patriarchal roots, with a history of oppression and underserving marginalised communities. This is compounded by the rise of biomedicalisation in the nineteenth century, which centres the empirical scientific method, further steering medicine from its foundations in social responsibility.

The development of queer theory, on the back of feminist work since the 1960s, has shifted cultural views on gender, sexuality, and human identity far from the pathologising models of queerness suggested by modern biomedicine. As these radical theories have developed, biomedical understandings of identity have expanded into the biopsychosocial model. However, it is uncertain whether biomedicine as a discipline will be able to fully integrate wider queer theory, due to a limiting language and framework based on patriarchal and empirical foundations. It is critical that the ideologies currently pervasive throughout medical schools accurately reflect contemporary thought on gender and sexuality.

This article calls for a radical analysis of the frameworks for understanding gender and sexuality that exist within biomedicine. Contemporary understandings of queer theory, and how that applies to the human body and good health, must be integrated in the education of medical students.

INTRODUCTION

Since its establishment, medicine has been a site of social power, shifting through its evolution to reflect the cultural and social ideals of the time. The reference points for ideal health standards, formed through medicine's development, have long been dictated by the contours of societal power, or patriarchy. Historically, bodies not deemed to be of value by patriarchal ideals have been left marginalised and oppressed. The othering of these bodies has been further compounded through the biomedicalization of health, beginning in the nineteenth century. (1) First appearing in medical dictionaries in 1923, biomedicine refers to "clinical medicine based on the principles of physiology and biochemistry", (2) and its gain in popularity represents a shift from a public health-based medicine to one focused on empirical science. The biomedical focus on viewing the human body through a biological and anatomical lens has led to the pathologizing of bodies and the creation of harmful binaries that are, to this day, prevalent throughout biomedicine.

With a chequered history of centring and protecting the white, able, cis-gendered, and heterosexual body, biomedicine has long considered some bodies 'normal', whilst pathologizing those that fall outside of these categories. (3, 4) Since the 1970s, theories of gender and sexuality have transcended the normal/pathological binary found within biomedicine, exposing a gap in medical understanding in relation to the treatment of queer bodies. (5) In response, the biopsychosocial model (6–10) aims to expand understandings of good health to consider the social and psychological aspects of a patient's experience. However, biomedicine has been slow to implement this contemporary understanding of health. In practice, those acute medical and surgical specialties holding greatest economic and political power have shown limited acceptance, with only general practice and psychiatry demonstrating a more holistic approach. (11)

The role of the healthcare provider lies in the definition of good health. Building on the biopsychosocial model, current definitions dictate a body that is not only free of pathological illness or disease, but also enjoys complete physical, mental and social wellbeing. (12) Despite this, current methods of medical knowledge production, as well as the frameworks used to create the biopsychosocial model, remain with a legacy of pathologizing queerness with discrete biomedical categories for patient identity. It is therefore unclear whether contemporary theories of queerness are compatible with Western medicine and its understanding of human identity.

This article will consider the historical biomedicalization of queer bodies, contemporary theories of gender and sexuality and the limitations of the biopsychosocial model in relation to preparing medical students to engage with queer communities. It is the contention of this article that the biopsychosocial model for good health is unable to offer queer patients care that aligns with contemporary queer theory. Queer communities are overburdened with poorer health outcomes due to a health system unable to serve them. (13) Radical change is needed to keep pace with contemporary theories of queerness, and to ensure medicine is fit to serve all.

The biomedical and biopsychosocial models of health and disease

An understanding of the origins and production of medical knowledge is fundamental if medical students are to situate themselves within the shifting landscape of contemporary theories of health. This includes an awareness of how the frames of reference through which we view our patients have evolved, and for whose benefit.

Prior to the nineteenth century development of biomedicine, the body was viewed as a whole, and treatment of disease was based on sacred and spiritual beliefs applied to the body, mind, and soul. (14) This model held true until the post-Renaissance period, when invention of current day medical tools, such as the microscope, stethoscope, and anaesthesia led to a proliferation of discoveries due to anatomical exploration. (15, 16)

The work of René Descartes is widely attributed to have resulted in the shift to a dualistic ontological view of the body, or the existence of mind and body as separate entities. (17) Viewing the body as a biological organism, and thus reducible to its constituent components, allows for the recreation of an ideal standard of good health; a standard in which disease is viewed as a deviation from the norm, to be rectified by medical intervention. This model for good health has evolved with societal changes, reflecting shifts in power and maintaining the white, able, cis-gendered and heterosexual body as the standard of normality and wellbeing. (18) The production of this ideal standard within biomedical discourse may serve to uphold patriarchal systems, whilst inevitably maintaining social oppression. By reducing a body experiencing ill health to a set of noncontextualized and quantified deviances from cultural norms, the nuance and humanity of the individual are lost. (19)

Traditional views of ill health in terms of deviance from a biological norm allow for no consideration of the psychological, environmental, and social factors that influence the experience of ill health. The biopsychosocial model, introduced by Engel between 1960 and 1980, (6–10) attempts to allow for the consideration of these wider factors. Despite this, it is argued that a model grounded in empirical diagnosis, prioritising the pursuit of causative agents of disease rather than centring the experience of the patient, is not a sufficient tool for either the clinician or the healthcare system. (20) The dividing up of medical knowledge into the empirical and perceivable creates a distancing of medicine from health, in search of an objective normality. (18) It is arguable that the inherent social power found in medicine, gained through nurturing the bodies that allow patriarchy to prosper, may have created a vulnerability to cultural and politicised influences that have shifted focus away from the social responsibility at medicine's foundations.

Whilst reinforcing and reproducing heterosexual hegemony, these medical standards have had damaging implications on patient care for those without white, able, cis-gendered male bodies. Inequalities can be seen widely in clinical encounters, where pain thresholds and patient credibility are questioned, and treatments drawing on cis-gendered and male-centred research may be used inappropriate-

ly. (21) Disparities in health outcomes are reported widely between cis-gendered men and women, with a higher rate of undiagnosed illness and negative experiences with healthcare providers amongst cis-gendered women. (22) Further research is urgently needed on the health disparities found in all LGBTQ+ patient groups.

Historical biomedicalization of gender and sexuality

In response to the societal promotion of a heteronormative health ideal, the pathologizing of those partaking in non-conforming gendered or sexualised behaviours followed. As of 1953 these were officially diagnosable in the Diagnostic and Statistical Manual of Mental Disorders (DSM). (23)

Homosexuality was a diagnosable condition until 1973, when it was removed from the DSM-II due to theories of immaturity, (24, 25) and normal variation, (26, 27) outcompeting those of a pathological basis for sexuality deviance. Medical theories of homosexuality have mapped closely to the wider language of binaries and reductionist views of the body. These theories are rarely separated from those of gender, with theories spanning the nineteenth to twenty-first centuries drawing on cultural concepts of inherent qualities of cis-gendered men and women. (5) Essentialist gender beliefs have led cultural notions that individuals not performing expected sexual behaviours may possess traits of the other sex, rarely deviating from the male/female binary. (28)

Following the removal of homosexuality from the DSM-II in 1973, a new diagnosis of 'sexual orientation disturbance' described homosexuality as an illness only if the person was 'disturbed by, in conflict with, or wished to change their sexual orientation'. (28) This was again altered in the release of DSM-III, with a diagnosis of 'ego dystonic homosexuality', and entirely removed in 1987. Gender variances have been listed as pathological conditions since 1980, when 'gender identity disorder' entered the DSM-III. (29) The pathologizing of gender variance in children and adults has been widely condemned as perpetuating stigma and traumas experienced by transgender individuals. (30) In 2013, following the publication of the DSM-V, the diagnosis of 'gender identity disorder' was removed in place of 'gender dysphoria', a diagnosis used to describe experiences of distress within gender-variant populations. (31) However, this new diagnosis may raise questions as to whether the vagueness of the diagnostic criteria limits their clinical applications, whilst maintaining stigma around gender variance. Furthermore, since the introduction of gendered pathologies in the DSM, wider discourse around the efficacy and purpose of such diagnoses holds that complete removal of gendered pathologies is the only way to take proactive steps towards reducing stigma experienced by gender-variant communities. (32)

Contemporary understandings of gender and sexuality

Historically, models of good health have been produced and reinforced through biomedicine and patriarchal power systems. This has been resisted by second wave feminist groups since the 1970s. Health activists have suggested the biomedical model imposes passivity, ignorance, and disempowerment on patients, thereby distinctly lacking feminist principles. During the 1970s and the following decades, a focus was placed upon feminist medicine. This centred prevention over cure, and the patient's social and interpersonal experiences as part of health management. (19)

Without the burdens of a prescriptive and pathologizing model of knowledge production, and on the back of decades of health and feminist activism, the social sciences have been at the frontier of sexuality and gender theory. (33) Rejecting the medical notion of inherent differences between cis-gendered men and women, the late 1980s saw the introduction of concepts of gender performativity (34) and social constructionism, (35) two foundational theories in contemporary gender studies that present gender as a product of intrapersonal, interpersonal, institutional and society-wide relations. (36) A social model of gender and sexuality is reflected in current definitions of health, as defined by the World Health Organisation as 'complete physical, mental and social well-being and not merely the absence of disease or infirmity'. (12) This holistic view of health harks back to pre-biomedical models of wellbeing, with the body containing an interconnection of components that can only be considered in the context of the whole. (17)

Can current models of health serve queer communities?

Despite progressive cultural shifts towards a more conceptual model of sexuality and gender, biomedicine appears slow to adapt, with limited evolution of the biopsychosocial model since its introduction. It has been suggested that this may be due to patterns of homosociality, or the relationships between cis-gendered men that act to propagate patriarchal systems and, reproduce medical traditions that resist radical change. (37) A study in Sweden in 2011 sought to investigate the views of cis-gendered male medical faculty members on the implementation of gender issues into medical education. The study reports ambivalent attitudes of the participants, who acknowledged gender as a determinant of health and the existence of inequalities, however ultimately considered gender to be 'important… but of low status'. Pertinently, gender education was viewed as a poor use of time and space, as well as considered to be unscientific. (37) The findings of this study draw close parallels to wider notions of the empirical and patriarchal origins and interests of biomedicine, seeking to centre and maintain dominance of the white, able, cis-gendered and heterosexual male.

Despite efforts by medical institutions to incorporate current LGBTQ+ health issues into medical curricula, (38, 39) this often falls short of the requirements of patients, leaving clinicians feeling inadequately prepared to support LGBTQ+ communities. In addition, studies have shown hidden curricula (that which is learnt inadvertently or passively during education) within medical schools that act to propagate compulsory heteronormative notions in its students, reinforcing homophobic stereotypes about queer patients. (40) The biases taught through medical education are pervasive, with a review of healthcare professional' views towards LGBTQ+

patients reporting approximately half of first-year medical students to express explicit negative attitudes towards lesbian and gay patients, and over 80% of students exhibiting implicit biases towards the same groups. (41)

It follows, then, that current attempts to include LGBTQ+-related health matters in medical education may be falling short of the needs of those communities, not only by creating clinicians ill-equipped to treat patients, but also exhibiting implicit and explicit biases. (41) Medical curricula have been shown to produce and reproduce sexual stigma and compulsory heteronormativity in both medical and hidden curricula. (42) Further, medical curricula have been shown to render specific sexual behaviours as natural and unremarkable, with others as excluded from this normality. (40) Considering these shortfalls, it therefore may be necessary to take more radical change when addressing the limits of medical education in relation to LGBTQ+ health.

A key question in rethinking LGBTQ+ health education is whether it is sufficient to treat these health needs as a discrete, peripheral learning opportunity, as health in relation to gender, sexuality and identity is experienced by all patients. Educating medical students to identify and treat patients only when they are deemed to have deviated from a heterosexual, cis-gendered normality may serve only to other and alienate patients, leading to a lack of engagement, failure to disclose health matters and, ultimately, inferior health outcomes.

It is critical that healthcare providers fully appreciate the significance of sexuality and gender to a patient, particularly when presenting in the clinical setting and seeking support as they experience ill health. (43, 44) In the clinical space, patients are often reduced to their diagnosable biological state. However outside of this space the patient exists in social and cultural spheres, where their identity and wellbeing are intimately linked. When patients feel that this part of themselves is not compatible with biomedicine, perhaps even disregarded by the clinician, they may feel forced to seek care from alternative providers. (19)

Alternative medicine (AM) is often sought out by patients due to increased time with care providers, (22) and by those seeking a clinical relationship that acknowledges and incorporates the patient's social realities into health management. (19) The use of AM may reflect the patient's resistance to the biomedical frame, whereby patients experience a loss of autonomy and humanity at the hands of a profession seeking to reinforce patriarchal power structures. (22) AM is widely considered within biomedicine to be effective only as far as placebo limits allow. (45) Therefore, it may be in the best interest of the patient to ensure that biomedical health providers are not enforcing unnecessary barriers to accessing care, for patients who are seeking only to be treated as a sum of more than their biomedical symptoms.

While the identification of at-risk groups is crucial in supporting specific communities and managing disease, the ideologies cultivated through medical curricula, hidden curricula and cultural discourse must be considered and carefully navigated. (46) Medical school can be considered a transformative site of professional socialisation, (42) where models for conceptualising gender, sexuality and identity may challenge or even supersede original understandings. Therefore, we must be intentional in ensuring that we produce healthcare professionals who are aware of and sensitive to the identity of their patients and actively create healthcare spaces that are safe for currently underserved communities.

Given modern theories of gender and sexuality as a transient set of experiences, expressions and behaviours, biomedicine appears to fall short in its ability to either define or incorporate contemporary queer theory. The requirement to fulfil discrete categories in diagnostic criteria to engage with treatment may place biomedicine at a distinct disadvantage when attempting to offer care to a community whose bodies fall outside of those categories. Careful consideration should be made as to how current and future medical professionals are educated, ensuring the language and frameworks applied to patient care are inclusive of, and accessible to, communities that exist outside of traditional medical narratives. Radical rethinking of the binaries applied to medical diagnoses and the pathologizing of the human experience are needed if care is to be truly patient-centred.

CONCLUSION

The biomedical and biopsychosocial models of healthcare were constructed on patriarchal ideals of physical, social and cultural standards. As sociological understandings of human identity develop, particularly in relation to sexuality and gender, biomedicine may not be equipped to incorporate contemporary queer theories into its frameworks of care. With distinct disparities in health outcomes between queer and non-queer communities, medical professionals, educators and students must rethink the ideologies that are being taught and are entering the clinical space, if biomedicine is to remain a model of healthcare that is viable for the future.
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