

UNIVERSITY OF CALIFORNIA, SAN DIEGO

It's Not Taboo, It's Just Not Relevant: The Absent Presence of Sexuality in Medical
Education

A dissertation submitted in partial satisfaction of the requirements for the degree Doctor
of Philosophy

in

Sociology

by

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The dissertation of Marie Heather Murphy is approved, and it is acceptable in quality and form for publication on microfilm and electronically:

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ABSTRACT OF THE DISSERTATION

It's Not Taboo, It's Just Not Relevant: The Absent Presence of Sexuality in Medical Education

by

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Doctor of Philosophy in Sociology

University of California, San Diego, 2014

Professor Hugh B. Mehan, Chair

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This dissertation ethnographically examines the processes by which teaching and learning about human sexuality were accomplished at “Buena Vista” Medical School, a top-twenty medical school in the United States. Despite indications that sexuality is broadly relevant to medical practice, little sociological inquiry has considered the contemporary production of medical understandings about sexuality, particularly as they are constructed within medical education. Through participant observation and in-

depth, semi-structured interviews with Buena Vista students and faculty, I examine the understandings about sexuality that were present at Buena Vista and the curricular processes through which they were produced.

The sexuality education that took place at Buena Vista was characterized by haphazard input and fragmented output. A set of teachings about sexuality were provided within the *formal curriculum*, or the planned, officially-offered, required classes, that were not insubstantial in the aggregate. But this content was not developed through collective planning and did not contain a consistent, cohesive set of messages about what sexuality fundamentally means or is, or how it matters to medicine.

These offerings within the formal curriculum were complicated by other simultaneously-occurring curricular processes. The *informal curriculum* sent a powerful, but highly variable set of messages about the presence and relevance of sexual diversity. A *hidden curriculum* of heteronormativity rendered a certain set of sexual possibilities familiar, obvious, and unremarkable, while keeping broad swaths of sexual diversity unfamiliar, invisible, or unintelligible. Although faculty and students recognized that anything associated with sexuality is potentially “sensitive” or capable of provoking discomfort, there was a *null curriculum*, or a lack of discussion of how to negotiate or mitigate this discomfort, thus reifying rather than challenging “sex negativity,” or the notion that anything associated with sexuality is taboo.

Bridging medical sociology, sociology of sexuality, and sociology of education, this research shows the particular utility of ethnographic methods for revealing how sexuality-related stigma may be produced even within settings in which participants are motivated to help others and have been exposed to norms that discourage overt homophobia and sexuality-related discrimination. It also underscores the importance of studying sexuality education in contexts other than secondary schools.

INTRODUCTION

What do doctors know or need to know about human sexuality?

What do doctors know – or need to know – about human sexuality, and how do they learn it? Although sexuality seemingly intersects with medical practice in ways that might seem obvious, or unavoidable – such as, for instance, the diagnosis and treatment of sexually transmissible infections – an exhaustive catalog of ways in which sexuality might be relevant to doctors’ work is hard to definitively establish. Little empirical research has attempted to inventory the range of ways in which doctors and medical students understand sexuality to be relevant to their work, what they understand “sex” and “sexuality” to fundamentally mean or pertain to, and how they experience negotiating or encountering sexuality as they go about their professional duties. Social scientists agree that sexuality is both inherently ambiguous (e.g., Weeks 1986; Jackson 2006) and uniquely associated with taboo, discomfort, or stigma (e.g., Rubin [1984] 1993; Epstein 2007). Examining doctors’ definitions of sexuality, how they grapple with its ambiguity, and how they negotiate the discomfort it may provoke, is important because doctors’ understandings about sexuality have the potential to impact patients’ health and experiences of health care encounters and contribute to patterned inequalities, such as health disparities.

A recent op-ed piece in the *New York Times* illustrates the salience of questions concerning medical understandings about sexuality. In an editorial published on August 19, 2014 entitled “Let’s Not Talk About Sex,” Dr. Paul A. Offit, professor of pediatrics and director of the Vaccine Education Center at the Children’s Hospital of Philadelphia, states that the uptake of the vaccine for human papilloma virus (HPV, a sexually transmissible virus that can cause cancer) is abysmal, and one reason why is that

“doctors don’t want to talk about sex.” But the good news, Dr. Offit continues, is that they don’t have to. Putting aside any questions about the HPV vaccine itself, Dr. Offit makes an interesting argument: avoiding talk about sex may help doctors deliver essential care and preventative medicine to patients who badly need it.

Doctors are likely to be particularly uncomfortable talking about sex with younger patients, according to Dr. Offit, and thus, facilitating the promotion of the vaccine to adolescents is simply a matter of separating the “sex talk” from the discussion about the HPV vaccine itself. Quoting Dr. Amy B. Middleman, chief of adolescent medicine at the University of Oklahoma College of Medicine, Dr. Offit pointed out that discussions of the Tdap vaccine in the doctor’s office rarely involve any talk about diphtheria. Following this logic, Drs. Middleman and Offit argue, the HPV vaccine is really about cancer, not about sex. In sum, Dr. Offit urged readers, avoiding talk about sex with young patients and their parents may be a great way to help doctors get the HPV vaccine to the millions of unvaccinated adolescents who could be protected from known causes of cancer.

Dr. Offit’s remarks illustrate several important issues. First, sexuality may be relevant to medical practice. This might seem obvious to the point of being unworthy of mentioning – after all, doctors diagnose and treat sexually transmissible infections, they examine the naked human body and probe its parts which are commonly understood to be fundamentally “sexual” in nature, they prescribe Viagra and contraception, and so forth. But, as Dr. Offit’s op-ed suggests, even if sexuality *appears* germane to a particular sort of exchange with patients or a particular health issue, it may not necessarily be so from the doctor’s perspective – or it may be possible or even sensible to extricate talk of sexuality from even the most seemingly sexuality-related issues.

Second, Dr. Offit’s op-ed piece demonstrates that sexuality may be something that doctors have a hard time talking about – that is, in the present, at the time of the

article's publication in 2014. Depending on one's perspective, this might sound either rather surprising or totally obvious. We live in an increasingly sexualized society, some argue, in which representations of sexuality are more prevalent within public life than ever before (Attwood 2006). Wouldn't this mean that doctors and patients alike are more comfortable talking about sexuality, especially since doctors are perceived to be experts on sexuality anyway (e.g., Leiblum 2001; Berman et al. 2003)? But at the same time, Americans are notoriously uncomfortable with sexuality in general and non-normative sexuality in particular (Epstein 2007) – should we expect doctors to be more comfortable talking about sexuality than anyone else?

Third, Dr. Offit's proposed solution to the difficulty of talking about sexuality was to *not* talk about it. Again, conventional wisdom offers the resources for perceiving this solution as perfectly reasonable or somewhat outrageous. Even as sexuality becomes increasingly visible within popular culture, the notion that sex is "private" retains power (Hearn and Parkin 1995; Epstein 2006; Kendall 2013) – despite the fact that privacy itself is complicated, and perhaps most so within the doctor's office. Moreover, discussion of adolescent sexuality is believed by some to encourage adolescents to engage in sexual activity (for discussion see Luker 2006; Fields 2008), which is not always considered a desirable outcome. To those who seek to prevent adolescents from engaging in sexual activity, not talking about sex might sound like an ideal course of action. Yet on the other hand, the fact that the doctor's office is private would seemingly make it the most appropriate place for broaching sensitive subjects like sexuality – and aren't doctors the experts on bodily, personal experiences such as sexuality, anyway? There is ample empirical evidence that some patients certainly think so (Leiblum 2001; Berman et al. 2003). And some medical professionals would likely take issue with Dr. Offit's analogy that not talking about sex in conjunction with the HPV

vaccine is just like not talking about diphtheria when discussing the Tdap vaccination. Former Surgeon General Dr. C. Everett Koop used the opposite logic to advocate for adolescent sex education, arguing that it is impossible to talk about the dangers of snake poisoning without talking about snakes (Fine 1988). While Dr. Koop's presumption of the risks associated with sexuality and the vulnerability of adolescents may be critiqued (Fine 1988), for the present purposes, the point is that medical professionals have made divergent arguments about whether or not talking about sexuality is extricable from talk about related medical and health issues.

Do medical professionals need to talk about sexuality? Interestingly, none of the letters of response to Dr. Offit's op-ed piece that *The New York Times* published addressed this question. But we know that patients experience sexuality as relevant to their health and well-being, particularly as cultural messages affirm that sexual satisfaction is central to individual happiness and quality of life (Irvine 1995; Marwick 1999; Loe 2004; Parish and Clayton 2007). Empirical data also shows that patients experience sexuality to be relevant to their interactions with doctors in a broad range of ways. Some patients see physicians as the primary resource for information, medication, and referrals for sexual questions and problems of all varieties (Leiblum 2001; Solursh et al. 2003). Others have experienced stigmatization on the basis of their sexuality or sexuality-related health condition from health care providers (e.g., Stevens and Hall 1988; Weitz 1990; Beehler 2001; Dewey 2008; Kinsler 2007; Harbin et al. 2012; Poteat et al. 2013). Sometimes patients have questions about how a medical procedure will affect their sexual functioning (Manderson 2005; Hordern and Street 2007).

Even if patients expect certain things of doctors when it comes to sexuality, we know that professionals' priorities are not necessarily shaped primarily or directly by what the consuming public wants from them (Abbott 1981), thus we would not expect

that patients' expectations translate into a predictable or complementary set of medical understandings about sexuality and its place within health care. And even if sexuality seems immanently, unavoidably relevant to some aspects of doctors' work, Dr. Offit's op-ed piece illustrates the importance of empirically examining medical understandings of sexuality's place within the practice of medicine. Moreover, this issue suggests the need for questions about what medical professionals understand sexuality to fundamentally mean or be or pertain to. Social scientists agree that "sex" and "sexuality" are inherently ambiguous and very difficult to define, even in the abstract (e.g., Weeks 1986; Plummer 2003; Jackson 2006). Sexuality's definitional ambiguity combined with the elusiveness of a definitive set of understandings about its relationship to or place within medical practice necessitates examination of medical understandings of sexuality. Just what do medical professionals think "sex" and "sexuality" fundamentally are, or mean, or pertain to? How do they conceptualize their relevance to medicine and medical practice? By what processes do they come to these understandings?

The production of medical knowledge about sexuality at "Buena Vista" Medical School

In this dissertation I examine the teaching and learning about sexuality that took place at Buena Vista Medical School, a top-twenty medical school in the United States ("Buena Vista" is a pseudonym, as are all names of persons and courses mentioned in this dissertation). Through participant observation and in-depth, semi-structured interviews with students and faculty, I provide "thick description" (Geertz 1973) of sexuality curricula in action at Buena Vista, and students' and faculty members' experiences of participating in these curricula.

Both faculty and students shared the belief that there was not much sex education happening at Buena Vista, but participant observation in classes revealed a

more complicated state of affairs. While it would not be appropriate to say that the focused attention devoted to sexuality-related topics within the *formal curriculum*, or the “stated, intended, and formally offered and endorsed curriculum” (Hafferty 1998: 404; Hafferty and Castellani 2009) was extensive, the formal sexuality-related teachings added up to more than anyone recognized. In addition to the few class meetings that were dedicated to sexuality-related topics, offhand, brief mentions of sexuality occurred fairly regularly, within the context of lectures with a range of primary emphases.

That these extended discussions and brief mentions of sexuality were not recognized as being significant in their totality is not surprising because even the more in-depth, intentional instances of teaching about sexuality were not connected in any explicit or obvious way, and did not contain a consistent set of messages, themes, or definitions. A continuous, well-developed set of messages about what sexuality fundamentally is and how it is relevant to medical practice did not emerge through collective efforts or through more organic, spontaneous processes.

The lack of a coherent set of teachings about sexuality within the formal curriculum – in other words, a sexuality curriculum that was understood as such - was not the result of indifference towards or intentional avoidance of sexuality. Faculty members tended to believe, at least vaguely, that sexuality was important to medical practice and important to teach about, and some faculty members did, of their own initiative, devote teaching time to the sustained consideration of sexuality. However there was neither an externally-imposed set of guidelines nor an internally-generated set of understandings of what should be taught about sexuality. Faculty members recalled having been taught little about sexuality within their own medical training, and tended to have a hard time defining sexuality. Tempering their belief that sexuality was important to teach about was the perennial problem of too much to teach and too little time to

teach it (e.g., Coombs 1968). Within this context, even faculty members who were committed in theory to allocating teaching time to sexuality struggled to do so when so many other important, oft-neglected topics competed for attention.

Whatever the amount or substance of the sexuality-related teachings within the formal curriculum and whatever the efforts faculty made to bring these teachings forth, the messages within these teachings were not received in a uniform manner by the students. This was due in part to the fact that students entered medical school with varying degrees of prior exposure to, experience with, and formal knowledge about sexuality, which shaped their reception of Buena Vista's formal sexuality-related teachings. But the presence of other, simultaneously-occurring curricular processes also complicated the messages presented in the formal curriculum.

The unwieldy processes of the *informal curriculum*, or the “cultural milieu” of the medical school (Hafferty and Franks 1994) sometimes had the effect of nullifying, or canceling out the messages about sexuality put forth within the formal curriculum – but it also served as a generative source of messages about sexuality, particularly sexual diversity, in its own right. The informal curriculum is made up of the unscripted, highly interpersonal, and primarily ad hoc forms of teaching and learning (Hafferty 1998: 404) that occur whenever students and faculty interact in unstructured settings (Maudsley 2001; Hafferty and Castellani 2009). At Buena Vista, faculty role modeling (Hafferty and Franks 1994) and peer-to-peer influences (Maudsley 2001) generated a powerful – albeit variable - set of messages about sexual diversity and its potential salience to health and health care. Contact with non-heterosexual peers gave some students their first meaningful personal encounters with sexual diversity, and students derived substantial educational value from these experiences. But non-heterosexual students at Buena Vista were a minority, and their willingness to be open about their sexual identity

was in no small part dependent upon the support they perceived from faculty and peers – which many of the non-heterosexual students regarded as limited.

Although Buena Vista provided some nuanced consideration of sexual diversity and devoted some teaching time to lesbian, gay, bisexual, transgender, and queer (LGBTQ) sexuality, a *hidden curriculum* of heteronormativity flourished within the formal curriculum. The latent, embedded, often unintended messages within an educational setting comprise the hidden curriculum, and serve to reinforce what is taken for granted within the medical education environment (Hafferty 1998; Hafferty and Castellani 2009). I show how many supposedly unsexual teachings within Buena Vista's curriculum were actually heterosexualized (Sumara and Davis 1999), and how the cumulative effect of these occurrences quietly reproduced the familiarity and obviousness of heterosexuality, while other sexual possibilities were not made equally visible or intelligible.

While minority sexuality, or non-normative sexuality, may bear the brunt of sexuality-related stigma, discomfort, or misunderstanding, social scientists point out that sexuality in general, or anything to do with sexuality, is potentially suspect, tainted, or taboo (e.g., Rubin [1984] 1993). At Buena Vista, sexuality was regularly referred to as a “sensitive” subject, but there was a *null curriculum* (Flinders et al. 1986; Hafferty and Castellani 2009), or a lack of systematic discussion about sex negativity, or the possibility that anything associated with sexuality might be not just “sensitive” but tainted in ways that could shape doctors' and patients' experiences of clinical encounters and potentially interfere with the delivery of professional, compassionate, equitable medical care.

In the past, social scientists who study sexuality argue, medical professionals played a significant role in shaping understandings about sexuality that gained traction within society at large (Foucault 1978). Here I show that medical knowledge about

sexuality may be produced through largely unintentional, incidental processes, and that medical professionals, rather than taking an active role in producing knowledge about sexuality, may reproduce the understandings about sexuality that are prevalent in society.

I argue that at Buena Vista, sexuality had an absent presence. Although everyone recognized that it was there, it did not garner sustained, thorough, dedicated attention, and as such, it remained more unknowable than known (Hearn and Parkin 1995). Sexuality was not totally ignored or neglected or actively silenced, but there was little collective clarity about what sexuality meant for the practice of medicine, and scant evidence of a collective sense of obligation to understand sexuality and patients' experiences of its relevance to their health.

My findings suggest that medical, professional knowledge about sexuality may be more arbitrary than systematic – in other words, not particularly “professional” at all. This research also suggests that medical education may inadvertently contribute to the eventual production of sexuality-related inequalities through the unconscious (re)production of normative understandings of sexuality and the notion that sexuality is, by nature, uniquely capable of provoking a particular sort of discomfort.

Medical education and sexuality

The collective production of medical understandings about sexuality has not been subject to extensive sociological study. This is surprising not only because of the indications that patients experience sexuality to be salient to health care encounters (and thus, we might want to know what is happening on the other end of the stethoscope, so to speak), but also because social scientists who study sexuality have long asserted that early medical conceptualizations of sexuality shaped common, shared understandings of what sexuality fundamentally is or means - including, for example, the

concept of sexual orientation – that remain salient to this day (Foucault 1978; Weeks 1986; Stein 1989). Given this, we might therefore have predicted that social scientists would devote more study to the contemporary production of medical knowledge about sexuality than they in fact have.

Medical knowledge about sexuality could have multiple sources and multiple sites of production. Sexuality is not an arcane subject, and medical students and doctors might learn about sexuality from non-medical sources of information – a possibility that seems particularly likely given that representations of or messages about sexuality are increasingly prevalent and prominent in our society (Attwood 2006). However, it makes sense to begin the examination of the collective production of medical knowledge about sexuality with a study of how this occurs within medical education because medical school has been recognized as a particularly potent, transformative site of professional socialization (Friedson 1970; Bloom 1988). We may expect that whatever medical students do or do not learn about sexuality within this context creates professional understandings of sexuality that reshape or even supplant whatever knowledge or beliefs about sexuality they bring with them into medical school. Studying the collective production of sexuality-related knowledge in medical school also enables insight into medical educators' conceptualizations of sexuality and its relevance to medical practice. Whether or not medical faculty drew their understandings of sexuality from medical or non-medical sources, the teachings about sexuality that they create and deliver within a medical school are constitutive of medical knowledge about sexuality.

Despite a long tradition of sociological study of medical education and the professional socialization of doctors in training, classic ethnographies of medical education (e.g., Merton et al. 1957; Becker et al. 1961; Good 1995) said little, if anything,

about sexuality. Some sociological research has examined specific, limited aspects of sexuality's relevance within medical education, such as representations of women's sexuality within gynecological textbooks and teachings (Scully and Bart 1973; Kapsalis 1997). In their ethnographic study of emotion management in medical school Smith and Kleinman (1989) noted that contact with the naked human body and particularly its "sexual" parts provokes discomfort for medical school students and faculty alike. Their research demonstrates that sexuality may be relevant within medical education even when the teachings at hand are not ostensibly or primarily about sexuality, and demonstrates that the discomfort so often associated with anything sexual is salient within medical training.

We know that some observers of medical education have advocated for the provision of medical sex education for decades (e.g., Coombs 1968; Lief 1970), and we know that teachings devoted specifically to sexuality have been provided, to some extent, by North American medical schools even if the current state of medical sex education is sometimes described as "limited" or "neglected," relative to its importance to patient care (Solursh et al. 2003; Rosen et al. 2006; Parish and Clayton 2007). But a comprehensive examination of sexuality's place within medical education is missing from the literature.

Background: sexuality, stigma, and the medical profession

The terms "sexuality" and "stigma" escape easy definition. Even social scientists who study sexuality agree that it is, at least to a certain extent, fundamentally ambiguous. The concept of stigma has its own set of definitional challenges (Link and Phelan 2001). Some sociologists argue "stigma" is over-used and under defined (Manzo 2004), but it remains indispensable to – or at least, ubiquitous within – the study of sexuality, health-related inequalities and particularly, sexuality-related health

inequalities. Since sexuality and stigma are integral to this dissertation, here I provide a brief overview of the sociological conversations about their definitions. I then acknowledge the history of medical knowledge and sexual stigma as a means of providing context for considering the contemporary production of medical understandings about sexuality at Buena Vista.

Defining sexuality

What exactly is sexuality, and where does it come from? Early sexologists believed in an overpowering, instinctual sexual drive that sprung from an essential, biological source (Stein 1989). Freud's famous conceptualization of libido, or the psychic energy that impels an individual to erotic activity gained traction within the scientific study of society and cultural understandings of sexuality and remains influential to the present, in part because so many people experience their sexuality as a powerful, natural, unchanging force (Stein 1989: 2). The conceptualization of sexuality as a biological drive can still be found within medical literature, such as "...individuals discover the types of persons they are sexually attracted to, i.e., their sexual orientation...[through] the powerful biological force that constitutes sexual drive" (Fagan et al. 2002: 2462).

Although the understanding of sexuality as an innate force driven by biology remains prevalent in some spheres, sociologists have come to emphasize the extent to which biological capacities are given meaning only within a social context. While biology – starting with the physical body itself – provides the capacity for sexual experiences, sexual behavior is learned in much the same way any other behavior is learned, and the extent to which understandings about what sexuality meaningfully is or pertains to take shape only within the context of social interactions (Plummer 1982). "Human sexuality –

as opposed to biological functioning – only comes to exist once it is... *defined* as sexual”

Ken Plummer notes (1982: 228; emphasis in original).

Thus what “counts” as sexuality, or what comes to be defined as sexual, is always a moving target. As Jeffrey Weeks put it,

...what we define as ‘sexuality’ is an historical construction, which brings together a host of different biological and mental possibilities – gender identity, bodily differences, reproductive capacities, needs, desires, and fantasies – which need not be linked together, and in other cultures have not been. All the constituent elements of sexuality have their source either in the body or the mind...but the capacities of the body and the psyche are given meaning only in social relations (Weeks 1986: 15).

Even if we acknowledge that what counts as sexuality varies, it remains difficult to draw clear distinctions between what is sexual and what is not. Stevi Jackson reserves the terms “sex” and “sexual” for that which “pertains to the erotic.” She goes on to say that “[w]hile ‘sex’ denotes carnal acts, ‘sexuality’ is a broader term referring to all erotically significant aspects of social life and social being, such as desires, practices, relationships, and identities” (Jackson 2006: 106).

It is helpful to identify sex as something that people do and sexuality as a broader term that pertains to multiple dimensions of interactions and personhood, but both “erotic” and “carnal” are synonyms for “sexual.” Thus, as Jackson acknowledges, sexuality has no clear boundaries. What counts as sexual to one person may not to another. While it may be hard to define what essential characteristics make one act sex and another something else, and even if it is difficult to draw a firm line between the sexual and the unsexual, there is still an understanding that “sex” pertains to certain acts or certain sorts of acts. Even if sexuality is always a moving target, even if what counts as sexual varies, there is still the powerful shared understanding that “sex” and

“sexuality” pertain to aspects of social experience that are unique, or to have distinct connotations even if their exact definitions are elusive.

How to gain analytical purchase on all of this ambiguity? Drawing from the insights of Kinsey and his colleagues, most sociologists tend to conceptualize sexuality in terms of behaviors or practices, identity or orientation, and desires, and recognize that these elements of sexuality may vary contextually and temporally within any given individual, and may or may not be consistent within any one person at any time. But even parsing sexuality into behavior, identity, and desire does not fully capture the range of ways in which sexuality can be experienced differently. Eve Kosofsky Sedgwick (1990) notes that people may have very different degrees of emotional attachment to sexual acts. Sexuality may contribute much to the self-identity of some individuals but very little to that of others. Some people want or need a great deal of sexual variety or spontaneity, while others rely on sexuality to provide a “needed space of routinized habituation and cognitive hiatus.” Some people experience their sexuality as inextricable from their gender and from the broader system of gender; others do not. Many people are mentally or emotionally invested in sexual acts that they do not engage in physically, or even want to. Some people experience their sexuality primarily in terms of autoeroticism while for others the autoerotic possibility is minimal or nonexistent. Some people think about sex quite a lot and others do not. And so forth (Sedgwick 1990: 25-26).

These elaborations illustrate the difficulty associated with developing an adequate analytical framework for conceptualizing sexuality that is broadly applicable. Part of the reason why sexuality is difficult to define is because it intersects with so many different dimensions of social life, and thus, what sexuality fundamentally is or seems to be may look very different depending on the perspective, or the particular ways in which

sexuality is socially constituted in a given instance. Sexuality, conceptualized as originating from the individual's biology or psyche, is often assumed to be part of the private domain, and perhaps because of this our conceptual vocabulary for examining sexuality as it manifests itself within the public arena has been limited (Hearn and Parkin 1995). But just like sex and sexuality, understandings of "public" and "private" are socially constructed (Hearn and Parkin 1995). Does the language of behaviors, identities, and desires, or Sedgwick's elaborations of how individuals may experience sexuality, adequately speak to all of the ways in which sexuality manifests itself or becomes salient in public life, for instance, within organizations? Even though sociologists argue that sexuality needs to be studied as a mundane (yet important) aspect of social experience (Plummer 1982), most people tend to experience sexuality as anything but mundane, and its mysterious quality is both cause and consequence of its unknowability (Hearn and Parkin 1995).

Two particular challenges associated with defining and conceptualizing sexuality are of particular relevance to this study. One is the challenge of appropriately balancing inductive and deductive understandings about what sexuality fundamentally is. As the preceding discussion indicates, social scientists agree that what counts as sexuality varies both contextually and individually. In the face of considerable diversity of understandings about what sexuality means or is, is it appropriate for the analyst to impose any definition of sexuality at all? How can we balance the need for conceptual clarity with the recognition that the considerable diversity in empirical understandings about sexuality may mean that the concepts we employ do not adequately capture the experiences we seek to study? In other words, how can we maintain the sociological position that "sexual acts have no inherent meaning" because "no act is inherently sexual" (Epstein 1991: 828) while at the same time acknowledging the possibility that

some social actors may regard certain acts, experiences, body parts, or interactions to be so fundamentally sexual in nature that it is difficult if not impossible to conceptualize them as being otherwise?

My response to this question is to assume that sociological definitions of – or perhaps more accurately, frameworks for understanding – sexuality are useful, but that social actors' definitions of sexuality are only knowable through empirical inquiry, and that empirical definitions of sexuality may bear little resemblance to sociological conceptualizations. Although social scientists have made many attempts to refine abstract definitions or explications of sexuality, less attention has been devoted to the examination of empirical understandings of sexuality. What do people – in this case, doctors and medical students – think sexuality is or means or is?

The other challenge – which this dissertation illustrates empirically, particularly in Chapter 2 - is that people think of sexuality as being a thing unto itself, even if they do not have a precise understanding of what it is or means or encompasses. In other words, even if definitions of sexuality are elusive within the public sphere, people tend to experience it as a social fact (Durkheim 1895), as something that is distinct and powerful in a multitude of ways, even if poorly understood.

Part of my objective within this dissertation is to illustrate the ambiguities within medical understandings about sexuality – but to do so without suggesting that there is an alternative to ambiguity. When I refer to sex and sexuality without qualification, I assume a sociological understanding of these terms. That is, like Weeks (1986), I understand that the body and the mind – which are commonly understood to be biological entities – are constituent elements of sexuality. But what comes to be understood as “sex” or “sexuality,” what makes something “sexual” in character as opposed to not sexual, is the product of social interactions and negotiations within a

particular context. When I use the terms “sex” and “sexuality” and “sexual” without qualification I intend to imply that their meanings may be broad and ambiguous – but that at the same time, they refer to aspects of experience that are understood to be primarily or singularly sexual, rather than something else. At other points, I qualify my usage of sex(uality), speaking specifically (for instance) to heteronormative understandings of what “sex” is. In these instances I attempt to be clear about the specifications I am referring to. And of course, in some places I point out the definitions of sexuality that were explicitly put forth by Buena Vista students and faculty.

Finally, a note about the relationship between sexuality and gender. Sociologists have debated the relationship between sexuality and gender from theoretical and empirical perspectives, and my intention is to acknowledge this conversation rather than contribute to it in any substantial way. My position is that sexuality and gender are closely related, but distinct domains of social experience (e.g., Richardson 2007), and that the ways in which gender and sexuality inform or constitute each other vary contextually (e.g., Martin 1993). Rather than making a claim about the empirical understandings about the relationship between sexuality and gender that were present at Buena Vista, I simply wish to acknowledge that gender is related to sexuality even though I do not emphasize questions about the relationship between them in my analysis. This is perhaps most essential to note because I discuss transgender issues within this dissertation, which is not necessarily best or primarily understood as a manifestation of sexuality (Valentine 2007), and in doing so, I may risk implying that the analysis of gender may be subsumed within the examination of sexuality. This is not my position. Rather, I discuss transgender within the context of sexuality without extensive consideration of gender because, at Buena Vista, content pertaining to transgender was understood to be about sexuality. Future research might usefully devote closer attention

to medical understandings of the relationship between sexuality and gender, but the specifics of that relationship are not the focus of this analysis.

Conceptualizing stigma

Despite the sociological debates about its definition (and sometimes, its utility) the concept of stigma¹ has long been central to discussions of sexuality, health, and inequalities, and remains so in the present. Recently and significantly, the Institute of Medicine recognized “stigma” related to non-normative sexuality as factor contributing to health disparities (IOM 2011) and studies of patients’ experiences of health care continue to indicate that patients experience “stigmatization” associated with their sexuality or sexuality-related health condition within clinical encounters (e.g., Poteat et al. 2013). The experience of stigmatization within health care encounters is associated with patients’ avoidance of health care in the future, ultimately contributing to patterned health disparities (e.g., Kinsler et al. 2007).

Most definitions of stigma start with a reference to Erving Goffman’s seminal formulation of the concept, and many stop there. Goffman defined stigma as “an attribute that is deeply discrediting” whose possession reduces the individual’s status in the eyes of society (1963: 3). Gregory Herek argues that “stigma refers to the negative regard and inferior status that society collectively accords to people who possess a particular characteristic or belong to a particular group or category” (2009: 66). Link and Phelan (2001) provide a useful elaboration, arguing that stigma exists when four

¹ The terms stigma, prejudice, and discrimination are sometimes used interchangeably by the same authors within the same texts, Phelan et al. (2008) point out. While some sociologists argue that there may be meaningful distinctions to be made between the terms, these distinctions are usually understood to have more to do with different research traditions and subjects of interest rather than major conceptual differences (Phelan et al. 2008; Stuber et al. 2008). As such I consider these terms synonymous for practical purposes within this dissertation.

interrelated components converge. First, people distinguish and label human differences. Second, dominant cultural beliefs link labeled persons to undesirable characteristics or negative stereotypes. Third, labeled persons are placed in distinct categories and there is some degree of separation between “us” and “them.” Fourth, labeled persons experience some degree of negative regard and status loss that leads to unequal outcomes (Link and Phelan 2001: 367). More succinctly, Poteat et al. speak of the social processes of “othering, blaming, and shaming” that stigma entails (2013: 22). These processes are contingent upon the access to social, economic, and political power that allows for the identification of “differentness” and decisions about what sorts of difference counts, for the construction of stereotypes, and for the execution of disapproval, exclusion, or any other practical form of negative regard (Link and Phelan 2001; Herek 2009).

Within the enormous array of circumstances in which stigma may be present and stigmatization may occur (Link and Phelan 2001), different dimensions of stigma may be salient and different questions about stigma and stigmatization may be more relevant. Some of these questions include: How are understandings of what constitutes undesirable difference created and sustained? How do those who are subject to these understandings, i.e., the stigmatized, experience the situation(s) and respond? How do those who are in power, i.e., the “perpetrators” (Phelan et al. 2008: 359) or potential perpetrators of stigma experience their position of privilege? What are the salient features of the broader social context in which all of this occurs? Questions like these are sometimes formulated through drawing distinctions between *enacted* stigma, or behaviors that express stigma; *felt* stigma, or individuals’ awareness of stigma and its consequences; and *internalized* stigma, which is individuals’ acceptance of the legitimacy of stigma, whether it is directed at them or others (Herek 2009).

Much research on stigma has had an individualistic focus, regarding supposedly fixed or static personal attributes as the source or locus of stigma (Siegel et al. 1998; Link and Phelan 2001) even though Goffman himself argued that stigma needed to be understood within the context of relationships rather than as individual attributes in isolation. Stigma research with an individualistic focus has conceptualized stigma as a process by which one person consciously does something to another person, leading to “personal tragedy” for the person in possession of the attributes deemed undesirable (Parker and Aggleton 2003; Scambler 2004). In response, scholars have called for increased inquiry into the ways in which stigma is promulgated – not just how individuals experience it – and the broader social-cultural-historical circumstances in which it is produced (Parker and Aggleton 2003; Stuber et al. 2008). Parker and Aggleton argue that “stigma and stigmatization function, quite literally, at the intersection between *culture, power, and difference*” (2003: 17; emphasis in original). In their view, “stigma plays a key role in producing and reproducing relations of power and control. It causes some groups to be devalued and others to feel that they are superior in some way” (Parker and Aggleton 2003: 16). Furthermore, Parker and Aggleton say, stigma is *deployed consciously* within the complex power struggles that are at the heart of social life, by “concrete and identifiable social actors seeking to legitimize their own dominant status within existing structures of social inequality” (2003: 18).

While many sociologists agree that stigma and stigmatization are inseparable from the broader social context in which they occur and the associated power differentials (Scambler 2004), some argue that conscious intent is not a prerequisite for stigma to exist or stigmatization to occur (Dovidio et al. 2008). Sociological studies of the changing nature of racism indicate the importance of this distinction. Scholars who study race, racism, and race-related inequalities argue that racial antipathy has evolved

considerably as social norms and legislation have increasingly frowned upon or sanctioned racial discrimination. In place of “old fashioned” or overt racism, a more subtle form of “color –blind” (Bonilla-Silva 2006) or aversive racism is more likely to be found amongst dominant racial groups (Dovidio et al. 2008). Even when members of a dominant racial group consciously adhere to egalitarian attitudes, they may unconsciously possess negative attitudes towards marginalized groups or persons (Dovidio et al. 2008).

Because of their explicit egalitarian orientation, the feelings that aversive racists experience toward other groups are not of hatred or open contempt, which motivate direct harm, but are rather of anxiety and discomfort which lead to avoidance...negative orientations toward groups and their members...are particularly likely to produce discriminatory actions when people lack the motivation or cognitive resources to monitor and control their actions, such as when they have time pressure or substantial cognitive demands (Dovidio et al. 2008: 479).

Such a conceptualization of stigmatization and discrimination is particularly useful for understanding the production of stigma in an historical era that is recognized as relatively egalitarian. As sociologists who study race have observed, understandings about what constitutes an unacceptable expression of racial hostility or discrimination may have changed, but that does not mean that beliefs in racial inferiority have themselves disappeared (Bonilla-Silva 2006). While expressions of color-blind racism may appear harmless or neutral to dominant racial groups, and whites may not think that racism is a problem, blacks experience racism everywhere (Bonilla-Silva 2006). In other words, the extent to which stigmatization or discrimination is recognized as actually occurring processes may depend to a great extent on one’s relative position of privilege.

For this reason, it is important to ask more questions about the extent to which stigmatization is recognized not only by the “victims,” or those experiencing stigmatization, but also by the “perpetrators.” The term perpetrator implies a certain

amount of ill intent. But the essence of color-blind racism is its appearance of neutrality to those who perpetuate it, and this may well be true for other forms of stigmatization as well. To those who do not experience it, the practices of color-blind racism seem unproblematic. Where, then, lies the possibility for social transformation? Many discussions of stigma emphasize the role of the “victims,” or those who are on the receiving end of stigmatization, and their capacity (or lack thereof) to resist stigma. Sociologists have debated about the extent to which the stigma concept implies that the role of victim is escapable or inescapable, and the extent to which victims themselves are involved in the labeling processes that they are subject to (e.g., Siegel et al. 1998). Resistance to stigma, to whatever extent it takes place, sometimes indicates a rejection of the stigma but an acceptance of the underlying social norms and values that construct it on the part of the stigmatized, some argue (Siegel et al. 1998). The advancement of stigma research requires closer empirical attention to the production of stigma, and instead of assuming intent to marginalize or dominate on the part of the perpetrators of stigma, we might ask questions about persons’ or groups’ recognition of their relative power over others, and their awareness of their capacity to marginalize others, even inadvertently.

Within this dissertation I am concerned with identifying some of the ways in which, or some of the contexts from which stigma may be produced without conscious intent. Specifically, I examine the processes by which understandings about sexuality that may ultimately lead doctors to act in a manner that patients experience to be stigmatizing are produced within medical education. My analysis only focuses on medical education – not doctors’ actions within clinical encounters, and not on patients’ experiences of their care - thus it is impossible to say for sure whether or not the sorts of processes and understandings I identify ultimately lead to patients feeling stigmatized by

doctors. My attempt is to contribute to two conversations: First what might be going on within medicine that could lead to patients' experiences of sexuality-related stigmatization at the doctor's office? Second, how might stigma be produced *in the absence of* "concrete and identifiable actors seeking to legitimize their own dominant status within existing structures of social inequality" (Parker and Aggleton 2003: 18; emphasis mine)?

Sexuality, stigma, and the medical profession

Sociologists argue that modern understandings of sexuality, including the concepts of sexual orientation and sexual identity, owe much to early medical conceptualizations of sexuality which originated at a time when the increasing professionalization of medicine coincided with new forms of state interest and intervention in their populations (Foucault 1978; Weeks 1986; Weeks 1987; Stein 1989; Irvine 1995; Plummer 1995; Terry 1999; Epstein 2003; Epstein 2007). By the late nineteenth century physicians had achieved a degree of professional authority that endowed them with near-complete jurisdiction over the realm of diagnosis and treatment of illness (Freidson 1970; Starr 1982). Medical knowledge concerning human physiology and pathology was accorded credibility and authority, and doctors were able to attain expert status on matters of sexuality because of their professional authority combined with their unique intermediary position: they had achieved the status of the sole or preferred occupants of the space between science and private experience, and people felt that doctors could help them make sense of their private experiences, including their sexuality, and wanted them to do so (Starr 1982; Epstein 1996).

As the early sexologists took on sexuality as an object of concerted inquiry in the late 1800s, they established categorizations and typologies of sexual persons (as opposed to behaviors) to which they assigned evaluations of normalcy or pathology and

became firmly entrenched within medical knowledge (Foucault 1978; Weeks 1986; Risman and Schwartz 1988; Stein 1989; Irvine 2003). These typologies included the categories of homosexuals and heterosexuals, along with pedophiles, zoophiles, exhibitionists, nymphomaniacs, and more (Foucault 1978; Weeks 1987). This emphasis on sexuality as a type of personhood, rather than as types of behaviors that persons engaged in, along with typologies of perversity and abnormality cast new light on normalcy (Foucault 1978; Weeks 1987). Procreative heterosexuality was deemed the norm by sexologists, while all else fell into the “vaguely written but powerful catalogue of perversity” (Weeks 1987: 35). Scholars argue that the early sexologists’ classifying endeavors heralded the beginning of the medical establishment’s history of treating sexual difference as pathology that has shifted forms but persisted in various manifestations to the contemporary era (Martin 1993). The codification of sexual variations as pathologies in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is one example of this. There have been changes in the sexual “disorders” included in the *DSM* – homosexuality was removed in 1973, albeit not without controversy, but various paraphilias remain (Hinderliter 2010), and some argue that the tradition of equating particular sexual interests with psychopathology as a moral endeavor has persisted (Moser and Kleinplatz 2006). In other words, even if what counts as pathological has changed, the practice of codifying some sexualities as pathological within medical knowledge persists.

What these tendencies meant for sexuality education within medical training in decades past has not been studied, and it may be that the relationship between medicine and sexual stigma is very different today from what it was decades ago. Much has changed within society in general and the biomedical establishment in particular since the sexologists’ classifying endeavors of the late 19th and early 20th centuries. For

instance, in the latter part of the 20th century, social movements reshaped many aspects of North American society. Of particular relevance, the women's health movement, gay and lesbian health activism, and health activism related to the AIDS epidemic challenged the normative workings of biomedicine in significant ways and altered the expert-subject power relationships within the production of knowledge about sexuality (Epstein 1996; Terry 1999; Morgen 2002; Epstein 2003; Epstein 2007). The demographic composition of the medical profession has also changed much within recent decades. Women, ethnic minorities, and lesbian, gay, bisexual, and transgender (LGBT) individuals have increasingly joined the ranks of the biomedical establishment (Beagan 2001; Epstein 2003; Fox 2005; Boulis and Jacobs 2008; Brosnan and Turner 2009; Lempp 2009), making the profession much more diverse than it was in the past. It would seem that these sorts of changes might reshape medical understandings about sexuality, but we lack a clear sense of the specific ways in which this may have occurred, and how they have shaped medical sex education specifically.

And despite many changes within society and medicine, there is evidence that sexuality-related stigmatization lingers within medical education and practice. Non-heterosexual medical students and medical professionals have experienced discrimination and hostility throughout the course of their training and professional careers (Townsend 1998; Brogan et al. 1999; Klamen et al. 1999; Murphy 2001; Eliason et al. 2011), and empirical research demonstrates that patients feel stigmatized by their doctors on the basis of their sexuality or sexuality-related health condition. Persons with HIV/AIDS have negotiated discrimination from doctors and other health care providers (Weitz 1990; Emler 2007), which sometimes takes overt forms, such as being refused treatment or hearing derogatory remarks from doctors and nurses, but has also come in more subtle configurations, such as receiving care that is less thorough or less emotionally

supportive than usual (Schuster et al. 2005). Transgender patients have experienced hostility, coldness, and outright rejection from health care providers (Dewey 2008; Poteat et al. 2013). Lesbian women have received nonempathetic responses to disclosure of their sexual identity and have felt at risk of harm within health care encounters (Stevens and Hall 1998). Gay men have experienced care perceived to be homophobic, heterosexist, or grossly ignorant (Beehler 2001). Even patients whose sexuality might be considered the most normative – i.e., heterosexual, married, disease-free – find that their physicians belittle them or are embarrassed, or impose their personal values upon posing a sexuality-related question (Berman et al. 2003). While particular stigma may adhere to non-normative sexuality, the stigma that is associated with all things sexual (Rubin [1984] 1993) has the potential to shape any doctor-patient encounter.

Even if there is agreement that medical professionals actively contributed to shaping understandings about sexuality and what counts as normal or pathological sexuality in the past, and even if it is clear that sexuality-related stigmatization is still a feature of persons' experiences of the medical arena, how doctors negotiate the discomfort, stigma, and taboo associated with sexuality today is another question. "Sex negativity" or the idea that anything that has to do with sexuality is inherently suspicious (Rubin [1984] 1993) now exists independently of the medical profession. In the current historical moment, medical professionals may be just as likely to be subject to sexuality-related discomfort as anyone else – that is, they may be far more likely to experience sexuality-related discomfort than to actively produce it. But even if medical professionals do not take an active role in producing sexuality-related stigma, they are certainly in a unique position to transmit or reproduce sexual stigma through their interactions with patients. Whatever their source, doctors' understandings about sexuality, and the actions they take that stem from these understandings, have a direct impact on patients'

experiences of health care. Although the doctor-patient relationship has undergone a shift from physician paternalism to increased patient autonomy (Balint and Shelton 1996), doctors are still likely to have more power within doctor-patient encounters, and thus, their definitions or understandings or beliefs about sexuality are likely to have consequences for their patients (Mehan 1990). Furthermore, doctors' beliefs about sexuality may have normative power in society due to physicians' professional authority (Starr 1982; Mathews et al. 1986), even if these beliefs do not originate from active attempts on the part of medical professionals to collectively define or conceptualize sexuality. Thus, within the current historical moment, the critical questions about medicine and sexual stigma may be, "Is the possibility that patients might experience sexuality-related stigmatization within clinical encounters recognized or conceived of?" or, "If we know that patients experience sexuality-related stigmatization within clinical encounters, how do doctors conceive of their responsibility to address this?"

Recent research on patient and provider perceptions of stigmatization within health care indicates the value of these sorts of questions. In their study of transgender patients' experiences of health care and health care providers' experiences of working with transgender patients, Poteat et al. found that, as previous studies have shown (e.g., Dewey 2008), transgender patients sometimes experienced care from health care providers that was "far from ideal" (Poteat et al. 2013: 23). Aside from clinicians' lack of awareness of their medical needs, transgender patients have experienced harsh language, physically rough or abusive treatment, or other forms of "outright mistreatment" within health care encounters (Poteat et al. 2013). Poteat et al. found that the health care providers in their study were sometimes aware of the stigma transpersons are subject to (although they did not quantify the difference, they imply that the providers' awareness of stigma that patients were subject to was less than patients'

own awareness of this stigma), but their beliefs about the eventual *results* of this stigma or what they as health care providers needed to do about it were different. Some providers felt they had an obligation to learn more about the social circumstances and medical needs of transgender patients in order to better meet their needs. Others believed that while transgender patients were subject to stigma, their internalization of felt stigma caused them to act in ways that made them problematic as patients. These providers did not conceive of the possibility that their actions contributed to the sorts of experiences that the transgender patients considered stigmatizing.

Poteat's et al. (2013) study illustrates how sexuality-related stigma remains "intimately linked to the reproduction of social difference" (Parker and Aggleton 2003: 13), particularly through symbolic violence and hegemony. "[T]he role of power in stigma is frequently overlooked because in many instances power differences are so taken for granted as to seem unproblematic," Link and Phelan write (2001: 375). Even if doctors are uncomfortable with transgender patients through no "fault" of their own, it is still, in the context of doctor-patient relationships, the patient who suffers. The doctor is the participant in the encounter with the power to deem patient behavior problematic or otherwise, and the one who has the privilege to recognize or ignore her or his own potential influence on the patient's actions. Within the context of clinical encounters, it is relatively taken for granted that the doctor is the authority figure, and their power to deem a patient difficult or compliant may well seem unproblematic – particularly to the doctor. As providers of services that are essential to health and well-being, doctors are in a unique position to enact stigma, even if they do not set out to do so intentionally.

Field site and research methods

Buena Vista is a medical school with a history of excellence in research and the basic sciences. It does not have a history of defining itself as placing a strong emphasis

on humanistic medicine, but it did, at the time of my research, require its students to complete a series of courses pertaining to the social aspects of medicine (hereafter SAM, or the SAM course sequence). This course sequence included classes such as Stages of the Life Course, The Physician-Patient Dynamic, Psychopathology, and Introduction to the Practice of Doctoring. The SAM courses had a multi-part format. Each class included at least two components, a large-group lecture that all students were required (nominally, at least) to attend, and small-group discussions following the lecture in which ten to thirteen students met with two faculty facilitators for the purpose of discussing course content in greater depth. Some of the SAM classes had additional components, such as medium-sized group “seminars” in between lecture and small group discussions, in which the medical school class would split into two or three groups and listen to presentations by guest speakers.

I focused my participant observation on the SAM courses because they were, according to faculty familiar with course content, the primary if not only courses in which sexuality was a planned topic of discussion. This strategy was the most practical choice for my purposes, and it is likely that by devoting my participant observation to the SAM courses I captured much of the total sexuality-related content, both planned and unplanned, that occurred within the formal curriculum. I found that sexuality came up spontaneously within the SAM courses, even when it was not the officially designated or sustained focus of a lecture, and this may have happened in classes outside of the SAM course sequence as well. But it seems less likely that sexuality would garner as much offhand mention in an organic chemistry class (or any of the other “hard science” requirements) as it would within a discussion of, for instance, human growth and development within a SAM class. Medical students and faculty reported little awareness or recollection of sexuality-related discussion within classes outside of the SAM

sequence during interviews, and while I do not assume that these memories were completely accurate, they do suggest that much of the sexuality-related curricular action indeed took place within the SAM courses.

Small group discussions

I participated in the SAM course sequence for the 2009-2010 academic year, and served as a “faculty facilitator” for two courses, namely, the Physician-Patient Dynamic, and Stages of the Life Course. Normally, the role of faculty facilitator was fulfilled by members of the Buena Vista faculty, or local practicing or retired physicians of various specialties. I received permission from the dean at Buena Vista and the faculty course directors to serve as a “faculty” facilitator in the small group discussions of two SAM courses, and the Institutional Review Board at UCSD also approved my participation in this capacity. Occupying this role enabled me to attend lectures and seminars, and to co-facilitate students’ small group discussions. I was also able to attend the faculty facilitators’ orientation meetings for each course, held prior to the beginning of the quarters. These components of the medical school environment were normally off-limits to anyone other than their designated participants, i.e., Buena Vista students and faculty. My participant observation in this fashion totaled approximately 100 hours of field work. I took field notes during participation to the extent that this was possible, and sat down immediately after participation sessions to develop a more complete set of field notes for the observation period.

For the first quarter that I served as a “faculty” facilitator, I did not reveal my status as a researcher until the end of the quarter. My co-facilitator and the students in my small group knew that I was a sociologist studying sexuality in medical education and not a medical doctor from the outset of our discussion sessions, but I did not disclose that I was studying *them* until the end of the quarter. The UCSD Institutional Review

Board as well as the director of the course approved my use of concealment in this instance. For the next class I facilitated, students and my co-facilitator were made aware of my research objectives at the beginning of the quarter. When I did conceal my role as a researcher I agonized over the ethics of my decision to do so and experienced a fair amount of anxiety, as have other ethnographers who have employed concealment or used deceptive research strategies (e.g., Lofland and Lofland 1993; Li 2008), but contrary to what some researchers have experienced, it did not seem that the covert portion of my research enabled me to gain access to substantively different data (for discussion see Li 2008). The quality and frequency of comments that students made within small-groups discussions during the quarter that I was undercover and the quarter that I was not were very similar.² Upon debriefing my co-facilitator and the students in my discussion group upon completion of the covert phase of my research, my co-facilitator expressed hurt feelings at having been deceived, while the students' reactions ranged from mild amusement to a certain amount of glee and pride upon learning that their doings had been subject to study. When I informed my small group of my research objectives at the outset of the quarter the second time I facilitated, everyone present smiled and nodded, and no one took me up on my offer to answer any questions they might have.

² I based my choice to engage in covert research initially upon the assumption that doing so would yield fundamentally different data than overt research possibly could – as other researchers have found (e.g., Li 2008). I was both surprised and somewhat relieved that my covert research did not yield data that were substantially different from those I gathered as an overt researcher. I suspect that the reasons for this lack of difference had much to do with students' investment in the small group discussions, which, as I will discuss in later chapters, was not terribly high. Furthermore, I did not get the impression that the students I encountered felt threatened by or vulnerable as a result of my presence. Quite the contrary. While a few students expressed deep interest in my endeavor to study medical sex education, I got the impression that some students not only found my presence unthreatening, but also though my research, disciplinary affiliation, *raison d'être*, etc., were of little importance compared to medical pursuits.

Even when my research agenda was concealed, I was never an “insider” to the medical profession or its culture within any setting at Buena Vista, even though I occupied a role that was natural to the setting (for discussion see Hammersley and Atkinson [1983] 1995). I have no doubt that my presence as an overt social scientist (and an outsider to the medical profession) made an impact on the proceedings, but it is difficult to ascertain the significance of this impact – however, uncertainty concerning the effects of a researcher’s presence is a common attribute (or pitfall) of fieldwork (Hammersley and Atkinson [1983] 1995). Within the context of small-group discussions, I had a very different agenda from everyone else in the room. Students were trying to enter the profession and succeed as medical students, and the faculty facilitators that I worked with, although tasked with facilitating the small-group discussions and fulfilling the bureaucratic responsibilities of taking attendance and evaluating students and the like, were eager to pass on their wisdom about the profession to the students. The two facilitators that I worked with shared a number of personal and professional stories with the students, and the students seemed to enjoy hearing these stories as much as the facilitators seemed to enjoy telling them. My outsider’s impression was that these discussions were primarily, for their legitimate participants, an opportunity to exchange the currency of professional belonging. Faculty got to tell stories, students lapped them up, and the facilitators seemed to enjoy the students’ attention. Discussions in small groups often veered far from their designated topics, and students asked their (real) faculty facilitator “What would you do in this situation?” as often as the facilitators offered such commentary without any prompting. In other words, these settings provided an opportunity for informal professional socialization that was relished by students and faculty alike.

I, on the other hand, had no medical war stories to tell, and I asked different sorts of questions and more frequently pushed students to explicitly consider the assigned class material than did my co-facilitators. Although in attempting to stick to the material presented in the SAM classes and facilitate student discussion I was following the instructions given to faculty facilitators by the course directors, I was also the person most committed to this agenda within each of my small groups, which ironically made my presence disruptive, or at least, incongruous to the naturally-occurring substance and flow of the discussions. As a researcher I fretted about whether this approach was the “right” thing to do or not. On the one hand, I feared that I might be failing to achieve the status of a “marginal native,” (Hammersley and Atkinson [1983] 1995; citing Freilich 1970) or a participant who fits in to the setting, but without actively participating enough to skew the proceedings. But on the other hand, I had been tasked with the duties assigned to faculty facilitators by the course directors who gave me permission to fulfill the role that enabled me access to the setting, and in part because of this, I felt allegiance to their pedagogical goals. And more personally, as a social scientist and an educator, I felt that the goals set forth by the SAM course directors were valuable and worth trying to adhere to. As I settled into my role and pondered my various dilemmas, I eventually decided that pushing students to think about things in different ways and to stick to the class material more than they might have otherwise probably was not a terribly unethical position to take. In William Foot Whyte’s (1993) discussion of the challenges associated with meeting the expectations of various different groups a researcher is beholden to while in the field, he notes that at the end of the day, the fieldworker also has to “continue living with himself [sic]” (1993: 316-7). With this in mind, I attempted to strike a balance between letting discussions take the course that their legitimate participants wanted to take them and facilitating in a manner that was

informed by my personal beliefs that the formal guidelines for faculty facilitators were worthy of adhering to, and that the content of the SAM courses was worthy of focused consideration.

In retrospect, I suspect that my concerns about the consequences of my choice to adhere to a particular facilitation style and degree of commitment to the course material were probably excessive, at least from the standpoint of the impact my actions had on students' experiences of the small group discussions that I facilitated. Although I saw students' eyes glaze over on a number of occasions when I posed questions that began something like, "So, if we take this into consideration with what we heard in lecture today...", students told me during my interviews with them that they considered SAM courses a "gimme" class, something that they had to merely get through as their energies were consumed by more demanding subjects – such as biochemistry or anatomy. Students told me that small groups were a time when everybody just said what they knew they were meant to say and then moved on. Despite my own anxieties, my impression was that if the students viewed me as a curiosity, the interest I provoked was fleeting at the most. They had biochemistry to study, after all.

Furthermore, although my presence might have been discordant, both facilitators I worked with maintained a dominant role within the small group proceedings. Dr. Aaron Bachman, my first co-facilitator, was avuncular, hard of hearing, and garrulous. A retired OB/GYN, he had been a small group facilitator for many quarters running, and clearly enjoyed the experience. Upon meeting me he promptly announced that he would take the lead as a facilitator because he had much more experience doing "this kind of thing." I politely concurred. But as our work together began, so too did his long-winded monologues during small-group "discussions." As I attempted to actively *facilitate* discussions, Aaron, as he insisted the students call him, took notice. After a clear

picture of our differing tendencies emerged, he told me that he was both surprised and impressed by my facilitation skills. He also asked that I let him “carry on at length” about his experiences, because he felt it was important for students to hear things from him because he “knew how it was.” Dr. Rava Chekini, the other co-facilitator I worked with, also told many stories of her professional experiences and quashed some of my attempts to direct discussion towards the day’s lecture or assigned readings.

Interviews

In addition to participant observation, I also conducted in-depth, semi-structured interviews with Buena Vista students, faculty, and staff. I interviewed a total of 17 Buena Vista faculty members, 19 students, one staff member, and two psychologists who lectured within the SAM course sequence. I employed a nonprobability, snowball and referral sampling method (Saxena 2013) to recruit faculty interviewees. My initial faculty contacts at Buena Vista were tremendously helpful in facilitating introductions to faculty who were willing to be interviewed, and these contacts led me to others. But like other researchers, I found that medical professionals’ busy schedules made them a hard population to recruit for interviews (Poteat et al. 2013). Many faculty who initially expressed willingness to be interviewed ultimately, after long email exchanges, stated their inability to make time for an interview, citing chock-full schedules. In many cases, pursuing faculty interviewees by phone and email led me to walk a fine line between pertinacity and stalking, and I eventually dropped the pursuit of some faculty who had indicated their interest in being interviewed at an earlier time.

Medical students too have busy schedules. Many of my student interviewees were recruited from the discussion groups that I facilitated. At the end of each term, I asked students if they would be willing to be interviewed for my research, and if I might contact them in order to arrange an interview. Every student in the small group

discussions indicated their willingness to be interviewed, but later, many of them told me that they simply couldn't spare the time. I attempted to recruit the assistance of the medical student affairs staff person, but after many discussions, he and one of the deans decided that it would be inappropriate to forward my request for interviews to all students through the medical student listserv. He also declined to put me in touch with representatives from the various student organizations, stating that medical students had busy schedules and many demands upon them, and he had the responsibility to protect them from undue stresses. He did, however, pass my request along to members of the LGBT student group, and some of them responded to my interview request. My paths with these students did not overlap through other, more coincidental means, and the comments of these particular students provided invaluable perspective.

My in-depth, semi-structured interviews ranged from forty minutes to two hours in length, and covered a range of topics regarding interviewees' definitions of sexuality, their understandings about the relevance of sexuality to medical practice, and their sources of knowledge about sexuality – both within and outside of medical education. I asked questions about sexual diversity at Buena Vista, about the negotiation of discomfort, and the achievement of “professionalism.” I also asked interviewees about their experiences of teaching or learning (depending on their role) about sexuality at Buena Vista. Because I had observed and participated in much curriculum in action by the time I conducted many of the interviews, I was able to ask students and faculty about their experiences of curricular events that I had actually witnessed. I did not initiate questions about interviewees' sexual or romantic experiences, but students and faculty alike sometimes volunteered personal information – about their own sexual experiences (or lack thereof), or about the sexual experiences of friends or colleagues and what they had learned from those. Interviews were tape recorded and transcribed, then along with

field notes, were stored, organized, and coded using ATLAS.ti, software for qualitative data analysis. Data were coded iteratively, using a mixture of deductively-generated and inductively-generated codes (Abramson 2009).

Attributes of interviewees

Twelve of the faculty interviewees were male and 9 were female. Thirteen of the faculty interviewees were white, 2 were Asian, 1 was black, and 1 was Latino. Two identified as gay and seventeen as heterosexual. None identified as transgender, queer, or any other sexual/gender identity. Six faculty specialized in family medicine, two in internal medicine, two in OB/GYN, one in pulmonary medicine, two in psychiatry, one in psychology, one in urology, and one in sexual medicine.

Ten of the students were male, and 9 were female. Twelve were Asian, six were white, and one was Latino. Thirteen of the students identified as straight or heterosexual, five as gay or homosexual, and one as queer. The average age of the students I interviewed was 23.

Because health care is a very role-conscious culture (Mills and Schejbal 2007), I refer to students by their (pseudonymous) first names, such as “Eleanor” and faculty by their (pseudonymous) titles, such as “Dr. Zamir.”

Representativeness of the case and interviewees

The extent to which the attributes of Buena Vista are statistically representative of those of other medical schools is difficult to say, not least because there is not enough research in place on medical sex education to determine which attributes of medical schools are the ones that matter for such studies. However idiosyncratic Buena Vista may be relative to other medical schools, it was appropriate for selection as the single case that this research was based upon because the intention of this research was to “broaden the framework of discussion” (Kendall 2013: 16; citing Peacock 1986) of

medical sex education in practice. Since so little research has ethnographically examined medical sex education, Buena Vista served as a good starting point for the development of sensitizing concepts (Hammersley and Atkinson [1983] 1995; citing Blumer 1954) within the study of sexuality curricula in action within medical schools. At points within the dissertation I will discuss the extent to which we might expect the sexuality education that took place at Buena Vista to be similar to or different from other medical schools, but further research will be necessary to gain a more precise sense of the extent to which Buena Vista is representative of other cases or not.

Neither the faculty members that I interviewed nor the students I interviewed are representative samples of either population by any measure. Most of the faculty I interviewed were involved with teaching SAM courses or had been in the past, or had been referred to me by a faculty member who was. Although it is impossible to know for sure, it seems reasonably likely that these faculty members might have a different perspective on sexuality and medicine and sexuality-related medical education than would their colleagues who had never been involved with teaching about the social aspects of medicine – but the nature and extent of these differences is not the subject of this research. Similarly, six of the students I interviewed – approximately a third of my student interviewees – identified their sexual orientation as something other than heterosexual. Although the number of non-heterosexual students at Buena Vista is impossible to determine, all indications (i.e., speculations on the part of the queer medical students themselves) suggested that fewer than ten percent of the students in each class identified as queer or gay. In other words, non-heterosexual students were clearly overrepresented in my sample. Although I actively reached out to more heterosexual students than non-heterosexual students, the sexual minority students seemed particularly interested in talking with me, probably in great part because by their

own account, their experiences of medical school were shaped by their experiences of being sexual minorities, and they welcomed the opportunity to talk with someone who was interested in their experiences and in the subject of medical sex education more generally.

Other differences between faculty members and students likely matter, too. Their ethnicity, place of birth, economic background, age, and so forth are no doubt important to their understandings about sexuality and sexuality's relevance to medicine, and their experiences of participating in medical sex education. But the emphasis of this study is not intersectionalities, and I leave it to future researchers to examine the ways in which different dimensions of identity shape participants' experiences of medical education.

Participant observation at the Annual Conference of the Gay and Lesbian Medical Association

In September 2011 I collected ethnographic data from the Annual Meeting of the Gay and Lesbian Medical Association (GLMA) in Atlanta, at which there was considerable discussion of LGBT specific medical curricula and LGBT “cultural competency” training. My participant observation at GLMA helped me develop a better sense of the ways that other medical schools in the United States conceptualized and implemented sexuality and LGBT-specific content within their curricula, and the challenges associated with doing so.

Overview of the dissertation

Chapter 1

Most of the sociological literature concerning “sex education” *in general* pertains to school-based sex education, or the sex education that occurs in (mostly) junior high and high schools. This literature is rich and well-developed, and provides many useful

questions for the consideration of sex education in contexts beyond K-12 schooling – however, it also tends to imply that sex education *only* or primarily occurs within junior high and high schools. In this chapter I briefly review the sociological literature on school-based sex education to provide a framework for thinking about the study of sex education elsewhere. I then provide a synthetic history of medical sex education, gleaned from the academic medicine literature. This step toward a comprehensive history of medical sex education is a contribution to the literature itself, and it provides context for the examination of the sexuality education that took place at Buena Vista.

Chapter 2

In this chapter I provide an ethnographic overview of the sexuality education endeavor at Buena Vista. I sketch the sexuality-related teaching, both sustained and deliberate and brief and spontaneous, that occurred within the formal curriculum, and I discuss faculty members' perspectives on teaching about sexuality at Buena Vista. I consider students' understandings about sexuality – both those they brought with them to medical school, and their impressions of what they had learned since coming to Buena Vista. I show how complex the sexuality education endeavor at Buena Vista was – if it was even appropriate to consider the sexuality-related teachings that Buena Vista provided an “endeavor” at all. Buena Vista faculty cared about teaching about sexuality, but experienced legitimate challenges to doing so. Buena Vista students had the sense that sexuality was at least theoretically important, but with so many demands on their time and attention, it was hard for them to conceptualize sexuality's importance in a concrete set of ways – particularly because it was reasonable to perceive the sexuality-related teachings they received as disparate and disconnected. Throughout the chapter I discuss similarities and differences between the sexuality education that took place at Buena Vista and sex education in other contexts.

Chapter 3

Advocates for medical sex education have argued for decades that its provision is limited or neglected, relative to its importance to patient care. Recently, there has been increasing concern that teaching specific to LGBT patients is underemphasized within medical training. The claims are based on survey research, which by design can only reveal how much teaching time within the formal curriculum is officially devoted to LGBT-specific content or sexuality-related topics. But much the curricular action takes place outside the lecture hall, through the ad hoc, unscripted, highly interpersonal interactions between and amongst faculty and students, i.e., through informal curricular processes (Hafferty 1998). In this chapter I explore how the informal curriculum sometimes served as a generative source of messages about sexual diversity and sometimes served to nullify the LGBT-related content within the formal curriculum – making the “neglect” of LGBT-specific training more complicated than surveys reveal.

Chapter 4

In chapter 4 I examine the production of a hidden curriculum of heteronormativity within the formal curriculum at Buena Vista. Through talk and action that seemed unremarkable, a certain set of sexual possibilities – namely, heterosexual ones - were repeatedly made visible, familiar, or obvious, while others were rendered unfamiliar, invisible, or unintelligible. This undercurrent of heteronormativity existed in the absence of more overt forms of hostility towards sexual minorities or non-normative sexualities, and coexisted with the provision of some LGBT – specific content. Examining heteronormativity helps provide a better understanding of how the marginalization of sexual minorities may occur even in an era of increasing awareness that overt displays of antipathy towards sexual minorities are unacceptable, and as biomedical institutions are increasingly aware of the relationship between sexual minority status, stigma, and

health inequalities. In this chapter I employ ethnographic data from the Annual Conference of the Gay and Lesbian Medical Association in 2011 to illustrate how the presence and potential impact of heteronormativity may elude even medical educators who are dedicated to ensuring the provision of equitable health care through the addition of medical curricula that are specific to LGBT patients.

Chapter 5

This chapter concerns the production and negotiation of what the anthropologist Gayle Rubin calls “sex negativity,” or the notion that *anything* to do with sexuality is considered negative, suspect, or “guilty until proven innocent” (Rubin [1984] 1993). Although particular stigma may be associated with non-normative sexualities, sexuality is not neutral territory even when it is disassociated from minority sexuality. Here I examine the manifestations and conceptualizations of sexuality-related discomfort at Buena Vista, and analyze the ways in which this discomfort was recognized and negotiated – or avoided. I propose that within the context of medicine’s substantial emphasis on professionalism, or treating all patients as “whole persons,” with “respect and dignity,” the absence of meaningful consideration of sex negativity constitutes a null curriculum (Flinders et al. 1986), or a meaningful omission from the curriculum.

Finally, in the conclusion, I explore the implications of my findings for further research on medical sexuality education – and, to a lesser extent, the study of sex education in other contexts. This dissertation helps to expand the conversation about sexuality education within medical training most specifically – but also, about formal sexuality education more generally, and with that, the relationship between sexuality-related inequalities and the production and transmission of formal knowledge about sexuality. In addition to articulating fruitful directions for future sociological research, I also discuss the implications of this study for the evolution of medical sex education

itself. As this dissertation will illustrate, sexuality education within medical training is shaped by a complex array of features of medical education and broader social forces. When discussing its future trajectory, I maintain awareness of the very real challenges medical educators face as they seek to incorporate sexuality into medical curricula, while also pointing out opportunities for medical sex education to develop in ways that stand to benefit doctors and patients alike.

CHAPTER 1

THE HISTORY OF MEDICAL SEX EDUCATION WITHIN THE BROADER CONTEXT OF “SEX EDUCATION”

Introduction

Because there is so little sociological literature on medical sex education, part of the task of studying it is exploring the scope conditions of the object of analysis itself. This is difficult not only because medical sex education is not fully recognized as a self-evident phenomenon, but also of the definitional challenges associated with the subject matter. While the theoretical discussion of how best to explicate “sexuality” and “sex” is rich and well-developed within the social science literature devoted to sexuality, the upshot of these discussions is that “sexuality” – what it fundamentally is or pertains to - is always a moving target. Yet even though social scientists have noted that sexuality is inherently difficult to define, there has been little empirical study of how this ambiguity is negotiated in practice. Understandings of what “sex” and “sexuality” mean shape social life, and in so doing, contribute to patterned experiences of privilege and marginalization, advantage and inequality – and the visibility thereof. How are these understandings constructed by professionals whose scope of practice intersects with sexuality?

Although I am specifically concerned with medical professionals and the sexuality education they receive, the broader questions that this analysis implies include: where and when and why and for who is the production and transmission of sexual knowledge considered necessary or important in our society? Conceivably, formal sexuality education is something that *could* occur in many contexts. Doctors – and other professionals – encounter sexuality in a range of ways as they go about their work, and we know little of the sexuality education they receive within their professional training. How and what do doctors, nurses, social workers, dentists, or psychologists learn about

sexuality – or do they? Does formal sexuality education exist at all, within the contexts of their professional training? Under what circumstances is the need for formal sexuality education conceived of, and how does this perceived need translate into educational practices? We know little about the range of contexts in which the formal construction and transmission of knowledge about sexuality occurs – or where it might usefully occur but does not.

The major exception to the lack of sociological study of sexuality education, of course, is the study of school-based sex education, or sex education that occurs within K-12 schooling (and primarily, middle schools and high schools). Sex education in these contexts has received a great deal of attention from the general public and from politicians and has been the subject of heated debates within the United States in the past several decades (Irvine [2002] 2004; Luker 2006; Fields 2008; Kendall 2013). No doubt because of the intensity of the public interest in school-based sex education, sociologists have devoted much attention to it and all of the concomitant social phenomena. Perhaps because school-based sex education has been the subject of so much public interest and scholarly inquiry, “sex education” is quite often assumed to necessarily or only pertain to the sex education that occurs within those contexts. Much of the sociological literature on school-based sex education reflects and reinforces this assumption by referring to school-based sex education as “sex education,” without any disaggregation of this *particular instance* of sex education from a broader set of possibilities of where, when, how, and for whom sexuality education might occur.

In this chapter I expand the conversation about what “sex education” includes by providing a synthetic history of medical sex education, gleaned from the academic

medicine literature.³ Although sociological study of sexuality education within medical training has been limited, the academic medicine literature reveals that medical sex education has existed for decades, even though its content and prevalence are not well understood. In order to frame the sociological analysis of medical sex education, I briefly review the sociological literature on sex education “in general” to illustrate the extent to which “sex education” is usually presumed to mean “school-based sex education,” and to demonstrate the need for examining sex education that occurs in contexts outside of junior high and high schools. This exploration of the literature on school-based sex education helps elucidate the questions that might usefully be asked about sexuality education within medical training. Some of these questions include: what has “medical sex education” meant, as a potential or empirical curricular event? Has it been, or should it ideally be a coherent set of related curricular offerings? Might it be sporadic and fragmented, yet robust enough in the aggregate to form a corpus of knowledge specific to “sex” and “sexuality”? Is it a somewhat random assemblage of mentions of sexuality that “count” by virtue of their very mention, but lack depth of discussion and explication? Or is it something else entirely? What definitions of sexuality are presumed or explicated within it? How is sexuality’s relevance to the practice of medicine understood? In this chapter I explore similarities and differences between school-based sex education and medical sex education, and articulate questions about medical sex education which necessitate ethnographic analysis.

The early history of “sex education” in the United States

Perhaps because there is not much of a scholarly tradition of studying sex education as a distinct object of inquiry, the history of sex education in the United States

³ In the absence of a more rigorous historical study, it is difficult to know for certain how comprehensive this history of medical sex education really is. However, the attempt to provide a synthetic historical overview is itself a contribution to the literature.

remains limited, and there are significant points of disagreement within the accounts of early sex education initiatives. Some scholars date the birth of sex education to the Progressive era of 1880-1920 (Luker 2006; Elia and Eliason 2010). "Sex education," Kristin Luker writes, "was invented in the midst of the first sexual revolution, in the Progressive era, between 1880 and 1920. It was conceived, so to speak, in 1913 in a luxurious red dining room in a mansion on New York's Fifth Avenue owned by one Grace Hoadley Dodge" (Luker 2006: 37). From its outset, Luker claims, sex education was imbued with both "values" and "pragmatism." The values at stake concerned the sanctity of marriage and norms of appropriate behavior for women and men, and pragmatism pertained to the prevention of the spread of venereal disease. The social hygienists of the Progressive era were interested in educating people about sex for a few distinct reasons. Prostitution was a significant worry for its potential to spread venereal disease and perpetuate a double standard for men's and women's sexual behavior. Declining rates of marriage and postponement of marriage fomented concerns about the appropriate place of sexuality as the disassociation between sex and marriage led to fears of social disintegration. Also at this time, "adolescence" began to be conceived as a distinct phase of life, and with the "discovery" of adolescence, a new class of persons with distinct needs were born. Situated squarely between puberty and marriage, adolescents were seen as requiring guidance and supervision in order to safely make it all the way to "adulthood" (meaning heterosexual marriage) in the midst of sexual temptation and all of the associated risks (Luker 2006).

Other histories suggest that sex education had earlier, more diffuse beginnings and may not always have been predicated upon the sort of motivations that Luker describes. April Haynes argues that the popular health movement in the United States in the mid-nineteenth century should be recognized as the "first wave of public sex

education in America” (2003: 544). Interestingly, while Haynes considered the popular health movement as a social movement that brought sexuality into the public arena she does not go so far as to claim that this constituted the *birth* of sex education per se. Haynes argued that although the popular health movement is often viewed as an effort, grounded in masculine notions of self-reliance, to overthrow the medical establishment and to “make every man his own doctor,” its later leaders catered to the needs of an increasingly feminized and feminist constituency. Many of the popular health movement’s luminaries critiqued conservative sex and gender arrangements, and challenged the utility of the institution of marriage – very much unlike the social hygienists in Luker’s account.

Frederick Hollick, one of the key figures of the popular health movement, achieved fame and notoriety during the mid-nineteenth century as a purveyor of sexual knowledge to the masses by holding public lectures and distributing home health manuals, including a sex manual (Haynes 2003: 545). He delivered lectures on the subjects of disease and anatomy, eschewed conservative ideologies associated with religion, and took a pro-pleasure, pro-individual rights approach to his “liberated” vision of sexuality. Even after being tried for obscenity, Hollick continued to insist that sexual pleasure was in and of itself a compelling and positive reason to have sex, and emphatically included women within these pronouncements. Hollick did not go so far as to endorse masturbation, even if he did conclude through his own research that 99% of the population practiced it. In other words, the sex education that Hollick provided was directed at a general audience for the purpose of enabling its recipients to better understand their own sexual experiences and improve upon them, based on the underlying assumptions that sexual pleasure was valuable for its own sake, and that everyone had a right to learn about sexuality.

Not all of Hollick's contemporaries endorsed his investigations of sexual pleasure or his championing thereof, Haynes argues, but even if Hollick's messages were somewhat idiosyncratic he garnered enough public attention and was perceived to have enough of a following to warrant a trial for obscenity. Haynes argues that Hollick's emphasis on sexual pleasure for its own sake in addition to his potentially more subversive anatomy lessons were the primary impetus for his trial, but in addition to the content of his messages, the audience he targeted fostered perceptions that he was dangerous. Some of Hollick's critics complained that the biggest problem with his lectures and printed materials was their accessibility: not only could they be obtained by nearly anyone, regardless of their professional pedigree, institutional affiliation, or total lack of either, they could also be understood by laypersons without advanced education or particular professional training. The information he put forth was not esoteric, medical knowledge, delivered to a limited audience of particular professionals, but relevant to any individual's sexual experiences and accessible to the laity (Haynes 2003). This, his critics believed, was inappropriate and dangerous.

Hollick's obscenity trial presaged many questions about the relationship between sexual speech, morality, and obscenity that would continue to shape debates about sex education well into the twentieth and twenty-first centuries. Who had the authority to speak with legitimacy about sexuality? What credentials, expertise, or institutional affiliation were requisite for doing so? What sort of information was considered appropriate for dissemination, and to what audiences? Where should the line between obscenity and explicit-yet-appropriately-so information about sex be drawn?

Contrasting Haynes's and Luker's accounts of the history of sex education reveals some of the gaps and inconsistencies within the research of the history of sex education in the United States, starting with a lack of consensus about what exactly "sex

education” means or entails. Luker’s suggestion that sex education in any form did not exist prior to that evening in Grace Hoadley Dodge’s living room in 1913 may perhaps be due to her particular conceptualization of sex education – which she never makes explicit. While Luker tells us that the sex education of the early twentieth century was not strictly about “sex” per se, but part of a broader “social hygiene” movement which encompassed concerns about gender-appropriate behavior, marriage and family formation, and the morality of sexuality, she never makes it exactly clear what the sex part of sex education did and did not pertain to. Nor does Luker ever define “sex” itself, although her continuous emphasis on marriage and reproduction throughout her discussion implies that sex is, by nature, heterosexual. In addition, Haynes’s research indicates how inadequate our comprehensive history of sex education really is. Haynes’s analysis of Frederick Hollick as but one figure within the popular health movement rather than a lone maverick sex educator suggests that there is much we do not know about the origins of formal, concerted sex education initiatives. Although Luker’s account of the origins of “sex education” is often used as a primary point of reference for the norms and trends in sex education prior to the 1960s, juxtaposing Luker’s work with Haynes’s suggests that the origins of sex education may be much more diffuse than Luker suggests, and makes clear how important it is to explicate what sex education means or entails, who it is for, and what its objectives are.

Putting aside these questions about the nature of sex education (or scholarly assumptions about it) the 1960s are widely regarded as a pivotal turning point for sex education in the United States. On the cusp of the 1960s, Luker tells us that although there is not enough data available to be sure of the exact nature and prevalence of sex education programs in the early decades of the 1900s there are indications that sex education initiatives were “quite popular.” Perhaps, Luker says, this was due to the fact

that the messages of most sex education initiatives promoted the idea that sex belonged within marriage, in keeping with dominant cultural ideals. These sex education initiatives, often included within “family life” education which encompassed topics beyond sex, took place in a variety of contexts, including public schools. Luker argues that by 1960, “sex education in American public schools was often the expansive, diffuse, and usually uncontroversial family life education that social hygienists had thought they could accomplish... and these programs were remarkable in their diversity” (2006: 62).

This characterization of sex education programs prior to the 1960s is not uncontested. Janice Irvine ([2002] 2004) argues that by 1960, sex education programs in American public schools were virtually at the point of extinction. Citing a 1965 survey of school administrators in all fifty states who claimed their schools’ sex education curricula were inadequate, the Department of Education issued a statement saying that American schools were providing “fragmented and uncomprehensive instruction” concerning sex. In addition, Irvine reports, most textbooks used for sex education programs around the 1960s condemned premarital sex and homosexuality, cautioned against masturbation, and generally disregarded sexual pleasure. If these topics were part of the “diversity” Luker claims was present in sex education programs as of the 1960s, she does not specifically say. Luker makes little mention of non-heterosexual sexualities, nor the experiences sexual minorities may have had of heterosexually-focused sex education programs. Moreover, she never explicitly acknowledges her heterocentric focus nor explains its rationale. Irvine is also less sanguine than Luker about the general responses to sex education programs prior to the 1960s. Irvine argues that talk about sex has a long history of being considered incendiary in and of itself, no matter the intended purposes, and that social conservatives have a history of

seeking to regulate sexual speech as part of the social control of sexuality that stretches back much further than the mid-twentieth century.⁴

Sex education in the 1960s and beyond

If the history of sex education up until the 1960s is fragmented and somewhat contradictory, much becomes clearer from the 1960s onwards. Luker, Irvine, and other scholars such as Jessica Fields (2008) and Nancy Kendall (2013) agree that the 1960s were a pivotal point in the history of sex education. Increased openness about sexuality in American society led to heightened debates about the presence and content of sex education in public schools – debates which have persisted up until the present (Irvine [2002] 2004; Kendall 2013). At stake within these debates were (and continue to be) competing notions of what young people are capable of and what is best for them (Irvine [2002] 2004; Luker 2006; Fields 2008; Kendall 2013). The social hygienists' belief that adolescence was a time of particular vulnerability and risk persisted to the 1960s and continued to gain traction, as did debates about how best to usher young people through the years of adolescent risk in order to bring them safely to adulthood.

The risks associated with sexuality were perceived as particularly extreme in the 1960s as the seemingly clear, shared moral order was challenged by social changes coming from all directions. Irvine argues that social norms which had previously deemed marriage the only or the most appropriate context for sexual activity were on the wane in the 1960s, and because enough Americans were worried about these changing sexual norms in their own right, sex education in schools served nicely as a repository not only for concerns about adolescents having sex, but all sorts of other broad, inchoate cultural anxieties as well (Irvine [2002] 2004). In this context, social change was considered the

⁴ Following Foucault, Irvine is quick to emphasize the irony that most efforts to regulate sexual speech necessarily require talking about sex – the very thing that regulators seek to curtail.

reason for public interest in sex education once again. These arguments for the need for sex education are similar to the reasons that motivated the social hygienists in the 1920s that Luker described: social changes related to sexual norms, marriage, and family structure, have continuously been deemed legitimate grounds for the provision of sex education. However, the discussions about sex education in the 1960s were significantly different from the discussions about sex education in the 1920s in some important respects. Within the churning seas of the socio-political climate of the 1960s, sex education proved to be an effective bridge issue connecting the Old and the New Right and an easy way to galvanize conservative politicians and voters who were dismayed about and fearful of the myriad changes that threatened their sense of the natural order of things (Luker 2006; Irvine [2002] 2004). Sex education was particularly incendiary because it flew in the face of beliefs that talk about sex in and of itself was dangerous, and because this talk was directed to “children.” Nearly everyone could agree that children, or adolescents, were innocent and that this innocence should be protected – the disagreement concerned how best to do this. Was it better to provide adolescents information about how to avoid the risks associated with sex – should they dare engage in it – or to simply tell them not to do it?

But what exactly should this sex education teach? What information would keep young people safe from the risks of sex, and what information might encourage them to have sex, or more of it? By the 1990s, the positions on sex education in the United States evolved into what could be roughly divided into two camps: proponents of “abstinence-only” sex education, which promotes abstinence as the only avenue to sexual safety until marriage, and “abstinence-plus” or “comprehensive” sex education, which discusses abstinence along with other means of avoiding pregnancy and STI infection (Irvine [2002] 2004; Luker 2006; Fields 2008). These two positions have

remained the typical poles within debates about sex education since the 1990s – although it is important to recognize that each position encompasses its own diversity of perspectives (Kendall 2013). Proponents of the more conservative abstinence-only approach tend to be deeply committed to keeping sex within the confines of heterosexual marriage, and tend to believe that talk about sex is dangerous in and of itself, for its potential to reduce sexual inhibitions and foment sexual recklessness of the worst possible kinds (Luker 2006). While this position is socially conservative, it is less conservative than the position that the place of sex education is the familial home, and that any kind of public sex education is morally inappropriate and potentially a violation of children’s innocence – a position that a significant minority of Americans hold (Luker 2006). The more liberal alternative, “abstinence-plus” (or “comprehensive”) sex education, typically includes teachings about abstinence in addition to covering contraception and means of preventing the spread of STIs.⁵

Embedded assumptions in school-based sex education

Both “abstinence-only” and “abstinence-plus” programs are necessarily much more variable in their implementation than they may look on paper (Fields 2008), but these two approaches reveal much even as ideal types. Both options are predicated on the assumptions that sex is inherently dangerous or at least risky, that adolescence is a particularly vulnerable phase of the life course, and that adolescents are incapable of the maturity and responsibility necessary for a “safe” and healthy sexual relationship. In an ever-shifting cultural and educational climate, some research indicates that acknowledgements of sexual pleasure may be on the rise within sex education (Kendall

⁵ Although this sort of curriculum is anathema to conservatives, proponents of “abstinence-plus” sex education for adolescents are often far from thrilled about the prospect of teenagers – theirs or anyone else’s – actually having sex (Fields 2008). Even more “liberal” American parents who believe that teaching teenagers about safe sex is better as a means to preventing pregnancy and disease than withholding this information tend to be conservative when it comes to their own children’s sex lives (Schalet 2000).

2013), but in general, much of the debate about sex education and most sex education programs in the United States have persistently elided consideration of desire and sexual agency, particularly young women's (Tolman 1994), and that of queer persons of color (Fields 2008; Kendall 2013). Even programs that are considered to fall on the more liberal end of the spectrum tend to promulgate essentialist understandings of sexuality and gender, and tend to presume a "standard student" of sex education who is white, middle class, and usually, heterosexual (Kendall 2013).

Although some school-based sex education programs may talk about "sexual health," health in these cases is equated with an absence of pregnancy or disease, rather than any positive markers of healthy sexuality (Fields 2008). The possibility that teens might want to get pregnant has been consistently ignored or pathologized, and STIs have been portrayed as inherently health- or life- threatening, rather than conditions to be prevented when possible, treated when necessary, that may indeed pose serious health risks but might also constitute little more than nuisance (Kendall 2013). On the other hand, while risk and danger were emphasized in conjunction with some topics, the impact of broader social forces such as gender, race, or class-based economic inequalities on the actual sexual risk that students experienced was usually ignored (Kendall 2013).

In addition to the assumptions they contain about the nature of adolescence (as a phase of life characterized by vulnerability) and adolescents (as irresponsible) and sex (as dangerous or at least risky, in multiple ways and for multiple reasons), both "abstinence-only" and "abstinence-plus" sex education posit sex as something that is fundamentally heterosexual (Fields 2008; Kendall 2013). Although school-based sex education does include instruction about sexually transmissible infections in many cases, these programs have typically emphasized the risk of pregnancy and the

prevention thereof. This focus presumes not only heterosexual intercourse, but a heterosexual life course that eventually leads to marriage – which of course, is deemed the proper place for reproduction, and, by extension, sexual activity that could lead to it. Curricula promoting “abstinence only until marriage” presumes that marriage is the natural, ideal trajectory of all students, and ignores the fact that marriage is not even legally available to everyone (Elia and Eliason 2010).⁶

Sex education that presumes heterosexuality and the eventual ideal of marriage contributes to social inequalities in two key ways. On a practical level, focusing primarily on heterosexual sexual possibilities excludes a great deal of information about safer sex practices, and students who do not engage in heterosexual practices or never plan to may gain little knowledge about what “safe sex” might mean for them. The persistent exclusion of sexual minorities from school-based sex education programs both reflects and reproduces the social inequalities associated with sexual minority status by rendering these persons invisible, or by suggesting that non-heterosexual persons or experiences are somehow lesser than or inferior to the “norm.” Sex education does more than simply transmit information about how to avoid pregnancy or disease, it also serves as instruction in what Fields calls the “practices of recognition” (2008: 133). The content of sex education renders some sexual practices, identities, and desires possible, legitimate and intelligible by virtue of their very inclusion within the curriculum, while others are relegated to marginality, invisibility, or unintelligibility by virtue of their exclusion.

⁶ It is worth noting that some sociological literature reifies rather than challenges these presumptions. For instance, Kristin Luker argues that suggesting that the ideal place of sex is within marriage isn't such a bad idea – and she makes this argument without discussing differential access to marriage, alternative forms of committed relationships, or more radical still, the socially constructed nature of the very ideal of monogamy.

Irvine ([2002] 2004) argues that the increasing visibility of non-heterosexual persons in the media and the gay rights movement galvanized conservative opposition to mention of homosexuality within classrooms. These concerns began in the 1980s, and gained momentum in the 1990s and beyond, with the televised coming out of Ellen De Generes serving as a rallying cry for both proponents and opponents of discussion of lesbian and gay issues within public schools. Irvine points out that preparing students for citizenship in a democratic society has always been part of the logic of providing sex education in public schools – and that citizenship necessarily meant heterosexual citizenship, and preferably the marital, procreative kind, at that. So more than homosexuality per se was at stake in the battles about whether or not to “allow” homosexuals to “spread their agenda” in public schools that raged in the 1990s – at heart were also questions or fears about the nature of legitimate citizenship, family structure, and traditional gender roles and relations. Luker (2006) argues that these concerns, particularly those about gender roles, historically have been and continue to be the deepest, most fundamental concerns within all considerations of sex education, which may be why school-based sex education programs have been slow to be more inclusive of sexual diversity, despite the ever-increasing prevalence of representations of non-heterosexual persons in popular culture and public life, and increased social acceptance of sexual diversity (Elia and Eliason 2010).

Even within the context of increasing social and legal support for same-sex relationships, many abstinence-only approaches continue to portray non-heterosexual sexualities as dangerous or threatening to individuals and to the social fabric (Kendall 2013). In her comparative ethnographic study of sex education programs in four different states, Kendall found that several tactics were common to this end. One obvious strategy was to discourage discussion of non-heterosexual sexuality, and if this

failed, to discuss these sexualities in terms of their risks, using scientific data, incendiary images, arguments for rational choice, and normative propaganda (2013: 184). In public schools, the most common strategy was the presentation of data from scientific studies that showed different health outcomes for gay and non-gay students. For instance, schools in Florida used a study comparing drug use and suicide rates of gay vs. non-gay young men and argued that being gay was the cause of the negative outcomes (ibid). Kendall found that while many abstinence-plus or “comprehensive sex education” programs attempted to recognize the existence of non-heterosexual identities and include sexual identity as a legitimate topic of discussion in classrooms, these efforts were often fraught with heteronormative, essentialist assumptions about gender and sexuality, and the sources or origins of gender and sexuality, among other challenges. Thus, even though non-heterosexual sexuality may be less avoidable within school-based sex education than ever before, its inclusion is probably uneven and contentious even in the schools that do not avoid it completely.

Understanding the outcomes of school-based sex education

Kendall’s comparative ethnography is one of the most current, comprehensive studies of school-based sex education in the United States, and in it she argues that “school-based sex education, as it is currently conceptualized and practiced, is not doing a lot of good for students, schools, and communities” (2013: 3). Kendall argues that not only did she as a researcher detect sexist, racist, heteronormative messages within the sex education curricula – regardless of whether its emphasis was on abstinence or not – but the students at the schools she studied did too. The students themselves believed that the sex education curricula that were directed at them were shaped by adults who had their own objectives, which had little to do with their own needs and concerns. The students were right about this – but they might not have known that the adults who had

the most influence of the sex education curriculum were not necessarily their teachers. Multiple sets of adult actors shaped the content of the sex education curricula in the communities Kendall studied, including parents of students, school administrators, and “concerned taxpayers” who may or may not have had children attending the schools in question at all. Teachers felt constrained in what they could say (and probably for good reason), and students felt their needs were ignored.

These findings are significant even if more “objective” measures of the “efficacy” of sex education are more mixed – which are of course dependent upon the ways in which the desired outcomes are conceptualized. The United States has the highest rates of adolescent and unwanted pregnancies among industrialized nations, and rates of sexually transmissible infections (STIs) amongst teenagers in the United States are some of the highest in the world (Kendall 2013). While measures of the effects of one type of sex education over another (i.e., abstinence-only vs. abstinence-plus) show mixed results in terms of whether or not one strategy is more effective than the other for promoting later age of first intercourse, use of condoms or birth control, and lowered pregnancy and STI rates (Luker 2006), my purpose here is not to adjudicate between these sometimes contradictory sets of findings. Rather, my intention is simply to summarize that for all of the controversy surrounding school-based sex education, there is little indication that a clear set of “successful” outcomes have been achieved, either by the quantitative measures of teenagers’ sexual practices or by the students’ own sense of satisfaction from the programs.

Scholars also propose that there are other outcomes of school-based sex education, beyond rates of teen pregnancy and STIs that we should be concerned about. As Fields (2008), Elia and Eliason (2010) and Kendall (2013) argue, school-based sex education also plays a role in shaping the kind of citizens in a democratic

society that young people are poised to become. These authors argue that sex education is not just about sex per se, but also teaches students about questions with broader impact, such as, whose identities do they learn to recognize and respect? How are controversial subjects handled within public spaces, and how are unpopular or minority opinions regarded? Whose rights or opinions count and whose do not? Whose experiences will everyone learn about and whose will be neglected or actively silenced? Kendall argues that in her research, sex education programs in US public schools failed uniformly to engage in the type of “democratic training” that engaging with these types of questions could provide (2013: 233).

For how long do these rules apply? The lasting impact of school-based sex education

Like the concerns these authors raise about what sex education teaches American students about the “practices of recognition” (Fields 2008) and how it prepares them for citizenship in a diverse democracy (Kendall 2013), my questions concern the later effects of school-based sex education, particularly on persons who go on to do work that pertains to sexuality. If school-based sex education is the primary or only place where formal sex education occurs, as is often implied, it would seem that school-based sex education could be the only place where professionals whose scope of practice encompasses sexuality receive formal education upon the subject, or constitute a significant portion of the formal sex education they ever receive. Whether or not this is the case, or the extent to which it is, are empirical questions, but given the lack of literature systematically devoted to sexuality education in contexts outside of school-based sex education, we might do well to wonder what impact the content of school-based sex education has on its recipients’ behaviors beyond their adolescent sexual activity per se.

Examination of the debates about sex education for young people – and looking closely at the sociological analyses of these debates – reveals the potential for sex education to be a controversial affair that is characterized by deep concerns about sexual knowledge and the impact of its provision. However, most of the controversy and the deep moral charge that surrounds school-based sex education are predicated upon two assumptions: that sex is inherently harmful or at least potentially so, and that adolescents are particularly vulnerable to the dangers of sex, including, in some cases, the danger presumed to be associated with sexual knowledge. Whether or not “adulthood” is code for “being married to a person of the other gender and engaging in procreative or potentially procreative sex,” or perhaps simply graduating from 12th grade, there are few indications that the rules of personal conduct presented in school-based sex education are supposed to apply to adults.

Thus, within the sex education that potentially occurs within medical education (and other potential sites of formal sex education, including but not limited to other professional training programs), much is different. The subjects of medical sex education – to whatever extent that it exists – are no longer minors in need of protection, but adults, for whom the rules about sex and knowing about sex are presumably if not explicitly different. Furthermore, we might assume that within the context of medical education, the objective would shift away from attempting to influence the behavior of the subjects (i.e., preventing high school students from having sex or having it later and using protection when they do), and towards enabling the subjects to deal with or respond to the sexuality of others. How do the parameters of what might usefully be considered worth teaching or knowing about sexuality within this radically different context? Or do they change? How is medical sex education different from or similar to school-based sex education? With this background on “sex education” established, I

now turn to a synthetic analysis of the academic medicine literature concerning medical sex education.

Medical sex education in the 1960s and 1970s

Although the sociological literature concerning “sex education” scarcely implies that sex education might even exist within medical schools, discussion of sex education for medical students can be found within the academic medicine literature since at least as early as the 1960s. As of the late 1960s there was agreement on the part of at least some medical educators that doctors and medical students needed sexuality-specific training in order to effectively fulfill their professional duties to patients, as well as recognition that not much of this sort of training actually existed. Harold Lief, a psychiatrist and early advocate of medical sex education, surveyed the curricular offerings of North American medical schools and found that as of 1964 only one had a required course in human sexuality. One other medical school offered a sexuality course as an elective (Coombs 1968; Lief 1970).

This quickly started to change. The Sex Information and Education Council of the United States (SIECUS) formed in 1964 and many physicians served on the board of directors in its early stages. SIECUS invoked the legitimating power of biomedical authority to define sexuality as a natural, normal component of health, and in so doing, to normalize open discussion about sexuality (Irvine [2002] 2004). Lief and other proponents of sex education such as Mary Calderone, one of the founders of SIECUS, and Clark Vincent, a physician, called attention to the need for medical students to learn more about sexuality and the lack of existing curricula on the subject. In March 1965 the American Medical Association (AMA) issued a statement expressing the need for medical schools to incorporate “appropriate learning experiences for physicians in the area of counseling related to sexual attitudes and behavior,” and the American College

of Obstetricians and Gynecologists issued a pamphlet entitled “Sex Education is a Professional Responsibility” (Lief 1970).

Medical schools responded quickly, resulting in what some observers called a “dramatic upsurge” in medical sex education (Golden and Liston 1972: 761; Marcotte et al. 1976). Lief reports that by the end of the 1960s at least 44 American medical schools offered courses in human sexuality (1970). The general consensus within the academic medicine literature on the subject is that by the mid-1970s it had become typical for medical schools to offer some kind of formal, required sex education course. Marcotte et al. state that in 1974 95% of 112 medical schools in the United States offered either required or elective sex education classes (1976). A study by Lief and Ebert published in 1976 showed that 60% of U.S. medical schools included sexuality education within required courses with another 32% offering such material within electives (Rosen et al. 2006). By the mid-1970s, discussions of medical sex education emphasized growth and positive change, and credited the efforts of Harold Lief and his colleagues for inspiring these changes (Marcotte and Logan 1977). Sex therapy clinics proliferated in the United States in the 1970s, and although little was known about their quality or the qualifications of those who ran them, their presence helped affirm the ideas that sexuality was associated with scientific, medical knowledge, and that sexuality was a normal component of human health (Lief and Payne 1975).

Marcotte et al. (1976) attributed this rapid increase in medicine’s embrace of sexuality and sexuality curricula in medical schools to changes in understandings about sexuality, marriage, divorce, contraception, and abortion that came as a result of the “sexual revolution” of the 1960s. Because of these broader social changes, they say, patients began to turn to their doctors for counsel regarding their sexual concerns more than ever before. Here we see “social change” used as the rationale for providing

medical sex education, just as it was many times for school-based sex education. Scholars would later argue again that social changes surrounding sex even later in the 20th century and early in the 21st century also prompted an increase in patients' expectations of doctors to serve as expert counsel on matters of sexuality. Changes in broadly shared understandings about marriage, family, and sexuality may well contribute to shifts in patients' concerns about sexuality, but while changes in patient demands are important to acknowledge, tying the need for sex education to particular social changes or historical events may obscure the ways in which sex education might *always* be valuable or necessary for physicians in any historical age. Associating the need for sex education with particular social changes takes attention away from important questions about doctors' professional jurisdiction and patients' concerns about sexuality. As I will discuss further in Chapter 5, physicians have unique professional authority over personal, bodily experiences, and it is reasonable to imagine that they would benefit from sexuality-specific education continuously, rather than only during periods of particular social upheaval.

Despite indications within the academic medicine literature that interest in medical sex education was building and course offerings were expanding as of the 1970s, it is difficult to know what these curricular offerings looked like in practice because, aside from a few case studies of specific programs (Tyler 1970; Golden and Liston 1972), the discussions of the increase in medical sex education refer to surveys of courses which yielded data that are hard to reconcile. In their review of the literature that reported on the findings from these studies, some decades later, Rosen et al. (2006) argue that the various surveys of sexuality-specific curriculum in the 1970s came up with very different results – some of the survey data indicated that medical sex education was indeed becoming prevalent while other data suggested that it was rarely a requirement.

Even if the actual prevalence of medical sex education is hard to pin down, it is still important that medical sex education was *perceived* to be on the rise in the mid-1970s. The confusion may be due in part to the lack of discussion of what “counted” as medical sex education within this literature. There is little indication that these early surveys provided specific definitions of the terms they used, thus leaving respondents to report their institution’s provision of “sex education” based on their own definitions of “sex,” which might well have varied considerably. Nor do we have a clear sense of how coherent or concerted these sex education endeavors were, and in fact, there were indications that many medical sex education initiatives were anything but cohesive. During the 1966 - 1967 academic year Robert Coombs interviewed faculty representatives from twenty nine North American medical schools, and his interviewees revealed that “sexuality education” initiatives were sometimes fragmented and haphazard. One of his interviewees described his medical school’s instruction pertaining to sexuality as “dribbles and drabs in various courses; but it is hit-and-miss, and nobody calls it sex education” (Coombs 1968: 272). But “dribbles and drabs” of sex education could look like a great deal of attention to sexuality from the perspective of a different observer. A faculty member who has worked hard to instill any curricula that is remotely related to anything that might reasonably count as “sex” or “sexuality” may see sporadic, limited discussion of sex as a great achievement, while another faculty member might see such “curriculum” as offhand and spontaneous at best. Also, since “sex” and “sexuality” are difficult to define, we might imagine that many medical schools may have lacked a clear, shared set of understandings about what “sexuality” itself meant, and by extension, what “counted” as medical sex education.

Early understandings about the need for medical sex education – and the difficulties of providing it

Even in the midst of some confusion about how much sex education was being offered and exactly what “medical sex education” might have meant, the literature indicates that there was some consensus amongst medical school faculty that sexuality mattered to clinical encounters and patient care in a variety of ways, that doctors needed to know about sexuality and be able to comfortably discuss it with their patients, that medical schools were the logical place to provide sexuality education for doctors, and that there were a number of obstacles associated with providing such training.

All but two of the medical school faculty that Coombs interviewed believed that medical schools had a definite responsibility to train medical students to deal with the “marital and sexual” problems of their patients (Coombs 1968). Many of the faculty members Coombs interviewed considered this responsibility “very great,” for the reason that patients expect doctors to have the expertise to deal with sexual problems and are more likely to consult with a doctor about sexual concerns than any other professional. Other doctors writing in this era similarly noted that whether or not physicians wish to engage in discussion or treatment of sexuality-related concerns, patients expect this information and care from their physicians (Lief 1970; Golden and Liston 1972), and furthermore, doctors were unlikely to develop knowledge of and comfort with the subject of sexuality in the absence of specific training. Citing several studies on the subject, Marcotte et al. (1976) noted that doctors lacked “basic sexual knowledge” and tended to respond to the subject of sexuality with “emotional reactions such as fear and anxiety,” rendering them unable to address patients’ sexual concerns (Marcotte et al. 1976: 117; also see Golden and Liston 1972).

But if there was agreement that doctors had a responsibility to provide sexuality-related information and treatment to their patients, there was also a consensus that there were significant challenges associated with actually doing so. Medical students were

likely to “have a block on the subject of sex,” according to Coombs’s faculty interviewees, and would retain their reluctance to discuss the topic unless specific educational endeavors were undertaken to help dissolve this discomfort. Medical school was viewed as the obvious place to accomplish this, but faculty members themselves tended to be uncomfortable with sexuality, and thus likely to avoid teaching about it (Marcotte et al. 1976). Coombs’s interviewees agreed, saying that since they and their colleagues had not received much training in sexuality themselves, they felt uncomfortable, unqualified, or some combination thereof when asked to teach on the subject. Coombs’s respondents explained that sexuality had been, at least until their recent recollection, a taboo subject. Medical school faculty knew little more than the average person did about sexuality, thus they could hardly be expected to inculcate their medical students with expert knowledge on the subject. Their ignorance of sexuality became a reason in and of itself for avoiding the subject, out of a desire to avoid revealing their lack of expertise. The result was “a circular system...where medical teachers who received their medical education devoid of sex education determined curriculum and all too frequently devalued its importance,” (Marcotte et al. 1976: 117). Some of the medical faculty Coombs interviewed also questioned the importance of sexuality education relative to their other professional concerns and obligations. They felt that learning about the biology of acute and widespread diseases probably took precedence over learning about “emotional” conditions such as sexuality – particularly as they believed that the burden of dealing with sexual matters was something that society had foisted upon physicians, while there was really no reason for physicians to have particular expertise in this area.

Even the writers that wholeheartedly embraced the idea of medical sex education recognized a number of questions about what exactly it should consist of and how it

should be structured. What should they offer, and how, and when? Should sex education be introduced early in medical students' training or later on, during residency? Should it be provided all in one clump, or interspersed in small segments over time? Should medical students be shown sexually explicit videos? In what format – small group discussions, or lectures? Writers concerned with sexual medical education agreed that medical students needed both factual knowledge about sex and an opportunity to explore their beliefs and prejudices about sex in order to effectively treat patients (Golden and Liston 1972; Marcotte et al. 1976; Marcotte and Logan 1977). But we know little about how these shared convictions impacted curriculum design or the teaching and learning experiences of faculty and students.

Furthermore, we know little about what these authors' unarticulated definitions of sexuality included and excluded, in terms of what sorts of practices, identities, or behaviors, and whose, that they felt should be taught about. A subset of the more recent commentary on medical sex education is concerned with the lack of curricula devoted to sexual minorities, but the recognition of sexual diversity in these early accounts of medical sex education is limited, and some imply that sexuality is synonymous with normative heterosexuality – such as Coombs's (1968) reference to medical schools' obligation to prepare students to address the “marital and sexual” problems of their patients, as quoted earlier. While a heterocentric focus within these authors' understandings of sexuality and medical sex education would not be surprising, given the historical context – after all, homosexuality was not removed from the *Diagnostic and Statistical Manual* until 1973 – it is still important to point out that the kind of medical sex education that was perceived to be necessary at this time may have been predicated on a particular understanding of sexuality that these authors do not specify.

Medical sex education from the 1970s through the 1980s

In sum, the academic medicine literature suggests that medical interest in sexuality and sexuality-specific medical education was gaining momentum in the 1970s, even if it isn't clear what exactly was meant by sexuality at this time and even though it seems likely that the understandings of what kinds of sexuality or whose sexuality needed to be covered might have been circumscribed in ways that reflected current social norms. But then what happened? There is no established explanation for or even a debate about what became of this "dramatic upsurge" in sexuality-specific medical training in the 1970s. Some authors claim that by the 1980s, medical sex education was on the decline (Rosen et al. 2006) while others argue that there was not so much a decline as a *perception* of decline (Dunn and Alarie 1997). But whether there was growth, stagnation, or decline in medical schools' sexuality-related curricula from the 1970s to the subsequent decades, we still know very little about the content and practice of medical sex education in the late 1970s and 1980s. Particularly considering the social changes of this time period and their relationship to biomedicine, this is a very significant gap in our understanding of medical sex education. Rosen et al. (2006) argue that under the pressures of curriculum reform and the growth of basic science and clinical topics, medical sex education programs were shortened or eliminated in the 1980s and 1990s. Although the ever-expanding growth of scientific and technological knowledge certainly poses a continuous, exponentially-growing challenge to medical educators, the HIV/AIDS epidemic and the political mobilization of the Christian Right around sexual issues may have been social changes more germane to the changing stakes of medical sex education during this time.

Much has been written about the apprehension towards sexuality in general, homosexuality, and HIV/AIDS that erupted alongside the HIV/AIDS epidemic, but while doctors recognized that the AIDS epidemic presented a new and unique set of

challenges to medical educators (Zuger 1987), the literature tells us little about how medical sex education was influenced by the AIDS epidemic. In the early stages of the AIDS epidemic, doctors and social scientists noted that physicians were just as likely as members of the general population to have negative attitudes towards gay persons, people with HIV/AIDS, and even more so, to gay AIDS patients (Douglas et al. 1985; Matthews et al. 1986; Kelly et al. 1987; Zuger 1987; Wallack 1989). As Kelly et al. put it, “It is naïve to assume that all physicians will have equally positive attitudes toward all patients. At the same time [our] data indicate that it is equally naïve to assume that AIDS patients are viewed nonjudgmentally by physicians” (1987: 791). In the face of a terrifying new epidemic within the midst of a politically conservative sexual climate, hostile or fearful responses to AIDS and persons associated with it – on the part of physicians or anyone else – are certainly understandable in some respects. But even if the fear or hostility doctors felt towards AIDS patients was far from unique, doctors’ attitudes have different implications than those held by the general population. Matthews et al. (1986) argue that doctors’ beliefs have normative power in society due to physicians’ professional status, and also have bearing upon patient care and health outcomes.

We know that many social changes – related to biomedicine and otherwise – came about as a result of the HIV/AIDS epidemic. For instance, AIDS activism challenged the politics and protocols of clinical trials and testing of pharmaceutical drugs, and contributed to the reshaping of the doctor-patient relationship (Epstein 1996). But although we know that the net social changes wrought by the AIDS epidemic have been very significant, we know little about how these changes *impacted medical training about sexuality specifically* even though the sexuality-related implications of the AIDS epidemic were recognized as a component of the stress that residents and physicians

experienced as they responded to the epidemic. In his discussion of the impact of the AIDS epidemic on residency training, Robert Wachter observed,

For the heterosexual resident, the anxiety invoked by dealing with a critically ill patient may be magnified by uneasiness with the patient's sexual orientation. This anxiety may make more traumatic the already difficult tasks of obtaining the sexual history, counseling the patient about the risk of transmitting the infection, and dealing sensitively with the patient's family and lover (1986: 178-9).

But how these challenges were *addressed* in residency trainings, or even earlier in the medical education process, is unclear. After the small but not insubstantial burst of literature devoted to medical sex education in the 1960s and 1970s, it is very significant that little published literature seems to have taken up the subject of medical sexuality education during the 1980s when the AIDS epidemic brought sexuality squarely into the path of medical practice.

In addition to the AIDS epidemic, the political rise of the New Right and their particular brand of social conservatism might have had an impact – however indirectly – on medical sex education starting in the 1980s, as it did on school-based sex education in the 1980s and 1990s. During this time, sex education for school-age children became the repository for myriad, inchoate cultural anxieties born of the social upheaval in the 1960s – 1980s (Irvine, [2002] 2004). Sex education itself, Irvine argues, symbolized imminent sexual pandemonium and broader cultural decline ([2002] 2004). Although Irvine is specifically concerned with school-based sex education which is different from medical sex education in significant ways, given the reach of conservative political mobilization around sexual issues (also see Luker 2006), it is possible that formal education about sex in other contexts would have been impacted too. For these purposes, my point is that it is surprising that the discussion of medical sex education within the academic literature that was burgeoning in the 1970s seems to have died

down completely in the 1980s, at a time when doctors' understandings about sexuality had if not an unprecedented degree of significance than at least a substantial one, and collective consideration of medical sex education was perhaps needed more than ever. Although social change had been – and would continue to be – cited as a rationale for providing medical sex education (as it was for school-based sex education), the AIDS epidemic apparently did not constitute the *sort* of social change that provided impetus for more or different medical sex education, or even more of different discussion of it. This might have been due to the conservative political climate of the 1980s in addition to the prevalence and extremity of the stigma surrounding HIV/AIDS, but in the absence of research that has closely examined the history of medical sex education at this time, this is speculative. Regardless of the reasons why, it appears that for once, “social change” seemed to shut down, rather than prompt, interest in medical sex education.

Medical sex education from the 1990s onwards

Discussions of medical sex education began to crop up again in the academic medicine literature in the late 1990s, revisiting many themes from previous decades. Most writers in the 1990s and 2000s echoed the comments that medical educators had made in the 1960s and 1970s. Parish and Clayton's comments, published in 2007, could easily have been written in 1967:

Sexual health education is an example of an often neglected, but very important topic. Sexuality is important to almost all patients; yet this topic is not adequately represented in most undergraduate and residency training programs. Healthcare providers are becoming increasingly aware of the importance of addressing male and female sexual health (Parish and Clayton 2007: 259).

In the 1990s and 2000s, social change was again invoked as the reason why doctors – apparently suddenly - needed to be knowledgeable about human sexuality. Writers in this time period cited social change in the form of “increasing public awareness of sexuality” and the increasing consensus that sexuality is a major factor in quality of life

for many persons as the impetus for patients' supposedly heightened interest in talking with their doctors about sex (Leiblum 2001; Berman et al. 2003; Kuritzky 2006). There were certainly changes in societal understandings of sex during the 1990s and 2000s (e.g., Irvine 1995; Irvine 2003 and Loe 2004), but while the specific changes may have been unique – Viagra was certainly a new development - change in broadly shared understandings about sexuality was hardly historically specific to this time period. Thus we see that “social changes” have been both selectively and repetitively marshaled as the reason why medical sex education is necessary or important. The changes associated with the sexual revolution of the 1960s were cited as reasons for physicians to learn more about sex, but the social changes surrounding the AIDS epidemic were not. The social changes of the 1990s motivated discussion of medical sex education, and advocacy for it once again.

In the 2000s, just as they did in the 1960s, advocates for medical sex education argued that patients are likely to perceive doctors to be their primary resource for sexuality-related treatment or information. “Like it or not,” Sandra Leiblum wrote, “physicians are seen as ‘sexperts’ and are expected to provide information, medication, and referrals for sexual difficulties of all kinds” (Leiblum 2001: 59; Berman et al. 2003; Solursh et al. 2003). But Leiblum and other writers who have made similar assertions about the need for doctors to be knowledgeable about sexuality in recent years made no mention of the fact that their predecessors pointed out the same thing decades earlier. North American medical schools' sexuality-related course offerings have recently been perceived as insufficient (Leiblum 2001; Barzansky and Etzel 2003; Solursh et al. 2003; Parish and Clayton 2007; Obedin-Malevir et al. 2011) – but the fact that this “insufficiency,” or the perception of insufficiency, is not unique within the longer history of medical sex education has not been addressed. I review the recent literature that

discusses findings from surveys of the amount of sexuality-related curricula currently offered by North American medical schools in Chapter 3, but for the present purposes, the important points that emerge from this history of medical sex education are as follows.

First, we see that there has been a conviction on the part of at least a limited set of medical professionals for decades that physicians ought to be knowledgeable about human sexuality and capable of responding effectively to patients' sexuality-related concerns. Second, and related to the first point, it is clear that at least some medical educators have believed that formal sexuality education was necessary to prepare physicians for the sexuality-related aspects of their work, and the place for that formal training was within medical education. Third, even if there has been at least some degree of ongoing agreement about the first two points for decades, a clearly-defined space for sex education in individual medical schools, or a top-down effort to ensure the provision of additional sexuality-related teaching do not seem to have emerged. In 2010 Swartzendruber and Zenilman argued in the *Journal of the American Medical Association* that "clinicians should be trained to provide greater recognition to the importance of sexual health throughout the life span" (1006). In 2013 Ford et al. wrote,

Health care providers could benefit from shifts toward education and training in comprehensive sexual health, rather than the more common disease focused training...a sexual health approach could benefit providers by increasing the efficacy of patient visits and creating more nonjudgmental and inclusive clinical environments...Providers can normalize interactions regarding sexual health by...discussing sex in everyday contexts (98).

Even though it seems that the certainty (at least, on the part of some) that medical sex education is important persists, its provision appears to remain elusive. Ford et al. continue to say,

Provider education and training is directly relevant to the issues described...providers often have difficulty adequately addressing sexual health issues for a number of reasons, including provider reticence and a lack of training... Ensuring that sexual health is a priority for health-care providers will require revision of educational efforts on three levels: undergraduate clinical education, postgraduate residency training, and continuing education for providers (2013: 99).

Thus it seems that even through the mid-2010s, medical sex education remained a perceived necessity rather than a reality, mandated from above or otherwise.

Fourth, it seems that a robust conversation about what medical sex education fundamentally is or should be, how it should be delivered and what it should accomplish, has yet to emerge. As recently as 2012 Eli Coleman noted that many potential questions about medical sex education have yet to be addressed, specifically:

- Is there still a need for a stand-alone course in human sexuality?
- How much training is needed?
- What are the best methods for teaching this type of course?
- Beyond sexual history taking, what are the essential content areas?
- What should be required and what should be elective?
- Recognizing that sexual health should be taught in an integrated and longitudinal fashion, what is the best model for delivering that curriculum?
- What are the best forms of evaluation?
- What are the faculty development needs? (Coleman 2012: 238)

Although I do not consider Coleman's list of questions exhaustive – questions about the meanings or definitions of sex and sexuality put forth in medical training are imperative, as are questions about the treatment of sexual diversity – his broader point is of paramount importance. Not only do we lack answers to these and related questions, it seems that considered discussion of these questions and related issues is not prevalent.

But even if these questions have not been explored within the scholarly literature, we know that many North American medical schools do provide some sexuality-related curricula (I discuss surveys of its prevalence in Chapter 3), and thus probably have to consider questions like Coleman's to a certain extent even if empirical research has yet to provide a sense of what those negotiations look like in practice. The medical schools

that do not provide any or much sexuality-specific coursework may grapple with the sorts of questions that Coleman raises too. The exclusion or limitation of sexuality-specific teachings may themselves be the results of a long, substantial decision-making process.

Conclusion

It appears that the provision of formal sexuality education in both schools and within medical education is subject to constraints, but the nature of these constraints are very different. School-based sex education has generated a tremendous amount of controversy due to commonly-held understandings about the nature of sex and adolescence, and because of the belief that talking about sex is risky in and of itself. The controversy surrounding school-based sex education has attracted the involvement of a diverse array of stakeholders – some of whom have little or no direct involvement with schools, teaching, or parenting – and a substantial amount of debate about the content and objectives sex education programs. Sociologists articulate a range of ways in which the content of school-based sex education is constrained by outside interests, and the detrimental impact of these constraints on the students who receive the teachings.

By contrast, medical sex education has not been subject to public controversy, but yet its provision has been constrained – for instance, by a perceived lack of time to teach about it and by medical school faculty members' beliefs about their own ignorance on the subject. Although in theory it might seem that barriers to teaching about sexuality would fall away within medical education, because the subjects are no longer minors in need of protection from the potential dangers of sex, but adult professionals-in-training who, medical educators have argued, need sufficient formal preparation to meet the sexual health needs of their patients, it does appear that this has happened in practice. Although some medical educators have advocated for the provision of medical sex

education for a long time, this has not translated into a shared understanding that it is *essential* – particularly because so many aspects of medical training are understood as higher priorities, such as the acquisition of technical, scientific competence.

In other words, it seems that the very aspects of school-based sex education that make it seem urgent are inextricable from those that render it controversial – that is, the protection of a supposedly vulnerable population from the risks or dangers of sex. But at this point we have only a hint that this might be what is occurring – whether or not this is actually the case, or the extent to which it is, are empirical questions. At any rate, a major difference between school-based sex education and medical sex education is that the intention of the former is to effect the behavior of its recipients (perhaps to prevent teens from having sex, or to impel them to use protection if they do so, etc.) while the intention of the latter is presumably is – to the extent that it has been conceptualized – to prepare its recipients to address the sexual health concerns of others.

Sociological analyses of school-based sex education raise questions that need to be asked of medical sex education as well. What meanings of sex and sexuality are explicitly or implicitly presented within medical sex education, and what normative messages about sexuality are put forth? How do these meanings and representations reflect, reproduce, or reshape broader social inequalities? For instance, sociologists argue that school-based sex education often presents a heteronormative view of human sexuality and that this has at least two important consequences: non-heterosexual students do not gain access to pertinent sexual health information, and all students lose out on an opportunity to gain awareness of the presence and legitimacy of sexual diversity. This, sociologists argue, has implications not only for students' own sexual agency, but also for their participation as democratic citizens in a diverse society. If the representations of sexual diversity that are present in school-based sex education have

important implications for students' democratic participation in diverse societies, and their capacity to recognize the presence and legitimacy of different sexual ways of being, we would imagine that the same and more holds true for doctors. It would seem that medical sex education has implications not only for its students' participation in democratic society, but also for their professional actions towards their patients, which are likely to have both immediate and diffuse effects. Both school-based sex education and medical sex education have potential consequences for the public construction of sexuality in everyday life, i.e., beyond an individual's own sexual self or sexual experiences, in ways that need to be explored further.

Most immediately, our understanding of medical sex education needs to be advanced through an understanding of what medical sex education is in practice. How do medical educators conceptualize questions about the provision of medical sex education, such as those raised by Coleman (2012), noted earlier in this chapter? How do medical schools go about deciding what sexuality education to provide, and how, and when, and by whom? Even medical schools that provide little sexuality education may have come to the decision about what to offer through a long process of considered negotiation – but of course it also possible that decisions about what to teach about sexuality are made with little deliberation at all. In the next chapter I provide an ethnographic overview of the medical sex education enterprise at Buena Vista to address these and related questions. I examine the sex education that was provided at Buena Vista and faculty members' experiences of constructing it, and I also consider students' impressions of what they learned about sexuality from these teachings.

CHAPTER 2
THE ABSENT PRESENCE OF SEXUALITY WITHIN THE FORMAL CURRICULUM AT
BUENA VISTA

Introduction

As I discussed in the previous chapter, the extant research on medical sex education has revealed very little about what teaching and learning about sexuality in medical schools looks like in practice in the contemporary era. We know little about how knowledge about sexuality is conceived of and transmitted by medical school faculty and students, and thus, there are many questions about medical sex education that ethnographic analysis might usefully explore. For instance, what is medical sex education understood to be, what are its purposes and objectives, what meanings or definitions of sex and sexuality are explicitly put forth or implied? What do the teachings of medical sex education consist of in practice? What do medical school faculty members think students need to know about sexuality, and by what point within their medical education and professional development? How do faculty construct and deliver teachings about sexuality, and what are their experiences of doing so? What internal and external factors enable and constrain their efforts? How do medical students receive the sexuality-related teachings that are put forth within medical education, and what understandings about sexuality do they possess? And so forth.

In this chapter I provide an ethnographic overview of the sexuality education that took place within the formal curriculum, or the officially-offered, required courses (Hafferty 1998) at Buena Vista, and faculty and student experiences of Buena Vista's sexuality education to broaden our understanding of what medical sex education looks

like in practice, and what participants understand it to be. In other chapters I examine particular themes within the formal curriculum in greater depth and detail, but in this chapter my intention is to provide a reasonably comprehensive sketch of the sexuality education endeavor at Buena Vista. I examine both the extended and spontaneous mentions of sexuality within the formal curriculum, and participants' understandings about medical sex education and definitions of sexuality.

The following comments from Dr. Bob Harrison, a doctor of family medicine hint at the potential complexity of medical sex education:

Interviewer: Tell me about the lawsuit where the doctor had sex with the patient and his defense was that he wasn't taught in medical school that this is not acceptable.

Dr. Harrison: Doctors having sex with patients is, unfortunately, as far as we know, frighteningly common... there's a story about a doctor that did admit that he had sex with a patient. I didn't have firsthand knowledge of the situation but I've heard about it from credible sources. There was a break-up [between the doctor and] the patient, or something went wrong, and the patient reported the doctor, or the patient's spouse or partner found out what happened and reported the doctor. Whatever happened, when the situation was exposed and the doctor had his hearing one of his defenses was, "I didn't know a doctor wasn't supposed to have sex with a patient because nobody taught me that in medical school." So the judge investigated that and went to the dean's office at the medical school. I forget which school it was, but it was a medical school [within this state]. It wasn't in Tibet or something like that! (laughter) They looked through the records and they looked through the curriculum and finally reported back, "He might be right. We can't really point to a class or a situation where we can say for sure that he was taught that you shouldn't have sex with patients and why," and the doctor got off. I guess it was supposed to be a lesson to medical schools [in this state] that they should get on the job...

In the same conversation, Dr. Harrison continued:

...then there was another situation that I experienced personally. I was sitting in the teaching area of my clinic and my colleague Dr. Verde brought a fourth-year medical student to me and he said, "Well! There's Dr. Harrison himself! Ask him if you don't believe me." When Javier said "himself" I thought, 'this is going to be bad,' because ordinarily he would usually say "Hi Bob," not "Here's Dr. Harrison himself, ask him if you don't believe me." The student, who I didn't know before that minute, sheepishly asked me, "Dr. Harrison, Dr. Verde says it's improper for

doctors to have sex with their patients. Is that true?" Well, as Jack Nicholson said at the Academy Awards, "I had that sinking feeling" – what he said about "Titanic" getting all of those awards. I thought, "How did we miss teaching him about the impropriety of doctors having sex with patients within four years of medical school?" But it can happen. Students don't go to every class, they're not paying attention every minute. They're tired and taking naps. Faculty sometimes forgets. Maybe it doesn't come up. Maybe you go through four years of education and it just never comes up that sex and patients don't mix. Then [the medical student thinks to her- or him - self], 'Well, why not? I'm a person. He or she is a person. It's a free country. Why not? What could possibly be wrong with that? Love is wonderful.' You can see how it happens and you can understand why a medical student wouldn't understand things like power differentials, because they feel powerless. So I think that's still a potential problem out there and that there probably are genuinely some students graduating from very good schools – such as ours - who really don't understand boundary issues and don't know how to think things through in novel situations.

Dr. Harrison's remarks reveal one clear thing that medical schools might consider important to teach medical students about sex: don't have it with your patients. But in this case, not wanting doctors to have sex with patients did not translate into ensuring that this matter was covered within the medical school's formal curriculum. Things that are considered important may also be considered obvious, and therefore it may not seem necessary to devote instructional time to such topics. But as Dr. Harrison's anecdotes illustrate, what is obvious to some may not be obvious at all to others.

This chapter will suggest a number of important historical continuities within medical sex education. Many of the challenges associated with medical sex education and barriers to implementing it that were recognized in the 1970s could be found anew at Buena Vista 40 years later. Faculty understandings of sexuality were underdeveloped, and few reported having learned much about sexuality from their own medical training. As educators, they believed that sexuality was something that medical students needed to know about, but disagreed about its ideal placement within the curriculum – and within the longer pipeline of medical training. Some of the reasons for this were continuations of the dynamics described in the literature on medical sex

education from the 1960s and 1970s. With too much to learn and too little time to learn it, it was hard to justify the prioritization of sexuality over other important topics that also needed coverage. Faculty cited their own lack of formal sexuality training as a reason why they avoided teaching about it, and some felt that it was hard to find experts who could speak authoritatively about sexuality.

My analysis will also reveal something important about medical sex education at Buena Vista that past accounts have not emphasized, namely, that medical sex education may be characterized by a lack of agreement about what sex and sexuality actually are, and how they are relevant to medicine. A clear set of suppositions about what sexuality is or pertains to were not present at Buena Vista. A consistent set of definitions of sexuality or explications of its possible significance were not continuously present in the formal curriculum. There were some moments when defining sexuality – and exploring the variability within its definitions – was the primary subject of consideration, but these curricular moments competed with frequent, offhand mentions of sexuality that made it seem natural, obvious, or self-explanatory. When pressed, faculty members had a hard time defining sexuality without falling back upon tautologies, and students had trouble too. Students did not possess a distinct set of understandings about sexuality, and their responses to the sexuality teachings that Buena Vista provided varied considerably. While some Buena Vista faculty members as well as some students believed that sexuality was something that could only be learned about “on the go,” or over time, gradually, as one progressed through their professional development, there were indications that this did not necessarily work out in practice, but moreover, there was little consensus about what medical students needed to learn about sexuality, when they needed to learn about it and why, and how they should be taught about it.

I begin the chapter by exploring the substrate of medical sex education: the understandings about sexuality that Buena Vista students brought with them to medical school. Then I provide an overview of sexuality's appearances within the formal curriculum, both planned and sustained, and brief and spontaneous. Next, I consider Buena Vista faculty members' experiences of teaching about sexuality and integrating sexuality-related content into the curriculum. I then discuss medical students' reflections on what they had learned about sexuality since coming to medical school, followed by their definitions of sexuality. From there, I examine faculty members' perspectives about the ideal place within the overall trajectory of medical education. Finally, I consider faculty members' own sources of knowledge about and definitions of sexuality. Throughout the analysis I contrast the sexuality education that took place at Buena Vista with what we know about medical sex education in other contexts, and with school-based sex education. I conclude by discussing what these findings suggest about the production and transmission of formal knowledge about sexuality in general.

Buena Vista students' sources of knowledge about sex(uality) prior to medical school

Questions about what medical students believe or understand or know about sexuality at the outset of their medical training have not been subject to empirical inquiry, but they are important for a host of practical and theoretical reasons. For the practical purposes of curriculum development, having a sense of what medical students already know about sexuality could help inform medical schools' decisions about what to teach – assuming that a shared set of learning objectives were in place. Medical students' sources of understandings about sexuality prior to coming to medical school may also tell us much about the acquisition of sexual knowledge. If we are interested in formal sex education as it occurs across contexts and its broader implications, we might ask

what impact, if any, school-based sex education had on the understandings about sex and sexuality that medical students possess as they begin their professional training. If the messages about sexuality within most school-based sex education programs are as problematic as scholars argue, are there longer-term, more diffuse implications of these messages, beyond the effects of their initial impact? Do medical students remember receiving school-based sex education at all, or recall any of its specific messages when they enter medical education? Although many outcomes of school-based sex education have been measured (such as incidence of STI infection, pregnancy, etc.), we have little sense of how the received messages of school-based sex education go on to shape the production of sexual knowledge elsewhere, as recipients potentially reproduce their content through their actions later in life. Or do they recall other sources of sexuality-related knowledge or messages as being more influential for them? Although formal sexuality education appears to be quite limited in our society, representations or depictions of sexuality are quite prevalent within it (Attwood 2006). To what extent does students' exposure to generally-available cultural messages about sexuality shape their reception of the sexuality education that medical school provides?

The Buena Vista students that I interviewed came of age in a culture steeped in readily-available sexual messages (Attwood 2006), in the era of Viagra commercials on television and headlines about sexual positions and how to have better orgasms on the covers of popular magazines (Irvine 1995; Loe 2004). But despite the prevalence of these sorts of messages – regardless of the ultimate value or utility of their content – “information” about sexuality within popular culture was neither equally available to them nor uniformly absorbed by Buena Vista students. Buena Vista students also possessed varying degrees of personal *experience* with sexuality (at least, as a set of relational practices) and personal *exposure* to sexuality as a domain of social experience, or how

sexuality matters “out there,” in the social world, in other people’s lives. Some students indicated that they had given very little thought to sexuality for most of their lives, either in terms of their own behavior, desires, or identity, or anyone else’s. It is likely that one of the reasons for this was, as the literature would predict, many Buena Vista medical students devoted much of their time and energy to academic achievement prior to coming to medical school (Smith and Kleinman 1989; Wagoner 2000). The pursuit of the goal of gaining admission to medical school often included an emphasis on science classes that directly or indirectly precluded participation in interdisciplinary sexuality-related classes. The focus on studies also left many students with little time for the pursuit of other major activities, and closed off opportunities for the sorts of experiences that might lead to making the acquaintance of an array of persons from different pockets of the social world and possibly lead prospective medical students to develop a perspective on what sexuality could mean within other people’s life experiences. People experience sexuality to mean many different things and to be salient to their experiences of living – and, more specifically, to their experiences of health care – in different ways, but one of the primary means to awareness of the diversity within these sorts of lived experiences may be through personal exposure. The potential educational value of this sort of exposure is under-conceptualized and under-studied as a form of “sex education,” but we might reasonably imagine that such exposure has potential bearing upon doctors’ work, in terms of their interactions with patients and their awareness of sexuality’s potential relevance to clinical encounters.

Buena Vista students also entered medical school with varying amounts of personal experience with dating, romance, and sexuality. Interestingly, some empirical research on medical students’ attitudes towards addressing sexuality within encounters with patients has conceptualized personal sexual experiences as a form of sex

education. In an anonymous survey of medical students' sexual histories and levels of comfort with talking about sexuality with patients, Shindel et al. (2010) found that students who reported limited or no previous sexual experience were more likely than their sexual experienced peers to report feeling uncomfortable with dealing with issues of sexuality in patients. Although their study had many acknowledged limitations, it demonstrated the potential for personal sexual experiences to have bearing upon medical students' comfort with certain aspects of their professional work, and as such, the utility of considering students' sexual histories as a form of curriculum. Further investigation of the relationship between medical students' sexual histories and their attitudes towards and practices when addressing patients' sexual health needs is complicated in many respects, not least because from a critical perspective, it is difficult to deductively determine what counts as "sexual experience" and what sorts of sexual experience "count".⁷

Even when there is uncertainty about how best to conceptualize and ask questions about what students "know" about sexuality prior to coming into medical school, my interviews with students revealed that Buena Vista students entered medical school with a range of understandings about sexuality. For some students, sexuality – whether their own or their awareness of other people's – had had very little presence in their lives prior to coming to medical school. Priscilla's comments, below, were exemplary of this end of the spectrum:

⁷ Perhaps particularly in the age of the internet and the proliferation of possibilities for online sexual encounters, it is difficult to say exactly what counts as "experience with sexuality" (Attwood 2006), and I did not ask students specifically about their past experiences with sexuality and what, for them, counted as "sexual experience." However the students who volunteered information about their sexual histories, or lack thereof, referred to relational practices with other humans in the same physical space, and no student mentioned online sexual experiences specifically. But even aside from online encounters, determining what counts as "sexual" within the realm of face-to-face interpersonal encounters is not clear cut.

Priscilla: Well in an Asian family...and this is a very small example, but even when I would watch TV my mom used to...whenever there was a kissing scene or anything sexual, even just a kissing scene really, she would hold up her palm and make sure my eyes were covered so I wouldn't see it. So I used to think, 'oh, kissing, you can't do it in public because it's taboo. I didn't have any idea about sexuality at all, and I didn't even think that I would ever need to know about sexuality in general. I didn't see any point of getting myself into it.

Interviewer: Tell me a little more – after you got older, when you were in high school, would your parents still cover your eyes when people kissed on TV?

Priscilla: It was the same in high school. I guess I was very receptive. Since I was very little I was very receptive to their upbringing and their philosophy so I didn't even consider – I didn't even bring it up because it was never talked about amongst our family. We used to believe that when you kiss...well...

Interviewer: That's when the baby appears?

Priscilla: Right. And then in high school they did have a sex education class. I guess slowly I had been more exposed to – I guess it's just like when someone tells you, oh, there's no Santa Claus. I just remember someone telling me and I slowly started to believe that, oh, that's not really true [that kissing leads to conception], that's not the reality.

Priscilla went on to say that when she went to college, her peer group was composed mostly of people that were very similar to her in background and upbringing – namely, conservative Asian families, as she described them. She told me that when her best friend in college started dating a Caucasian male student and began having sex with him, she felt that her friend was doing something wrong because she was having sex before marriage. But although she disapproved of her friend's premarital sexual relationship, in retrospect she recognized its educational impact. Through hearing about her friend's sexual adventures, Priscilla learned of "French kissing" for the first time, and about what she termed "the positions." Her friend's relationship served as her first source of exposure to what physical, sexual practices might entail. Priscilla also learned something from the Korean exchange students she met during college. Most of these students had not only engaged in premarital sex, but premarital sex with multiple

partners. Priscilla remembered that at the time, she took a dim view of these students' sexual practices but she also recognized that she was being enlightened by learning about them. Even if she did not like the looks of the sexual practices that she saw beyond the confines of her like-minded group of peers, she also realized that her world was expanding. Specifically, she recognized that other people's sexual experiences did not necessarily look anything like her own (lack of) experiences, and that this, whatever she thought about it, was an undeniable part of the social reality that surrounded her.

Other students I interviewed reported similar experiences of not talking about sex with family members when they were growing up, and being surrounded by peers who did not talk about or have sex in high school or even up through college. Some of the students who described growing up in conservative families in which sex was never discussed did go on to gain exposure to sexuality as they grew older and had opportunities to draw upon influences outside of their families. For instance, Darcy reported that as an adolescent she gained awareness of sex and sexuality from MTV, other television programs, her peers, and the powerful presence of Brittany Spears. Arun, whose father was a doctor, never discussed anything related to sex with his parents while he was growing up, but pieced together information from junior high sex education classes, books and movies, girls he dated, and the internet. Some students reported learning about sexuality from their friends or older siblings.

A handful of students made reference to learning about the relationship between sexual behavior and gender identity, although they alluded to this relationship and what it meant rather than defining it in any concrete terms. Having a gay friend or cousin provided some of the heterosexual students with early personal exposure to sexual diversity. A number of students' comments suggested that much of what they had learned about sexuality did not come from any particular, distinct source, but from the

general grab-bag of cultural messages combined with their own personal experiences.

Elizabeth's comments illustrate this sort of mixture of influences.

Elizabeth: I think I [learned about sexuality] through hearing things from friends and from having boyfriends and from, you know, things that happen to you. In college I had a friend who was having questions about her sexuality and talking to her kind of opened up some discussion.

Interviewer: So no classes ever, no human sexuality class in high school or college or anything like that?

Elizabeth: No, there was one class that was offered in college but I didn't take it. I don't know what they taught.

Interviewer: What about reproductive information in biology classes or anything along those lines? Any information about safe sex?

Elizabeth: No, just kind of trial and error and friends and whatever.

Interviewer: *Cosmo(politan)*; the magazine)?

Elizabeth: Yeah, *Cosmo*, totally!

Interviewer: The internet?

Elizabeth: Yeah.

Other students' comments revealed that like Elizabeth, they were aware that sex and sexuality were "out there," part of the social world, and were at least vaguely aware of generally-available depictions of sexuality within the surrounding culture. Lucy's comments indicate that readily available cultural messages about sexuality may trump formal education about sex:

Interviewer: From what sources did you learn the most about sexuality before you came to medical school?

Lucy: I would say probably from peers and the media. I wouldn't say formal education.

Interviewer: Did you get any information about sexuality from formal education?

Lucy: I feel like everything I learned formally was very cursory like 'these are the terms used and here's some statistics.' I did take a class in undergrad on the disparities in health care based on different populations and the main factors we looked at were race and sexuality and in that

class we did just go through statistics and terminology and I guess I also learned from people I knew and also the media, what you hear from TV and movies.

Although learning about sexuality in conjunction with “statistics” suggests the conveyance of precise information, however limited in scope, Lucy could not articulate specifically what she had learned about sexuality within these classes, and later insisted again that formal education had not been a significant source of her understandings about sexuality – although what exactly these consisted of she never did make quite clear.

Arun, the student mentioned earlier who told me that he had learned about sex in part from the internet, told me that in the age of the internet, having “the birds and the bees” talk wasn’t really necessary - but he could not articulate what a talk about “the birds and the bees” would entail, nor what specific information he obtained from his online education. So although information about “sex” was clearly “out there,” it wasn’t entirely clear what that information specifically included and what it meant to these students. A student named Cindy told me that she had “many sources of information” regarding throughout her life prior to coming to medical school, but she also told me that when she chatted with friends about sex they would remark, “Like, what is there to talk about? We know STDs are bad. We get it.”

Generally, these students’ comments lend support to Feeona Attwood’s (2006) claim that even as mainstream culture is increasingly sexualized and representations of sex and sexuality become increasingly prevalent, there is still considerable confusion about what sex and sexuality actually are or mean even within the context of proliferating representations of sexuality within the public arena. But Cindy’s comments about “STDs” are also important in particular ways. The notion that sexually transmissible infections, or STIs “are bad” resonates deeply for many people and is both an effective

rationale for the provision of school-based sex education and a tactic for teaching high school students about sexual behavior – whether to avoid having it because of the gravity of the risks associated with it, or to be absolutely sure that they use protection if they do (Kendall 2013). And indeed, STIs are not without their risks, and moreover, some of these risks are very significant, particularly for HIV. But messages within school-based sex education frequently fail to point out that most STIs are fully treatable, and if treated in a timely manner, have no long term health consequences (Kendall 2013). Moreover, Kendall (2013) argues, most school-based sex education reifies exactly the notion that Cindy professed – that STIs are “bad,” and in so doing, contributes to the stigma associated with them that often inhibits the use of protection to prevent their spread, discussion of them when necessary, and seeking treatment for them in a timely fashion. Kendall's (2013) position is that fear-based approaches to STI education in high schools may have unintended consequences, and one of those might be that medical students come to medical school primed to reproduce the stigma so commonly associated with STIs. Cindy's comments were not representative of all students at Buena Vista, but they serve as a good example of why the source and nature of understandings about sexuality that medical students bring with them are important to take seriously and are worthy of further, more extensive study.

A few students reported that they gained formal knowledge about sexuality through formal education in college-level classes. Nicole and Duc mentioned taking a human sexuality class and a queer theory class, respectively, as part of their undergraduate education, and both said that these courses had significantly shaped their understandings of sexuality. Arthur took a sociology of sexuality class as an undergraduate, and told me that he had loved the course when he took it, but since coming to medical school, had forgotten “everything he learned” from it. He expressed

to me that what he had been learning in medical school had transformed his understanding of everything he had previously known, and told me stories of looking at the ingredients in NyQuil and understanding each of them and their mechanisms and how they acted upon the body, and looking at his body parts in a totally different way – as composed of an infinite number of specific components, instead of simply being a “shoulder.” Although he might have had significant exposure to formal knowledge about sexuality prior to coming to medical school, his comments revealed that as a result of the transformative experience of medical school, many of his old understandings had been supplanted by new ones. Arthur’s experiences suggest a possibility very different from what Cindy’s understandings about “STDs” suggested: perhaps medical education is such a transformative site of professional socialization that whatever students learned about sexuality prior to coming to medical education will no longer matter, as medical training begins to reshape their understandings of many aspects of human experience. As with Cindy’s comments, I do not present Arthur’s remarks to suggest that they are representative, but rather to illustrate that not only do we know little about the knowledge about sexuality that medical students bring to their training, we know little about what happens to that knowledge within medical training. Does medical education reshape students’ preexisting understandings about sexuality, even in the absence of or outside of the direct influence of medical *sexuality* education per se?

All of the students quoted above (within this section) came to medical school directly out of college. Students who were a little older than the fresh-out-of college majority and had lived and worked in multiple settings had, predictably, different sources of information regarding sexuality than their younger peers. Emily’s understandings of sexuality were the product of a range of life and work experiences that was broader than those of most Buena Vista students:

The whole parental/church influence was pretty strong when I was growing up, and then I had to do my own exploration and understanding. I've lived in places where I was the only straight girl in a group of however many – like, I was the token straight friend. In Portland I had a huge group of friends [who were not heterosexual] and I used to go to their parades and their events and so I learned a lot. I learned the ins and outs of being transsexual. I volunteered at an HIV/AIDS clinic for homeless people so I gained a lot of exposure to different things there, too.

Emily also told me that she had worked at Planned Parenthood for some time, and told me a little about her own sexual experiences. Through Emily's professional and personal experiences relating to sexuality she gained what she referred to as "exposure and experience," and her impression was that most of her peers in medical did not have much of either. As the aforementioned students' comments indicate, Emily was at least somewhat correct.

Whether students' varying degrees of knowledge about, experience with, or exposure to sexuality matter, and how they matter if they do are open questions. But even if the implications of students' varying degrees of sexual awareness are unknown, these data clearly indicate that even in an historical context when sexuality is more prominent within public discourse than perhaps ever before, medical students do not necessarily come to medical school with a baseline, standard amount of knowledge about sexuality or degree of exposure to or experience with it. As I will discuss, there were indications that students' exposure to sexuality prior to coming to medical school had an impact on what they felt they learned about sexuality within medical school. But before examining students' reflections on what they learned about sexuality in medical school, I describe the sexuality education that Buena Vista provided and faculty members' experiences of crafting it.

Coverage of sexuality within the formal curriculum

Sexuality was not as absent from Buena Vista's formal curriculum as the official database of courses and course content indicated upon my initial meeting with the assistant dean of educational computing at the outset of my research. The data base suggested that was little sexuality-related curricula that were officially designated as such, and little sexuality-specific content within classes. In other words, it appeared that there was little to be studied. However, my participant observation revealed that sexuality came up regularly in the Social Aspects of Medicine (SAM) courses that I observed, although these mentions were often brief and posited "sex" or "sexuality" as concepts that were straightforward or self-explanatory. But in addition to these fleeting mentions there were also several lectures that focused specifically on sexuality or on subjects very closely related to it, and took time to explore or provide definitions of sex and sexuality. These sexuality-related curricular offerings were not coordinated within any concerted, self-conscious curricular initiative specifically considered "medical sex education," but considered together they constituted a set of transmissions of information about sexuality that were not insignificant, at least, from the perspective of a researcher dedicated to looking for mentions of sexuality both offhand and concerted. To students – or faculty – who were not so singularly focused on tracking the sexuality content within the curriculum, its sporadic mentions were not often perceived as cohering into a recognizable corpus of accumulated knowledge.

Nearly all of the major instances of sexuality-related content within the formal curriculum occurred within the SAM course sequence (I discuss the causes and consequences of this placement in Chapter 3). One such lecture came within a class entitled The Physician-Patient Dynamic and was more of an interactive discussion than a lecture per se – although it did take place within the "lecture" portion of the class, when all of the students were required to be present. This curricular event gave students the

opportunity to explore definitions of sexuality, and through polling of students' own sexual behavior, made visible some of the sexual diversity within their own cohort. A lecture during Stages of the Life Course explicitly defined sexuality as a combination of behavior, identity, and desire, and considered the potential relationship between these aspects of sexuality in depth and detail. The formally designated topic of this lecture was "adolescence," and the lecturer used the topic of LGBTQ youth to anchor a discussion of sexuality that began with then extended beyond these particular groups of persons. Another lecture within Stages of the Life Course pertained to marriage, family, and divorce – aspects of human experience that are closely associated with sexuality. However, this lecture did not discuss or define sexuality explicitly, even though its main premise – marriage – was predicated upon sexual orientation in most parts of the United States at the time of my participant observation. One lecture that had a great deal of sexuality-related content that fell outside of the SAM course sequence was Dr. Arnold Jun's urology lecture about "male anatomy." Dr. Jun's comments about penile structure and function were laced with jokes and references to sexual functioning and activity. But even though Dr. Jun *referenced* sexuality regularly within his lecture, as I will discuss in greater detail later in the chapter, Dr. Jun's intention was not to *educate* students about sexuality per se. I describe each of these extended curricular considerations in greater detail in the subsequent chapters.

The more offhand, brief mentions of sexuality occurred during lectures that had a broad range of officially designated topics. For example, during the Psychopathology lecture on the topic of depression, the lecturer mentioned that "sexual side effects" were a common side effect of drugs designed to treat depression. But the lecturer said nothing else, about the nature of the side effects or what might be done about them. Similarly, in another Psychopathology lecture concerning alcohol abuse, the lecturer

stated that “sexual performance problems may be related to alcohol,” but said nothing more, leaving the nature of “performance” just as ambiguous as the nature of sexuality. During a brief discussion of the *Diagnostic and Statistical Manual*, one Psychopathology lecturer mentioned that homosexuality was once included in the manual, but it was dropped because of changes in “the criteria for inclusion.” Each of these mentions of sexuality was fleeting and isolated, yet each of the lectures within which they were contained ended early, meaning that time was not lacking for a fuller discussion. This is important because some Buena Vista faculty felt that one of the challenges associated with teaching about sexuality was the problem of too much worthwhile content to cover and too little time to do so. Part of what these sorts of mentions of sexuality illustrated is that sexuality can be relevant to many aspects of medical practice, and that it might be important for a doctor to be aware of the relevance of sexuality in many patient care scenarios that were not primarily or directly about sexuality. But this possibility was never raised specifically, and there was little indication that these offhand mentions of sexuality instilled the idea in students that sexuality is related to many aspects of patients’ health, and to doctors’ work. This might have been at least partially due to the fact that these brief mentions of sexuality did little to make clear what sexuality “is” or was within these contexts.

At times, sexuality was briefly mentioned as a source of discomfort, or designated as a “sensitive subject.” One SAM lecture devoted to the topic of “the physician as person” touched briefly upon the need for doctors to have compassion for patients of all walks of life. The lecturer, a doctor of family medicine named Dr. Nora Fischer, told the audience “If you’re dealing with ex-convicts, if you’re dealing with people that have killed someone, you have to show regard for them even if you might dislike them or you don’t respect what they have done. When they come to you for

treatment and you are their physician, you have to help them.” But moments later, Dr. Fischer backpedaled a little. She said that sometimes physicians can experience discomfort because of their patient’s sexual orientation, and told the audience that it’s important to “be really honest with yourself if there are people that you just can’t deal with because they make you uncomfortable.” Dr. Fischer told the class that sometimes you just have to tell patients, “You know, it really would be better for both of us if someone else was your doctor.” She gave little explanation for her transition between saying “you have to take care of everyone who comes to you” and “you may have to extricate yourself from working with certain patients because of your own feelings and biases,” and she did not pause to explore how these caveats might create patterned inequalities. Given that she went on to quote Martin Luther King Jr. by saying “an injustice anywhere means injustice everywhere,” this was a particularly striking point to neglect. Although Dr. Fischer probably had no intention of saying that the rule of showing compassion to all patients and taking care of everyone who comes your way literally applies to former criminals but not to patients whose sexuality a doctor finds unpalatable, her words did suggest exactly that. What could have been a point of entry into a discussion of why sexuality provokes discomfort and what medical students and physicians might do about this was instead a suggestion that the physician’s responsibility to treat patients with care and respect is not applicable to sexual orientation. I discuss this curricular moment and others like in in greater detail in Chapter 5, but for the present purposes, it is simply worth noting that at Buena Vista, sexuality sometimes explicitly designated as somehow special, or sensitive.

During his review of the content of The Physician-Patient Dynamic class during its final lecture, Dr. George Sorin, the lecturer who led the interactive lecture concerning definitions of sex and sexuality and student sexual practices (analyzed in Chapters 4

and 5), designated sex as a “sensitive matter” – something he had not done on the day of the interactive lecture itself. In his recap of the content of the course as a whole, he said to the class, “We have learned how to deal with the sensitive matter of sexuality, and leading into sensitive questions by warming the patient up.” For instance, he offered, instead of abruptly asking a patient, “‘Did you have sex last night,’ you ask other questions first. Like, ‘how are you today, are you dating, did you have sex last night?’” His delivery was crisp and humorous, and might have served as an unthreatening introduction to talking about how to negotiate a line of questioning that could be somewhat challenging in practice. But he moved away from the “sensitive matter” of sexuality as quickly as he brought it up, suggesting that the sensitive nature of sexuality is quite straightforward. Sex is sensitive. Ask other questions before bringing it up. And that’s all there is to it.

Many of the students I interviewed reported to me that they were given instruction in taking “sexual histories,” but many of these students equated taking a “sexual history” with asking patients if they have sex with “men, women, or both,” and were not certain of what other questions they should ask. And indeed, I often observed lecturers reminding students to ask patients “Do you have sex with men, women, or both?” rather than assuming knowledge of the patient’s sexual orientation. However, I witnessed little discussion of what to do with the answers patients might provide to this question, and students frequently remarked that they themselves were unsure of how to follow up on, and other studies have found that this is likely to be the case elsewhere as well (Ford et al. 2013).

These fragmented appearances of sexuality did not coalesce into a unified or consistent set of messages about what sex and sexuality fundamentally *are* and how, specifically, they are relevant to the practice of medicine, but nevertheless they did

constitute the de facto sex education at Buena Vista. So while sexuality was far from absent from the formal curriculum, its mentions were frequently brief and offhand. Even though the formal curriculum contained a few discussions of sexuality which were nuanced and extensive, these more frequent, spontaneous mentions of sexuality sent competing messages: that sex is sensitive, and that sex and sexuality are self-explanatory and require little explanation.

A set of contrasts between medical sex education and school-based sex education begin to emerge from this outline of Buena Vista's sexuality-related teachings. At Buena Vista, sexuality-related knowledge was presumed to be sensitive, as it so long has been in school-based sex education (and even in the context of Frederick Hollick's public lectures on anatomy and sexual pleasure). But at Buena Vista, sex was explicitly deemed sensitive, rather than implicitly designated as such (or as far worse) by carefully policing the boundaries of what can and cannot be taught or said. While school-based sex education has been informed by contentious debate about what adolescents should and should not know or be able to learn about sex, there were indications that at Buena Vista it was assumed that students knew whatever they needed to about sex – as demonstrated within the lack of instruction about how to follow up on the question, "Do you have sex with men, women, or both?" – or perhaps, that there wasn't any agreed-upon specific knowledge that was necessary for them to gain in order to ask follow-up questions within a sexual history, for instance.

Unlike school-based sex education, medical sex education has not been subject to fervent national political controversies involving multiple groups of stakeholders. However, the faculty who planned and delivered sexuality curricula faced their own set of challenges as they sought to integrate sexuality-related content into the medical school curriculum. In the next section I describe their experiences of creating or

integrating sexuality-related curricula, and their understandings of the contextual circumstances that shaped these efforts.

Faculty members' experiences of integrating sexuality into the curriculum

Most of the faculty members I was able to interview were either involved in the teaching of the SAM courses or at least in favor of teaching about the social aspects of medicine. Accordingly, it came as no surprise that most of my faculty interviewees expressed support if not enthusiasm for the idea that medical students should learn about human sexuality. However, these same faculty members also said that actually integrating sexuality-specific content was difficult for a number of reasons. The most obvious, frequently-reported challenge was the problem of too much material to cover and not enough time to do it. Another issue was that some of the more bioscience-oriented faculty felt that the social aspects of medicine, including but not limited to sexuality, were a low priority for the use of teaching hours. Because of this, the instruction time that was officially devoted to sexuality was confined within the designated place for all of the social aspects of medicine, the SAM course sequence.

Dr. Nancy Green described these issues in this way:

Dr. Green: You know the issue of sexuality doesn't – I wouldn't say it's taboo, I just don't think it's...all the basic science guys, that's just nothing they're going to – I mean they're just not going to do it.

Interviewer: So it's not taboo, it's just not relevant.

Dr. Green: It's just not relevant, yeah, you know it's not relevant in physiology, organ pathology, or anatomy, or histology, in microbiology, it's not [seen as] relevant in any of those courses. So I think really the only places you could fit it in are the Physician-Patient Dynamic, Stages of the Life Course, Intro to the Practice of Doctoring, and the fourth one which I don't think is all that appropriate because it makes it negative is Psychopathology.

Since the SAM course sequence functioned as the logical place to formally situate all curricula pertaining to the social aspects of medicine, the faculty involved in developing

those courses often found it difficult to make space for all of the topics that they felt were important and wanted to include. This, according to Dr. Ronald Davidson, Dr. Green's course co-director for one of the SAM classes, made it difficult to include sexuality-related content, simply because there were so many other topics that were also important to cover within the SAM classes.

I wanted to introduce – Nancy and I talked about it, when we first started here, a lecture on sexuality...and I was told that it's already being covered in the Patient-Physician Dynamic class... and we needed room for another lecture, so we dispensed with it.

Dr. Davidson made it clear that decision to dispense with a lecture on sexuality was by no means easy. It simply seemed like the right thing to do, given his knowledge that sexuality was being at least touched upon in another class, how could he pass up the opportunity to teach about something that might not be receiving any coverage elsewhere?

Even faculty members who explicitly expressed the belief that sexuality is relevant to medicine and important to educate about sometimes also suggested that even if sexuality was important, it wasn't germane enough to medicine or quite significant enough in its own right to garner status as a stand-alone topic. Two of the ways that faculty members expressed this was by designating sexuality as an "orphan topic" or an issue that was salient as the special interest of a limited group of persons. These comments from Dr. Daniel Benjamin, another faculty member who was very involved in curriculum development, contain elements of both perspectives:

...honestly, there are so many, I don't want to say orphan topics, but there are so many topics that people advocate for that aren't done particularly well that could be done better, and... they're all important! And everything is important, but we learn also that there's some way, there's a critical mass of what students can learn. And integrate, and... what's appropriate to expose them to, are we exposing it just so we can say we checked a box and DID it, or did we really put it in the right space? And that's just an ongoing challenge. Everyone who comes, and

we hear from a lot of groups about, “MY AREA IS NOT...” or, “What about the deaf?” or whatever, and it’s all important.

The designation of “orphan topic” served to reflect and reinforce the idea that while sexuality might have been important, it wasn’t seen as being clearly related to medical issues of greater or more obvious urgency. Dr. Miriam Elizondo expressed this perspective during our interview:

Interviewer: You also point to a timeless issue, this matter of, in a world of limited time and so much to know, how do you make these critical decisions? And one of the things that I think is so interesting about sexuality within medical education is that I’ve heard so many people say that it is important in so many ways, but among other things –

Dr. Elizondo: Is it more important than diabetes? Is it more important than well exams on babies? Is it more important than infectious disease? Yeah, I don’t, I can’t...I don’t think you can answer that.

Another challenge associated with teaching about sexuality that faculty perceived was a dearth of “experts” who could deliver a lecture on some aspect of sexuality. But this sentiment seemed to ignore the fact that Buena Vista faculty members did deliver lectures about sexuality (those described above). Whether this meant there were unrecognized experts in their midst or that “expertise” was not truly necessary to lecture about sexuality is unclear, and furthermore, there was a bona fide expert in “sexual medicine” in practice near Buena Vista. Dr. Gil Zimmerman, a self-described specialist in “sexual medicine” made frequent overtures to the Buena Vista dean of undergraduate medical education, offering to help integrate more sexual medicine into the curriculum. According to the dean, Dr. Zimmerman had been very helpful, and according to Dr. Zimmerman, the dean had brushed off his offers to help. So while finding an expert to talk about sexuality was a perceived problem, the deeper issue might have been the difficult decisions that faculty members were forced to make about how best to use limited teaching time.

The difference in opinion between the dean and Dr. Zimmerman was likely tied to the structure of curriculum development, which gave individual faculty members control over whether and how to bring sexuality into the educational segments they developed. Dr. Norm Gallo provided some useful insights into the processes of curriculum development, and explained why Dr. Zimmerman's offers to help might not have gone very far:

At our last meeting we had a discussion about trying to include more sexual health into the curriculum because there was an offer by a local expert on sexual medicine, Dr. Zimmerman, who offers services on education, faculty development, et cetera, and to help develop curriculum with regards to that. So the way our course is set up is that we have writing groups for each of the monthly topics. So we have generally somewhere between two and four faculty per writing group, and then each of the writing group has certain topics and they are responsible for creating the detailed curriculum within that topic. And so if they want to include a component of sexual health within that then they have the freedom to do so.

But just as faculty members had the freedom to integrate sexuality into their teaching segments, they also had the freedom to leave it out of their teaching segments. The option to include it did not approach an encouragement to do so, much less a mandate. Like Dr. Goldberg, Dr. Gallo referred to sexuality as an "orphan topic," and expressed that while he thought that sexuality was important, it was in competition for coverage along with an array of other ethical issues, psycho-social issues, and cultural competency issues. Ultimately, Dr. Gallo referred back to the challenge of too much to learn and too little time, and lamented that within this reality, sexuality was not addressed very systematically at all:

So again, at some points [sexuality] is woven in, but it's, you know...I don't want to say haphazard, but it's just not as woven in as deliberately, I think. But again it runs into the same problem as that, you know, you have so much to teach – where do you put this all in?

Interestingly, Dr. Gallo later identified "GLBT stuff" as another orphan topic – distinct from the orphan topic of sexuality. His comments, like those of many other faculty

members, reflected implicit understandings of what “sexuality” did and did not encompass. And despite Dr. Gallo’s reluctance to describe the inclusion of sexuality-related material as “haphazard,” it looked to be exactly that.

Conversely, in one instance, sexuality appeared within a lecture without any tough decisions from the faculty member about whether or not it should be included. Dr. Arnold Jun’s urology lecture was filled with pictures of penises in various stages of disease and dismemberment, and jokes about penile function, sexual and otherwise. His lectures left distinct impressions upon the students who witnessed them. One medical student, Arthur, described Dr. Jun to me as a great example of a “stereotypical raunchy, perverse, frat-boy, body-man urologist” – a stereotype of urologists that I had not previously been aware of. “He’s incredibly sexist,” Arthur told me. “The girls in the class absolutely hate him.” On the other hand, Arthur told me that his male classmates who aspired to be urologists themselves found Dr. Jun hilarious and admirable.

When I interviewed Dr. Jun he gave me little indication that he hoped to provoke extreme responses of like or dislike from the students, but he acknowledged that he intentionally used humor to help get his messages across. He explained to me that although he joked about sexuality during his lecture, his intention was not to teach *about* sexuality, but rather, to use sexuality-related humor as a heuristic for helping students get past their discomfort surrounding the subject matter and remember his teachings.

Interviewer: So tell me a little bit about the lecture.

Dr. Jun: Oh the lecture. It’s kind of fun because it’s male anatomy. And...

Interviewer: What’s fun about male anatomy?

Dr. Jun: Well when you look at most of the – a lot of the jokes that people tell have to do with, you know, anatomy and then more so when you’re dealing with sexuality. Sexuality I think is a funny subject for some people. I think it’s funny because when you laugh it kind of displaces the

nervousness and you can kind of – it's something about laughter that if you're nervous you can... if we're nervous, we laugh. So it's something about sexuality that's uncomfortable for people, so it's something we can make kind of light, you know, and once I make it facetious then it's easier for them to I think digest. So it's a fun lecture in that sense.

Dr. Jun was one of the few interviewees – faculty or student – who mentioned of his own initiative that sexuality might provoke discomfort, and not only that, he was one of the few faculty members who discussed a mechanism for addressing this discomfort. But Dr. Jun's comments were also tautological. Was sexuality funny because it makes you nervous? Did it make you nervous because it is funny? Dr. Jun's explicit recognition of the potential for sexuality to provoke discomfort was significant, as were his efforts to address this nervousness. But he did not recognize the possible significance of his remarks equating sexuality with nervousness that only humor could resolve. He may well have accomplished his goal of helping students let go of their nervousness or apprehension about sexuality, but in doing so, he suggested that the natural alternative to feeling nervous about sexuality is to joke about it. While such a strategy might well help some students shake off some of their apprehension related to sexuality, it also serves to keep sexuality in a "special" category by presenting it as humorous (and perhaps uniquely so), as opposed, for instance, to discussing the discomfort itself and then attempting to reposition sexuality as just another mundane, yet important, aspect of human experience and medical care. Despite the fact that Dr. Jun did not set out to teach *about* sexuality, his remarks about sexuality - even if they were an incidental part of his lecture rather than his main teaching points - still constituted a set of teachings about what sexuality is and the kinds of feelings it provokes.

All indications suggested that Dr. Jun's lecture was unique in some respects. I did not observe or hear of any other lecturers who combined humor with sexuality-related content to the same extent that Dr. Jun did, but Dr. Jun's reflections on his

lecture point to another aspect of faculty experiences of teaching about sexuality that are very different from those articulated by the faculty quoted earlier in this section. Instead of making difficult decisions about whether to cut or include sexuality-related content, faculty may sometimes transmit messages about sexuality without intending to teach about sexuality per se, or transmit messages about sexuality that are very different from those that they intend to put forth. The production of latent messages or unintended messages is not exclusive to the topic of sexuality, of course, and these sorts curricular processes have been explored at great length within various education literatures. Latent messages are often referred to as a hidden curriculum (Hafferty and Franks 1994; Hafferty and Castellani 2009), and I discuss an example of the production of a hidden curriculum – specifically, of heteronormativity - at Buena Vista in Chapter 4.

Thus we see that at Buena Vista, sexuality was regarded at least by some faculty as important and worthy of teaching about, but integrating sexuality into the curriculum was difficult because in addition to questions about what exactly should be taught and who had the appropriate expertise to teach it, the ever-present problem of too many important topics to cover and too little time to do it made it difficult to figure out how and where sexuality “belonged.” As earnest as these efforts were, and however substantial the sexuality teachings that Buena Vista intentionally provided may have been, it is important to note that the steps taken to provide sexuality-related teachings were not organized within any sort of overarching initiative to develop a coherent sexuality curriculum with a consistent set of meanings, a corpus of agreed-upon content, and a clear set of educational objectives. That is not to say that the SAM courses in which the sexuality-related content was housed did not have educational objectives; indeed they did. But to my knowledge there was not any effort made to coordinate a set of learning objectives that pertained specifically to sexuality, nor any discussion of how to best tailor

the curriculum to meet those objectives. And for all of the reasons why faculty struggled to include sexuality, this is not surprising: simply fitting sexuality into the roster of topics to which official attention would be devoted was difficult enough. However, Dr. Jun's remarks illustrate that even as some faculty agonized over where and how to best (or simply, to manage to) integrate sexuality into the curriculum, the transmission of messages about sexuality may have also occurred without anyone recognizing that it was happening.

Buena Vista's sexuality education in perspective

The picture that begins to emerge is that the medical sex education that existed at Buena Vista bore similarities to medical sex education initiatives of the 1960s and 1970s. As I discussed in Chapter 1, one medical school faculty member that Coombs interviewed during the 1966-1967 academic year described his institution's sex education as being "hit-and-miss," comprised of "dribbles and drabs" of sexuality-related information that nobody considered "sex education" per se (Coombs 1968: 272). While the "dribbles and drabs" that Coombs's interviewee described might well have seemed like something more substantial depending on one's measures or perspective, the point is that it appeared at Buena Vista, as it did to the medical school faculty Coombs interviewed in the 1960s, that a concerted approach to sexuality education as a distinct, related, coherent curriculum was missing even if sexuality-related content was not totally absent.

We also begin to see the emergence of a key difference between medical education and school-based education. School-based sex education, if not officially governed by entities external to the schools, is heavily influenced by an array of institutions and actors outside of schools. In contrast, none of the faculty members that I interviewed mentioned pressure from an external entity, such as, perhaps, the American

Medical Association (AMA) or the American Association of Medical Colleges (AAMC), as either impetus for or barrier to integrating sexuality-related content into the curriculum. This may be because biomedical institutions do not have a standard position on “sexuality” in medicine or medical sex education. If one searches the websites of the AMA and the AAMC for “sexuality” and “sexuality education” one finds much – particularly within the last few years – pertaining to LGBT health, or LGBT inclusion, or LGBT-specific curricula. Sexual abuse is a distinctive category, as is sexual harassment. The AMA takes the position that the primary place for sex education should be in the home, but also offers its explicit support for comprehensive sex education in schools, and urges physicians to assist parents to provide sexuality education to children and adolescents (see policies H-170.968; H-170.966). Article 11 of policy H-170.986 states that “State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, [and] sexual responsibility...Teachers should be qualified and competent to instruct in health education programs.” But despite these recommendations and the general expressions of support for sex education as it might occur within contexts outside of medical education, it seems that the AMA has not produced a comprehensive, overarching set of guidelines for what a comprehensive sex education for medical students (or residents, or practicing physicians, for that matter) should look like or include. And although some advocates of medical sex education have urged for more of it for decades, there is no indication that any other institutions or groups of actors – within or outside of biomedicine - have attempted to shape the content and delivery of medical sex education. Moreover, none of the Buena Vista faculty members I interviewed spoke of an externally-mandated set of guidelines for sexuality-related teachings.

I now turn from faculty experiences of integrating sexuality into the curriculum to examine students' impressions of what they learned about sexuality within medical school. The question of what students learned about sexuality in an absolute sense while at Buena Vista is not one that I attempt to answer exhaustively here or anywhere else within the dissertation, not least because the question itself is complicated. My objective, when I interviewed students and asked them what they had learned about sexuality at Buena Vista, was to understand their *impressions* of what they had learned or their reflections on how their understandings of sexuality had changed since coming to medical school.

Medical students' reflections on what they learned about sexuality in medical school

Most of the medical students I interviewed were in their second, third, or fourth year at the time of their interview, and thus had theoretically experienced most or all of the planned sexuality-related content within the formal curriculum that I mentioned earlier and offhand mentions of sexuality as well. So what did students take from the instruction regarding sexuality, and whatever definitions of sexuality were embedded within these curricular moments?⁸ One of the most striking features of students' reflections about what they had learned about sexuality, or how their understandings about sexuality had changed within medical school, was the range in their responses.

⁸ Sociologists of education in general and medical education in particular agree that the teaching and learning that occurs in any educational setting occurs through multiple levels of curricular processes, and is not strictly the result of what is offered within the formal curriculum (e.g., Hafferty and Castellani 2009). Here I reference students' responses to or recollections of the formal curriculum, and in doing so my intention is not to imply – in contradiction to my other points – that the formal curriculum was the only source of sexuality education at Buena Vista. Rather, it is uniquely, inductively relevant as a source of meanings here because students referred to teachings within this level of curricular processes when I asked them what they had learned about sexuality within medical education.

Some students, such as Eric, had little sense of having learned anything about sexuality from medical school:

Interviewer: How would you say your understandings of sexuality in terms of what it is or why it is important have changed since you've been in medical school?

Eric: This may be a failing of the system, but I don't think that they have.

Although some students freely admitted that they skipped lectures or had a hard time remember content, Eric told me that he had faithfully attended lectures for all of his classes, including the SAM classes, and I had seen him in attendance in SAM lectures myself to trust his estimation of his attendance record. However, later in our interview, Eric's comments about the relevance of sexuality to clinical practice suggested that his understandings about sexuality had indeed been impacted by his experience of medical education.

Interviewer: How do you think sexuality matters to clinical practice?

Eric: In a couple of ways. In epidemiology there are sexual behaviors associated with specific infectious spreads, so physicians do need to ask questions that probably seem very probing to patients in order to rule things out, to avoid unnecessary tests or possible harmful medications and harmful side effects by simply knowing it is or it isn't this based on the patient's history. Let's face it, sex and authority have always had a dicey and abusive relationship.

Interviewer: So what does that translate into for your...

Eric: Doctors have to avoid anything that can even appear inappropriate, both in the stance of statements and physical touch, even if they are doing a physical exam, they need to explain what they are doing and why to their patients, because they have no idea what the patient's views are and the patient may think something the doctor is doing is sexual. That's bad on several levels, one is if the patient freaks out the patient is going to miss out on the care they actually sought help for and two, there may be perceived impropriety. The doctor probably did something slightly wrong, but there may be exaggerated claims against the doctor that he or she will later have to deal with. Other ways that it's relevant to clinical practice...infections in actual epidemiology, patient comfort, potential physician abuse which I'm not saying doesn't happen...I suppose way down on the list is relationships between medical professionals, but that's along the lines of any office romance. If things go south it affects work.

Eric's remarks were interesting for many reasons. I personally did not observe any teachings about the "dicey and abusive relationship between sex and authority," nor did any of my other student interviewees mention anything about this, so it may have been that Eric brought these ideas with him into medical school. But he also mentioned epidemiology and patient comfort, medications and side effects, and these were probably topics that he had learned about only within the context of medical school. My impression was that Eric's understandings about sexuality had probably been shaped by medical education in ways that he probably didn't fully recognize, which were impossible for me to parse out.

Although the content of Eric's reflections was certainly unique, in one respect his comments were representative of a broader pattern. More than a few students said they had "not learned much" about sexuality within medical education, but there was variety within the contours of this "not knowing." Norman, for instance, put it like this:

There were a few courses during first year that did explore human sexuality issues and how to deal with patients that are LGBT, but everything was sort of superficial, just introduced – nothing was talked about in-depth. Then I realized, like, there are a ton of things that need to be taught, a lot of other things are taught superficially as well – not just sexuality and LGBT issues.

Although Norman had a hard time recalling any specifics about what he had learned, he was one of the few students that mentioned learning "how to deal with patients that are LGBT." Norman did not define "LGBT" within our conversation, and other students who referenced sexual orientation did so in very different terms. For instance, Miguel had this to say about sexual "variations":

Interviewer: In your classes, to the best of your recollection, was sexuality ever a part of discussions, or a part of course content?

Miguel: (Long pause.) Not...not any more than a couple of sentences or maybe a lecture on, you know, the different forms of sexuality. But I can't imagine it being more than, you know, fifteen or twenty minutes in the

entire first two years of classes. I don't think it's taught formally besides, 'these are the variations of sexuality.'

Interviewer: The variations meaning...?

Miguel: Meaning, straight...gay...just kinda...transgender...yeah, that's all that I can remember in terms of formal teaching.

Thus it seemed that although Miguel remembered learning about sexual variations, his understandings of what "the variations" might include were vague at best.

Miguel told me that he had skipped many required lectures and shown up for classes only for tests or other events when his presence would actually be checked, so he might have missed much of the formal curricula pertaining to sexuality that Buena Vista provided. But even students whose active participation in sexuality-related lectures I had observed later had a hard time recalling these curricular moments when I interviewed them. For instance, I observed Jalil asking questions and making comments in sexuality-related lectures, and on one occasion, a question he asked the lecturer provoked a round of raucous laughter in the lecture hall. Despite this, Jalil told me that "there hasn't really been much education regarding sexuality" when I interviewed him. But Jalil felt that there was a reason for this, namely, that sexuality couldn't really be taught about because it wasn't a concrete subject and couldn't be taught scientifically:

Jalil: So, there hasn't really been much education regarding sexuality. There were a couple of lectures last year. One, I mean, the distinct one that I remember is the professor was kind of polling everyone on their experiences and opinions. And I thought that was really interesting because as future physicians we're going to need to talk about this and be comfortable with it with all of our patients and I think people came to very different conclusions. I don't think it's...it's not a concrete subject and it's not something that can be taught with that scientific mindset and I think maybe for that reason it's either not as focused on, or... I'm not really sure. But I don't think we've gotten much education regarding sexuality. We got a little regarding taking histories of patients and their sexual past.

Interviewer: Tell me about that experience.

Jalil: It was in one of the SAM classes and the sad reality is that it wasn't emphasized at all. I mean, it's just a quick, like, take a history and you know you have to say that you recommend wearing condoms and that sort of thing but like actual, like eliciting our feelings about this sort of thing I feel was never really done other than that one lecture.

Convolved as Jalil's remarks were, they suggest a set of tensions that may have broader relevance. He indicated a certain amount of interest in learning about sexuality and saw it as relevant to his work. But he also was under the impression that sexuality wasn't concrete or scientific enough to be taught about, even though he simultaneously recognized that the lecture that included a poll of students' experiences and opinions was interesting and important training for patient care – even if it wasn't a set of scientific teachings, per se. Within the context of a limited amount of formal sex education at Buena Vista, an emphasis on all of the “hard science” that is essential to medicine, and a lack of other opportunities (i.e., prior to coming to medical school) to take sexuality seriously as an object of inquiry, these sorts of confusions or almost-articulated questions probably served as the barely-recognized backdrop of many medical students' impressions of the medical sexuality curriculum. And it seems possible that this might not only be the case at Buena Vista, but perhaps at other medical schools too. For Jalil, the nature of sexuality as a topic that was not concrete or scientific seemed to preclude its appearances within the formal curriculum from taking hold in his mind. During our interview, Jalil mentioned that he was doing well in his classes and suggested, with a combination of sheepishness and pride, that if anyone at Buena Vista might be called a “gunner,”⁹ he would be one of them. But even though Jalil was committed to excelling on exams and mastering the information put forth in his classes, he did not necessarily

⁹ “Gunner” is a slang term for medical students who are excessively competitive or aggressive (Coombs et al. 1993). At Buena Vista, students used the term to refer to students who were consistently (or obsessively) committed to receiving the highest possible grades, even when a passing score was all that was required.

retain or recognize a need to retain the sexuality-related content of lectures, even when he had actively participated in them.

Other students reported gaining a distinct impression that sexuality was important to health and well-being and relevant to patient care, but the comments within this category of understandings also varied considerably in their specifics. The student named Grace felt that it was important for a physician to be able to understand their sexuality and find resolution for any concerns they might have about it, and in her view, doctors should play a role in helping patients find sexuality-related information.

Interviewer: What have your classes suggested to you about the place of sexuality within the overall picture of human health?

Grace: I guess you want to make sure that the patient is satisfied and has an understanding about their sexuality if they do have concerns. You want to help them understand their own sexuality and understand the risk factors. You want to address those with the patient and make sure the patient is aware of them, and you also want to help patients who have questions find resources.

Interviewer: Finding resources, so that's your responsibility, not the patient's?

Grace: Sometimes a patient might need help finding resources because they might not know where to look. They might have come from a very closed family or something like that. So they may not know where else to turn, except to their physician, and then I'm sure we, the physicians, could find resources for them.

Interviewer: Where would you begin to look for resources? Has that been suggested to you?

Grace: No but I would probably look online and then find groups or a hotline for them to call.

Grace's recognition that patients might want to turn to their physician for advice or information pertaining to sexuality, and her indication of willingness to provide this assistance are not insignificant. Buena Vista students were not always inclined to view sexuality as having a definite place within their professional responsibilities. Yet Grace's

comments also suggested that physicians are not necessarily likely or able to possess enough knowledge about sexuality to be a source of sexuality-related information themselves, and moreover, that sexuality-related information is always somewhere else – available through a hotline or a website that Grace did not know of herself, but presumably existed somewhere.

In further demonstration of the variation in student understandings of the messages about sexuality at Buena Vista, the student named Arthur had gotten the distinct impression that sexual activity is considered medically healthy.

Interviewer: How does sexuality fit into the conception of human health that's presented to you here?

Arthur: It's considered healthy. Like, sexuality is considered healthy.

Interviewer: How do you know that? How is that made clear, or implied?

Arthur: I feel like watching the clinicians that I'm shadowing, they don't say 'good' if the patient is having sex, but it's clear they view that as good. Libido is a sign of health. Diminished sexual drive is considered an unwanted side effect of a lot of drugs. There's a joke about this anti-seizure drug. One of its side effects is increased sexual drive, and people are like - why is that a side effect? That should be considered a benefit! Sexual drive is considered a good thing. If you are sexually active, and you protect yourself, and you have libido, basically you're healthy. You're a normal human being, that's good.

Interviewer: So when has that come across - when you're talking about side effects of drugs?

Arthur: They say, 'Oh that's a bad side effect of a drug that diminishes sexual drive'. Or, they'll say to a patient, 'Why aren't you interested in having sex anymore? That's something we should discuss.' You need to talk to your patient if they bring that up.

Interviewer: In what context has that come up?

Arthur: In classes where we talk about sexual history taking.

Arthur was the only student that I interviewed who mentioned hearing about libido or sex drive or patients' interest in sex. Although his reflections were shaped in part by his

observations of physicians that he shadowed, and these experiences may have been relatively unique, he also cited class discussions about taking sexual histories, which were collective events. Other students made reference to learning how to take a sexual history within their classes, but no other students told me that they had gotten the impression that sexual activity was considered a sign of health.

Whether or not the curricular moments that led Arthur to his unique impression that sexual activity was considered medically healthy were idiosyncratic, students' varied recollections of the interactive lecture/discussion/poll within the PPD class illustrated the potential for diverse responses to the same teachings. Students who were present for the same iteration of this yearly curricular event had very different responses to the data yielded by the poll. Nicole was surprised by the "surprisingly high number of students who indicated they were gay or lesbian." Grace was surprised that "so many" of her peers had "had sex" at all, regardless of the gender of their partners. Emily was shocked that so many of her peers reported that they had never had sex before. Eric was somewhat irritated that so many of his classmates were so surprised by the fact that there were gay students in their midst. I discuss this poll/discussion/lecture in greater detail in Chapter 4, but for the present purposes, my intention is simply to note that while some of what students learned about sexuality at Buena Vista was probably due to the idiosyncratic experiences that they had in small-group discussions and interacting with faculty members during their years of coursework, students were also exposed to common set of teachings, and drew a different set of impressions from them. This variety was likely due at least in part to the range of prior knowledge about or exposure to sexuality that the medical students brought with them to Buena Vista.

For instance, the student named Priscilla who was quoted earlier in this chapter, whose baseline knowledge of sexuality prior to entering medical school was very limited,

felt that her understandings about sexuality had changed substantially since coming to medical school – unlike some of her peers quoted earlier in this section.

Interviewer: What do you think the relationship and sexuality and overall human health is all about based on what you've learned in medical school?

Priscilla: Before coming to medical school I probably would have said that sexuality is something you can live without. You can disregard it. It can just not be a part of your life at all until you get married. Obviously, I didn't know what it would be like after marriage, but pre-marriage I thought it was something...I didn't know it was a concern. But the SAM classes have given me more experience seeing the whole span of a person's life. I like how we've looked at the infants, children, adults, adolescents and all the way to the elders. I thought it was really nice because you get a different point of view about how a person's life would be like at each stage. And thinking about that, and incorporating the sexuality lecture, I feel like now I understand that [sexuality] is an essential part of a person's life that keeps them...I mean, I can't speak from my own experience, but just hearing people's stories has made me realize that [sexuality] is what keeps a lot of people's mental health healthy. It's actually like coffee. Like, you can get addicted to it but it's something where, you know, it does help your sanity and it does help you with your relationship with your significant other. Especially for men, they feel more connected with the females by having a sexual relationship as opposed to females who just, you know, feel that connection without a sexual relationship.

Priscilla's understandings of sexuality evolved considerably within the early portion of her medical education – from seeing it as something that one can “probably live without” to viewing it as something that is “actually keeping a lot of people's mental health healthy.” While this shift is significant, her understandings of how sexuality might be relevant to patients' lives were still characterized by suppositions which might have bearing upon patient care, such as the idea that “females” just “feel that connection even without a sexual relationship,” or in other words, that sexuality has very different significance for women and men.

Of course, there are many other features of Priscilla's comments that are also worthy of examination. Her comments suggested a focus on heterosexual sexuality, and

her mention of addiction along with the comparison between sexuality and coffee raise questions about the construction of medical understandings of sexual desire and its appropriate amounts.¹⁰ But while the components of Priscilla's understandings about sexuality are interesting in their own right, perhaps more important are the broader set of questions they, in conjunction with her peers' understandings about sexuality, imply the need to ask about all medical students. Before suggesting what these questions might include, I consider another aspect of Buena Vista students' understanding about sexuality.

Medical students' definitions of sexuality

In addition to asking questions about what they felt they had learned about sexuality in medical school or how medical school had shaped their understandings about what sexuality and medical practice, I also asked my student interviewees to define sexuality. That this question proved vexing for many of them is not terribly surprising, but even if Buena Vista students' struggles to define sexuality affirm what we would suspect – that sexuality is difficult to define in practice – the extent of their uncertainty about the meanings of sexuality is still significant, and the contours of their uncertainty reveal important theoretical and practical considerations.

Elizabeth, a student who was deeply interested in women's reproductive health issues and was considering becoming an OB/GYN seemed particularly flustered as she attempted to define sexuality:

Interviewer: How do you define sexuality?

Elizabeth: Oh god.

¹⁰ For discussion of medical understandings of "inhibited sexual desire" and "sex addiction" see Irvine, 2003. Outside of Arthur's remarks, I did not observe or hear of talk about inhibited sexual desire or sex addiction – or topics that even reasonably resembled either – at Buena Vista.

Interviewer: And this is not – there's no trick in this question. However you define it is fine.

Elizabeth: I guess it's just like that within you that like your thoughts and your attitudes and just your inner kind of beliefs, your gut, you know, reaction to different issues about sexuality. Well I guess I can't say 'sexuality' when I'm defining it, but I just think it's how you feel about sex and about all of that. I could probably come up with a better answer, like... (long pause). I don't know. Just yeah.

Elizabeth's hesitation as she tried to formulate a definition of sexuality, and the circularity within the answer she produced were not unusual. The student named Grace initially protested when I asked her to define sexuality:

Interviewer: What is your definition of sexuality?

Grace: That's really difficult because I'm not really sure about the actual definition of sexuality itself, so...

Interviewer: This isn't a test.

Grace: Sexuality, I guess it's about all aspects concerned with sexual... the actual physical, mental, and emotional behind that and also like gender, different genders like the other emotional and physical that comes with that and also how each person's sexual relations and sexual orientation and all the emotional and physical issues that come with that. So aspects related to gender and identity.

Arthur, who had taken a sociology of sexuality class as an undergraduate, had this to say:

Interviewer: Can you tell me how you define sexuality?

Arthur: Okay. But honestly, I don't remember how we defined it in my sociology class.

Interviewer: That's okay, any answer is great. I'm just interested in your definition as Arthur the med student.

Arthur: Okay. Human expression of sex as a practice and as an identity.

Doug, a student who was recognized by students and faculty alike as a lone, staunch advocate of queer persons' rights and healthy representations of queer persons within the curriculum, rightly acknowledged the difficulty associated with defining sexuality during our interview. "I don't know how to define sexuality," Doug said. "It's something

that is not very easily defined.” While his point was absolutely fair, it was still interesting that someone who had given considerable time and attention to thinking and talking about sexuality-related matters within a variety of contexts, as Doug had, would have trouble producing a working definition. “Sexuality is anything to do with your desire to have sex or feel things on the spectrum of how you would define love...” Doug said, before trailing off, and reiterating that sexuality is just difficult to define.

Even if it is sexuality is undeniably ambiguous, it is still important to note that medical students, having lived twenty-plus years of life and having gone through a significant amount of formal schooling – and having completed medical coursework that included some explicit discussion of sexuality and its potential relevance to medical practice – were as uncertain as they were about the meanings of sexuality. This lack of certainty in addition to the range in students’ understandings about sexuality at this early stage of their professional development points to questions about what medical students (and, ultimately, the doctors they become) need know about sexuality and when they need to know it. Does it matter that Arthur has gotten that “libido” is a sign of health (or perhaps, that other students did not mention getting this impression)? Does it matter that he presumed that “libido” spoke for itself? Does it matter that Miguel thinks of the “sexual variations” as “gay, straight, and transgender”? What sorts of sexual knowledge do doctors need and how and when should they acquire it? Comments from the student named Jalil suggested that part of what medical students might need to learn about sexuality how to process their own in order to address its manifestations within their work.

Interviewer: Can you define sexuality for me – what is your understanding of what ‘sexuality’ means?

Jalil: I think that word sexuality used to mean something different to me and now as a medical student, it... I can’t help but think of some sort of scientific component to it because –

Interviewer: Tell me what it used to mean to you before you came to medical school.

Jalil: I mean, as a teenage boy with hormones and as an adolescent I think sexuality evokes those sort of emotional experiences and I think it gets a lot of guys excited, I think guys like talking about sex, and they're thinking about it a lot, and being that it evokes – it's purely emotional as to now I don't think, I think I've got this sort of intellectual approach to sexuality too. I think for me personally sexuality still evokes much more emotions than it does science, but when I think of sexuality now I think of maybe diseases associated with it or different, like homosexual versus heterosexual. I never would have thought of that sort of thing when I heard 'sexuality' before medical school. I guess it was much more personal before and now it's... I have a different perspective too. Not just purely personal and emotional but maybe more of an intellectual perspective.

Interviewer: Interesting, when you say an intellectual perspective and a scientific perspective do you mean in terms of your own experiences or other people's behaviors and medical needs?

Jalil: No, mainly other people's behaviors and needs. I think everything personally regardless of even when if I'm like a physician and my specialty is something related to sexuality, I think still a personal, just purely emotional personally. And it's kind of a different perspective scientifically and it's not a – you know, you kind of have to turn off that kind of mindset.

Although many students fumbled as they attempted to put forth a coherent definition of sexuality, Jalil's remarks were particularly lacking in clarity. But both despite and because of this, they illustrate important possibilities such as the potential for students to experience their personal thoughts, feelings, experiences or perceptions about sexuality as being in tension with the "scientific" aspects of sexuality that they learn about in medical school. Although though Jalil did not say this himself, one possible implication of his comments is that there is something about the nature of sexuality itself that leads to a complicated and potentially antagonistic relationship between one's personal experiences with sexuality and their professional duties pertaining to it. What exactly it is about sexuality that would make it necessary for medical professionals to acknowledge and address their own sexual selves and their

own sexuality-related concerns in order to feel comfortable talking to patients about their sexual issues is a question I will not attempt to answer here.¹¹

For now, the question worth considering is how medical sex education conceives of the type or nature of knowledge or training pertaining to sexuality that medical students (and doctors) need to effectively go about their work. Is it necessary for medical students to understand certain aspects of their own sexuality in order to effectively make use of abstract knowledge about sexuality and ultimately be of service to their patients? Some discussions of medical sex education have hinted that this might be a possibility worth considering, and at least one explicitly discusses that this is likely to be the case. In 1972 Golden and Liston noted that it had become clear to the instructors of a required human sexuality class at the UCLA School of Medicine that medical students “needed an opportunity to discuss the moral and ethical problems of sex” (762). Without resolving their own “major conflicts” about sexuality, the medical students would never be able to treat their patients’ sexual problems, they argued (Golden and Liston 1972: 762). Upon this recognition, various steps were taken at UCLA to offer a sexuality course that provided students with a structured opportunity to address their own sexual questions and concerns while simultaneously building knowledge and skills relevant to clinical practice. One such measure was to offer the sexuality course at night and allow the medical students to bring their “wives and girlfriends” along to the class, which many did. The medical students who participated in the sexuality class in this format confided to their instructors that the course had been of tremendous help to them personally in solving “emotional or technical problems in their

¹¹ In Chapter 5 I approach the related issue of what Gayle Rubin terms “sex negativity” and the construction of sexuality’s special status at Buena Vista. But even if there is persistent evidence that sex and sexuality are deemed sensitive or taboo or private or especially likely to provoke discomfort, this does not answer the question of why one might feel it necessary to reckon with their own sexuality before addressing the sexual health of others.

sexual relationships” (Golden and Liston 1972: 763). While the ultimate effects of these educational experiences on these medical students’ actions as clinical practitioners is unknown, Golden and Liston’s observations provide some empirical indication that medical students experience a need to develop a better understanding of or sense of comfort with aspects of their own sexuality before attempting to address their patients’ sexuality-related concerns.

Thus it seems that Jalil’s concerns about separating his personal, “emotional” experiences of sexuality from his “intellectual” or “scientific” approach to it may be part of a broader pattern. Obviously, further research is necessary to explore how medical students and doctors experience the relationship between their understandings of their own sexuality and their understandings of sexuality as it exists in the social world or within a particular patient’s life – or their sense of comfort with or capability in addressing patients’ sexuality-related concerns. What is more clear is that little discussion of the potential for there to be a complicated dynamic between personal experiences of sexuality and professional approaches to sexuality exists within the medical sex education literature. Golden and Liston (1972) and other authors of their era (see for instance Lief and Payne 1975; Marcotte et al. 1976) also note that medical students’ *attitudes* about sexuality or opinions about sexual norms in general or the behavior of others, matter for clinical care and need to be addressed within their training. But attitudes about other people’s behavior are not synonymous with understandings of one’s own sexual self, and may also result from one’s feelings about or assessment of their own personal sexual state of affairs.

Ultimately, the findings presented here about Buena Vista students’ varied understandings of what sexuality means, what they learned about it within medical school, and how it matters to human health indicate how much there is to be learned

about the ways in which sexual knowledge might be parsed into different types, how sources of sexual meanings of information matter, and the collective understandings of the nature and amount of sexual knowledge that is deemed necessary for medical practice. I observed little consideration of these particular questions at Buena Vista, but a related question did present itself with some regularity, namely: when is it possible or when does it make the most sense to teach about sexuality within the medical training pipeline?

Where does sexuality education belong within the medical training process?

Both faculty members and students had definite ideas about the placement of sexuality within medical education, and there was disagreement within their perspectives. One faculty member, Dr. Bob Harrison, thought that medical students should come to medical school “already knowing about sexuality.” Dr. Harrison believed that medical students should start medical school with a clear sense of ethical considerations related to sexuality, too – such as the prohibition against doctors having sex with patients. In order to achieve this, Dr. Harrison thought, colleges should offer a standardized pre-med curriculum so that incoming medical students would possess a common, baseline set of knowledge and values and everyone could start off on some sort of equal footing. Although he was my only interviewee who proposed this particular solution, others viewed the problem in the same way: medical sex education, while important, did not have a logical or convenient home within medical training.

As I discussed earlier, faculty experienced difficulties integrating sexuality content into the coursework portion of medical education that stemmed from the overarching, ever-present problem of too much content to cover and too little time to do it. But some faculty who were involved in the design of classes also felt that aside from the issues associated with time constraints, medical students were unlikely to absorb

much information about sexuality at this point in their training anyway, because they were, according to Dr. Nancy Green, “professionally quite young.” Dr. Green believed that during the coursework stage of their training, medical students couldn’t really learn much about sexuality because they had so much basic science to learn and memorize, and were very concerned with getting a grasp on the technical aspects of medicine. Dr. Green believed that a better place for a sexuality-related course would be within residency training, after students had a little more experience seeing patients and had gained, through exposure, a better sense of the ways that sexuality could matter to clinical encounters.

Although other faculty agreed with Dr. Green that medical students were unlikely to be able to absorb sexuality education in the coursework phase of their training, one mentioned that even if sexuality content was unlikely to gain optimal traction at this time, introducing it early in the students’ training had the effect of “planting seeds.” Dr. George Sorin, the course director for the Physician-Patient Dynamic knew that even if medical students did not recognize the value of the sexuality content of their classes at the time they received it, later on, they would look back on those curricular moments and draw benefit from them then. Later in their training, Dr. Sorin said, students would come back to him and tell him that this was the exact effect that the sexuality-related content of their classes had. Interestingly, Dr. Sorin was the only faculty member who explicitly mentioned the possibility for this sort of delayed effect. Implicit within many faculty members’ discussions of sexuality content within medical training was the suggestion that it could only occur in one place, or in one phase of medical training and the question was, which particular place was the best to put it. That this suggestion emerged is not particularly surprising within in the context of so much content to fit into a limited amount of time, but from the perspective of looking at what sex education is or means or entails

within a particular context, it is still important to note that medical sex education was implied to be something that happens in a distinct, limited moment – rather than, perhaps, something that occurs over time and is integrated, repeatedly, into multiple points within the training process.

While faculty members who designed the medical students' coursework tended to believe that residency was the best place for doctors-in-training to learn about sexuality, the faculty members who worked with residents did not share this view. Part of the reason for this was that some of the challenges associated with teaching about sexuality in the earlier stages of medical training persisted into later stages of medical training. Like the faculty who were involved with the development of undergraduate medical curriculum, they too faced time constraints. They too had to juggle the need for teaching specifically about sexuality with the need to also teach specifically about many other topics and procedures. But while faculty who mostly dealt with developing and delivering coursework and students who were in that phase of their training felt that sexuality curricula could not gain the most traction if introduced at that time, faculty who worked with residents believed that residents already needed to be knowledgeable about sexuality and comfortable discussing it with patients by the time they came out of medical school and took on the role of resident.

Dr. Elizondo: You know, plenty of medical students get through medical school and they can't ask people about their sexual history. They can't even ask a patient simple questions like how many partners they've had, or if they use condoms... not to mention more in-depth sexual questions that might be more anxiety-provoking.

Interviewer: Like what?

Dr. Elizondo: Like what sexual practices the patient engages in. You know, do they use sexual toys, do they have anal sex, do they have oral sex? And so when we talk about STDs or specific kinds of preventative things, those questions might come up, and I think those prove to be very difficult sexual questions [for the residents to ask]. You know, it's what

kind of partner too, you know, they can't ask, 'What kind of a partner do you have? How many kinds of partners do you have?'

Dr. Samantha Whitman, an OB/GYN also observed that residents were not necessarily comfortable talking with patients about sexuality. She noted that sexuality was neglected within medical training, but she also thought that life experiences, or a lack thereof, contributed to residents' capacity to talk about sex.

Dr. Whitman: Inexperienced residents do not necessarily have the same maturity level that other students do. It seems like there are times when we are talking about things that might be seen as shocking to them.

Interviewer: When you say 'inexperienced' what do you mean?

Dr. Whitman: Inexperienced in life. The inexperienced ones seem to be less comfortable talking about sexuality, whether it's sexual history or other medical issues or social issues. They just seem to be uncomfortable. I'll ask questions like, 'Oh, did you ask the patient about this?' [and the resident will say] 'Oh, I hadn't thought about it.' Or, 'I didn't know how to ask that question.'

Dr. Bernard Lumumba, a family practitioner, was even more detailed about residents' lack of knowledge about sexuality and lack of ability to talk about it.

Dr. Lumumba: First of all they don't know how to ask questions about anything sexual because if they do they open Pandora's Box because they don't know how to fix it. And they're generally ignorant of sexual practices. Medical students can wing it and get their degree rather than having to go through the process of learning how to discuss sexuality.

Interviewer: What happens when they become residents?

Dr. Lumumba: I think the key problem is when they have to confront a patient whose issues are sexual, direct or implied. For example, a woman will ask 'How come everybody get an orgasm and I never get one?' So the resident [talks around the issue], they don't know where to go. They get stuck. The second thing is lack of understanding of the physiology of sexuality, both men and women. So the ignorance and personal discomfort makes it very difficult for residents, and also experienced physicians to deal with the issues. So they tap dance around it, they tap dance around it and then the dance is over quickly. So that's a lot of air for telling you that it is inadequate in medical school and also it is not well taught in residency and people just sort of survive it on their own. I don't know, they either just quietly mislead the patients and get it over with, or I don't know what. And then the patient goes cursing these people that they trust so much.

Dr. Lumumba felt constrained in his capacity to provide any sort of remedial sexuality-related education to his residents not only for reasons related to time constraints, but also because of the risks he understood to be associated with talking openly about sex.

Dr. Lumumba: I had a female resident here. I tried to ask her why this [female patient] is having a recurrent bladder infection all the time. 'I don't know, I don't know,' [the resident said]. I said – I broached the idea that maybe it has something to do with the patient's sexual activities, both anal and vaginal – have you asked about that? [The female resident] turned beet red in the chair. So I said to myself, now I'm going to be accused of sexually harassing the residents.

Interviewer: Oh my. Is that really the sort of –

Dr. Lumumba: It depends on the upbringing of the residents. If they don't know anything about sex in their family, they didn't think that their father and mother had sex... [they think] they just came out of the bark of a tree. Or they are a fundamentalist from North Carolina. So what do you do, so should I teach them about the position with sex? Should I? No. In about two seconds I have to go over to the patient that has been sitting there waiting forever and so that told me that [the resident] has no clue, and then yet this [patient] entrusts, gives [the resident] a window of opportunity to talk about sexual problems. And the resident can't handle it. So I pinch myself for opening my big mouth as usual.

Dr. Lumumba was not the only faculty member I spoke with who brought up concerns about speaking about sex openly. For instance, Dr. Davidson worried that talking about sex openly – whether with students, residents, or patients - could lead to repercussions. "What if I say things in the wrong way, what if I say something about sexuality or ask a question, and the person takes offense, and they *report* me!" Dr. Davidson mused. "We have this anonymous whistleblower hotline and I think it makes good sense, it's a good idea...but it also makes us all more *vigilant* and I think it works against opening up and talking about some things that could be perceived as sensitive," he said.

The negotiation of sexuality as a sensitive subject fraught with complicated implications is a topic I return to in Chapter 5, but for now the point is that even within the context of teaching adult medical students and residents about patients' immediate

sexuality-related health needs, medical school faculty feared that talking about sexuality was risky. What other imaginable circumstances, within or outside of the medical arena, might provide a more justifiable context for the transmission of sexuality-related knowledge? What we see here is an indication that the sorts of potential barriers to the transmission of sexual knowledge that were evident in other contexts – such as school-based sex education, and even Frederick Hollick’s public lectures – are not entirely absent from sex education in the medical context. Although the standards of what counted as appropriate sexual knowledge or the parameters of what it is acceptable to teach about did not seem to be defined by an obvious external entity, as they have been in other cases (for instance, parents, school administration, politicians, or “concerned taxpayers” as in the case of school-based sex education), faculty experienced a sense of constraint when the subject of sex came up, even during teaching moments with residents.

Perhaps in part because of the risks perceived to be associated with teaching about sexuality, some faculty members professed that sexuality was something that medical students and doctors would learn about somewhat automatically, gradually, in practice, over time. Dr. Elizondo explained to me that because there was so much that one needed to know, as a doctor, it was simply inevitable that some things could only be learned “on the go,” outside of the context of formal training. And while it is undeniable that some education can only come from experience, however, the oft-repeated “you just learn as you go” maxim also suggested that there is a body of knowledge that is transmitted, naturally and unproblematically, over time, as the medical student or doctor goes about their business. This implies that having too much to learn and too little time isn’t really a problem, because in the end, doctors learn what they need to learn to be

competent and effective regardless of whatever they have or have not formally been taught about the subject.

Some students also believed that sexuality would be learned about “on the go.” For instance, Miguel told me that he thought that sexuality was very important to overall health, but that he hadn’t gotten that message directly from any class or set of explicit teachings. How, then, did he come to understand that sexuality was important for patient health and for physicians to be aware of, I asked him. Miguel thought for a long time before he responded, and finally replied, “I think if you’re a decent doctor you just recognize its role.” Obviously, at the time of our interview, Miguel was not yet a doctor so it was interesting that he came to the conclusion that he did about how sexual knowledge could develop.

But did it, or does it, necessarily work out that way in practice? Do medical students, residents, and doctors effectively learn about sex on the go, even if sexuality has the status of an “orphan topic” both within their classes and in later parts of their training? Because of the lack of consensus on what medical students should learn about sexuality and what doctors need to know about it, it is impossible to answer this question and even difficult to grapple with it without imposing a set of assumptions about what counts as enough or the right kind of knowledge about sexuality. Furthermore, only longitudinal research can assess what doctors learn throughout the progression of their training and into their experiential development as a professional in practice. However, what is clear is that many Buena Vista faculty did not have a coherent set of understandings about sexuality as a result of their own medical education, or their own “learning on the go” experiences as practicing physicians.

Buena Vista faculty members’ sources of knowledge about and definitions of sex(uality)

As I discussed in the previous chapter, Robert Coombs argued that one of the challenges to providing medical sex education in the 1960s was medical school faculty members' lack of knowledge about sex, or their lack of confidence in teaching about sexuality. The faculty he interviewed had received little, if any, formal sexuality education in their own medical training, and their feelings of ignorance on the subject served as justification for avoiding it. Decades later, a number of Buena Vista faculty told me, similarly, that their own medical education had included very little sexuality-specific content. A few faculty members recalled seeing sexually explicit films as a desensitization tactic. "Sexuality didn't receive much attention at all when I was a med student," Dr. Harrison told me. But, he went on to say, there was one lecture that he remembered clearly, and figured that all of his classmates would remember too.

You have to remember that this would have been in 1971 or 1972 and America was pretty culturally stodgy back then. So I think the idea behind this lecture was to de-sensitize and de-stigmatize aspects of human sexuality that we medical students might not have known about. A lot of the medical students were not married and had just spent their whole lives grinding away to get into medical school and had not had a lot of personal experiences. It was a different world. So anyway, they showed us these films and photos of people having sex, gays having sex, and finally pornography with kinky things and some with animals involved. There was nobody dozing off in class at that moment. Most of us had never seen anything like that before and that was the idea. The lecturer's point was, "It's better for you to know that this stuff is out there in the world here where you can talk to me about it, instead of you finding out later when you're in practice in some remote clinic off by yourself somewhere and you don't know how to handle yourself."

Even though Dr. Harrison said that the sexuality-related content in his own medical training was limited, his remarks about what it included were more extensive than those of any other faculty member I interviewed, and many told me that there hadn't been any sexuality-related content within their training at all. "I don't think we discussed sex in my med school – which was a great med school – ONCE, except in terms of ribald humor and jokes, in obstetrics and gynecology," Dr. Davidson told me. Dr. Whitman, the

OB/GYN, concurred. “In terms of my knowledge about sexual health and sexuality, I don’t have any training,” she told me. “It’s just part of what I do every day.”

That Buena Vista faculty remembered little or no sexuality-specific content within their own medical training is unsurprising, given the indications that medical sex education has been relatively limited in prevalence and duration in the United States. But even if we might expect that Buena Vista faculty members would not have received much formal sex education, we still know little about the impact of this lack of formal training. Does it matter if faculty receive little formal sexuality education themselves? As I noted in the previous chapter, in the 1970s, Marcotte et al. (1976) argued that it did. They argued that medical educators who received little or no formal sexuality education themselves were likely to place little emphasis on sexuality when then took on the role of educator and that in effect, a lack of sex education in one generation of doctors’ training made it likely that the next generation of medical students would not get much of it either.

Marcotte et al. (1976) did not consider any alternative pathways to the acquisition of medically-relevant sexual knowledge outside of formal medical training on the subject, and in fact, their discussion (and those of their contemporaries) implied that formal education is the only means through which sexual knowledge is acquired. They do not propose that students, residents, and doctors might learn about sexuality “on the go,” as they progress through their training and professional development, as some Buena Vista faculty and students did. Although Marcotte et al. and others concerned with medical sex education in the 1960s and 1970s debated the ideal content and format of medical sex education, they did not articulate a view that physicians might automatically accumulate a corpus of knowledge as they progressed through their careers that would be “sufficient” for their work.

Questions about what can or should be taught through formal medical sex education and what might best or only be learned “on the go,” through professional experience are useful from both a practical and a theoretical perspective. For the present purposes, I seek to illustrate that Buena Vista faculty members had not necessarily emerged from their own process of learning on the go with a well-formed understanding of what sexuality is or means. I asked Buena Vista faculty to define sexuality, just as I did the students, and they too struggled to formulate answers, just as the students did. Although this is unsurprising to the extent that sexuality is undeniably difficult to define, and even though articulating a definition of sexuality is at best a very partial measure of what anyone “knows” about it, it is still striking that considerable uncertainty about what sexuality is persisted amongst faculty even after years of going through the process of “learning on the go,” which many of them championed.

Even the Buena Vista faculty members who had little trouble producing a definition of sexuality sometimes came up with answers that obscured more than they revealed. Dr. Salvador Molina, a psychiatrist, had this to say:

Interviewer: How would you define sexuality?

Dr. Molina: How do I define sexuality? Sexuality, I guess, is feelings, emotions, beliefs, values, and behaviors related to sex in a human being.

Dr. Terry Olsen, another doctor of family medicine, also came quickly to her definition. “Well for me...” she said, “It’s just anything that has to do with sex, and your sexual orientation, and... you know for me, I define it as anything to do with sex. It’s pretty broad.”

Other faculty members struggled a little more to come up with their definitions, and some seemed genuinely surprised by the question itself, even when I asked it at the end of the interview in which we had already been talking about sexuality for some time. Dr. Elizondo, the doctor of family medicine quoted earlier in this chapter, told me that

she “didn’t have” a definition of sexuality, and apologized, but then provided a thoughtful (if tautological) attempt at a definition anyway.

I think sexuality is, you know, an individual person’s, you know, sexual desire, you know, and sexual health, you know, whether, you know it depends on, you know, whether they have a partner or not. You know, I think their sexuality is in – because maybe my patient who has never even had sexual intercourse with another person before but could have a very healthy sexuality, I think not, I think she was very uncomfortable, but I think some people can, you know, and so it’s probably somewhere, you know, in there with people’s sexual desires, their preferences, their health, something like that? I mean this is a mixture of sexual health, sexual desire, comfort with their own sexuality. I think it seems like a mixture of those things, now that I think about it.

Dr. Elizondo seemed to be thinking through her definition of sexuality as we talked, and after she concluded her remarks she apologized again for “not having a definition.” Her lack of certainty about her definition was particularly interesting given that the one she provided was nuanced and insightful in some respects. Dr. Daniel Benjamin, a doctor of internal medicine, thought for a moment before answering.

Interviewer: One last question. What is your definition of sexuality?

Dr. Benjamin: Um...I think it’s a broad array of topics, so it could be sexuality in terms of sexual function and physiology, it could be issues of interpersonal relationships, um, sexual and emotional, male-female, male-male, female-female, um... it can relate to issues of gender, and...sexual preference.

Dr. Whitman, an OB/GYN, recognized the potential for understandings of sexuality to vary significantly, yet ironically, she referred to a limited range of what aspects of sexuality might be variable:

Interviewer: How would you define sexuality?

Dr. Whitman: There’s no strict definition. What’s normal to one person isn’t normal to another. I mean there’s a whole range of normal. For instance, like someone might think that having sex once a week is normal. Other people think that that’s too often or not often enough. And some sexual practices one might find normal to them and important to them, and other people have a very different set of experiences and ideas about what’s normal. So it’s a very individual patient dependent thing.

Interviewer: So it sounds to me like the first thing that comes to your mind when you think about sexuality is practices and frequency thereof.

Dr. Whitman: I think that's the first thing that comes to most people's mind, but you know, to me sexuality isn't just having vaginal intercourse. You have to understand that there is a whole range of practices. You can't just assume that by asking the question 'are you having sex?' that what you are referring to and what the patient understands are the same thing.

Some of the faculty members who referred repeatedly to sexuality during our interviews had trouble defining it specifically when asked, such as Dr. Jun, the urologist who had explicitly discussed sexuality-related discomfort and made sexual jokes during our discussion. At the end of our interview, after the joking had wound down, I asked him how he defined sexuality. This was his response:

Oh god. I was sure a question like this was going to come! I don't even know how to define it. Gosh, embarrassingly... sexuality is the discussion of male or female intimacy. Yeah, I guess that's how I would define it.

Even more revealing were the comments of Dr. Zimmerman, the doctor of sexual medicine. When I initially asked him to define "sexuality," he deflected the question, so after he referred repeatedly to "sexual medicine" during our interview, I asked him to contrast "sexuality" with "sexual medicine."

Interviewer: You have raised a really interesting distinction between 'sexuality,' broadly defined, and 'sexual medicine.' Can you tell me a little bit more about your definitions of each of those terms?

Dr. Zimmerman: Well, I only work in sexual medicine so I only understand sexual medicine. When people say 'sexuality,' I don't know what that means. To be honest with you I don't even know what that means. So, I understand what sexual medicine is, and I link it to my world. So sexual medicine...so we're in the field of sexual medicine, we're not in the field of medicality, I mean, whatever that is. So sexuality and medicality, we're in medicine, so there's orthopedic medicine and there's cardiology medicine, and there's family medicine and geriatric medicine, bariatric medicine, I can go on for decades, but the point is, there should be sexual medicine.

Interviewer: Meaning?

Dr. Zimmerman: Which I guess engages sexuality but the idea is we're here to help humans who have problems. So, we're the people in the largess of all of medicine that say, "Okay, if you have a problem with the orgasms, if you have a problem with who you think you are, you're in a male body but you're really a woman, here's your safe haven. Come to us, this is what we do for a living, we love it, we have research, we are people who are interested. If you have pain during sex, come see us, don't go to someone who isn't interested who says, 'Have a glass of wine and go home.'" You know, which is 99 percent of all of the responses here.

Dr. Zimmerman's emphasis on 'sexual medicine' and insistence that he did not know what 'sexuality' meant were unique, but no two responses that I received to this question were the same. No semblance of a shared understanding of what sexuality meant or pertained to emerged from the faculty. While I do not mean to suggest that coming up with a definition of sexuality should be the only measure of what anyone knows about it, the difficulty that faculty had in producing definitions is important because it indicates the extent to which sexuality may remain unknowable within the medical context. Even if definitions of sexuality are elusive, the absence of collective attempts to define it and the absence of individual and collective understandings of what it is are still important (Hearn and Parkin 1995). We might reasonably imagine that the absence of collective efforts to define sexuality have been both cause and consequence of incoherent approaches to medical sex education, and could continue to be.

Conclusion

Medical sex education at Buena Vista was not a straightforward affair. The fact that *any* time within the formal curriculum was officially devoted to teaching about sexuality attests to faculty members' recognition of its importance. Faculty members perceived substantial challenges to teaching about sexuality, and yet they managed to allocate time within the formal curriculum to do so. But these teachings were not developed through collective planning and consideration of the subject matter, and the messages about sexuality within them did not cohere – whether through careful effort or

organically and spontaneously – into a self-conscious sexuality curriculum with a clear set of content or objectives per se. Interestingly, the brief, offhand mentions of sexuality within the formal curriculum demonstrated that sex and sexuality are salient not only unto themselves, i.e., as isolated aspects of human experience of medical curricula, but to multiple aspects of human health, and thus, medical teachings. But these fleeting mentions of sexuality did little to make the meanings of sexuality clearer as they occurred, and may have even reinforced the idea that sexuality is simultaneously self-explanatory and undefinable. Although both students and faculty recognized, at least vaguely, that sexuality was relevant to health and to patients' experiences of health care, neither students nor faculty had a well-developed set of understandings about what sexuality meant – nor a clear sense of what they might need to learn or teach about it in order to effectively care for patients. Under these conditions, sexuality effectively had an “absent presence.”

This absent presence, or this state of not-knowing about sexuality at Buena Vista suggests that medical sex education may occupy a place within medical schools that is very similar to what medical educators in the 1960s and 1970s described. The difficulties that Buena Vista faculty perceived to teaching about sexuality were similar to those that medical educators experienced decades ago. Although sexuality has become more visible within public life and less taboo in many respects, these social changes do not seem to have translated into the development of a clearer set of medical understandings about what sexuality fundamentally is, or a more sanctioned space for sexuality within medical education. And in a sense, this is not surprising. Back in the 1960s and 1970s, medical educators cited the enormous volume of scientific, technical content that needed to be covered within medical education as an obstacle to teaching about sexuality, and biomedical knowledge has proliferated since then. The problem of

too much to teach and learn and too little time to do it all is increasing exponentially, rather than finding resolution, and as such, a clearly demarcated space for medical sex education may remain elusive.

Of course, the absence of specific understandings about sexuality at Buena Vista are representative of a broader trend, namely, the considerable confusion about what sex and sexuality actually are or mean that persist in society in general, even within the context of proliferating representations of sexuality within the public arena (Attwood 2006). In other words, the issue is not that medical schools are uniquely lacking in well-developed understandings of and teachings about sexuality. However, doctors arguably do have a particular need to know about sexuality and thus while the absence of concerted medical sex education is but one manifestation of a general societal lack of formal sex education, it is perhaps a particularly important one. But further study of the provision and content of formal sexuality education across contexts is necessary for a more complete understanding of just how limited the transmission of formal knowledge about sexuality is.

This chapter suggests the possibility that even if our culture is understood to be increasingly sexualized (Attwood 2006), shared understandings that formal knowledge about sexuality is not only important but legitimate may remain elusive. As I discussed in Chapter 1, we know that talking about sex in other contexts – most notably, in junior high and high schools - has been understood as risky. Thus there needs to be a strong justification for the transmission of formal knowledge about sexuality - and in schools, the concern that vulnerable minors will be threatened by the perceived dangers of sex serves as that justification. The picture that emerged at Buena Vista was even if sexuality education was not as clearly circumscribed as it has been in public schools, even the medical context did not definitively remove the risks associated with talking

about sex, or provide a clear justification for its legitimacy - all the way up through residency training. This suggests the importance of questions about where else, if anywhere else, sexuality education occurs in our society, and what it looks like. Where and when is sexuality deemed worthy of serious educational attention? Assuming that formal sex education might exist in contexts that have not yet been studied extensively (or at all), what is the impetus for its provision within them? What counts as an adequate rationale for teaching about sexuality? Who really needs to know what about sexuality, and when do they need to know it and how will they learn it – and who gets to make these decisions? The research on sex education in schools makes it clear that the transmission of sexual knowledge can be contentious. But the research on sex education in medicine suggests that the neither the absence of heated controversy nor the belief that sexuality education is important in theory guarantee that it will flourish.

CHAPTER THREE

THE INFORMAL CURRICULUM AND THE COMPLICATED NATURE OF THE “NEGLECT” OF SEXUALITY-RELATED TOPICS

Surveys of the prevalence of sexuality and LGBT-specific curricula

Among observers of medical sex education and LGBT-specific medical education, the consensus is that insufficient attention is being devoted to these topics relative to their importance to patient care (Wallick et al. 1992; Leiblum 2001; Solursh et al. 2003; Kuritzky 2006; Parish and Clayton 2007; Obedin-Malevir et al. 2011). In 2007 Sharon Parish and Anita Clayton remarked that “Sexual health education is an example of an often neglected, but very important topic...this topic is not adequately represented in most undergraduate and residency training programs” (259). These concerns are based upon surveys of medical schools’ allocation of curricular hours by subject. In 1999, Solursh et al. surveyed North American medical schools about the educational experiences on human sexuality they provided for their students. While they were pleasantly surprised to report that 32.7% of the schools that responded to their survey provided 11 or more hours of human sexuality training, they also found that some schools offered little or no sexuality education (Solursh et al. 2003). Nearly 32% of the responding institutions provided 1-5 hours of sexuality education. Two medical schools reported that they, to their embarrassment, did not provide any sexuality related curricula, and Solursh et al. speculated that this sort of embarrassment could have been the reason behind other institutions’ failure to respond to the survey at all. In 2012 Eli Coleman speculated that if Solursh et al. conducted their survey in the present, they would find that medical schools’ sexuality-related curricula had dwindled since 1999.

In 1991, Wallick et al. surveyed North American medical schools' allocation of curricular hours devoted to the topic of homosexuality and found that a mean of 3 hours and 26 minutes were devoted to it, among the 82 institutions that responded to the questionnaire (a response rate of 65%). Eight institutions "indicated the topic's total absence in the curriculum, a disturbing finding," they reported (Wallick et al. 1992: 601). In 1994, the American Medical Association (AMA) issued a policy statement indicating commitment to educating physicians "on the current state of research and knowledge of homosexuality," starting in medical school and persisting through continuing medical education (Kelley et al. 2008). Despite this strong statement of support for the inclusion of LGBT curricula, "integration of LGBT health issues has been slow and inconsistent," Kelley et al. argued. Obedin-Malevir et al.'s more recent survey of LGBT-related content in North American medical schools during the 2009-2010 academic year suggests that this continues to be true. Obedin-Malevir et al. found that North American medical schools devoted a median of five hours to these topics, but the placement of these hours varied widely between the medical schools that responded to their survey. Some of the LGBT-specific curricula fell within required courses, but often, it was delivered within electives that may have garnered self-selecting audiences (Obedin-Malevir et al. 2011). Obedin-Malevir et al. reported that many of the medical school deans that they surveyed expressed dissatisfaction with the amount or content of their schools' LGBT-specific material. It would seem that the amount of LGBT education medical schools provide continues to lag behind what both the AMA and advocates for LGBT health consider ideal.

The informal curriculum and the "neglect" of medical sex education

Survey research, by nature, only captures a very limited piece of the curricular pie, namely, the formal curriculum, or the formally-offered, officially-endorsed curricula

such as required classes (Hafferty 1998) – and only as they exist on paper, rather than how they are transmitted in practice. The formal curriculum is an important part of any educational institution’s offerings – it is, after all, where the institution explicitly defines itself and its identity, by designating certain material important by virtue of its inclusion and other material less germane to the institution’s endeavors through its exclusion. But while the formal curriculum as it exists on paper does reveal an important set of truths about an institution, the problem is that it is often implied to be the *total* curriculum, and static at that: as something educators develop ahead of time, then deliver in the exact manner it was planned to students who passively receive it (Hafferty and Castellani 2009). This is unlikely to be what actually happens in practice, sociologists of education argue. The formal curriculum is likely to be complicated by other levels of simultaneously-occurring, potentially-competing curricular processes. Thus, what students learn or do not learn about sexuality or LGBT sexuality more specifically is not likely to be strictly the result of the amount of attention devoted to these topics within the formal curriculum.

In this chapter I examine the ways in which informal curricular processes complicated the “neglect” of education pertaining to sexual minorities at Buena Vista. The informal curriculum is the “unscripted, primarily ad hoc, and highly interpersonal form of teaching and learning that takes place among faculty members and students” (Hafferty 1998: 404). Ethnographic investigation of informal curricular processes revealed that at Buena Vista, education pertaining to sexual minorities was simultaneously more and less neglected than survey research could suggest. Distinct yet compounding, mutually-reinforcing features of the informal curriculum sometimes worked against the content of the formal curriculum to effectively nullify the messages put forth within it. The teaching time devoted to sexual minorities at Buena Vista that

survey research would be most likely to capture or detect was not necessarily received by the students. But the informal curriculum was also a generative source of messages about sexual diversity in its own right. Informal curricular processes had the potential to make sexual diversity much more visible, salient, and relevant than ever before to some students, while for others, the ad hoc, unscripted interactions within the medical school environment suggested an absence of sexual diversity – and prompted some students to develop the impression that this absence was not particularly remarkable or problematic.

Sexuality vs. LGBT-specific curricula

Both research on the prevalence of “LGBT-specific” curricula and “sexuality”-related curricula imply that these topics are distinct in self-evident ways. But are they, or have they been distinct in practice?¹² Should they be, going forward? Historically, discussions of medical sex education within the academic medicine literature have said little about sexual diversity or the need to prepare medical students to work with sexually diverse patient populations (e.g., Coombs 1968; Lief 1970; Marcotte et al. 1976), so it would seem that these topics have indeed been distinct in the past, or more accurately, that education about sexual minorities (conceived as LGBT persons or otherwise) has not existed. Solursh et al., who conducted the most recent survey of curricular hours devoted to “human sexuality” education in 1999 say little of sexual orientation in their discussion of their findings, but noted that “altered sexual identification” – presumably, non-heterosexual sexualities (Eliason et al. 2011) – was a topic covered by some of the medical schools who responded to their survey (Solursh et al. 2003). The substance of these discussions of “altered sexual identification” is unknown.

¹² In the next chapter I consider questions about the nature of “LGBT”-specific curricula or training for LGBT cultural competence and explain why these conceptualizations of sexual diversity and approaches to teaching about it may be problematic. In this chapter I assume that teaching about sexual diversity is important and focus on LGBT-specific curricula as the primary, recently empirically-occurring form of this.

On the other hand, those who have noted the lack of LGBT-specific medical education (e.g., Obedin-Malevir et al. 2011) have not made reference to the previous studies of the prevalence of sexuality curricula, nor to the discussions within the academic medicine literature about the need for more sexuality education that have been going on for decades (e.g., Woods and Natterson 1967; Parish and Clayton 2007). Perhaps because the integration of LGBT-specific content seems particularly urgent given its historical neglect, its advocates have said little about where LGBT content might fit within a broader approach to sexuality education in medical schools. And indeed, making sexual minorities (as well as sexual diversity within the “majority”) visible and familiarizing students with the health experiences and medical needs common to particular populations are important components of medical education. Their absence, as a relatively distinct set of topics is certainly problematic, even if their inclusion as an *isolated* set of topics may be problematic too. I explore potential limitations to the “LGBT cultural competence” approach to teaching about sexual diversity in the next chapter. In this chapter, I focus on Buena Vista’s curricula pertaining to sexual minorities because it is an important component of understanding medical knowledge about sexuality. Although teaching about LGBT cultural competence in the absence of a broader discussion of sexuality and minority sexuality might well be problematic, advocates for LGBT-specific curricula rightly point out that the exclusion of sexual minorities from medical teachings is problematic too. Examining the production of medical knowledge about sexual minorities is important both as a component of a broader sociological analysis of medical sex education, and because understanding this specific component of medical sex education may provide insights into the processes by which sexuality-related health inequalities are produced. In addition, examining the teaching and learning about sexual minorities that took place at Buena Vista provides a useful case

for examining the role that informal curricular processes play in complicating our understandings of the “neglect” of any type of curricula – sexuality-related or otherwise.

Defining the informal curriculum

The informal curriculum presents unwieldy material for study since, as it pertains to the “cultural milieu” of medical education (Hafferty 2006), its breadth far exceeds that of the formal curriculum. It is produced through any and all interpersonal interactions between and amongst students and faculty within the “life-space we call medical education” (Hafferty 1998: 404), and these interactions are relatively boundless. The informal curriculum is produced whenever students gather, whether outside of a lecture hall or in a coffee shop to study or over a phone call to gossip (Maudsley 2001: 432). It results from interactions between students and faculty that occur outside of the curricular moments structured by the formal curriculum, which is to say, in any encounters outside of the classroom (Hafferty 1998). Faculty members’ “backstage” actions – potentially, anything they do beyond delivering formal lectures - are considered by medical school faculty and sociologists alike to be an important component of the informal curriculum (Hafferty and Franks 1994; Maudsley 2001). Students tend to internalize and replicate the patterns of behavior that surround them, particularly those that are modeled by their superiors (Suchman et al. 2004). In sum, the concept of the informal curriculum prompts the recognition of medical schools as cultural entities and moral communities (Hafferty 1998). It draws the attention of both medical educators and sociologists to the fact that counting curricular hours may tell us about what a medical school teaches or hopes to teach, but it usually does not tell us much about what students learn (Hafferty 2006).

One of the contributions of this chapter is its extensive application of the concept of the informal curriculum to empirical data, and an examination of how the formal curriculum and the informal curriculum shape each other. The concept of the informal

curriculum is regularly employed within the academic medicine literature, but within this body of scholarship, it is often theoretically underdeveloped and is rarely applied extensively to empirical research. Here I briefly review the usage of the concept of the informal curriculum within the academic medicine literature before I outline my analysis of it in this chapter.

Usage of the “informal curriculum” within the academic medicine literature

Some authors recognize that the informal curriculum exists, but conceive of it as being less important than the formal curriculum. The passage below reflects such a view:

Medical schools continue to develop formal curricula that attempt to ensure that students will have acquired a body of knowledge, skills, attitudes, and values necessary for their future as physicians. While it has been argued that students also learn during informal interactions with their teachers and through the influences of the organizational culture, it is in formal instructional offerings that the educational objectives of the medical school are addressed (Barzansky and Etzel 2003: 1190).

This quotation alludes to a precarious relationship between the carefully, sometimes painstakingly crafted formal curriculum, and the vast, largely uncontrollable components of any educational environment that are the inevitable bedfellows of the formal curriculum in any educational setting. While the tendency for educators who agonize over the construction of the formal curriculum to hope it will have a paramount impact on what students learn is certainly understandable, most curriculum scholars and observers of medical education argue that the informal curriculum is likely to have a very substantial influence.

Other scholars have briefly acknowledged the importance of the informal curriculum without extensive engagement with the theoretical construct or its empirical manifestations. In their discussion of formal curricular hours devoted to LGBT-specific training, Obedin-Malevir et al. (2011) allow that some of the teaching and learning about

LGBT issues that takes place occurs in informal contexts – but examining these exchanges was beyond the bounds of their study. Discussions of minority students' (including but not limited to sexual minorities) experiences of medical education affirm the importance of informal interactions amongst peers and between students and faculty that send messages about who is welcome and who is less welcome within medical school environments (Townsend 1998; Beagan 2001; Murphy 2001). While this literature demonstrates that (sexual) minority students experience marginalization within medical school through the course of their interactions with both faculty and peers, it stops short of examining how the climate in which this marginalization shapes what all students, regardless of their place within the majority-minority continuum, learn about human diversity and how it matters to patient care.

Some observers of medical education have argued that informal curricular spaces are ideal for teaching and learning about human sexuality. Because, in their estimation, sexuality provokes anxiety and the best way to alleviate this anxiety is for students to share their feelings with peers and mentors, Woods and Natterson recommended “the teaching of sex by small group seminar” (1967: 330). Such a format would allow the students to “share their anxieties and questions and to learn from each other’s experiences.” Put differently, Woods and Natterson were advocates for the formal creation of spaces for informal curricular processes to occur.

Finally, some research about medical education and teaching about diversity alludes to the importance of the informal curriculum but does not address it specifically. Scholars have recognized that physicians are just as likely as members of the general population to be prejudiced against or uncomfortable with patients belonging to stigmatized or marginalized populations – for instance, as Herek and Capitanio (1999) discuss, homosexual men with AIDS – and that these attitudes matter for patients’

experiences of health care and for their health outcomes (Matthews et al. 1986). There is also recognition that increased contact and familiarity with persons belonging to marginalized groups tends to reduce ignorance and discomfort (Herek 1984; Kelley et al. 2008). Although medical education has not devoted much attention to the potential for doctors to stigmatize or otherwise marginalize patients in patterned ways (a subject I return to in Chapter 5), it does recognize a need to prepare doctors to work with demographically diverse patient populations. This has led to the implementation of training for cultural competence, which social scientists have subjected to extensive critique (e.g., Taylor 2003; Wear 2003; Wear 2006).

Training for cultural competence has been criticized for its reductionist approach to presenting human differences, and to treating the exploration of human difference as a curricular add-on, rather than integrating consideration of the implications of human diversity into the curriculum more extensively. For instance, educators may employ the tool of bringing in guest speakers or panelists to illustrate what it's like to be a member of the "LGBT community" (or another aspect of diversity), and this approach has been critiqued for creating a "safari" type experience where medical students briefly "view" different sorts of patients in the absence of longitudinal curricular arrangements that allow students to develop relationships with persons whose life experiences differ substantially from their own (Wear 2003: 553). On the other hand, some argue that this sort of curricular intervention can be beneficial, particularly for students who have not had *any* exposure to persons from a particular group before (Kelley et al. 2008). Increased familiarity with unfamiliar persons, however artificially generated and limited in context, may be beneficial.

But less has been said about the tendency for training for cultural competency programs to situate human diversity outside of medicine, and elide the diversity that

exists (or doesn't exist) within the medical profession itself. Neither the proponents nor the critics of cultural competence approaches have had much to say about the curriculum that is created through the diversity – sexual or otherwise – that is present within medical schools themselves, amongst faculty and students, and how diversity is responded to and negotiated within medical institutions. If much of what faculty teach is through modeling (Hafferty and Franks 1994; Maudsley 2001), then the presence or absence of sexual diversity amongst faculty may have more of an impact on what students learn about sexuality - and particularly the extent to which sexual diversity becomes normalized - than any efforts within the formal curriculum to promote awareness of sexuality in general or sexual minorities in particular. Unlike guest speakers or panelists who show up for a designated time slot and then disappear, faculty presence is ongoing. And unlike guest panelists who serve only the purpose of an “exhibit” or “specimen” of a particular experience or feature of humanity, faculty also serve as normative models of professional success and have power over students' professional success or lack thereof. The messages that faculty members send simply by virtue of being who they are and the teachings that educational institutions put forth through the demographic composition of their faculty are important components of the informal curriculum that have not been studied as such.

Sexual diversity in the informal curriculum at Buena Vista

In the following analysis I examine the transmission of messages about sexual diversity within three components of the informal curriculum to demonstrate the ways in which curricula pertaining to sexual minorities may be simultaneously more and less neglected than survey research suggests. First, I describe the reception and negotiation of formal curricula pertaining to sexual minorities within small-group discussions, which were formally-designated spaces for informal curricular processes to occur. Composed

of ten to thirteen students and two faculty facilitators, these discussion groups met after each Social Aspects of Medicine (SAM) lecture with the instruction to talk about its content in greater depth and detail. These settings created exactly the kind of forum for discussion of sexuality (and other topics) that Woods and Natterson (1967; quoted earlier) recommended, but true to the “unscripted” nature of the informal curriculum, however, these small-discussions did not necessarily serve the purposes that Woods and Natterson (1967) would have thought they could, nor those that Buena Vista faculty intended them to fulfil.

Second, I examine the messages that faculty members transmitted about sexual diversity simply by virtue of being who they were, and students’ interpretations of these messages. I explain why an absence of visible sexual minorities within a medical faculty may create or contribute to the production of a “spiral of silence” in which sexual minorities keep their sexual identity private, out of a desire to avoid marginalization. Although the role modeling that faculty members provide is widely considered a powerful element of the informal curriculum, within most conceptualizations role models’ *actions* are considered the basis of their influence. Here I argue that faculty members’ influence as role models includes the sexual diversity they represent and make familiar, not only their actions per se. Third, I examine the messages about sexual diversity that students’ drew from peer-to-peer interactions. The teachings about any topic that are created through students’ interactions with each other are a relatively under-explored aspect of the informal curriculum.

These aspects of the informal curriculum may seem disparate, and they are indeed distinct. But the concept of the informal curriculum pertains to a broad set of processes that lack a clear external boundary, so an in-depth empirical examination of informal curricular processes is necessarily multi-focal. I first explore the ways in which

curricular discontinuities were produced within small-group discussions, the formally-created spaces for informal curricular processes to occur.

Creating space for informal discussion of formal curricula: the structure of Social Aspects of Medicine courses

As I described in Chapter 2, the formal curricula intentionally devoted to sexuality at Buena Vista were housed within the SAM course sequence, as were many of the spontaneous, unplanned discussions of sexuality. Theoretically, the placement of sexuality-related curricula within these particular courses had distinct benefits. The structure of the SAM courses allowed for the delivery of formal content and regular opportunities for students to digest this content and explore their reactions to it with peers and mentors. Course directors assigned readings to be completed in advance of each weekly class meeting, which consisted of a lecture delivered to all of the medical students within a cohort, followed by the small-group discussions. Discussion questions or vignettes were assigned for each small-group meeting in order to provide structure and direction. Some of the SAM courses included a third “seminar” component, during which the class broke into medium-sized groups to hear guest speakers or panel discussions after the lecture and before the small group discussion. Students from each small group were split up to ensure attendance of different seminar options within each small group of students, and theoretically, students would later share their seminar experiences during the small-group discussions, too. Put together, these components were intended to provide both variety in the formatting of the presentation and consideration of content, and an opportunity for students to incrementally digest the material and increase their personal engagement with the topics presented. Lecture would introduce content; during seminars, guest speakers would bring the content to life

through sharing their experiences; and in small groups, students could talk about the content and their responses to it.

Buena Vista faculty created this particular structure of the SAM courses in order to provide students with what faculty member Dr. Charles Benjamin called a “home base.” The composition of the small groups remained constant throughout each quarter (and sometimes for longer than that) for the intended purpose of giving students and faculty an opportunity to become comfortable with one another so that they could discuss sensitive topics that came up within the SAM courses such as sexuality or death or physician impairment openly and honestly. These arrangements fulfilled the conditions that early observers of medical sex education thought were ideal for teaching and learning about sexuality. “Attitude modification” is most medical students’ primary need in the realm of sexuality education, Lief and Payne wrote in 1975. Like Woods and Natterson (1967), quoted earlier, Lief and Payne argued that small-group discussions were the best means of increasing students’ comfort, tolerance, and understanding of matters related to sexuality (1975: 2026). The small-group discussions in conjunction with the other components of the SAM courses at Buena Vista were intended to provide the opportunity for these very sorts of processes to transpire.

The faculty in charge of the SAM courses put a tremendous amount of time and effort into the conceptualization, development, organization, and execution of these classes and were very invested in their success. The SAM course sequence was *the* designated space for curricula related to the social aspects of medicine, so the course directors, working with limited time, had to make tough decisions about what sorts of material to include and what to leave out. Even when they might have wanted to devote more time to sexuality-related topics, it was difficult to do so in the context of so many other important topics related to the social aspects of medicine. Here, though, I am not

concerned with how much time was or was not ostensibly devoted to sexuality in terms of hours of formal teaching time, I am concerned with the amount of traction sexuality-related topics gained, and the curricular processes through which this occurred.

In order to illustrate the potential complexity of the “neglect” of sexuality in medical education, I will describe the most extensive consideration of non-heterosexual sexuality that I observed or heard about within the formal curriculum at Buena Vista, and then discuss the ways that informal curricular processes combined to lessen or even nullify the impact of this lecture.

Sexual diversity in the formal curriculum

As its name would suggest, the course called Stages of the Life Course focused on human development, and devoted most of the weekly class meetings to a particular phase within human life, such as infancy, middle age, and so on. At the outset of the lecture devoted to adolescence, prior to the commencement of the guest lecturer’s remarks, Dr. Nancy Green, one of the course directors, told the audience that after lecture, each small group discussion section would receive two guest panelists from a nearby high school. These high school students were coming to the small groups for the sake of giving the medical students a chance to practice asking questions about the topics that lecture would cover, Dr. Green explained. Dr. Green was explicit about what sorts of questions the medical students should ask their guests. “Start off by asking neutral questions,” she told the auditorium that was only partially full of medical students, “and then move gently into indirect questions about sex and drugs. You need to ask these kinds of questions, but you want to build a little rapport before you do so.”

And then the lecture itself began. The guest lecturer of the day was a pediatrician named Dr. Michelle Thompson who began her remarks with the pronouncement, “Adolescence is not a disease! But, you will hear that it is from some

clinicians!” Dr. Thompson went on to tell the audience that one of the developmental tasks of adolescence is developing a sexual identity, and, because she understood that the medical students had “not gotten much information regarding LGBTQ youth,” she had decided to provide some. She proceeded to deliver a talk that encompassed a range of sexuality-related themes and clear explanations of their relevance to clinical practice within the framework of talking about experiences common to adolescence. Her lecture was not the only instance within the formal curricula that sexuality was the sustained topic of focus, but it was one of the few, and it was the only instance of sustained, nuanced discussion of non-heterosexual sexuality that I observed at Buena Vista.

Just as noteworthy as her focus on LGBTQ sexuality was Dr. Thompson’s discussion of sexual minority experiences within the context of consideration of sexuality in general. During early adolescence, she lectured, “Curiosity about one’s body and the bodies of others, sexual fantasies, self-exploration, and limited dating and intimacy are important and normal.” Some of her patients were having sex at this age, she told the medical students, but she honestly didn’t think that they were ready for sexual activity as early adolescents. “I have twelve year old girls that have had consensual sex,” Dr. Thompson said, “but when I have to do any kind of physical exam they’re totally grossed out.” Although she didn’t linger on the issues, the very mention of consent and age of “readiness” for sexual activity was significant. At no other time during my fieldwork did I hear these subjects addressed. From one perspective, it might seem that even the explicit mention of these issues – however brief - could have some benefit, on the other hand, sexual consent and readiness for sexual activity are complicated subjects, often fraught with moral undertones and subject to contextually-specific interpretations

(Archard 1998; Schalet 2000), and thus probably would have been worthy of further exploration.

The lecture progressed to middle adolescence, the features of which included multiple plural relationships, heightened interest in dating and sex, preoccupation with romantic and sexual fantasies, testing of the ability to attract romantic partners, denial of the consequences of sexual behavior, and establishing the parameters of masculinity and femininity. “It is very difficult to get them to stay on a consistent method of birth control,” Dr. Thompson commented. “A lot of girls actually *want* to get pregnant at this point, and we tend to forget that.” Again, each of these briefly-made points might have been worthy of longer discussions, but their mention alone was remarkable. I did not observe, nor hear of, any other consideration of the consistent or inconsistent use of birth control, nor for that matter did I hear or hear of any linkage between sex and contraception and desire for pregnancy. Although a required course covered the endocrine, reproductive, and metabolic systems, students that I interviewed recalled no mention of the possible links between sexual behavior and reproduction within the course, nor any consideration of the social-sexual dynamics surrounding the use of birth control. Also noteworthy was Dr. Thompson’s recognition of young women’s sexual-reproductive agency that is so often silenced or stigmatized within American society (Tolman 1994). Even if she did not make a case for what the physician should or might do when faced with a teenage girl who wanted to conceive, she indicated the need for doctors to be aware of their patients’ choices and desires – and alluded to the possibility that these could be at odds with what the doctor might assume to be best.

As she moved on to a discussion of late adolescence, Dr. Thompson returned to the topic of adolescents’ task of establishing a sexual identity, and proceeded to define sexual orientation. She defined sexual orientation as a combination of gender identity,

sexual attraction/arousal, sexual behavior, and sexual identity, and provided some explanation of each component. She explained that each of these components intersect in varied ways, and are expressed as a continuum, rather than a static set of limited options. “There’s not just gay, straight, and bisexual, there is a continuum of identities here – some people are one hundred percent one thing or the other, but some people shift,” she continued. Furthermore, she cautioned, sexual attraction, identity, and behavior do not necessarily line up neatly in a person’s lived experience. “Lots of lesbian girls are having sex with boys because [boys] are more accessible. But once a young woman has identified herself as a lesbian to her health care provider, she may feel like it then ‘isn’t cool’ for her to ask for birth control. There is a misconception that lesbians are the protected population [from sexually transmissible diseases], but they’re not,” Dr. Thompson explained. In actuality, she continued, lots of lesbian- and bisexual-identified teenage girls have higher rates of heterosexual activity than heterosexually-identified females, and higher rates of pregnancy.

This chunk of information was significant for several reasons. Outside of this lecture, sexual orientation was referenced but rarely explored in any depth or detail. I regularly heard faculty remind students not to assume a patient is straight, and to always ask patients if they have sex with “men, women, or both,” but outside of this lecture I never heard any discussion of what it exactly it might mean to assume that a patient is straight, or what being straight might actually mean in practice. Dr. Thompson’s disaggregation of “sexuality” into the fluid components of gender identity, sexual identity, behavior, and desire was a step towards destabilizing the tendency to see sexual orientation as both static and overarching parameters of an individual’s personhood which is common in American society (Risman and Schwartz 1988) and was an underlying assumption at Buena Vista. While recent social science research on

sexuality takes for granted the human capacity for “plasticity in sexual behavior” most people in the United States tend to classify others as heterosexual or homosexual, with some allowance for bisexuals (Herek 1984: 3). Dr. Thompson’s remarks illustrated why such assumptions may be problematic, and what the medical consequences of these assumptions might include.

Although she did not put it this way herself, another implication of Dr. Thompson’s points was that the potential for the complexity of “sexuality” to be relevant to doctor-patient communication and subsequently, health outcomes, was significant in scope and unpredictable in nature. Dr. Thompson stopped short of emphasizing this, but the essence of her comments pointed to the fact that a seemingly simple question like, “Do you have sex with men, women, or both?” or “Are you gay, straight, or bisexual?” might pose wrenching internal calculations for the respondent. Providing answers about identity or orientation that affirmed a sense of identity might obscure important behavioral information related to the health concerns that precipitated a visit to the doctor. On the other hand, the revelation of sexual practices might be complicated by their conflict with a patient’s cherished sense of identity. Hypothetically, this could lead to facts being withheld, or to an uncomfortable clinical encounter (“You told me you were straight but now you said you just had sex with two men last week. Why didn’t you just tell me you were bisexual?”).

Dr. Thompson went on to explain the problems with assuming relationships between identities, behaviors, and risk factors. She explained that incidence of STIs in non-heterosexual populations were presented as being associated with LGBTQ *persons*, but the incidence was actually measured along the lines of *behaviors* – “which may or may not match up with how people identify themselves,” she said. Moreover, she continued, the association between any particular sexual behaviors with particular

sexual orientations is often mistaken, as is the assumption that having a particular sexual identity means that a person is sexually active at all. “Don’t assume that if someone comes in and says he’s gay that he’s having sex,” she elaborated.

The literature concerning patients’ experiences of health care indicates that recognizing the complexity of the relationships between sexual identity or orientation, behaviors, and health risks or health outcomes is important, and sometimes in surprising ways. Many scholars have written about the association – perceived and empirical - between male homosexuality and HIV infection (e.g., Weitz 1990; Herek and Capitano 1999; Herek 2002), and the stigmatization that gay men have experienced as a result, but it is not only categorically marginalized groups that suffer when sexual orientation is presumed to have categorical implications for behaviors and risk for illness. In a study of predominantly white, middle-class, heterosexual women with HIV/AIDS, Grove et al. (1997) found that one of the biggest challenges these women faced was getting to their initial diagnosis. The women in Grove’s et al. study had access to health care and at least some form of health insurance, and many had ongoing relationships with a particular physician. But despite or because of this, their physicians were slow to test them for HIV even as they presented symptoms associated with HIV infection and other possible causes were ruled out. When they were finally tested for HIV, these women’s doctors made comments to them along the lines of, “You can’t possibly have it, but I’m going to have to test you for HIV anyway...” only to be met with a positive diagnosis. These women explained that they felt let down by their health care providers, who presumed that they could not be HIV positive because of who they were. With their relatively abundant health care resources, these women could have reaped significant benefits from being diagnosed earlier (Grove et al. 1997).

As Dr. Thompson's lecture continued, she shifted her focus to the specific consideration of LGBTQ youth, who she defined as "lesbian, gay, bisexual, transgender, queer, questioning, non-heterosexual, or sexual minority." The very usage of these terms was significant – I never heard the words "queer," "questioning," "sexual minority," or "non-heterosexual" used again within the formal curriculum throughout the course of my fieldwork, nor did I hear faculty use these terms during small group discussions or interviews. Faculty regularly instructed students to refrain from assuming that patients are straight, and this was a move towards the inclusion of non-heterosexual persons, but it stopped short of recognizing that sexual identity and its nomenclature may factor into the process of building rapport with patients – something that many lecturers referred to the need to do.

Dr. Thompson presented some statistics about the prevalence of adolescents and young adults who self-identified somewhere within the LGBTQ spectrum. Both the results of surveys concerning teen sexuality and their operationalization of sexuality were instructive. Dr. Thompson referred to one study of college students in the United States and Canada that distinguished between students who were "gay identified," "bisexual identified," "uncertain-identified," "hetero-identified with same-sex fantasies," and "hetero-identified with same-sex behavior." The very listing of these possibilities served to reinforce the complexity of "sexuality" and its constituent components, and the conceptualization of sexual orientation as continuum. She concluded her breakdown of the numbers of students who fell into each group by saying, "So, to sum up: by the time you add up all those number of youth that have some kind of non-heterosexual feature, we have 13-15%. You will encounter them; *you need to be prepared.*" She emphasized these words.

Dr. Thompson went on to talk about the ways in which LGBTQ youth are stereotyped by the media – as “drug-abusing, prostituting, body-piercing, HIV-positive, suicide-attempting, and doomed to troubled lives.” She told the group that clinicians too are inclined to pathologize LGBTQ youth, and to ignore both their resilience and their broader similarities to their heterosexual peers. In reality, she said, there is “no evidence that sexual orientation per se is a risk for suicide.” Rather, she told the group, it is more likely that the stress associated with being stigmatized as a sexual minority is a risk factor for suicide or suicidal ideation. This distinction was significant, but it was at least as significant that she discussed the very idea of stigmatization of sexual minorities, and the ill effects of experiencing this stigmatization. This was the only time I ever observed discussion of the stigma and stress associated with sexual minority status, which is increasingly recognized within mainstream biomedicine as a factor that contributes to sexuality-related health disparities (Institute of Medicine, 2011).

“In general,” Dr. Thompson summarized, “there are many youth with same-sex attraction. Same-sex attraction is a matter of degree, and sexuality is not salient in the same way to everyone. Many young people will not fit the ‘gay youth’ stereotypes. Furthermore, as society changes, gender and sexuality blend in new ways, and different identities and societal expectations are emerging.” These points were important in several respects. Dr. Thompson’s discussion of gender identity was the only mention of it that I ever encountered during my fieldwork. From a strictly biomedical perspective, gender identity may seem to have little to do with medical practice¹³, but sociologists of sexuality have demonstrated the great extent to which gender and sexuality inform each other, and are often inextricable from one another within individuals’ self-understandings

¹³ Sociologists argue that gender identity has at times been relevant to biomedicine. Karin Martin (1993) argues that “sexuality and gender [were] controlled together” within biomedical efforts to use scientific authority to “prescribe normal sexuality as a means of controlling gender relations” in the United States from 1900-1950.

(e.g., Richardson 2007). If the goal is building rapport with patients, a doctor's awareness of their gender identity (or gender-sexual identity) may matter a great deal.

Furthermore, understandings of gender and sexuality inform biomedical decisions in ways that are not often recognized by medical practitioners. Of the treatment of intersex infants Katrina Karkazis writes, "Falling between the interstices of idealized male and female anatomies, the bodies of infants with gender-atypical anatomies have become embattled sites where clinicians and parents rely on folk rules about gender when interpreting biological information to make treatment decisions" (2008: 288). But while cultural understandings of gender shape physicians' criteria for "normal" genitalia, physicians themselves often see these distinctions as independent of social influences (Kessler 1998). Within the scope of Dr. Thompson's discussion of adolescence, extensive consideration of how understandings about gender and sexuality shape decisions about surgeries for intersex infants might have been a little tangential, but discussion of how intersex teenagers negotiate the tasks of adolescence that she described would have been germane.

Dr. Thompson's point about the shifting contours of identities was also an isolated, fleeting mention of an important matter. The coalescence of lesbian, gay, and bisexual identities that are taken for granted today is a relatively recent historical development, and these identities are not only variable at any given historical moment, but continuously evolving over time (Herdt 1997). The emergence of contemporary transgender identities and a broader cultural recognition of transgender persons is an even more recent occurrence. Although these identities have been integrated into mainstream recognition to an unprecedented extent (Herdt and Koff 2000), understanding the ways in which sexuality and gender shape identities both separately and together is an ongoing process, as culturally available identities continuously shift.

Although Dr. Thompson did not say this herself, the continuously changing nature of gender and sexual identities is an indication of why it is important to provide education about any particular sexualities – such as “LGBTQ” - within the framework of discussion sexuality in general – i.e., what it is, and the ways in which it matters to health care. Otherwise information about “sexual minorities” may present an overly-static picture of sexual identity and identities, and quickly become outdated.

From lecture to silence: the fate of sexuality formal curricula in small-group discussion

Dr. Thompson wrapped up her lecture by reiterating Dr. Green’s instructions for interviewing adolescents about their health and well-being. “Start with the questions that are the least invasive – or at least theoretically so – and then move onto the more invasive questions about drugs, sex, and suicide,” she instructed. She concluded with some tips for avoiding assumptions, avoiding the tendency to lecture or moralize, and overall rapport-building strategies. After the lecture ended, the medical students headed towards their small-group discussions to receive their high school student guests and practice interviewing them as they had been instructed to do during lecture. Within the small-group for which I was a co-facilitator, the medical students received their high school student guest panelists with nervousness. None of the medical students, even those who were the assigned “discussion leaders” for the day, jumped in to begin asking questions of the guests. The void was quickly filled by Dr. Chekini, the other faculty co-facilitator, who quickly began to praise the high school students who attended a rigorous college-prep high school, for their hard work. She embarked upon a long series of questions, directed to the high school guest panelists regarding school work and stress. None of the medical students tried to get a word in edgewise. They sat and silently watched Dr. Chekini interact with the high school students. Perhaps their lack of

engagement with their guest panelists was due to the fact that Dr. Chekini had dominated the conversation from the moment the high school student guests had arrived and settled into their seats; perhaps the medical students' reluctance was due to other factors, such as nervousness on their part. Students who normally participated actively in small-group discussions were uncharacteristically mute on this day and it is not unreasonable to imagine that the prospect of asking the guests questions about sex had something to do with their collective inhibition.

All of the small group's participants were seating in a circle that day, and as the medical students continued their silence, I made eye contact with them and urged them directly to ask questions of the high school students and practice questions about the subjects suggested in lecture. In keeping with her usual practice, Dr. Chekini had not attended lecture that day, so she had not heard the instructions that Dr. Green had given to the medical students at the beginning of lecture concerning the kinds of questions that they were to ask their high school student guests. Nor had she heard the substance of Dr. Thompson's lecture. After I prodded the medical students a little further, a few of them tentatively began to ask the high school panelists questions about their school work and stress levels, following the lead of Dr. Chekini. They didn't ask follow up questions, they didn't probe for further information after the high school panelists gave their answers, and a few of the medical students remained silent the whole time. Finally, I looked around at the medical students and said, "These are great questions, guys, but what about asking questions pertaining to some of the other topics that we discussed today in lecture?"

One brave soul, Elizabeth, hesitantly asked the high school guests if they were able to talk to their parents about sex. As she asked this question, Kenneth, who was usually vocal, insightful, and ready to take on any topic gazed down to the table and

started smirking. His shoulders shook as he repressed a laugh, and Elizabeth went on to ask the high school student guests if they knew where to get “birth control” if they needed it. This was the extent of their foray into asking questions about sex – or any of the other potentially sensitive topics, such as drugs or suicide, that they had been instructed to ask about.

After the high school panelists left, I pointed out to the medical students that they had avoided a large subset of the questions that they had been instructed to ask of their guests. “For instance,” I pointed out, “the questions about sex were very limited.” Before the words were fully out of my mouth, Dr. Chekini jumped in and said, “No, and you guys SHOULDN’T have asked them about sex, either. Not in front of their friends. That would have made them uncomfortable.” Her tone was harsh, her comments a definitive end point to the line of discussion.

With this pronouncement, Dr. Checkini put forth a very different set of messages about talking about sex than the messages that were presented in lecture. The medical students made no response to Dr. Checkini’s admonition. If they noticed that her comment was a direct contradiction of the messages put forth in lecture, they did not say. Although the medical students were “required” to attend all of the SAM lectures, attendance was not taken during lecture, and all of the other means for indirectly measuring lecture attendance lacked teeth. While the content of lectures was theoretically subject to inclusion in the end-of-quarter exams, these exams were watered down to the point of being nearly impossible to fail, whether a student had attended lecture regularly or not, Dr. Nancy Green, one of the SAM course directors told me. Because student regard for the SAM courses ran low, the norms of appropriate behavior amongst students did not compel them to attend SAM lectures. I regularly observed students arriving to lecture just as it was ending, or intercepting their classmates during

the transition between lecture and small group discussions. More than a few times I heard a student say to a classmate, "Tell me what went on in lecture today so that I can make a comment and get participation credit in small group" under these circumstances. Unless you noticed a particular student within the large lecture hall within the sea of however-many students attended on a given day, it was hard to know for sure who had attended lecture and who had not, because the substance of small-group discussions frequently strayed from the content of lecture, and the faculty facilitators themselves were often responsible for directing small-group discussions away from the day's designated theme. But whether the students had attended lecture or not, Dr. Checkini's comment ended up being the final word on the subject of sex and asking questions about it, and as such, she reinforced the acceptability of steering clear of topics that challenged the students' own understandings of privacy and comfort. More specifically, her comments reinforced the idea that sex is taboo, sex is private, sex is something you should not ask about. Nobody initiated discussion of the lecture's content pertaining to LGBTQ youth.

This class meeting of "Stages of the Life Course" was not the only time that I witnessed a rather significant discrepancy between the content of the formal curriculum, i.e., the contents of lecture (and assigned readings and the seminar portion of class, if there was one) and what transpired in the subsequent small-group discussion. Students did not necessarily enthusiastically take up discussion of the topics presented in lecture, even when the potential for sexuality-related discomfort was not a threat. However, I never heard or heard of a faculty facilitator contravening the content and instructions from lecture in quite the same way as Dr. Checkini did when she told the students that it would have been inappropriate to ask the high school guests questions about sex. What conditions enabled such a curricular disjuncture?

The informal curriculum and the production of curricular discontinuities

In addition to carefully planning the format and content of the SAM courses, the faculty who directed SAM courses also took care to orient the faculty facilitators to the courses and to promote their efficacy in their roles. An orientation meeting prior to the commencement of each course was the course directors' main means of communicating with faculty facilitators about their roles and responsibilities. These manuals contained, among other things, an articulation of the overall goals of the small group component of the SAM courses:

Small group experiences can be powerful learning vehicles. Each of you will be a co-facilitator for a small group of medical students in which the goal is to provide an opportunity for discussion of segment material (lectures, panels, readings, interviews and films). The Social and Behavioral Sciences Course Committee has found the small group to be an ideal format for teaching the material in the behavioral science series.

The manual also contained concepts and instructions pertaining to leadership and discussion facilitation. Procedural guidelines for facilitators were prefaced by the statement, "To accomplish our goal, there are certain skills and knowledge of the small group process which we feel our facilitators should have. The co-facilitators' role is to foster small group process and harness its force to create an environment in which people can share and learn from each other." It also contained these instructions:

Your role as a co-facilitator is to "**facilitate**" the formation of a cohesive group experience which supports each of the students, but also pushes them forward in their learning of new cognitive/intellectual material. The experience may also provide an opportunity for students to reveal a degree of their personal selves as it relates to the subject at hand (emphasis in original).

Next, the manual listed a series of "DO's" and "DON'Ts." Some of these "DO's" included conveying active listening skills, cutting off inappropriate and tangential discussions and redirecting discussion to topics germane to the course content, mediating disagreements, and asking thought-provoking questions. "DON'Ts" included overdoing

it with war stories, being overly verbal, feeling like it was necessary to fill silences, and letting any particular individuals monopolize discussions.

My experience of participant observation and small group meetings and comments from my student interviewees suggested that the facilitators were not particularly likely to follow these guidelines. The two faculty with whom I worked closely as co-facilitators had very different approaches to small-group facilitation, and very different lecture attendance habits. One attended lectures religiously, the other, Dr. Checkini, did not attend any. Even though these two facilitators had very different amounts of exposure to the contents of the formal curriculum as delivered through lectures, neither was particularly apt to stay on topic or encourage the students to do so. They each tended to tell lengthy stories about their own experiences in medicine, and frequently weighed in with their own opinions rather than pushing students to explore theirs. Although I only co-facilitated with two different faculty during the course of my participant observation, my interactions with other faculty facilitators suggested that the two I worked closely with were not the only ones prone to going “off label” in varying ways during the small group discussions. Dr. Katherine Banks was famous amongst the students she facilitated for her “maps.” She would carefully think through the small-group discussion questions or vignettes prior to each class meeting, and put together a diagram of “answers” to the questions or scenarios for discussion which she then shared with the students in detail. Emily, one of the students in Dr. Banks’s small group told me, “We can’t get a word in edgewise once she gets going [during discussions].” Another facilitator who attended lecture regularly told me of the phone conversations she had with her co-facilitator the night before each class meeting. Together they would talk about the vignette or discussion questions and “figure it out” so that they would be able to “explain” the “answer” to the students in their small group the next day.

The faculty facilitators were composed of currently practicing or retired doctors, psychiatrists, or clinical psychologists who were volunteering their time. Dr. Green spoke of the difficulty in getting enough volunteers to facilitate each time the course was offered. For every ten to thirteen students, two faculty facilitators were needed, and Dr. Green said that it was often hard for her and the course co-director to get this many facilitators on board for the course, even with a long list of volunteer psychiatry faculty who were potentially available for the task. The SAM course directors were totally dependent upon these volunteer facilitators to ensure the small group discussions were used for their intended purpose of delving into the contents of the formal curricula in depth and detail.

The faculty facilitators were invited, but not required, to attend lectures, and given that they were volunteering their time, it is not surprising that some of them regularly opted not to come. The faculty facilitators' manuals contained printouts of every single assigned reading and set of discussion questions or vignettes, as well as many of the lectures' PowerPoint slide printouts, so facilitators who did not make it to lecture could easily keep current with the content of the formal curriculum through other means – but they did not necessarily do so. During the facilitators' orientation meeting for The Physician-Patient Dynamic a veteran facilitator remarked, upon seeing me flip through my thick binder full of readings, "There's a little light reading for you to do in your spare time. Or not." So while the facilitators were theoretically in a position to evaluate students' awareness or of or engagement with the formal curricula vis-à-vis the quality of their participation in small group discussions, they were not necessarily familiar with the "required" materials themselves. The result was that even though formal curricula (i.e., assigned readings and lectures) were "required," the informal curricula in the form of

small group discussions was actually a lot more required, since this was where attendance was taken.

In addition to being a critical ingredient in achieving the fulfillment of the pedagogical goals of the SAM courses through ensuring curricular continuity between the content of the lectures, seminars, assigned readings, and the substance of small-group discussions, the faculty facilitators also fulfilled several essential bureaucratic functions. Because it was impossible to take attendance when all one hundred and twenty-something medical students were (theoretically) assembled together in the lecture hall, attendance of the entirety of each multi-part SAM class meeting was monitored by the faculty facilitators during small-group discussions. The facilitators' manuals contained printouts of the each facilitator's small group roster, complete with a picture of each student, for each week of class. These sheets had enough space for the entry of remarks about each student's participation for each class meeting, and the facilitators were instructed to keep notes on the quality and substance of the students' participation. In theory, faculty could likely determine whether or not students had actually attended lecture or completed the assigned readings based on the extent to which their comments reflected a nuanced understanding of these curricula, but if they had not done the readings or attended lecture themselves, it was unlikely to work out this way in practice.

Thus, even though the SAM courses were carefully planned and even though the intention behind their design was the creation of curricular continuities and space for the informal digestion of formal curricula, the structure and arrangements of these courses were such that curricular discontinuities were just as likely as continuities – particularly in conjunction with other features of the informal curriculum.

The culture of prioritizing bioscience

Faculty facilitators' practices within the informal spaces of the small-group discussions contributed to the curricular discontinuities between lectures and discussions, but their actions were not the only reason why the SAM material did not always gain the desired amount of traction. The prioritization of bioscience at Buena Vista was a major force within the cultural milieu that shaped students' attitudes towards the material and the extent to which they were expected to master it. Dr. Ron Davidson told me that from its inception, Buena Vista was driven by a high-tech, basic science, "wet bench" research emphasis, and he and other faculty members agreed that this had earned the medical school a strong reputation in these regards. As Dr. Daniel Benjamin put it, "What we've done well, we've done *really* well. There are buildings going up all over the place." Although most of the faculty who I interviewed agreed that the climate was changing, they also agreed that for much of Buena Vista's history, the medical school had venerated bioscience above all else, and this emphasis had made a lasting impact on curricula, faculty interactions, and student culture. "The rumor on the street for many years was that the first slide that the medical students saw on their very first day of their very first class in medical school said 'The cell is the patient,'" Dr. Green told me. "I never saw the slide, but I believe the rumor. I'd love to find out that it's actually an urban legend, but I don't think that it is." Dr. Terry Olsen told me that in the past, Buena Vista had made attempts to emphasize the "biosocial" aspects of medicine, "But they really *weren't* operating under that model. It's the bio-bio, not the bio-social model, around here!" she said. "In their teaching, it's bio, bio, bio!"

Many students embraced this emphasis and the culture it created. Several students who I interviewed cited Buena Vista's reputation for strength in basic science and research as their reason for choosing the school, and nearly every student that I interviewed referred to emphasis that the majority of students placed on studying for

exams and achieving mastery of the scientific material they were assigned. Some students, however, described this aspect of the culture with chagrin. Elizabeth's comments to this end were particularly revealing:

So many people here are like, 'I love science!' and really get into anatomy and neuro and stuff like that. That seems to be the dominant ethos, and I've had trouble with that because for me, I feel like when I'm practicing medicine, it's not going to be for the sake of science. I was at dinner with a friend who's really into ortho, and I told her about this nice old lady that I'd met in my family medicine clinic, and she was like, 'Oh that's great, let me tell you about this tendon I saw today!' So I guess... it's not that I don't like science, it just seems like there are little random things that I like better. But it seems like wanting to go into family medicine, or being excited about primary care, is sort of looked down upon here. It's like, you go into family medicine if you don't do well on anything else.

Elizabeth's voice shook as she spoke these words, and her eyes glassed over a bit.

Just as telling as her display of emotion was her choice of words: characterizing her interest in patient care as "random little things" that she happened to enjoy suggested that there was little validation for such interests within the informal culture of the school.

But even students like Elizabeth who professed an interest in the social aspects of medicine felt that the SAM classes were less than great. "It's seen as this BS thing that you just have to get through," Elizabeth told me, "which is sad, because I think the students who need it the most are going to dismiss it because they think it's stupid."

Lucy mused that it was hard to take the SAM courses seriously after receiving consistent messages that the faculty did not take them seriously either. Several faculty members acknowledged that there was tension between faculty who felt that teaching about the social aspects of medicine was essential and those who felt it was superfluous. Dr.

Green told me that some her colleagues openly referred to the SAM classes as "BS."

Whether they did so in front of students or not she did not know, but either way, students got the message that faculty didn't think the SAM courses were important. "In our science classes we're evaluated every single week," Lucy told me. "So it's really easy to

ignore the SAM classes if they don't make it seem important and they don't make us accountable for learning the information they throw at us."

Figuring out how to make the students accountable for the SAM material was no simple matter within the climate of hostility towards "social stuff" and the SAM courses. Deciding upon how to most appropriately test student learning in the SAM courses had been something the course directors agonized over, Dr. Green told me. She described the student "hysteria" that regularly ensued when Stages of the Life Course subjected students to "real" exams that tested their understanding of course content. Several years prior, a handful of students had failed an SAM exam and gone on what Dr. Green described as a "war path." Although 95% of the class had passed the exam, quite a few with honors, this small group of students complained vociferously that the exam was not "fair," because they were being tested on material that did not have a clear set of right and wrong answers in the same manner as their hard science courses. Dr. Green and her SAM colleagues interpreted this feedback as the ranting of a select group of students who simply had not invested energy into the class nor studied for the exam, but other faculty members involved in curriculum planning who were less amenable to the entire SAM enterprise and had never been involved in the teaching of a social science class interpreted these students' concerns as confirmation that the SAM courses were problematic, from their very existence to their execution. After attempts to institute other ways of examining the students were also met with negative feedback from students and faculty concern over this feedback, Dr. Green and her Stages of the Life Course co-director, Dr. Davidson, settled upon a single final exam that was nearly impossible to fail. "It really isn't fair to students who do care about the material and do study for the exams," Dr. Green sighed. "Then the message these students and eventually all of the students get is that you don't have to study for [the SAM classes]." Another problem

with evaluating the students was the difficulty in ensuring that a consistent set of criteria were used for grading. The small group faculty facilitators were recruited to grade exams, and the SAM course directors provided them with grading criteria. However, Dr. Green told me, the facilitators did not necessarily use the provided grading rubric. “Some will strictly follow the criteria, and do a good job grading papers... others just want to give everyone the top grade,” she said. “The facilitators will say, ‘They’re med students! It’s hard for them!’ and [the facilitators] want to reward even the students who really are barely doing average work.”

The tendency for medical students to make distinctions between the “real” and the less-important material is nothing new and has been well documented within the sociological and the academic medicine literature (Becker et al. 1961; Taylor 2003), as had the tendency for the differential regard for certain types of curricular over others on the part of faculty to influence student perceptions (Tervalon 2003). Buena Vista medical students situated the SAM courses firmly within the realm of the “unreal” or unimportant curricula. Some students told me that they didn’t like the SAM courses because they knew “all of that stuff” already. Others complained that the presentation of the material made the take-away points a little too obvious. While it was clear on many occasions – one being the lecture within Stages of the Life Course that I just described – that the take away points were not necessarily obvious at all, there were few compelling reasons for students to see it differently when they consistently received the message that the “hardcore science classes,” as Lucy described them, were what really mattered.

The prioritization of bioscience was a feature of the informal curriculum that enabled curricular disjunctures which impacted the amount of traction multiple topics, not only sexual diversity, ultimately gained. But yet there were some indications that sexuality-related content suffered particularly within these circumstances. Never did I

hear Dr. Checkini shut down discussion of another other subject as abruptly as she did the matter of asking the high school guest panelists questions about sex, and students who were typically garrulous during small group discussions remained quiet on this particular day.

One of the students that I interviewed told me that the atmosphere in the small groups he participated in shifted considerably when the subject of sex came up. At thirty, Eric was older than most of the other medical students and he felt that this set him apart from many of his peers. He told me that he was opinionated and slightly full of himself, and while I detected a whiff of arrogance from time to time throughout our long interview, he was also more reflective, incisive, and ready to question authority and critique the medical profession as a whole and Buena Vista as an institution than most of the students I interviewed. Eric's view was that his peers were incredibly concerned with maintaining an aura of political correctness, and that any discussion of sex was dangerous because it threatened to lead them to say things that might reveal their truly conservative views.

Eric told me that on the day of the Physician-Patient Dynamic when sex was the designated subject of discussion during lecture (I discuss this lecture in detail in Chapter 4), students in his small group were unusually "tight-lipped" as they "attempted to sound fairly non-judgmental." For most of the students in his small group on that day, Eric remarked, "The whole thing seemed like an exercise in disclosing as little of your personal experiences and views as possible." Eric told me that his fellow small-group participants recited phrases such as "Well sex is private business," or "Well who really cares?" while the two most vocal participants tried to move topics along as quickly as possible. The faculty facilitators that were present seemed just as relieved as the students did when time ran out and forced an end to the discussion, in Eric's estimation.

The structure of the SAM courses and the valuation of social science material within the informal culture of Buena Vista combined to create a scenario in which all of the formally-offered content within the SAM classes was at risk of “neglect.” No matter how much effort the course directors and lecturers put into crafting the formal curriculum, the structure of the SAM classes combined with the cultural devaluation of the social science content created a scenario in which students could remain in good standing without having any serious contact with the SAM course content. Students could skip SAM lectures without repercussions, and had little incentive to particularly concerned about the content of SAM lectures whether or not they attended. Although attendance in the small-group portion of SAM classes was monitored, there was no guarantee the contents of lectures would serve as the basis of these discussions. Thus however much sexuality-related teaching time the formal curriculum included and no matter its content or quality, it was not necessarily received by students at all. Whether or not sexuality was *especially* disadvantaged by the curricular discontinuities between lectures and small group discussions relative to other topics, these dynamics tell us something important about the “neglect” of sexuality or LGBT-specific sexuality curricula.

But even if these sorts of curricular dynamics potentially disadvantaged any of the topics within the SAM classes, LGBT-specific content in and of itself is not exactly beside the point. The American Medical Association (AMA) affirms that “educating physicians on the current state of research in and knowledge of homosexuality”¹⁴ is important, and all indications suggested that Dr. Thompson’s lecture was the only time sustained moment of explicit emphasis on anything remotely approaching this within Buena Vista’s formal curriculum. Even if this material was relatively limited, theoretically,

¹⁴ <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-adv-advocacy-committee/ama-policy-regarding-sexual-orientation.page>

all students would be exposed to it since her lecture was part of the “required” coursework. But since the officially-required material was not exactly required in practice, there are two potentially important implications. Some students got the impression that sexual diversity or LGBT-specific content were completely absent from the curriculum. Other students recalled mentions or representations of non-heterosexual persons, but there were indications that these representations did not exactly reflect “the current state of research in and knowledge of homosexuality” that the AMA recommends.

A student named Duc had this to say about LGBT content within the curriculum:

I feel like even when we talk about diversity, or about disparities in health care, it's only about racial disparities. We've never talked about occupational disparities, for instance, and we've certainly never talked about sexual orientation as a form of diversity or in relation to health disparities. I don't think the curriculum is tailored for LGBT issues, so people just don't think about it.

Duc confessed that he didn't go to lecture all that often, but he wasn't the only one.

Comments like Duc's underscored the possibility that students who did not attend lecture regularly might hear little mention of homosexuality at all. Others recalled a memorable representation of homosexuality within a video they saw in small group discussions. I did not see this video myself, but students recalled that it was shown within the context of learning how to take a sexual history featured a portrayal of a “promiscuous” gay man who was “at risk of AIDS.” A student named Doug found the video extremely offensive and spoke up and said so immediately after viewing it. Doug described the experience to me like this:

And so I just threw a fit. I said – I was sitting there and they called on me. They were like, ‘Doug, what do you think of this video?’ And I said ‘I just am wondering if the entire clinical arm of this medical education view is based on negative stereotypes of underrepresented minorities.’ And so in response to that – it was really funny, because the next video was about a drunk Irish person and it was just – well, they just gave me this *look*.

But I went on to complain to quite a few people, starting right then and there with my facilitator.

Doug, who sexually identified as “gay-ish, queer,” acknowledged that associating gay men with numerous partners was a “double-edged sword” because of the “different [sexual] norms” prevalent in gay communities. The ultimate issue for Doug was not that the video was entirely inaccurate but rather that as an isolated portrayal of gay persons, it did more to contribute to negative stereotypes than it did to create a better, more nuanced understanding of sexual diversity, safe sex, and the risks – or lack thereof – associated with having multiple sexual partners. The fact that several of his classmates mentioned the video to me as an instance of Buena Vista’s inclusion of sexual minorities suggests that Doug’s concerns were well-founded. Other students who I interviewed who did not view the video with Doug (and thus, did not hear his response to it) remembered the video but did not necessarily see it as stereotypical or problematic. A student named Nicole complained that it was “Out of date, clearly made in the eighties,” and seemed bothered that the material was dated, but did not articulate a specific concern about why its content might be misleading or less than accurate. But many of my student interviewees who told me about this video took it as a much more literal representation of sexual minorities, and viewed it as an instance of the medical school’s inclusion of sexuality-related content, and an attempt on the part of the medical school to recognize sexual diversity.

I now shift my focus away from the ways in which formally-offered sexuality curricula were negotiated in informal spaces and turn to an examination of a more diffuse set of informal curricular processes, specifically, the messages that faculty sent about sexual diversity simply by virtue of being who they were, and the ways in which students modeled sexual diversity to each other through their presence and actions.

Normalizing (the absence of) sexual diversity: the importance of faculty role models

There is broad agreement amongst medical educators and medical sociologists alike that faculty role models have a substantial impact on students (Hafferty 2006), but many considerations of role models focus narrowly on their capacity to influence what students learn about ethics and professionalism (e.g., Grady-Weliky et al. 2000; Maudsley 2001; White et al. 2009). However, as one Buena Vista faculty member pointed out, faculty members also model sexual diversity (or its absence) to medical students. Dr. Bruce Stevens, an older, openly gay physician told me about the homophobia directed towards patients that he witnessed on hospital floors and that he experienced personally from colleagues in the earlier years of his career. “I was very committed to being out in the workplace,” he told me. “I don’t like to make a big deal about it now, but because I was known to be out, some of my superiors in my department felt that I might do something to embarrass the university. They actually had someone assigned to keeping an eye on me, and at the time, this was quite aggravating.” I asked Dr. Stevens what he thought medical curricula could or should do to cultivate understanding about sexuality and address the lingering presence of sexual stigma, and he told me that he had offered his services to various SAM course directors over the years for the sake of teaching about sexual diversity and offering himself or other colleagues as a potential mentor for gay medical students. These offers had largely been turned down, he said, and while he felt sexuality- and minority sexuality-related formal curricula were important, he felt that the most important thing was for faculty members to come out and be open about who they are.

We’re still a minority, and it’s much easier for the majority to assume that their experience and viewpoint is representative of everyone else’s. And that’s why I keep coming back to the matter of coming out, if people just

come out, it changes the cultural expectations. I mean, that was Harvey Milk's whole thing! Just COME OUT. Most [of the other non-heterosexual] faculty here are not out to the general faculty. So the faculty at large aren't aware of it – they don't incorporate [sexuality] into their understanding of how diverse the community is.

Throughout the years he had spent at Buena Vista, Dr. Stevens encountered the sentiment of “Okay you're gay, but why make an issue out of it?” many times. He expressed concern that his non-heterosexual colleagues had responded to these sorts of comments by remaining closeted, and he felt that such reservation was a disservice to the medical school and profession.

It seemed that Dr. Stevens' concerns remained salient. To the best of my knowledge, openly gay faculty were relatively rare at Buena Vista at the time of my research. I knew of only one openly gay small group faculty facilitator, Dr. Terry Olsen, who told me that she herself knew of no other openly gay faculty at Buena Vista, and knew of only one doctor in the area who was “kind of out.” During my interview with Dr. Green, the SAM course directors quoted earlier, she suggested that I interview Dr. Thompson, who gave the lecture on LGBTQ youth. “She's gay,” Dr. Green told me, “but she doesn't make an issue of it.” Indeed, Dr. Thompson had not directly or indirectly identified herself as such during her lecture on adolescence and sexuality. Whether or not gay faculty kept quiet about their identity because they had received the impression that it was better for them not to “make an issue” out of their sexuality, heterosexual faculty were not similarly encouraged to keep their sexuality to themselves, nor did they. Within lectures, small-group discussions, and faculty facilitators' meetings, markers of heterosexuality such as wives and children (if the speaker was male) or husbands and children (for female speakers) were proudly referenced, serving to reify the “naturalness” of heterosexuality while other sexualities remained invisible.

The lack of visible sexual diversity made an impact on the medical students. Non-heterosexual students who I interviewed spoke of their hopes of finding an “LGBT mentor,” and referred to the difficulty of doing so. The student named Norman told me that he had not found a mentoring relationship with an LGBT faculty member because he was not entirely sure which faculty members were out. Norman had heard rumors that certain attending physicians were gay, but he never asked these physicians about their sexual orientation himself. Interestingly, Norman put the burden of discovery upon himself, rather than on any particular gay physician or gay physicians collectively, in his quest for a mentor. “I think the opportunities are there [to find an LGBT mentor],” Norman told me, “I heard this one attending was gay, from some of the residents, but I didn’t get enough time to sit down with him myself. I think he would have felt comfortable talking with me, but I didn’t find the time. It was a busy clinic.” As a participant observer at the Annual Conference of the Gay and Lesbian Medical Association (GLMA) in Atlanta in 2011, I met other queer students from around the country who told me similar things. One student at the conference, an aspiring surgeon, told me that his primary motivation for attending the GLMA conference was to find a gay surgeon who could serve as some sort of a mentor for him, or at least provide him with some sort of confirmation that gay surgeons did in fact *exist*.

If we accept that faculty role models matter greatly for what students learn, the sexual diversity that faculty model – or the absence of sexual diversity that they model – should be taken as seriously as a form of teaching as the presence or absence of LGBT-specific formal curricula. An absence of openly gay faculty does not only leave queer students without easily-identifiable mentors or indicators that people like them are welcome within the profession, it also serves as a form of instruction about sexual diversity for all medical students. Frances Bowen and Kate Blackmon (2003) argue that

within heterogeneous groups, individuals who perceive their positions to be different from those of the majority are likely to refrain from sharing their opinion, stating their position, or, in the case of sexual orientation, outing themselves as something other than heterosexual. Within this phenomenon, known as the “spiral of silence,” the “dominant [position or group] exerts control over individuals through the threat of isolation for deviance” (Bowen and Blackmon 2003: 1396). Individuals’ perception of the climate of opinion within an organization determines the extent to which they will speak up about issues or problems that they consider important – or keep silent. Members of a group who share the dominant opinion or identity will feel free to speak out, and those who perceive that they are in the minority and fear marginalization will tend to remain silent. This has the effect of diminishing not only individual minority voices, but the visibility of the minority opinion or position altogether.

Because of this, Bowen and Blackmon argue that spirals of silence are detrimental not only to the individuals whose perspectives or experiences are silenced, but to the breadth and viability of perspectives or collective understandings within the greater organizational culture. Bowen and Blackmon’s research pertained to workplaces, and differential valuation of contributions to organizational decision-making processes. Although demographically homogeneous groups are more likely to be socially integrated and work together more easily than do heterogeneous groups, homogeneous groups of people tend to know the same things, value the same things, and approach problems from a similar angle. Groups of people with diverse backgrounds and varying personal attributes tend to know different things, and these diverse points of view create a richer, broader set of perspectives from which an organization can take action, thus strengthening its policies and approaches.

Despite the demonstrated potential for heterogeneous perspectives to lead to durable, innovative workplace output, spirals of silence tend to occur because within any group, the collective desire for social cohesion is usually high (Bowen and Blackmon 2003). Members of dominant groups, or persons who hold more power than others have little motivation to adjust their behavior or their expectations to allow those who are different from them to feel more included or valued. Members of outgroups may feel pressure to conceal their differences or assimilate into the dominant culture in order to avoid marginalization, and this is particularly likely to be so when these members perceive a threat of isolation, and fear this possibility. Sexual orientation, Bowen and Blackmon argue, is particularly vulnerable to being silenced because of its relative invisibility. Unlike other aspects of individual difference such as gender and race which are usually (although not always) observable, sexual orientation can be concealed. Bowen and Blackmon argue that while some sexual minorities will always choose to be visible and others will always maintain invisibility for reasons independent of their impressions of the surrounding environment, the majority will carefully assess the prevailing organizational climate and choose to reveal their sexual orientation only if they think the local cultural climate is likely to be supportive (2003: 1401).

Although Bowen and Blackmon's findings do not pertain to curricula per se, their findings can be applied to educational settings which are also workplaces for some participants in addition to being centers of learning for others. The dynamics within the workplace portion of an educational environment shape the educational messages presented. This may be particularly true within medical education. Martin Christensen (2005) argues that as a conservative, hierarchical profession, medicine tends to encourage its incumbents to become like their peers and superiors. If there are no indications that non-heterosexual faculty are present within an institution, sexual minority

medical students may be less likely to come out themselves, perpetuating a spiral of silence that creates an informal curriculum of messages about the presence or absence of sexual diversity. This is perhaps particularly true for students who may see their medical school as representative of the profession as a whole, rather than but one institution within it, at least during the early part of their training.

The informal curriculum of peer-to-peer interactions

As it turned out, sexual diversity was not completely lost within a spiral of silence within the informal interactions amongst medical students at Buena Vista even if little sexual diversity was apparent amongst faculty. The informal curriculum produced through peer-to-peer interactions yielded, for some students, more evidence of sexual diversity and its implications than did the medical school's formal curriculum – or any other experience within or outside of their formal education, medical or otherwise. But for other students, peer-to-peer experiences reinforced an understanding that sexual diversity was not particularly salient, even if it was present. I present my findings on the informal curriculum of sexual diversity within the context of medical students' impressions of diversity – its presence or absence, importance or irrelevance – more broadly conceived in order to illustrate the extent to which the visibility or invisibility of sexual diversity determined the messages about sexuality that students took from the informal curriculum of peer-to-peer interactions. But first, I examine historical perspectives on diversity within medical education and the particular challenges that sexual minority students experience within professional education.

Historical perspectives on diversity within medical education

In their seminal treatise on medical education, Howard Becker and his colleagues argued that because the demands of medical training were so extreme, individual background differences really didn't matter much in medical school. The

pressures of medical school were an equalizing, homogenizing force, and prior roles and experiences ceased to matter much (Becker et al. 1961). In many respects, these points were fair and are still relevant. Medical school continues to be recognized as a particularly potent, transformative site of professional socialization, and the professional identity of the doctor is regarded as being one of the most tenacious and all-encompassing (Jaye et al. 2006). Experiencing medical training and taking on the professional identity of a doctor may fundamentally alter individuals' deepest understandings of who they are, and the students at Buena Vista were very aware of having these sorts of experiences, or being in the midst of such a transition themselves.

However, this does not necessarily mean that the backgrounds and attributes of medical students have little importance or are mitigated completely by the forces of socialization within medical school. When Becker et al. wrote *Boys in White*, most of the medical students they encountered were *white boys* in white (Beagan 2001), so medical students' backgrounds may have *seemed* less salient given that the students were relatively similar in many important respects, such as "race" or ethnicity, and class. It is probably more appropriate to say that for some time, inquiry into the ways that social inequalities manifested themselves amongst medical students was limited.

Since Becker et al.'s time of writing, medical students have become a more heterogeneous bunch than they used to be, particularly in terms of gender (Beagan 2001; Boulis and Jacobs 2008). North American medical schools have become also become more diverse in terms of "race"/ethnicity since the 1960s, although African Americans, Mexican Americans, Native Americans, and mainland Puerto Ricans remain woefully underrepresented within medical education (Cohen et al. 2002). In the 1950s and 1960s, underrepresented racial/ethnic minorities constituted about 2% of medical school matriculants, and that number rose to about 11% by 2001 (Cohen et al. 2002).

Although most medical schools have anti-discrimination and anti-harassment policies, ample research shows that medical students in the minority – by virtue of their gender, race or ethnicity, sexual orientation, or socioeconomic background – experience marginalization in medical school (Townsend 1998; Klamen et al. 1999; Beagan 2001; Murphy 2001; Witte et al. 2006). At times this may take the form of outright discrimination or harassment, but at other times, students in the minority may be experiencing the more subtle effects of the “culture of medicine” that tends to create an environment in which some are implicitly more welcome than others (Taylor 2003). In other words, even if incumbents to the medical profession are increasingly *not* white and middle- or upper-middle- class, the latent cultural of medical training reflects white, middle-class norms (Wear 2003). Research has shown that students who are in the minority by virtue of any aspect of their identity struggle in medical school as they grapple with not quite fitting into the culture of medicine. In one Canadian study, one of the only two self-identified working-class medical students at a medical school remarked that the hardest thing for him to learn was the appropriate behavior at the “wine and cheeses” – informal social events which required a certain form of cultural capital that was familiar to those of a certain class background (Haas and Shaffir 1987: 23).

Sexual minorities’ experiences of professional education

The literature paints a particularly dreary picture of sexual minorities’ experiences of medical education. Surveys conducted in the 1990s indicated that a majority of lesbian, gay, and bisexual students heard faculty and students make negative comments about homosexuality or homosexual patients, and many reported that they were personally criticized about their sexual orientation (Townsend 1998; Murphy 2001).¹⁵ In

¹⁵ Surveys of medical students’ attitudes towards homosexuals and homosexuality from the 1990s suggest the importance of taking these findings seriously. In one, a quarter of medical students surveyed said that they believed homosexuality to be “dangerous and immoral to the

conjunction with a lack of gay-specific and gay-affirmative coursework or informal curricula, non-heterosexual students tended to feel pressured to keep their sexual identity a secret, and marginalized if they did not (Townsend 1998). Quite obviously, under these circumstances, non-heterosexual students experience special pressures within professional education. They get the message that revealing their sexual identity would subject them to ridicule or discrimination, and might compromise their professional standing, and these circumstances create the perfect environment for a spiral of silence. Having the “option” to remain closeted and possibly avoid scrutiny or harassment was hardly an attractive one.

The nature of medical education and other professional training programs requires students to spend much of their academic and social time amongst peers and superiors. Medical students spend long hours together during classes and labs and then studying, and this inevitably leads to a narrowing of students’ social circles due to spending not only a great deal of time working together, but most of their leisure time with one another as well (Townsend 1998). Within such conditions, medical students and students in other demanding professional training programs can only put off discussion of their personal lives, and with that, revelation of their sexual identity, for so long (Cech and Waidzunas 2011). In 1998 Townsend argued that these circumstances created an intense pressure upon sexual minority medical students who, according to his research, felt a nearly-universal pressure to conceal their sexual orientation, and thus had to devise strategies for concealment and deal with the stress associated with doing so.

institution of the family” and said that they did not enjoy keeping company with homosexuals. Nine percent of students in this study believed homosexuality was a mental disorder (Klamen et al. 1999).

Townsend based his claims upon data collected in the 1990s. In the subsequent years, much has changed in terms of social awareness and acceptance of non-heterosexual persons, and much has changed in terms of the social and legal protections for sexual diversity. There is a perception that homophobia is declining, and this perception is partially accurate. Yet significant homophobia still exists within the United States (Jenkins et al. 2009), and research indicates that it persists in places that might seem unlikely havens for prejudice. Although homophobia is negatively associated with higher levels of education and most universities have anti-discrimination and anti-harassment policies that encompass sexual orientation at this point, educational environments are not necessarily bastions of tolerance for sexual diversity. In their recent, in-depth study of lesbian, gay, and bisexual (LGB) engineering students at Gold University, Cech and Waidzunas (2011) found that LGB students observed general expressions of homophobia such as gay-related jokes and derogatory comments and experienced negative reactions of varying severity if they chose to share their sexual identity with peers. The students in their study feared professional and personal sanctions for disrupting the heteronormative culture of engineering, and frequently chose to remain closeted or revealed their sexual identity only very selectively. Cech and Waidzunas collected their data in 2008, and their relatively recent findings indicate the importance of recognizing that non-heterosexual professional students continue to experience marginalization, even as social and legal rights for sexual minorities increase, and even within the relatively progressive context of higher education.

The unique challenges that sexual minority students continue to experience in medical education and other professional education programs is an important component of the broader landscape of sexuality-related inequalities, but the aforementioned research focuses on queer students' experiences of marginalization as

something that is a problem for them, without considering how the marginalization or invisibility of non-heterosexual students constitutes a component of the informal curriculum.¹⁶ The experiences of marginalized students shape the informal interactions and the cultural milieu of the medical school environment, which are experienced by all medical students and thus shape all students' impressions about the presence and nature of sexual diversity.

I found that sexual minority students continued to face particular strains by virtue of their sexual orientation at Buena Vista. Although this is important in and of itself, here my focus is on what all medical students, regardless of their place within the minority-majority continuum, learn from the diversity within the medical school environment. The realm of informal interactions amongst medical students has not yet been sufficiently regarded as a type of curriculum, where students teach each other and learn from each other simply by virtue of being who they are interacting with others. The following analysis will suggest that the visible presence of sexual diversity within the informal curriculum may teach students just as much if not more about sexual diversity as do formal teachings devoted to this topic. I situate this discussion within a consideration of medical students' impressions about diversity in general in order to illustrate why the relative invisibility of sexual diversity makes it vulnerable to a lack of recognition of its importance.

Majority students' impressions of diversity and its salience

¹⁶ This is understandable in the case of engineering students, whose future work does not have the same humanitarian impact as does medicine (and other professions). Although medicine is similar to engineering insofar as it is a highly technical field with a culture that prioritizes and rewards scientific competence, unlike engineers whose future objects of professional manipulation are things, doctors apply their technical competence to humans whose experiences of their scientific prowess are often contingent upon their doctor's capacity to respond to them not only as a technical puzzle, but as a whole person.

Buena Vista students' perceptions of the amount, nature, and salience of diversity within the medical student population tended to have much to do with their previous exposures to diversity of any sort, and the extent to which they had ever experienced being in the minority by virtue of any aspect of their identity. Students who did not identify as a minority (sexual or otherwise) themselves typically considered Buena Vista to be a pretty diverse place. One student named Diana put it this way:

I think the med school class is the most diverse setting that I've ever been in. I grew up near here and I went to school here, and even though there was diversity in my high school, what was funny is everyone hung out with people of the same race. And there wasn't animosity, but most of my friends growing up were white.

Diana identified herself as white, and she counted herself amongst those who had hung out with people "of the same race" for most of her life. I asked Diana to tell me a little more about the kinds of diversity she noticed amongst her medical school peers, and she told me that she saw the members of her cohort as being "socially different" from each other, meaning, in her words, "how you grew up and what group you were in in high school, you know - there are different groups, such as the jocks or the nerds or whatever." Diana's conceptualization of what the parameters of "diversity" might meaningfully include ("jocks or nerds or whatever") was unique, but she was not the only Buena Vista student who conceptualized diversity in terms of individual differences that were not linked to patterned inequalities. Arthur, who came to medical school right after completing his bachelor's degree, described his cohort as a "diverse bunch." When I pressed him to elaborate, he explained that the students in his class had majored in a variety of different subjects in college, and that the students possessed "different life backgrounds." I urged him to tell me more, and he said that in his class there were:

People coming from different areas of life. There's a couple who just had a baby. Some people coming at all ages. I'm part of the younger group. I'm still 21 and there's a 19 year old MD-PhD student. It's just all different

people coming from all different...I don't want to say it's typical, but it is kind of your expected diversity if you have a large group of 120 people.

I asked Arthur if he felt that his cohort was ethnically diverse, and he replied that "ethnic diversity is not great in the area of underrepresented racial minorities...it's a typical white and Asian predominance." Arthur identified as Asian but did not consider himself a minority. When I then asked him about socioeconomic diversity, he conceded that as far as he knew, most of the class came from upper-middle-class backgrounds. "For most of the people that I know, money doesn't seem to be an issue," he told me. Diana's and Arthur's stories were representative of a category of impressions, in which the presence of a few older students, a first Muslim or gay friend, or the stories of one particular student who had travelled extensively and worked abroad signified that the class, on the whole, was diverse.

On the other hand, some of the "majority" students felt that the student population was not particularly diverse, but their conceptualizations of what "diversity" might encompass were limited, and they did not see its absence as problematic. A student named Arun put it like this:

Interviewer: Tell me a little bit about the diversity of your medical school class.

Arun: Class diversity, I think it's actually pretty representative of the number of people that go into pre-med.

Interviewer: In what ways do you mean?

Arun: Just like ratios. I don't know the exact number but it's about thirty percent Asian, thirty percent white, and then the rest is kind of a mix and I think that's kind of like how many people are pre-med, at least that's how it was at [my undergraduate institution]. There was about an equal number of Asian and white and kind of like the rest, so I think it represents pretty well how many people want to go into the medical field. I think it's a good mix of people.

Interviewer: What about other aspects of diversity, such as economic background or –

Arun: Yeah, I feel like economic background, I don't know about all of the people in the class, as in their stories but they... well, I actually have no idea.

Interviewer: Put another way, would you say that ethnic background is probably the most salient aspect of diversity that people are aware of here?

Arun: I think when people say 'diversity' people immediately think racial, just because that's what you see and so you don't need to know people, you can immediately see that by putting a label on them. Diversity here... I guess is diversity of personalities, just like background or where you grew up or something.

Interviewer: I've heard that most of the students here came from [this state]. Have you found that to be the case?

Arun: It definitely is, but ... I think it makes sense to keep the doctors from this state here.

Clearly, Arun had not given a great deal of thought to diversity one way or another, but even the fuzziness of his ideas is revealing. Arun's comments suggest that in the Buena Vista environment, diversity was not a paramount concern, and if it was going to be salient, it needed to be visible.

A student named Darcy also felt that the lack of diversity amongst the medical students was not particularly problematic:

Darcy: Once you get into medical school I don't think diversity is on the forefront of anybody's mind, you know... I mean, it's not a terribly diverse med school class.

Interviewer: What does that mean?

Darcy: I guess it's reflective of the applicant pool, I think the administration is trying its best.

Interviewer: Back up a little bit. When you say it's not a terribly diverse class, what do you mean by that?

Darcy: I would say it's mostly white and then mostly Asian and then a sprinkling of anything else. So we have three African Americans who are in our class and that's a lot. That's the largest number they've had in years. I mean the Asian American thing is kind of interesting because Asian Americans are not minorities in this part of the country.

Interviewer: Is sexual identity seen as an aspect of diversity that is important on campus?

Darcy: Not specifically. I think it's included whenever they say, you know, "We don't discriminate on the basis of race, gender, sex preference" but I don't think it's specifically a focus for anybody.

At another point during my interview with Darcy, she talked about how her own identity and preexisting interests had been subsumed by medical school, and lamented that her entire identity could be reduced to a single element: "med student." She seemed to think that her peers experienced medical school similarly, and implied a perspective similar to that of Becker et al.'s (1961): given that they were all subject to the same intense pressures, working towards the same goal, what other aspects of experience could be relevant?

These seemingly contradictory majority positions, one which viewed the medical school as diverse by virtue of its students' varied "life experiences" which had little to do with patterned inequalities and power differentials and the other which regarded the medical school as lacking in diversity, but unproblematically so, both affirmed the belief that "medical student" was the most salient aspect of everyone's identity, and elided experiences of students who experienced their difference from the majority as a source of marginalization. On the other hand, students who felt that they were different from the majority by virtue of any aspect of their identity shared the belief that the students were not all the same at all, and that these differences mattered.

Minority students' experiences of diversity

Students who felt they were in the minority or different on any account tended to regard the medical school population as relatively homogeneous, and viewed this homogeneity unfavorably. Emily, who was in her late twenties, and had lived and worked in several different cities, shared this impression of her classmates:

I haven't found a community of people I connect with here. I feel like it's very homogenized. Well, there are outliers, but there's a huge population that came straight out of college. Thirty or forty percent of the students came straight out of college, maybe more. Probably more. Actually, probably half or more! These people are just out of college, so they're very young, and they've been pre-med their whole lives.

The ways that Emily was different from her fellow students were not linked to patterned inequalities, but her perspective as a person outside of the norm is still informative, particularly because other students who were different from the majority had similar impressions of how alike most of the other students were. Eric, another older student, had this to say:

The majority of the medical student body are young, twenty-two or twenty three or maybe younger, and the dynamics amongst them are like the dynamics of a normal high school. They are all very interested in keeping up with each other, interested in who is dressed how, who is in what relationship, who said what about who, where they're going to go out that night... there seem to be a lot of little cliques that revolve around one person, and some of the cliques have personality conflicts with each other...

Aside from the "youngness" of most of his peers, Eric noted that the racial/ethnic diversity of the medical student population was a pretty standard breakdown of diversity along these lines within higher education, so "no one gives it a second thought, because we consider it to be standard." Eric reported hearing a fair amount of gossip amongst students about the sexual lives of their peers, which included some speculation about who might be gay, but other than that, he didn't see sexual diversity as a salient aspect of campus life. Eric identified himself as Caucasian and hesitantly as heterosexual, and although he felt like an outsider amongst his peers, he had not experienced any marginalization on the basis of any aspect of his identity.

Miguel, one of the few Latino students at Buena Vista and the only one who I was able to interview, told me that he felt that being an ethnic minority was one of the toughest aspects of medical school. Out of every medical school class of one hundred

and twenty, he told me, the cohort would include “ten or twelve minorities and within that, one or two black people.” Miguel told me that he and the only black student in his cohort “kind of stuck together.” Miguel implied that sharing a feeling of difference from the majority of their class brought him and his classmate together, and helped them make their way through medical school. “I think that if we hadn’t roomed together, I would have felt kind of isolated,” he remarked. Miguel also had the impression that most of his fellow medical students came from comfortable financial circumstances, and observed that they thus had a hard time understanding the experiences of hospital patients who were worried about covering the cost of their health care. “I know what it’s like to struggle financially, so I have compassion for [these patients],” Miguel told me. “But some of my classmates have never had to work, have never struggled financially, and I’ve seen [these students] struggle to interact with patients because they can’t relate or empathize [with patients who are worried about money].” Miguel was the only student I interviewed who spoke of experiencing financial constraints.

One of the faculty members that I interviewed brought up the issue of diversity at Buena Vista without any prompting from me. “We have a big problem with diversity at this medical school,” Dr. Bob Harrison told me. “All you have to do is read the newspaper to know that. We have a hard time attracting Latino and black students and it’s an institutional embarrassment and I think most of us feel that we will never be globally successful as an institution until we are truly diverse,” he said. At the time of our interview, Dr. Harrison had recently received reports about faculty making racist comments to students, and he was very upset by this and had passed the information on to the deans. But despite Dr. Harrison’s conviction that most of his colleagues shared the belief that the lack of diversity at Buena Vista cast a shadow upon its reputation, none of the other faculty that I interviewed brought this issue up. And when I asked Dr.

Harrison about diversity based on sexual orientation, he told me that his inner circle of colleagues included gay female and male physicians, and they all cared deeply about each other as coworkers and friends, but aside from that he had little knowledge of the sexual diversity or any recent sexuality-based discrimination. Given his acute awareness of ethnic/racial diversity, his comparatively limited insights into sexual diversity were striking.

The preceding discussion indicates that sexual diversity was not on the radar of many medical students who were not themselves in the sexual minority – even those medical students who considered themselves different from their classmates in some significant ways. Next, I show how sexual minority students' experiences at Buena Vista revealed sexual diversity to be salient in ways that often went unrecognized by the wider medical school population.

Sexual minority students' experiences at Buena Vista: Negotiating outness

Some of the queer students I interviewed described experiences of negotiating the disclosure of their sexual orientation as being every bit as stressful as previous literature has described. Norman, for example, was fairly sure that being out as a medical student was risky:

I'm constantly having to think about, like, who can I be myself around. So it's pretty hard, because I'm never quite sure of the repercussions it might have in terms of when I apply to residencies, or if I'm getting evaluated for a clerkship... I'm always wondering if my performance assessment will be colored by what someone thinks of my sexual orientation. I'm always sort of guarded, which is pretty straining on a day-to-day basis. It's almost like code-switching - acting differently, watching my mannerisms, things like that.

Norman told me that he maintained a tight-knit group of friends within the medical student pool with whom he freely shared his identity, but outside of this circle, he managed the disclosure of his sexuality very closely. He sounded tired and somewhat wary as we talked, and asked me several times about the confidentiality of our interview.

His overall experience of being an “LGBT person in medicine” had taken a lot out of him, he told me, and at the time of our interview he was concerned about how to negotiate his sexual identity within residency applications.

Norman’s sense that it was not entirely safe, or professionally wise, to be an openly gay medical student was shared by other gay-identified students that I interviewed. Other gay-identified students reported that they heard homophobic comments expressed by their peers and supervisors often enough to feel uncomfortable about divulging their own sexuality. For instance, William and Don, two gay male students, told me about a discussion concerning same-sex marriage that took place within the medical students’ online forum. The exchange of views became heated, and opponents of same-sex marriage expressed not only their opposition to same-sex marriage but also to homosexuality in general. Reading about their peers’ negative dispositions towards homosexuality and same sex marriage rights impacted William’s and Don’s sense of safety and belonging within the medical school community. Don told me that after reading the comments in the online forum, he felt so upset that he couldn’t study for a test he had the next day. William felt that some of the comments were an indication that he was not fully welcome within the medical school environment:

It was not pleasant...it was kinda divisive, and it even made me not want to talk to certain people anymore, just based on their comments. There are certain people that we just avoid now. Because we know their stance, and knowing what they think of people like me, I’d rather avoid them.

Despite their dismay, William and Don both felt that the opponents of same-sex marriage had the right to express their views, but they were alarmed by the lack of response to the anti-same-sex marriage rhetoric within the online forum. They knew that there were supporters of same-sex marriage in their midst in addition to the vocal opponents, but both William and Don felt that these supporters’ responses to the anti-same sex

marriage commentary did not directly address the hostility and “rudeness” of the anti-homosexuality contingent. Instead of arguing for the fundamental acceptability of same-sex marriage or same-sex desire, the supporters of marriage equality responded to the opponents’ remarks with comments like “let’s not be closed-minded,” rather than defending the fundamental validity of same-sex marriage and non-heterosexual sexuality. William and Don recognized that the number of supporters of same-sex marriage probably outnumbered the opponents, but they also wished that this support could have been made as loud and clear as the anti-gay rhetoric.

I personally did not interview any totally closeted medical students, but heard of their existence. Dr. Terry Olsen, one of the faculty facilitators for SAM small groups told me that in her small groups, she always identified herself to the students as a lesbian physician. Never did students follow her lead and come out within the small groups themselves, but several times, she said, students came up to her at the end of the quarter and told her that they were gay but had been afraid to say so amongst the rest of the small group. These fears might not have been totally unwarranted. Dr. Olsen told me that for a few years running, students complained about her mention of her sexual orientation when they evaluated her as their facilitator. “There were a lot of born again Christians [at Buena Vista] for a while,” Dr. Olsen said, “and I imagine that they were the ones who complained about me outing myself. They wrote that they thought I shouldn’t have said that.” Although I did not observe it myself, the significant Christian student presence was something that more than a few students and faculty remarked upon. Apparently, there was a history of Christian students making their religious views well known, and I heard that one year a few of the Christian students were asked to leave the medical school after “inviting” patients to pray with them.

Although most of the queer students I spoke with mentioned the visible, vocal Christian student presence at Buena Vista, not all of them felt specifically inhibited by it. Doug, the student quoted earlier in the chapter who spoke up immediately and forcefully when he found a film's representation of a gay person stereotypical and offensive, never entertained the question of whether or not he should or could out himself – he simply was who he was, and hiding or attempting to hide his sexuality was not a consideration for him. But Doug's life experiences were broader than those of many of his peers, and he had lived in a few major cities where sexual diversity was a taken-for-granted if not celebrated aspect of society. His perspective on the broader context of gay rights and queer visibility was substantially more developed than most of his peers, and thus while he experienced Buena Vista's social climate, including its degree of gay-friendliness, to be oppressive, closeting himself was not even a remote consideration.

Other queer students I interviewed found the question of whether or not or how to come out or be out more complicated. Duc told me that he was “pretty out” and that his classmates were extremely accepting of him as a gay person. He had posted a picture of himself with his boyfriend on Facebook, and several fellow students had made approving comments about the photo. Duc knew other gay students who felt that they couldn't be out, and he understood why they might feel this way given, as he put it, that “medicine in general is a pretty conservative field.” But he didn't think of himself as being as constrained by medicine's conservatism as his classmates were. However, it seemed that Duc also tended to hedge his bets a little bit, as this story revealed:

At one of the very first events during orientation week we had to do this ‘getting to know your classmates better’ exercise, and they asked the whole group of us questions and people had to stand up when their answer was ‘yes.’ One of the questions was, stand up if you are in a long-term committed relationship, so I stood up for that, and for months afterward people would come up to me and ask me about my girlfriend. I'd say, ‘I don't have a girlfriend,’ and they'd say, ‘oh I remember you

standing up for that thing...' and I'd say, 'well I did but I don't have a girlfriend,' and they would get a confused look on their face and then just walk away rather than ask.

So while Duc felt that he was “pretty out,” and that his classmates were “very accepting,” his version of “outness” was perhaps a little muted. When his classmate asked him if he had a girlfriend after he identified himself as being in a long term relationship, he said no, but he stopped short of saying “No, I have a *boyfriend*” or making some other, more direct reference to the gender of his partner. Duc was a member of one of the small-group discussions I co-facilitated, and during these discussions, he referred to his “significant other” when the subject of dating came up. Other students freely referred to their other-sex partner as “my girlfriend” or “my boyfriend” during these discussions. Duc referred to the “conservative” climate of medicine at multiple points during our interview, and as our interview progressed, I learned that one of his sources of this impression was very close to home: Duc’s older sister was a doctor, and she had urged him not to come out in his medical school applications. He respected her advice, yet also wanted to speak authentically about himself so ultimately, he split the difference with his sister and mentioned only his participation in LGBT organizations in college on his medical school applications, without any other reference to his sexuality. My impression was that Duc had internalized the conservatism he perceived to an extent that he did not quite recognize, and when I told him that, he seemed surprised. I reminded him of how he had referred to his “significant other” rather than specifying the gender of his partner during small group discussions, and the entire expression on his face changed immediately. “I wasn’t even aware that I was doing that,” he told me. While Duc was keenly aware of a normative sexual climate in medicine he was far less aware of the ways in which he responded to it.

“Representing the cause”

Whether or not they agonized over whether or to what degree they should out themselves, the queer students at Buena Vista all shared the stress of feeling like they had to continuously represent gay people as a group in the face of homophobia or inaccurate information. Having to continuously “represent the cause” was something that each of the gay students I interviewed experienced as a strain. These students did not want to sit silently when opportunities arose for them to say something constructive about sexual diversity or LGBT persons, but they also felt that that they were solely responsible for speaking up on behalf of the representation or inclusion of LGBT persons and issues, and they experienced this as both frustrating and unjust. During the online debate about same-sex marriage, Don felt obligated to turn the situation into the “perfect educational moment:”

That situation could have been the perfect educational moment I suppose, if our school had a forum for the discussion of LGBT rights. But we don't have that, and I admit I did not want to go post things like “Hi everyone, as the local gay man, let me educate you on everything related to LGBT issues and being gay.” I could have done that, though... I could have done a lot of things, geared towards providing information for [other students] who were thinking – who have logical minds but weren't thinking logically per se at that moment. Some people don't understand that sexual orientation is not a choice, believe it or not - some people in my class just don't understand that, I've actually had those conversations with them...and they need more information. But the listserv debacle did not provide that.

As a sexual minority, Don felt like he needed to be an ambassador for LGBT issues because if he did not speak up, no one else would, and he did not want that to happen:

There's this sense that, because there's so few of us, we have like this extra burden of carrying, of vehemently carrying that flag. You know, being sort of the spokesperson for EVERYTHING queer, for everything gay, LGBT. If it comes up, WE have to be the one that says, like, THAT'S not gonna fly. That comment's not gonna fly.

Other non-heterosexual students told similar stories. As I described earlier in this chapter, Doug spoke up promptly and did not mince words upon viewing a video that

contained a portrayal of a gay man that he found stereotypical and offensive. But speaking up took a lot of time and energy on his part, and he didn't necessarily want to define his experience or his reputation at the medical school in this one particular way. Despite the fact that Doug had a history of activism for LGBT rights, he experienced Buena Vista to be a particularly challenging place to be queer. As an advocate for himself and other queer persons at Buena Vista, he felt isolated and alone within what he experienced to be a very conservative climate in a way that he never felt before. Although Doug did not feel like he had to retreat into the closet, he did feel like he had to continuously advocate for the fair representation of gay persons on a regular basis, and he neither enjoyed this role nor the environment that pushed him into it. Doug told me a story about one of the times when he found himself in such a situation:

I went to the politics elective and I was sitting the second row and there was a guy in the row in front of me. And he started talking to me about gay marriage. And somehow this got him telling me that he was against gay marriage and I didn't really want to have a conversation with him about that, especially in the first week and in the front row of the politics class which was taught by a republican. But he just kept pushing me to talk with him, and I said, 'Well I don't agree with you and I don't want to talk about this.' And he said, 'Oh but the only way the world's ever going to get better is if people who disagree come to a consensus and try to convince each other.' And I said 'Well, I personally feel hugely outnumbered. I'm the only gay person in this room and I don't really feel like having to explain to you why I deserve the same rights as you. I've talked to people like you before and I know that this is not the way that you convince people that you have your own point of view. I'm not going to argue with you just to make you feel better, like you've listened to the other side.' And he kept pushing me and pushing me, and finally I got him to shut up because he said to me, 'Well, I just think it's disrespectful. I mean I value your opinion. Why don't you value my opinion? I think we're both smart. We can have a reasonable discussion.' And finally I didn't want to talk to him anymore so I said to him, 'I don't know what it is that I've said that indicates to you that I think you're as smart as me,' and that shut him up.

Doug's strategy for dealing with his distaste for the Buena Vista medical school environment and the culture of its surrounding city was to get out of town regularly,

missing classes as he did so. After his absences began to accumulate, Doug eventually found himself in the position of having to explain his situation to multiple deans, who, he said, were both sympathetic to his situation and also perplexed by it. They had every desire to keep him enrolled, and they wanted to do whatever they could to help him. But they also had a hard time understanding how he felt or why he could possibly feel the way he did. They found a gay faculty member to serve as a mentor for Doug, but ironically, it turned out that the faculty member also employed the coping technique of taking frequent trips away from campus and its surrounding locale, so Doug had a hard time hunting down the designated role model because he was often out of town himself.

For these students, the stress of feeling not only like less-than-welcome minority person but also like isolated representatives for all minorities in their category, i.e., non-heterosexual persons, was draining for some and intimidating for others. Before I discuss the broader curricular implications of this trend, I consider non-sexual minority students' impressions of the amount and significance of sexual diversity at Buena Vista. These students' impressions both affirm the validity of the frustrations and challenges experienced by sexual minority students, and suggest that when sexual diversity is made visible within the medical student population, it serves as a very powerful form of informal curriculum.

***Non-sexual minority students' understandings of sexual diversity at Buena Vista:
Equivocal acceptance and limited recognition***

Heterosexual students did not experience the need to make decisions about whether or not being open about their sexual identity might be detrimental to their career, nor did they have to expend time and energy advocating for their rights and recognition. Neither did they necessarily recognize the burden of having to engage in such calculations, or even see these considerations as legitimate concerns. A student

named Nicole told me that her lesbian medical student friend worried about outing herself, but Nicole thought that her concerns were unfounded:

[My friend] told me she feels like [she can't be out]. Her girlfriend moved here, and we were going to go on a class trip, and she wanted to bring her girlfriend but she didn't really know how the class would respond, and she couldn't figure out what to do. But I feel like she's more concerned than she should be. I always tell her, 'Who cares! If people are going to be judgmental that's just embarrassing for them, not you!' I think she worries more than she needs to.

Nicole felt that because she herself was accepting of her friend's sexuality, all of their classmates would be too. Other heterosexual students displayed a similar lack of understanding about the potential salience of sexual orientation. Diana, the student quoted earlier in this chapter, identified as heterosexual and told me that "we're all pretty much one group" when I asked her about the sexual diversity she observed amongst her classmates. When I asked her to explain what she meant, she went on to say:

It's mainly just a heterosexual group. And though I know that there are people that would define themselves as homosexuals, there aren't very many of them, you know, and I don't think that anyone discriminates against that. I just don't think it isn't as prevalent...we're a mainly heterosexual population.

By all indications, Diana was correct in her assessment that the medical students were a predominately heterosexual group. The medical school did not collect data on the sexual orientation of the students it admitted, but all sources I spoke with suggested that there were fewer than ten students who openly identified as something other than heterosexual in any of the cohorts at Buena Vista at the time of my research. But while Diana's comments may have been statistically *accurate*, her words also suggested that she didn't see sexual diversity as being *important*. Darcy, also quoted earlier, identified as heterosexual and told me that sexual orientation "didn't matter" at Buena Vista because the general attitude towards sexuality on campus was, "whatever floats your boat." But Darcy also referred to a social outing that some of the medical students had

taken to a gay dance club one weekend as a “special” trip, taken as a “favor” to accommodate a particular gay student’s “special” request. The contradiction between Darcy’s remarks about the relevance of sexuality suggested that sexuality did indeed matter, but only when it was non-normative.

Other stories that I heard contributed support to this possibility. Emily described the same social outing to the gay club that Darcy had mentioned, but described the reactions of some of her heterosexual male classmates to the experience. When Emily arrived, she found some of the male students waiting outside the club. “Dude, we’re not going in there by ourselves,” they told her. Another student named Elizabeth told me about the discomfort one of her friends experienced upon witnessing a same-sex couple’s interactions at a party:

Elizabeth: [When I was in college] people experimented a lot and you’d heard about someone having a threesome and the collective mindset was something along the lines of, ‘same-sex hooking up, oh, why not try it?’ So that was my experience and frame of reference prior to coming here. But here...here, I’ve noticed that some people are weirded out by that kind of stuff.

Interviewer: Can you give me an example of somebody being weirded out?

Elizabeth: I was at a pumpkin carving party, and one student from the neuro program brought her girlfriend and they were being kind of touchy-feely, like any couple might act with each other, and then a girl that I was with said, ‘oh my gosh, they’re all over each other!’ Her comment made me feel really awkward. I felt like she might not have said that if it had been a boy and a girl, instead of two girls.

Although Elizabeth found it upsetting that her friend was put off by the women’s public display of affection, she kept this to herself and said nothing about the matter to the friend. We might explain her reluctance as the result of a desire to avoid a “courtesy stigma” (Goffman 1963), or as the “spiral of silence” approach would conceptualize it, a desire to avoid the isolation associated with expressing an unpopular opinion (Bowen and Blackmon 2003). For Elizabeth to feel supportive of same-sex relationships herself

but to hesitate to speak up on behalf of them illustrates that it was not only non-heterosexual students who believed that it was risky to talk about sexual diversity or associate oneself with it.

Peer-to-peer interactions and the visibility of sexual diversity

Peer-to-peer interactions also had the potential to make sexual diversity familiar to students in ways that other educational experiences did not. Some Buena Vista students had the experience of coming into contact with sexual diversity for the first time and medical school, and took this exposure as an eye-opening, learning experience. One student named Priscilla told me that she had not had any kind of sexual relationship in her life, and that the same was true for most of her friends. Gay people and people who engaged in sexual activity before marriage were not part of her circle of contacts prior to medical school, so even this amount or degree of sexual diversity was eye-opening for her. Priscilla went on to explain that she had become good friends with one of the gay students within her cohort, and that experience, more than any other, had been educational for her. As she put it,

I guess when you talk about diversity you always talk about just race and ethnicity. Sexuality is probably one of the last things you talk about, but lately I've met people with different sexual identities, and I never really would have known about this stuff if I hadn't met these particular students. I think a lot of education has to come from your classmates because your classmates are so diverse so if you have friends that are gay, and you know, engaging in different sexual practices, by dealing with them and by becoming friends with them and spending time with them, that's how you learn how to interact with patients that are like that. So I feel like... the real education [about sexuality] comes from interacting with your classmates.

Priscilla described herself as introverted and not necessarily inclined to make friends outside of her comfort zone, but the structured demands of her medical school classes gave her the opportunity to have routine contact with and then become familiar, and finally, friendly with students – and *types of persons* – that she might not have otherwise

gotten to know. In order for her to become more aware and understanding of gayness in general, she had to make friends with a fellow student who was gay, and for her, the only way that this could happen was through the sustained, informal contact with peers that the medical school environment engendered.

Another student named Grace described a similar set of experiences. She went to the same college as many of her friends from high school, and she remained close with this group of friends throughout college without making many new ones. She described her background and that of her friends as “conservative and Asian.” Upon entering medical school, she made friends with Duc, the gay-identified student quoted in this chapter. Through her interactions with Duc, she became aware of the salience of sexuality as a potential dimension of human diversity, and recognized, from Duc’s influence, that discussion of sexuality in general and LGBT-specific issues in particular were largely absent from their classes. “If it weren’t for Duc, I don’t think I would have been aware of the lack of sexual diversity in our class,” Grace told me. Grace’s experience is telling in many respects. By her own estimation, her total lifetime awareness of sexuality-related and LGBT-related matters stemmed primarily from a particular aspect of her medical school experience: her friendship with a gay classmate. She identified herself as heterosexual, and also told me that she had not yet “had sex,” nor had the friends that she kept prior to entering medical school.

Priscilla’s and Grace’s comments evoked themes that were present in other students’ comments. A handful of students mentioned that they had never had a romantic partner before, or had not dated much in the past. Many students described life experiences that centered around formal education and academic achievement – to the exclusion of extraneous activities - crowned by the achievement of getting into medical school. This is not an unusual path for medical students to follow (Smith and

Kleinman 1989; Wagoner 2000), and their lack of sexual or dating experience and their lack of exposure to persons with different sexual identities or different sexual experiences were but one manifestation of their limited life experiences. But even students who did not reflexively consider themselves to have had a particularly limited set of life experiences prior to medical school reported learning about sexual diversity from their peers:

Interviewer: What have been your sources of information about sexuality since coming to medical school?

Lucy: Mostly the people around me, I would say. Pretty much from one particular friend who is gay and posts about events that are going on. I would say him, and from my brother [a fellow medical student at Buena Vista, who was gay] too.

Interviewer: Can you tell me how your attitudes about sexuality or your understandings of the relevance of sexuality have or haven't changed since you've been in med school?

Lucy: I feel like I am more exposed to different dimensions of sexuality because I've learned from other people...just what is out there besides heterosexuality. About sexual identity and the challenges that people of a different sexual orientation have to go through in society. It's like, wow, I didn't know that or I had no idea that this existed or I didn't know that people had to go through this, so I feel like my perspective is still growing. I've been learning more and more since med school started, but not because of med school.

Translated into the language of curricular processes, we might say that while Lucy did not feel that she had learned much from the formal curriculum of the medical school, she learned a lot from its informal curriculum.

I heard a number of stories from gay students about hearing homophobic jokes made by peers or faculty members, and understandably, being witness to these situations made the queer students feel very uncomfortable. In some instances the student told me that they did not have the power to speak up and challenge the person who made the joke without taking on the brunt of both the homophobia of the joke and the possible desire for recrimination from the joke-maker, but in some instances students

took the situation head on and responded to the person who made the comments. Duc told me a story of a hearing a male classmate wonder aloud during anatomy lab, “Does it make me gay if I know what outfit I’m going to wear a couple of days in advance?” “No,” Duc told him in response, “It makes you kind of offensive.” It turned out that this joke-making classmate had had little previous exposure to gay persons, and he ended up befriending Duc and asking him all sorts of questions about what it was like to be gay, and what sorts of things he should avoid saying, as a straight person, to avoid causing offense in the future. Duc was amused by the questions and glad that his classmate was able to learn and gain some exposure and new perspectives. Duc, of course, was an interesting case – as I described earlier, when a classmate who knew he was in a long term relationship asked him about his girlfriend, he responded to the assumption that his romantic partner was female in a manner that allowed for some confusion about his sexuality to remain. But his equivocation in one setting does not make his challenges to a classmate’s derogatory remarks in another setting any less significant. For some students, interactions like these ended up being a very important source of learning about sexual diversity.

Conclusion

This chapter demonstrates that the informal curriculum – previously under-explicated within the theoretical literature and unwieldy as an object of study – is a substantial source of meanings about sexuality, which may ultimately have more bearing upon what students learn about sexuality and sexual diversity than the formal curriculum. While surveys of curricular hours provide a starting point for understanding the current state of medical sex education, looking beyond the countable hours of teaching devoted to a particular topic is critical for a nuanced, comprehensive understanding of what students may actually learn about sexuality or sexual diversity. In

this chapter I have focused on three aspects of the informal curriculum, or three types of informal curricular processes, that influenced what students learned about sexual diversity at Buena Vista.

At times, informal curricular processes reduced the impact of formally-offered teachings about sexual diversity. The culture of Buena Vista prioritized bioscience, and this shaped the structure and delivery of the social science curriculum that was provided, as well as the faculty and student responses to it. Because students did not feel compelled to attend SAM lectures and were not effectively required to do so, the majority of their exposure to the SAM curricula came in the small group discussion settings where no one present was likely to have a vested interest in delving deep into the designated content, especially when the subject of sexuality pushed the threshold of comfort levels or threatened students' veneer of political correctness. Thus, whatever sexuality-related teachings were provided within the formal curriculum were likely to be lost – so even if Buena Vista had provided more hours of LGBT-specific content, they might not have achieved the desired impact in the absence of additional structural and cultural changes.

Informal curricular processes were also a generative source of messages about the presence or absence and importance of sexual diversity. Previous research has affirmed the importance of the informal curriculum in the form of spontaneous, faculty-student and peer-to-peer interactions for determining the experiences of minority medical students and the marginalization they have faced, but it has not examined the ways that sexual minority students' experiences may tell us something important about what *all* students learn about sexual diversity. This chapter moves beyond the examination of individuals' experiences of marginalization and shows that the experiences of sexual minority medical students have profound consequences for what

all medical students learn about human differences. If gay medical students choose to stay closeted, or choose to get out of town as often as possible in order to escape an environment that they experience as stifling, conservative, or hostile, their physical absence or their invisibility creates a certain sort of sexuality curriculum. Within such a context, other (i.e., non-sexual minority) medical students may be pardoned for getting the impression that sexual diversity is not present or “doesn’t matter.”

But on the other hand, when students like Doug speak up and say things like, “You know what, this portrayal of gayness is stereotypical, limited, and offensive,” as he did in response to a video that was shown during a small-group discussion, all students who are present to witness the exchange learn something about sexuality, sexual diversity, and perhaps, the likelihood that these aspects of identity will remain invisible in the absence of any efforts to make them less so. The irony is that when gay students choose to remain closeted for their own protection, they may unintentionally contribute to the reproduction of the notion that sexual diversity “doesn’t matter” or does not exist within medicine. Of course, Doug experienced stresses of his own for being unequivocally out – he experienced the surrounding culture to be stressful and oppressive just as Norman did, even though Doug was unabashedly out and Norman was very selective in revealing his sexual identity. Herein lies the opportunities for institutions to influence the informal cultures that medical students experience.

One practical implication of this chapter is that if medical schools are concerned about what their students learn about sexual diversity, or seek to teach their students to develop “LGBT cultural competence,” fostering an environment in which faculty make the visibility of their own sexual diversity a priority may be a key ingredient. This is likely to require a recognition that sexual diversity is important on the part of an entire medical school faculty, not just non-heterosexual faculty themselves, in order to prevent the

development of a climate in which the attitude “Okay you’re gay, but why make an issue of it?” prevails. When sexual diversity is visible amongst faculty, sexual minority students are more likely to get the message that they can be open about their own sexual identities without fear of personal or professional repercussions.

If medicine is or is likely to remain a profession that is conservative in the sense that a strict hierarchical structure governs relations between its established members and its incumbents, then faculty influence matters much for what students learn about sexuality. If faculty regard for sexuality-related curricula is perceptibly high, students will likely be influenced to regard it similarly. If sexual diversity is modeled amongst faculty, students will be more likely to regard non-heterosexuality as normal and routine, and queer students will be more likely to come out themselves. This visibility of sexual diversity amongst faculty and students will either augment already-sufficient formal curricula concerning sexuality, or, as this chapter suggests, potentially serve as the most meaningful set of teachings about sexual diversity that medical students receive.

As a theoretical construct, the “informal curriculum” pertains to a broad set of processes that would benefit from a combination of additional theoretical explication and empirical application. This chapter indicates the utility in devoting additional empirical research to informal curricular processes for the sake of developing a better conceptualization of the various types of informal curricular processes and the relationships between them. However broad or unwieldy informal curricular processes may be as a category of phenomena, this chapter indicates how important these processes may be to understanding what medical students ultimately learn about sexuality and sexual diversity – and the extent to which their impact may be unpredictable. The findings from this chapter illustrate the importance of additional ethnographic study of medical sex education to better understand the reception of formal

curricula, and the other processes which contribute to the net messages about sexuality that are available within an educational environment.

CHAPTER 4

THE HIDDEN CURRICULUM OF HETERONORMATIVITY

The subtle (re)production of normative sexuality

In this chapter I discuss the processes by which a hidden curriculum of heteronormativity was produced at Buena Vista at the level of the formal curriculum, or the officially-offered, required classes and related activities (Hafferty 1998). In doing so, I show how a certain set of sexual possibilities (i.e., heterosexual ones) were repeatedly rendered natural, knowable, and unremarkable, while other sexual possibilities were largely excluded from the realm of the obvious, the normal, and the intelligible. Judith Butler (1999) argued that the cultural intelligibility of persons, or the extent to which a persons can be recognized qua persons by others, as fellow humans embodying “livable” ways of being, is predicated upon the presentation of normative sex, gender, and sexuality. The achievement of intelligibility is important – to put it mildly – insofar as it guarantees the recognition of shared humanity from others. We do not yet have a theoretical framework for understanding the relationship between the intelligibility of patients to doctors and health care outcomes, but we might reasonably imagine that the extent to which doctors understand patients as fellow humans, embodying recognizable ways of being, shapes their capacity to deliver care that patients experience as sensitive, compassionate, and effective.

I also show how the processes by which normative sexuality was constructed “hid in plain sight,” through talk and action that seemed unproblematic, if it was even noticed at all. The creation of vague yet powerful distinctions between appropriate and inappropriate sexuality was accomplished unintentionally through practices that seemed unremarkable and harmless. Previous research has noted the presence of homophobia and heterosexism within medical education (Townsend 1998; Murphy 2001), and a lack

of curricula specific to the needs of lesbian, gay, bisexual, and transgender (LGBT) patients in most North American medical schools (O’Hanlan et al. 1997; Eliason et al. 2011; Obedin-Malevir et al. 2011). Because the essence of heteronormativity is its veneer of harmlessness, it is less easily detected than overt denigration of sexual minorities, which, while still a feature of American society, is increasingly understood to be unacceptable (Jenkins et al. 2009), or a lack of curricula devoted specifically to sexual minorities, which can be measured objectively.

Examining heteronormativity is particularly important in the context of mounting medical interest in a certain type of medical sex education, specifically, the training that medical schools provide their students to address the specific needs of lesbian, gay, bisexual, and transgender (LGBT) patients (e.g., Obedin-Malevir et al 2011). This heightened attention coincided with, and was probably driven by a 2011 report from the Institute of Medicine (IOM) entitled, “The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding” which acknowledged the unique stigma associated with sexual minority status, the stress that comes from experiencing this stigma, and the need for medical professionals to better understand these patient populations. As awareness of the relationship between medical professionals’ actions and sexuality-related health inequalities grows, questions about the production of normative understandings about sexuality within medical education are particularly salient.

As I discussed in Chapter 3, informal curricular processes may interfere with the reception of material provided within the formal curriculum, rendering isolated moments of LGBT-specific content even more “limited” than critics argue these curricula already are. In this chapter I show how prevalent an embedded set of messages that quietly privilege some sexual possibilities over others may be, and argue that their recognition is

essential to any effort designed to promote awareness of sexual diversity or to reduce sexuality-related inequalities. This is important not only in conjunction with the relatively recent uptick in interest about the amount of curricula that is specifically devoted to LGBT issues, but also because of the research that has associated the medical profession with overt hostility towards non-normative sexuality in the past.

Medical knowledge and the (re)production of sexual stigma

Sexuality scholarship attributes the historical origins of much of the stigma associated with sexuality in general and non-normative sexualities in particular to the medical establishment (Martin 1993; Epstein 1996; Terry 1999; Irvine 2003). Drawing upon the work of scholars such as Michel Foucault, Gayle Rubin 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 non-normative sexuality is by definition especially harmful to participants and threatens the stability of society ([1984] 1993). Medical professionals (along with other entities) helped create and maintain a line between normal, natural, healthy sexuality and abnormal, unhealthy, immoral sexuality. This line between the “charmed circle” of good sexuality and the “outer limits” of bad sexuality was maintained through overt discrimination against and hostility towards sexual nonconformists, and laws and policies pertaining to sexual behavior. Medical opinion served to legitimate a hierarchy of sexual value that rationalized the well-being of the sexually normative and the stigmatization of the sexually deviant (Rubin [1984] 1993).

There is plenty of evidence from recent decades up to the present of sexual stigmatization within the medical realm, and thus, Rubin’s formulation of the relationship between the medical profession and sexual stigma remains compelling. Within health care, sexual minority patients have experienced hostility, discrimination, coldness, or

neglect from health care providers on the basis of their sexuality or sexuality-related health condition. Persons with HIV/AIDS have negotiated discrimination from doctors and other health care providers (Weitz 1990; Emler 2007), which sometimes takes overt forms, such as being refused treatment or hearing derogatory remarks from doctors and nurses, but has also come in more subtle configurations, such as receiving care that is less thorough or less emotionally supportive than usual (Schuster et al. 2005). Transgender patients have experienced hostility, coldness, and outright rejection from health care providers (Dewey 2008; Poteat et al. 2013). Lesbian women have received nonempathetic responses to disclosure of their sexual identity and have felt at risk of harm within health care encounters (Stevens and Hall 1998). Gay men have experienced care perceived to be homophobic, heterosexist, or grossly ignorant (Beehler 2001). Within medical training, queer medical students have experienced marginalization (e.g., Townsend 1998; Brogan et al. 1999; Murphy 2001), or negotiated the negative beliefs about homosexuality professed by their heterosexual peers (Klaman et al. 1999).

Conceptualizing the production of inequalities in an era of increasing egalitarianism

But even if there is ongoing and recent evidence of sexual stigma within medical education and health care encounters, the processes by which sexual stigma is collectively produced within medicine are not fully understood – and have probably changed in important ways as shared societal understandings about sexuality in general and sexual minorities in particular have changed substantially in recent decades (Seidman 2009). There has been a retreat from systemic discrimination against sexual minorities in many institutions in the United States, and demonstrations of overt antipathy towards sexual minorities are less acceptable (Seidman 2009; Jenkins et al.

2009). Many medical schools are among the institutions that include sexual orientation clauses in their anti-discrimination and anti-harassment policies. Within the context of increasing social and legal protections for sexual minorities, it seems possible that more and more medical professionals and students would recognize, at least nominally, that antipathy towards sexual minorities is antithetical to the delivery of effective, equitable medical care, particularly considering that medical students frequently cite a desire to help others as a primary reason for seeking entry into the profession and medical professionals often see themselves as people who make positive changes in people's health, and save lives (Wagoner 2000; Boulis and Jacobs 2008). In other words, we might expect that whatever distinctions between "good" and "bad" (or, at least, "less good") sexuality are still being drawn occurs through processes that are softer, more subtle than past approaches to distinguishing between "healthy" and "pathological" sexuality.

Scholars argue that this sort of social evolution has occurred within the realm of race/ethnicity-based inequalities. Even as civil rights for racial/ethnic minorities have increased in recent history and overt expressions of racial discrimination or prejudice have become less acceptable, race-based inequalities remain a marked feature of American society (Bonilla-Silva 2006). As norms of egalitarianism have become more prevalent, Eduardo Bonilla-Silva argues, "color-blind racism" has emerged which is subtler and less obvious than the overt racism of the Jim Crow era. Color-blind racism relies on an "arsenal of rhetorical tools to avoid the appearance of [hostility towards the minority]" (Bonilla-Silva 2002: 63) and allows members of the dominant racial group to express antipathy towards minorities without crossing the threshold into what currently counts as "racist" talk. Race and sexuality are different in many respects as axes of social inequality, but the important point to take away from the analysis of color-blind

racism is Bonilla-Silva's claim that the expression of "resentment" or "hostility" toward minorities is "largely irrelevant for the maintenance of privilege" (2006: 8).

The conceptualization and terminology of sexual marginalization

Although overt expressions of antipathy towards or the systematic exclusion of sexual minorities have not disappeared entirely and remain important as objects of inquiry, the literature on sexual inequalities has devoted more attention to blatant forms of oppression and less to processes that are akin to color-blind racism: exclusionary, but more subtly so. Much of the terminology used to conceptualize sexuality-related marginalization and antipathy assumes that their expressions are overt and obvious. Here I provide a brief review of the terminology of sexual marginalization and explain the particular utility of heteronormativity for examining the production of what Brenda Beagan calls "everyday inequalities," or daily practices of inclusion and exclusion whose effects as individual instances may seem minor or even innocuous, but, through frequent repetition, have tremendous impact in the aggregate (2001: 590). "Heteronormativity" is related to "homophobia" and "heterosexism" and what Gregory Herek (2004) terms "sexual stigma" and "sexual prejudice." Among social scientists concerned with sexuality, these terms have been both debated and conflated. Some scholars argue that one term is more useful than the others, some argue that there is more overlap than distinction between them, and others imply consonance when there is actually room for meaningful distinctions.

My position is that there are meaningful differences between these terms, and the distinctions between them help provide analytic purchase on different aspects of the production of sexuality-related inequalities. My argument in this chapter is based on Celia Kitzinger's claim that within the broader set of concerns about LGBT discrimination and what to do about it, little attention is paid to the continuous processes by which "a

heteronormative social fabric is unobtrusively reweaved, thread by thread, persistently, without fuss or fanfare, without oppressive intent or conscious design” (Kitzinger 2005: 478). While concern about the amount of LGBT-specific curricula that medical schools provide is far from unimportant as is the problem of patients feeling stigmatized on the basis of their sexuality within clinical encounters, so too is it important to attend to the latent messages about sexuality that are produced when nothing unfair or even unusual seems to be going on, for, as I will show, it may be in these moments that normative sexuality is produced in ways that no one even recognizes. And as Bonilla-Silva’s argument about the changing nature of racism suggests, it may be these sorts of normative regulation that we should be concerned about as the social and legal climate surrounding sexual diversity changes in ways that are generally considered to be progressive.

Homophobia

The term “homophobia” has come to be widely understood as a referent to anti-gay attitudes, ideologies, and practices (Adam 1998). Coined by psychologist George Weinberg in 1973, the term had great historical significance as it helped shift the analysis of social problems associated with homosexual persons away from homosexuals and towards their antagonists (Herek 2004). In the decades since, the term has come into widespread use within popular and academic discourse, and has also been critiqued by scholars. Their points of critique are numerous, so here I briefly consider only the most salient issues.

Gregory Herek argues that the “phobia” suffix inappropriately suggests that *fear* of homosexual persons is the primary issue, and implies that fear of homosexuals is on par with other phobias, such as a fear of spiders or heights – while little empirical data supports either of these possibilities (2004). Barry Adam points out that the concept

rests upon an individualist, psychological conceptualization of social problems:

“homophobia” is commonly understood as an irrational fear of or a mistaken set of ideas about homosexuals held by a limited group of prejudiced individuals (1998: 388). This conceptualization, he argues, is in line with typical explanations of social problems in liberal, democratic nations insofar as it locates the source of social problems within individuals, rather than as a feature of society itself. Within such a framework, homophobia becomes seen as a “personal pathology of specific individuals who deviate from the supposedly egalitarian norms of society, thus obscuring analysis of our oppression as a political problem rooted in social institutions and organizations” (Kitzinger 1987: 154).

Another flaw of “homophobia” is its implication that sexuality-related antipathy is (“always” or “only”) a matter of “heterosexuals” reacting negatively towards “homosexuals” (Herek 2004). Discrimination or stigmatization related to sexuality does not always operate in this unidirectional manner, and furthermore, the implication that the categories of “heterosexuals” and “homosexuals” are ontologically stable is problematic in and of itself. As queer theory makes evident, part of the problem with studying homophobia or relying too heavily on the term is the possibility of reifying the notion that there are persons, identities, cultures, institutions, acts, etc., that are fundamentally, inherently “heterosexual” or “homosexual” (Seidman 1996).

Despite these and other critiques, “homophobia” remains a powerful referent for hostility and violence directed towards sexual minorities. Even if the term is under-defined when put to use, scholars continue to make use of it as a social fact, pointing to the enduring presence and consequences of homophobia in North American society (e.g., Walters and Hayes 1998; Aguinaldo 2008; Jenkins et al. 2009). Furthermore, it is likely that homophobia is widely understood and recognized by the general public as an

expression of anti-gay belief and action – and an increasingly unacceptable set of beliefs and actions, at that. Other terms connoting sexual marginalization likely do not have the same recognition outside of academic discourse, and thus, homophobia remains a powerful link to public understandings of sexual marginalization. For these reasons, I use “homophobia” as shorthand for various forms of overt hostility towards sexual minorities, which, as Herek acknowledges, often takes the form of heterosexuals stigmatizing non-heterosexuals.

Heterosexism

Herek defines heterosexism as the ideology that “denies, denigrates, and stigmatizes any non-heterosexual form of behavior, identity, relationship or community” (1992: 89). Like other ideologies, heterosexism supports socio-legal and cultural arrangements that distribute material rewards in a particular way. Laws pertaining to sexual behavior (such as anti-sodomy laws); policy and law regarding marriage and the adoption of children which are often linked to sexual orientation; immigration and asylum rights; and the inclusion (or exclusion) of sexual orientation from anti-discrimination policy are all examples of how sexuality is formally tied to the distribution of rights and resources. The strength of the term “heterosexism” is its emphasis on the systematic differential distribution of material resources on the basis of sexual orientation. As Herek (2004) rightfully points out, “heterosexism” has at times been used interchangeably with “homophobia” - and sometimes with “heteronormativity” too (see for instance Land and Kitzinger 2010). As a solution to the definitional problems and conceptual murkiness, Herek proposes “sexual stigma” and “sexual prejudice” as solutions.

Sexual stigma and sexual prejudice

Herek argues that regardless of their personal beliefs or attitudes, all members of American society share the knowledge that homosexuality is widely considered wrong or

bad or at the very least, inferior to heterosexuality, even if not all members of society consciously adhere to such beliefs themselves (2004: 14). Because of this, non-heterosexual persons are subject to sexual stigma, or the discrediting of their entire personhood on the basis of their sexuality. While Herek acknowledges that “sexual stigma is continuously negotiated in social interactions,” (2004: 15), he also posits a “set of hierarchical relations” in which heterosexuality being seen as superior to homosexuality, and the stigmatized, i.e., the homosexuals, have less power than the non-stigmatized “normals.” Within this conceptualization, the complexity of sexual possibilities and the normative regulation thereof is reduced to a heterosexual – homosexual dichotomy. But Herek does propose that “sexual prejudice” might replace “homophobia” as a referent to hostility associated with negative attitudes towards sexual orientation, pointing out that this terminology helps get away from the presumption that sexuality-related hostility is always or only a matter of heterosexuals marginalizing homosexuals. But even if this terminology might represent a conceptual upgrade over “homophobia,” its use has yet to catch on.

Heteronormativity

Heteronormativity is not completely distinct from the aforementioned terms, but contributes much to the theoretical framework for analyzing the production of sexuality-related marginalization. Heteronormativity refers to the innumerable ways in which heterosexuality is posited as the natural, normal, unproblematic, taken-for-granted way of being (Sumara and Davis 1999; Kitzinger 2005; Jackson 2006). Furthermore, it pertains to the myriad ways in which heterosexual *privilege* is insidiously and pervasively woven into the fabric of everyday life, ordering everyday existence (Jackson 2006: 108).

Heterosexuality (and with it, heteronormativity) is predicated upon an understanding that gender and sexuality and the relationship between them are the

expression of an “underlying natural universal order” that presumes two and only two sexes and genders that are “naturally” opposite and naturally attracted to each other, prescribing both normative sexual relationships and a normative way of life (Kitzinger 2005; Jackson 2006). What exactly this appropriate, natural life should look like varies across contexts and shifts over time (Seidman 2009), but despite this variability, there remains a generalized set of cultural myths about what the quintessential heterosexual identity and its idealized life course should entail (Sumara and Davis 1999). Thus, heteronormativity regulates heterosexuals too – attaining full sexual normalcy is not only predicated upon claiming a particular identity, but engaging in all of the appropriate behaviors ascribed to it, such as monogamy, marriage, and having children (see for instance Fields 2001; Jackson 2006). Heterosexuals who eschew monogamy or engage in commercial sex or BDSM (an umbrella acronym for bondage, domination, submission/sadism, and masochism) activities are likely to derive little moral capital from their participation in the realm of other-sex desire – and have a long history of being stigmatized by medical professionals (Bezreh et al. 2012). Conversely, it is increasingly common for homosexuals who engage in heteronormative rituals such as committed, life-long monogamous relationships and childrearing to benefit from heteronormative privilege – or at least, to experience privilege over homosexuals that do not conform to heteronormative ideals (Seidman 2009)¹⁷.

The term heteronormativity has been critiqued for implying that “anti-gay practices and ideologies are *simply* a question of norms” (Adam 1998: 388; emphasis mine), but norms give rise to and are sustained by structural and institutional patterns, and set the parameters for “natural” or default attitudes that govern the framework for social action. For instance, the default assumption that everyone is heterosexual, *and*

¹⁷ This may be described as “homonormativity.” For discussion, see Pfeffer 2012.

heterosexual in a certain way (even in conjunction with the abstract knowledge that this is not actually the case), may translate into practices such as asking a man “What does your wife do?” or “What does your girlfriend think about this?” which reflect heteronormativity if asked prior to questions like, “Do you have a partner? What is their name?” Such questions may seem harmless, and they are indeed very different from violent, homophobic hate crimes or systematic exclusion of sexual minorities from particular rights or privileges. But the cumulative effect of these occurrences is significant (Beagan 2001), because these are the sorts of questions that queer patients find stressful and prohibitive to open communication within clinical encounters (Harbin et al. 2012). Non-heterosexual patients cite experiences of heteronormativity in medicine as reasons for delaying medical treatment or avoiding it entirely, leading to adverse health outcomes (e.g., Epstein 2007; Kinsler et al. 2007; Poteat et al. 2013).

A critical distinction between heteronormativity and the other terms I have discussed – homophobia, heterosexism, and sexual stigma – is that unlike these other terms, heteronormativity does not necessarily require any malicious or hostile feelings towards non-heterosexuals, or non-normative heterosexuals, or any deliberate attempts to discriminate against sexual minorities (Kitzinger 2005). On the other hand, “homophobia,” “sexual stigma,” and “sexual prejudice” each imply a certain amount of negative regard. “Heterosexism” most usefully pertains to structures that distribute resources and shape life chances in particular ways. While the perpetuation of these structures may be more the result of inertia than ill intent, laws and policies and other institutional forms that privilege some over others were the result of conscious choice, at least at their inception. The whole point of heteronormativity is that it is likely to occur in the absence of intentional exclusions or conscious antipathy.

Furthermore, scholars have noted that heteronormativity can easily coexist with increasing social and legal rights for sexual minorities and a decline in homophobic attitudes, particularly among more educated demographic groups (Jenkins et al. 2009; Seidman 2009). As sexual diversity is increasingly subject to institutional protections in a manner similar to race/ethnicity and gender, it is ever more important to examine the ways in which inequalities are produced through seemingly innocuous behaviors. This is particularly important for understanding how inequalities are produced within institutions that have anti-discrimination and anti-harassment policies firmly in place, and are populated by persons who define themselves by a desire to help others – such as medical schools.

Thus, the concept of heteronormativity directs our awareness to the frontier of the production of social inequalities. When we limit the study of inequality to looking for practices that are deemed discriminatory or prejudiced, we capture only behaviors that more or less everyone has already agreed are unacceptable. Heteronormativity often is not recognized because it is produced through behaviors that reify taken-for-granted social arrangements and thus are not usually deemed problematic. Powerful groups often do not recognize their own identities as particular rather than as one specific possibility within a host of others, and often do not recognize the ways in which their particular identities place them in a position of relative privilege or advantage – nor the ways in which others are relatively disadvantaged (Seidman 1996; Kimmel [2000] 2008). But even persons who do not identify as heterosexual may not necessarily notice the heteronormativity that surrounds them. For these reasons, heteronormativity is a particularly important and particularly challenging concept to research.

One of the contributions of this chapter is thick description (Geertz 1973) of heteronormativity in action. Although the term heteronormativity has come into

widespread use within the sexualities literature, relatively little empirical research actually shows what heteronormativity looks like in practice. This may be because examining heteronormativity requires an examination of the “obvious as phenomenon” (Zimmerman and Pollner 1970: 80), or an examination of social practices that ordinarily seem so routine or unremarkable that there seems to be little reason for their systematic study. Looking for the “mundane quotidian actions that result in the routine achievement of a taken-for-granted world that socially excludes or marginalizes non-heterosexuals” helps us better understand why normative heterosexuality remains impervious to change (Kitzinger 2005: 478), even in the absence of overt hostility to sexual minorities and even when there is some nuanced, insightful, inclusive LGBT-specific material within a curriculum. Celia Kitzinger’s (2005) use of conversation analysis shows how heteronormative understandings of nuclear families are reflected and reproduced through after-hours emergency medical calls is an example. But some research that purports to demonstrate heteronormativity actually extrapolates from respondents’ experiences of what might more accurately be characterized as homophobia in order to make the case that heteronormativity exists (e.g., Cech and Waidzunus 2011). The distinction between heteronormativity and more overt forms of sexual stigma is not only theoretically important, but also has implications for the practice of medical sex education and the recognition of the processes by which inequalities are produced, as I will discuss throughout this chapter.

The hidden curriculum

In the educational context, one specific way that heteronormativity may come to be encoded and transmitted is through the “hidden curriculum.” Sociologists of education in general and medical education in particular agree that much of what is learned within any given educational environment comes from the hidden curriculum, or

the unintended, embedded, latent messages within curricula (Hafferty 1998; Hafferty and Castellani 2009). Many observers of medical education have taken up the concept of the hidden curriculum to point to discrepancies between what is officially taught at the level of the formal curriculum, especially within required coursework pertaining to ethics, and the behaviors that are modeled at the level of the informal curriculum, within the interactions between students and faculty or the interactions between faculty and patients that students witness (e.g., Jaye et al. 2006; Browning et al. 2007).

This usage of the concept of hidden curriculum within the literature on medical professionalism suggests that the hidden curriculum is only or primarily produced through contradictions between what is formally taught during pre-clerkship years, i.e., in the classroom, and what is later informally modeled by attending physicians and other superiors during clinical rounds. The implication is that the messages within the formal coursework are “correct” or internally consistent or both, and that contradictions arise when students go on to witness less-ethical or contradictory practices on hospital floors. But the content of the formal curriculum may not be as internally consistent as it is presumed to be, and what students learn in practice on the hospital floors may not necessarily trump what they learn in class – although it is often assumed that this is so. In the ensuing discussion I illustrate how embedded messages can be present earlier in the pipeline of medical training¹⁸ than is commonly recognized, and how a hidden

¹⁸ As I discussed in Chapter 2, one of the many things we do not know about medical sex education is what medical students “should” learn about human sexuality and when they should learn it. Some Buena Vista faculty argued it could only be effective during residency, when students had a little more clinical experience under their belts. Others were sure it needed to be placed during the pre-clinical coursework, so students would be better prepared for residency. Still others believed that students would learn about sexuality through experience, over the course of their careers one way or another. One Buena Vista faculty member told me that he thought medical students should receive adequate human sexuality education *before* they even started medical school. Questions about when and in what context particular medical knowledge should be transmitted are far from open-and-shut matters, as are questions about the relative impact of different periods or phases of the course of training.

curriculum may be produced solely *within* the formal curriculum, not only *between* the formal curriculum and other levels of curricular processes.

Part of what this chapter demonstrates is the strength of ethnographic methods for examining the contours and content of a hidden curriculum. Because heteronormativity resides in the realm of conduct, rather than in beliefs or attitudes (Kitzinger 2005), and through talk and action that seems innocuous, especially when examined as isolated occurrences, participant observation in ongoing medical curricula-in-action yields insights into the production of sexual inequalities that are not accessible through other types of inquiry.

This chapter also demonstrates how a hidden curriculum of heteronormativity can coexist with LGBT-specific content. As I described in Chapter 3 (and will provide additional examples of in this chapter), LGBT-specific curricula was not absent from the formal curriculum at Buena Vista, and during some years (depending on student interest) supplemental LGBT-specific lunchtime lectures were offered too. While all indications suggested that sustained discussions devoted explicitly to sexual diversity were limited to a few hours at most and thus might have been considered insufficient from the perspective of some, my intention here is to show how focusing on medical schools' LGBT-specific teachings within the formal curriculum bypasses many other important questions about the processes by which normative understandings of sexuality are constructed and sexual inequalities may be produced. I now turn to an in-depth examination of how a hidden curriculum of heteronormativity was produced within the formal curriculum at Buena Vista.

What counts as “sex”? Defining the parameters of sexual diversity

For many years at Buena Vista, the first significant moment of discussion of sexuality came early in the medical students' first quarter of medical school. Although

some aspects of this day in the Physician-Patient Dynamic (PPD) class varied from year to year, many components of the day remained consistent for quite some time. Both medical students that experienced “sex day” at the time of my participant observation and medical students who had experienced it a year or more earlier, referred to this educational moment as “sex day,” or the “day we pushed the buttons and answered questions about our sex lives.”

“Sex day” began like any other day of the PPD class. Theoretically, lecture began at 8:00 a.m., but this was not so much an actual starting time as the time at which things slowly began to cohere within the lecture hall. School had been in session for a little over a month, but already, attendance of the PPD lectures was dwindling. At 8:05 a.m. the lecture hall was barely half full, and the talk had not begun. Students quietly trickled in as the lecture got underway, but the lecture hall was never as full as it had been the first two weeks of the quarter. Dr. George Sorin started off the day’s lecture by telling the class that he was going to pose a series of questions to them as a group, which they were to answer honestly using an electronic polling response system. Dr. Sorin, the overseer of the PPD class, was a semi-familiar figure to the students. He had introduced the course on the first day of the term, but he had not participated in subsequent lectures. Dr. Sorin asked the students to answer the questions seriously and honestly, because their responses would be anonymous and it would really screw up the exercise if people intentionally provided false information for the sake of being funny. The rules of button-use were briefly articulated. Each student had a set of buttons in front of them which were wired to the auditorium’s automated polling system. Students were to press a certain button based on their gender, and their response to the particular question. Thus, if the question was, “Have you ever had sex before?” a female student and a male student answering yes would use different buttons to indicate

their response, disaggregating their responses by gender. Their answers would show up as aggregated data on the projector screen for the whole class to see.

Dr. Sorin's first question to the class was, "Have you ever dated?" Male voices called back in response, "You mean a GIRL?" Hooting and hollering erupted against a backdrop of whispers and giggles. Without missing a beat, Dr. Sorin clarified his question. "Have you ever dated romantically?" he rephrased. Thus began a lecture/discussion/curricular event in which heteronormativity was disrupted in one moment and reproduced in the next. By asking "have you ever dated?" the lecturer left the door open for students to respond based on their own understandings of "dating." By responding, "You mean a GIRL?," male students in the room loudly suggested the normative contours of what "dating" entailed for them. By not responding directly to their question, Dr. Sorin subtly destabilized the assumption of heterosexual dating by keeping his question gender-neutral even as he made it more precise, through the specification of "romantic" dating. Whether or not this made an impression on the audience is another question entirely.

Dr. Sorin continued to pose questions, students continued to comment, and answers continued to be provided in this relatively staccato fashion. Sometimes one question led to the next, sometimes the lecturer lingered on a definition or exploration, but in general, he kept the pace quick, moving rapidly from one question and topic to the next, with relatively little exploration or discussion of particular points. When the opportunities came, students pushed the buttons to answer the questions, their answers lit up the screen, and then the questions continued. In quick succession, Dr. Sorin asked the students the following questions. "Have you ever had sex? Are you currently sexually active? What does it mean to have sex?" Male students yelled out: "INTERCOURSE." The atmosphere remained rowdy yet restrained. Students allowed

the lecturer to lead them down a path, but at every opportunity, their contributions flowed freely. Most of the comments, however, came from male voices, and pertained to heterosex.

Dr. Sorin lingered on the question of what it meant to “have sex.” “Can two women have sex?” he asked the group. Students laughed. A male student in the audience spoke up and said, “Two women can’t have sex!” So what did that mean for sexual activity between two women, Dr. Sorin wanted to know. He proposed “outercourse” as something that two women can do together, and students laughed again. He then asked, “Does intercourse imply penis and vagina?” The students called out various comments, and finally came to a consensus of ambiguity. Intercourse, they decided, is “Hard to define,” but, they agreed, “It’s not *anything*.” Dr. Sorin did not let this one go easily. “So then what IS sex?” he persisted. After some deliberation, a few students raised their hands and suggested that “people answer the question according to their own definitions of sex.” Getting the medical students to this sort of revelation was Dr. Sorin’s intention, but just moments earlier, the laughter about two women “having sex” had been loud and widespread. One of the most basic features of heteronormativity is the assumption that everyone is heterosexual, and one of the features of this assumption is that normative heterosexual sex in the form of penile-vaginal intercourse is “the” sex act, or the only sex act that “counts” as “sex” (Jackson 2006).

The discussion of what “sex” might be continued. Dr. Sorin proposed various heterosexual activities to the audience. “If I’m sitting on my parents’ couch with my girlfriend and I’m touching her breasts, what am I doing?” “If I insert my finger into her vagina, what am I doing? – Is this sex?” Students said no, that heterosexual “intercourse” equals sex. Dr. Sorin pointed out that understandings of what counts as

sex are definition-dependent, and took that moment as an opportunity to tell the group how “incredibly homogeneous” they were. He told them that they might think they are diverse in various ways but compared to society at large they were not very diverse at all. “We need to be aware of the great potential for variance in the interpretation of words,” he stated. To illustrate this point Dr. Sorin asked the audience if interacting with a stripper at a strip club constituted sex. The class came easily to an answer of “no.” Dr. Sorin told them that fifteen years ago students overwhelmingly answered “yes” to the same question, and remarked that meanings not only vary across groups but change over time.

Within this grouping of points, Dr. Sorin touched on many significant themes very quickly. Pointing out the variability of meanings associated with “sex” was conceptually intriguing for these medical students - and this discussion did not even veer into the territory of how the variability of meanings might matter for medical practice. Telling the students how homogeneous they were was move towards urging students to consider their own context, their own experiences, their own definitions and conceptualizations, and to understand them as particular, rather than the obvious frame of reference. Ironically, although some of Dr. Sorin’s comments explicitly challenged heteronormative assumptions, some of his comments served to reify the naturalness of heterosexuality as the standard way of being. By asking students what counts as “sex” and pushing the students to consider what exactly two women might do together sexually if it isn’t “sex,” Dr. Sorin subtly disrupted heteronormative conceptualizations of what “sex” is and who can have “it.” Yet in the next breath, he proposed a series of heterosexually-specific activities (“If I – a man –am touching my girlfriend’s breasts, is that sex?”) as he continued to prod the students to consider what “sex” might encompass. And these heterosexually-oriented examples likely spoke to the audience present. These

examples just might have seemed more relevant, more real, and close enough to their reality in order to be simultaneously intelligible yet just perplexing enough to push the limits of their understandings. However, for a lecture that was designed to expand students' understandings of what sexuality might mean to a diverse array of future patients, these examples kept fairly close to the shores of familiar territory.

Dr. Sorin redirected the class back to the endeavor of defining sex, and proposed a few options: "penis vagina," "oral sex," and "manual contact with genitals." A female student raised her hand and asked Dr. Sorin if heterosexual intercourse is sex if the "guy does not have an orgasm." She did not mention the female's orgasm, or lack thereof. Dr. Sorin did not probe her question further but brought the students to the point of answering the question of whether or not they've "had sex," so the issue was momentarily deflected. But later Dr. Sorin came back to the question about orgasm and said, "It's interesting that the definition was contingent upon male orgasm, not female orgasm." Upon hearing this, this a few students laughed, but they laughed nervously, and the laughter was much more subdued and short-lived than the laughter that occurred earlier in class when the male student asked if by dating Dr. Sorin meant "dating a girl."

Eventually, Dr. Sorin summoned the students to answer the question of whether or not they have "had sex" with a person of the "opposite sex" using their push buttons. Most students in the class answered that they had "had sex" with a person of the "opposite sex." The common expression "opposite sex" reflects and reinforces the cultural assumption that there are naturally two and only two sexes – or genders – that are fundamentally opposite from and complementary to the other. These assumptions form the foundation of cultural assumptions about the naturalness of heterosexuality, or the attraction between these supposedly opposite and complementary sexes (Schilt and

Westbrook 2009; Jackson 2006; Ingraham 1994).¹⁹ The notion that females and males are made for each other as sexual partners and otherwise is predicated upon an idea of anatomical sexual compatibility, but ironically, also fuels discourses of inherent sexual differences stemming from this compatibility (Jackson 2006). The notion that women and men are naturally suited as sexual partners because of their differing and complementary reproductive capacities simultaneously serves as the grounds for different and competing notions of their sexual “needs” (such as, for instance, the idea that women are biologically predisposed towards monogamy and men are not...or perhaps, in this case, that men’s orgasms are more important than women’s).

As gender scholars point out, it is much more scientifically accurate and politically equitable to refer to the “other sex” rather than the “opposite sex” when speaking of women and men. Human females and males are more biologically similar than different, and reinforcing the differences rather than the similarities within our shared understandings of what people are like functions to create and maintain gender inequalities (Kimmel [2000] 2008). Furthermore, there is much more variation within the supposedly coherent categories of biological femaleness and maleness than common cultural understandings imply. Intersex persons, or persons born with ambiguous genitalia, reproductive organs, sex chromosomes, or ambiguous combination thereof, occur frequently enough to warrant disruption of our typical sex classification scheme, Anne Fausto-Sterling argues (1993). While the statistical frequency of intersex is subject to debate (Sax 2002), Fausto-Sterling’s suggestion that sex be viewed as a continuum rather than a dichotomy helps denaturalize the notion of two fundamentally

¹⁹ Although they are distinct, sexuality and gender inform each other, sometimes to the point of being inextricable from one another (see for instance Richardson 2007). However the relationship between these two domains of social experience is complex and has at times proved contentious within the gender and sexuality literatures. Thus, although the relationship between gender and sexuality is theoretically relevant to conceptualizing heteronormativity, a more extensive consideration of this relationship is beyond the scope of this discussion.

different, opposite sexes (Fausto-Sterling 2000). Sociologists have shown how medical understandings about biological sex that undergird medical care – including decisions concerning intersex babies that have at times led to irreversible surgeries - are informed by cultural understandings of gender (Kessler 1998; Karkazis 2008). As Suzanne Kessler argues, "...doctors make decisions about gender on the basis of shared cultural values that are unstated, perhaps even unconscious, and therefore considered objective rather than subjective" (1998: 25). Seemingly innocuous references to "opposite" sexes contribute to the production of these unstated cultural values and the medical decisions that are shaped by them.

Terminology and its implications aside, two men and four women responded that they had "had sex" with a person of the same sex. The responses that showed up on the projector screen vanished nearly as quickly as they appeared, but the fleeting information suggested that a handful of students in the room had not "had sex" with anyone of the "same" or "opposite" sex. Dr. Sorin then asked the audience, "Have you ever had sex with more than one person at a time?" A male student yelled out with gusto, "You mean, like, a THREESOME?" and Dr. Sorin responded, very seriously, "Or a foursome or a fivesome or a sixsome." Various male students repeated the word "threesome" with apparent relish. The students were prompted to punch in their answers to the question without much clarifying discussion, and seven males and three females punched in a "yes" response – they had had sex with more than one person at a time. Dr. Sorin told the class that based on those numbers, it would be quite possible that ten percent of their future patients will have had sex with more than one person at a time.

The questions continued. Dr. Sorin then asked the class "What defines being unfaithful?" and the students' varied responses were predicated upon a range of

interpretations and definitions of sex and relationships. Dr. Sorin took up all of the points raised in turn, but interestingly, he did so without returning to his earlier point about the variability of definitions and interpretations. He said that he had several patients who were “swingers” and their definition of being unfaithful might be very different from that of non-swingers. This was another comment that presented a paradox: on one hand, pointing out that relationships may be based on different standards of fidelity or sexual exclusivity helped disrupt “mononormativity,” or the often unspoken assumption that monogamy is the natural standard for any committed relationship (Barker and Langdrige 2010). On the other hand, the language Dr. Sorin used in this nod to diversity of sexual practices implied a *particular* sort of non-monogamy. “Swinging” is a term that was once equivalent with wife-swapping, a practice that presumed heterosexual married couples who partner-swap with other heterosexual, married couples (Varni 1972). A more inclusive discussion of non-monogamy could have simply used more inclusive terminology such as “polyamory” which is employed by non-monogamists of various sexual and gender identifications (Klesse 2006; Noel 2006; Pfeffer 2012). But perhaps even more to the point would have been a discussion of how cultural ideals of monogamy or “faithfulness” may vary, and how having more than one partner is not necessarily a health risk in and of itself.

The sexual possibilities that were excluded within this curricular event – either explicitly or by omission – made the frequent references to heterosexuality more significant. Later in the lecture, Dr. Sorin asked the students if they had ever received fellatio, and then quickly added, “Women *can’t* receive fellatio.” This pronouncement posed an interesting contradiction to his preceding comments about the contextual variability of the meaning of “sex.” Although from a certain perspective it seems obvious that women do not have penises and therefore unremarkable to say that women cannot

receive fellatio, this perspective relies on heteronormative understandings of bodies, gender, and sexual practices. In practice, subjective experiences of receiving fellatio may not be quite so clear cut. The complex relationship between gender identity, genitalia, sex toys, and surgical interventions may mean that some persons who identify as “woman” may claim penises, whether they were born with them or surgically endowed with them (a process over which medical professionals preside), or strap them on sporadically and take them off. Intersex persons may present further challenges to definitions of “fellatio” and understandings of who can and cannot receive it. For a lecture that was designed to provoke discussion and encourage students to explore their understandings of “sex,” it might have been reasonable to expand the discussion to sex toys, understandings of gender, and how the definitional ambiguity of “sex” might conceivably extend to other sexual practices, such as “fellatio.” Even if Dr. Sorin had no intention to exclude, telling the class that “women *can’t* receive fellatio” rendered swaths of sexual possibilities invisible or unintelligible – particularly, queer women’s understandings of their gendered, sexed, sexual selves, and understandings of what “sex” can be (e.g., Hammers 2009).

Dr. Sorin then asked the students, “Did you pay for sex?” and a collective gasp arose from every corner of the auditorium. This was the only question they responded to in this manner, with a great, unified expression of shock from voices from all corners of the room. Dr. Sorin then clarified what he meant by “paying” for sex – he meant a literal commercial transaction, not a figurative “Oh god did I ever pay for that!” kind of “payment.” Before he asked the students to answer his original question, he asked them how they defined “paying for sex.” One male student responded, “Cash or drugs,” and the audience laughed. Other definitions were proposed, and Dr. Sorin asked if buying

someone dinner was a form of payment for sex. There was a little discussion about this but no consensus.

Dr. Sorin then interrupted his own trajectory to ask the group, “Has the world become a little bit grayer today? I hope this conversation is making you think.” His next question to the class was, “Do you know anyone who is bisexual?” He defined “bisexual” as “someone who has sex with both genders.” This resulted in questions from the group, which led Dr. Sorin to then ask, “Is your sexual orientation defined by your activity or who you’re attracted to?” A male student said that you have to go by what people self-identify as, and many students clapped. But this did little to resolve the questions on the table, and the debate about how to define bisexuality continued. One student asked if “making out” with a person of the same gender made someone bisexual. Another student spoke up and asked if fantasies were the criteria. The discussion continued without conclusion. Finally Dr. Sorin told them to just punch in their answers to the question, and after the numbers were displayed – most of the students responded no, they did not know anyone who is bisexual – Dr. Sorin said, “Well, some of these answers are wrong, you all know someone who is bisexual, they just haven’t told you.”

This comment was probably hugely revelatory at face value, for most students, but not only that, it hinted at – whether inadvertently or not - the fact that bisexuality is often enigmatic to scholars and laypersons alike. Bisexuality is not well understood even within sexuality studies, despite the fact that research suggests that bisexual behavior and desire is widespread (Weinberg et al. 1994). Dr. Sorin’s statement which indirectly asserted the invisible prevalence of bisexuality was incredibly significant in the context of the substantial misunderstanding that surrounds bisexuality, which may be due in great part to cultural predilections towards the heterosexual – homosexual

dichotomy (Weinberg et al. 1994). Some studies have found that people who are bisexual in terms of their sexual practices (or desires) may not, for a variety of complex reasons, identify themselves as bisexual (Weinberg et al. 1994) – and this may have tremendous medical contexts. Thus, Dr. Sorin’s allusion to the invisible prevalence of bisexuality was in many respects a radical statement, but because the discussion of this topic went no further, the impact of this passing remark may have been very limited. I never heard students mention bisexuality during interviews or during small-group discussions, and although Dr. Michelle Thompson talked about sexuality as a continuum (in the lecture I described in Chapter 3), she did not discuss bisexuality per se, or why its invisibility might be relevant to health care. Dr. Sorin’s brief mention of bisexuality and its invisibility might well have been the isolated mention of a topic that was relevant to medical care and worthy of further discussion.

The conversation within the “lecture” turned to the subject of dating patients and whether or not it’s okay to date patients. More male students than female students responded “yes” to the question of whether or not it is okay to date patients. This matter – of doctor-patient dating – would turn out to be a hot topic for small group discussion later that day, and for discussions beyond this particular “sex day.” As the lecture drew to a close, Dr. Sorin asked if students were offended by the content of the day’s discussions. The students punched in their answers, and two men and four women responded with a “yes.” Dr. Sorin asked the students if they were ashamed of any of their answers to the various questions that day. A few “yeses” showed up on the answer display screen.

Even after all of this, the piece de resistance came when Dr. Sorin asked the students if they were attracted to anyone in their class. The general response to this was animated. Laughter emanated from all corners of the room, some “yes” responses

appeared on the screen, and the students erupted into discussions among themselves. Dr. Sorin then asked if students have “had sex” with anyone in their class and there were a few “yesses” to that too. The volume rose within the student discussions around the room, but time was up, and Dr. Sorin said so, and the students applauded and filed out of the auditorium, and continued to talk excitedly amongst themselves as they left.

In many respects, this lecture brought the complexity of sexuality to the table for student consideration, in ways that were new and thought-provoking to many of them. It introduced the idea that “sex” needed definition and that definitions vary contextually. Asking questions of the students about their sexual behaviors and displaying their aggregated, anonymous responses provided an organic demonstration of diversity of sexual practices. But just as this lecture complicated “sex” and sexual behavior in important and valuable ways, it also implicitly affirmed the normalcy or obviousness of a certain set of sexual possibilities by repeatedly mentioning them. Heterosexuality quietly served as the reference point for nearly all of the discussion, but was not explicitly identified as such.

Students were given few guidelines for processing the information they received within this lecture – and its affective impact. Although the medical students were riled up during this lecture, in most of their other classes they were trained to look for biomedical causes and biomedical effects (and even within the SAM courses, the atmosphere was rarely rowdy). Over and over again they said of SAM classes, “What does this stuff have to do with being a doctor, anyway?” Although they were more excited during the “sex day” lecture than they were about most other SAM lectures, what insights would they pull from this educational experience to integrate into their professional schema? When I interviewed Dr. Sorin, he told me that the intention behind his approach to this material was to give students an opportunity to talk about sexuality openly. He had conducted

this curricular activity for many years, and afterwards, students always came to him and told him how helpful they had found it to “hear the big words used in casual conversation, to hear ‘penis’ instead of ‘dick,’ and to learn how to speak about sex as a clinician rather than a person on the street,” he told me. The goals of facilitating students’ comfort with sexuality and ability to speak about it as a clinician have a great deal of obvious value – particularly considering that students’ overall lack of experience with and exposure to sexuality, and considering that they were not given other formal opportunities to practice speaking and hearing about sex in quite the same way anywhere else within the curriculum. But even if Dr. Sorin’s intentions were positive and even if the lecture achieved his desired outcomes, he lacked awareness of how the content of his lecture might have contributed to the reinforcement of heterosexuality as the taken-for-granted standard and to the reinforcement of the invisibility of non-heterosexual sexualities, and why this might have been problematic.

Students reported varied responses to this class event. Some had never heard so much talk of anything sexual in public, and were simultaneously a little surprised by and appreciative of the removal of sexuality from the realm of the private. Others were more interested in what the poll revealed, however anonymously, about their classmates’ sexual activity. Perhaps the most telling responses to this lecture were those of the self-identified gay or queer students that I interviewed. Some reported feeling marginalized by this curricular event, but couldn’t describe exactly why they felt that way or what it was about the poll and related discussion that made them uneasy. These students recognized that neither the lecturer nor their fellow students had made any derogatory remarks about non-heterosexuals, and the poll had contained a nod to non-heterosexual practices, including the question, “Have you had sex with a person of the same gender?” These students struggled to find a vocabulary for naming their

relative exclusion from this curricular event, because it was produced through talk that seemed so far from the blatant, overt stigmatization that is easier to recognize and more commonly understood to be unfair.

However two students, William and Don, did articulate a specific set of concerns about the “sex day” poll. Their concern was that the question “Have you had sex with a person of the same gender?” reduced gayness to sexual practices. “Some people who consider themselves gay haven’t had sex yet,” William pointed out. “When you reduce sexual identity to sexual behavior, you really miss out on the essence of the identity.” Don agreed, and acknowledged that it was typical within medicine to reduce a phenomenon down to its simplest or most essential components. His argument was not that this tendency pertained exclusively to sexuality, but that it had particular implications for understanding LGBT persons’ experiences. Don continued to say this:

We’re trained to think about cause and effects, behaviors and risks. So for sexuality, it’s the same thing. We’re trained to boil it down to, ‘a man who has sex with men has these certain risks, who CARES if he’s gay, lesbian, straight, or whatever, if he engages in a certain behavior, he has certain risks’ and that’s it. And I understand that sometimes that’s good, but sometimes with this approach you miss so much. You’re missing the fact that there’s a whole psychology behind LGBT...and personally, as a gay person, I feel like half of my identity is in my head. When you just look at behaviors you miss that. There’s a culture behind the words ‘gay,’ ‘lesbian,’ ‘transgender.’

William got the impression that gay identity was off the table from consideration both within the “sex day” discussion/poll and from Buena Vista’s curriculum in general.

“Maybe they just don’t want to talk about it,” he said. William and Don were frustrated because while they knew that they were not being denigrated, they still felt that important aspects of their own experiences were being excluded from a discussion that ostensibly pertained to sexual experiences in general and they felt that it was difficult to explain the legitimacy of their concerns when they were not, after all, being completely excluded or

regarded with contempt. Although they did not put it in these words themselves, the discussion posited heterosexuality as the baseline, implicit standard way of being sexual or experiencing sexuality, without sufficient acknowledgement that other possibilities of sexual experience existed and were worthy of direct, explicit recognition. Patients do experience sexuality as salient to health care, and as Gregory Beehler's study of gay men's experiences showed, doctors are not always prepared to respond to sexually diverse populations:

No participants felt that their primary care physicians (who were most often heterosexual) were particularly well informed about issues related to gay men's lives, or gay men's risk factors for disease. This lack of knowledge was true even for gay friendly physicians. Gay men readily noted the importance of gay lifestyle differences, such as riskier sexual behavior, more frequent sex, and frequent socialization at bars. They also reported increasing the number of care episodes if they feared infection from HIV or other issues as related to their lifestyles. Physicians did not seem aware of these issues, whereas gay men readily noted these in their own lives and the lives of their friends. *Generally, physicians were unprepared to deal with the gayness of gay men* (Beehler 2001: 138; emphasis mine).

Dealing with "the gayness of gay men" is of course but one of the ways physicians may be called upon to engage with patients' sexuality, and there are many different ways of being gay, and many different experiences and expressions of "gayness." But this excerpt speaks to the ways in which patients often experience sexuality to be relevant to their health and to the clinical encounter, and to the ways in which the elision of non-normative sexuality from medical curricula may ultimately matter to patients' experiences of visits to the doctor's office. The point is not that a curriculum need enumerate all of the possible aspects of the "gayness of gay men," but rather that the extent to which sexual diversity is routinely made visible within a curriculum, the scope of that diversity, and the potential salience of sexual differences for health care encounters matters for what medical students learn about patients' experiences of sexuality and health.

Isolation vs. integration of non-normative gender and sexuality

In keeping with the multi-part format of the SAM courses, immediately after the poll/lecture/discussion led by Dr. Sorin, the medical students split up and went off to one of two seminars. Half of the medical students attended a seminar that featured a panel of transgender guest speakers. For several years in a row, Dr. Terry Olsen, one of the faculty facilitators for the PPD small group discussions, had convened this panel, inspired by the recognition that transgender patients “currently bear the brunt of ignorance, discrimination, and hostility from medical professionals,” as she put it. When Dr. Olsen introduced the guest speakers, she prefaced her remarks by introducing herself as a “lesbian physician” to the audience. This was the only instance in which I observed a faculty member explicitly state their sexual identity in front of an audience of students, and the announcement was “necessary” because the speaker was distinguishing herself as a sexual minority. Although many faculty members passively identified themselves as heterosexual, they did this by making references to their heteronormative family arrangements – for instance, male lecturers frequently referred to their “wives” in an offhand manner in the midst of their remarks. Never did I hear a faculty member casually reveal their non-heteronormative identity in a similar fashion. Thus while Dr. Olsen’s disclosure illustrated sexual diversity within the faculty, as an isolated instance, it may have been the exception that proved a rule rather than a counterbalance to the heteronormativity portrayed by faculty in general.

Dr. Olsen spoke of the homophobia she had experienced as a medical student and as a practicing physician, and explained to the students that she had convened the panel of transgender guest speakers to share their experiences because she knew that the curriculum did not provide information about transgender elsewhere. It is important to note that Dr. Olsen was not directly responsible for the design of the PPD course, nor

the content of any other part of the curriculum. She had served as one of the faculty facilitators for the PPD course for several years, and the director of the course was amenable to her idea to integrate a little transgender education into his class. Without her participation in the class or her initiative to include this content, it seems possible that the curriculum at Buena Vista might not have contained any transgender-specific content. However, the transgender-specific content provided by this panel raised as many questions as answers, and reified heteronormative conceptions of sexuality, gender, and personhood in addition to providing the medical students with at least a little sheer exposure to transgender persons.

The speakers, Gloria and Jackson emphasized from the outset that they and other transgender persons they knew had had “awful awful” experiences with medical professionals, and they had come to talk to the medical students because they wanted to prevent such things from happening in the future. Gloria was a nurse in an emergency room, and as such, she told the audience, she felt “Pretty darn qualified to evaluate the actions of emergency room personnel that I have encountered as a patient.” She told a story of a time when she went to the emergency room for pneumonia and the doctor asked if she had any abdominal pain. “And I said to him well, yes, to an extent, but that’s secondary - but he wanted to give me a pelvic exam. And you know why? He just wanted to see it.” The implication was that the doctor wanted to give Gloria a pelvic exam because he suspected that her genitalia did not match up with her outward presentation of gender, but Gloria did not explicate this to the audience of dumbstruck medical students. The atmosphere in the room was nothing like the rowdy vibe of the preceding lecture. The combination of heightened tension and heightened curiosity was palpable. Gloria went on to ask the students what the first part of the Hippocratic Oath states. “Do no harm...” the students responded, quietly and somewhat

hesitantly. The students were out of their comfort zone. These speakers confounded their sense of comfort and authority, and there was no more shouting out of answers, no more giggling, no more hooting and hollering as there had been in the lecture hall just minutes earlier. Gloria told the medical students that treating a patient can lead to harm if not done with respect. She talked about the importance of treating patients with respect and dignity. Although she really drove these points home, she kept her comments general. What did it *mean* to treat someone with “respect”? Could “respect” be as contextually specific as “sex”? How, exactly, does a doctor treat a patient with respect, or for that matter, what does it mean to treat a *transgender* patient with respect and what does a medical student need to know in order to execute this properly? Her instructions provided little explicit guidance.

Gloria told the audience a little bit about her life story but said little about her transgender identity, what “transgender” might mean in general, and how she herself wanted to be regarded in terms of gender. She admonished the audience that “This ain’t tranny 101 – and by the way don’t EVER use that word. Only WE get to do that.” She gave the audience a firm stare as she delivered this comment. My impression in this moment was that most of the students in the audience had very little preexisting knowledge of what she was talking about that might provide some context for processing her remarks, and for that matter, would benefit tremendously from something exactly along the lines of “Tranny 101.” Only half way through the presentation did the speakers announce that Jackson was an “FTM” (female to male transgender) and Gloria an “MTF” (male to female). But they did not explain what this meant, and many members of the audience who were previously unfamiliar with transgender likely had no idea what they were talking about.

And this particular group of students was probably far from unique in this regard. The term “transgender” has become institutionalized across a broad range of political, medical, and social contexts in the United States since the 1900s, and encompasses a diverse array of persons and experiences (Valentine 2007). In other words, although the category implies a certain amount of homogeneity, it captures a great deal of variation. David Valentine argues that the emergence of transgender as an intelligible social category is “central to the ongoing working-out of what ‘gender’ and ‘sexuality’ can mean in contemporary US American activism and social theory” (2007: 15). For these reasons, understanding transgender as an abstract concept and gaining ease with individual trans patients may present particular challenges for medical practitioners. Transgender presents a combination of ambiguities, and perhaps with them, the ultimate trump card to the certainties of science and medicine.

Jackson had more to say about his life story in general than his difficult experiences with the medical profession in particular. He emphasized the stress associated with failure to fit neatly into established gender categories. He asked the class, “How many of you identify as female?” and the women in the room raised their hands. Jackson then asked one student in the front row how she knew she was female and the student, perceptibly uncomfortable, replied that she didn’t know, she “was just born that way.” Jackson’s eyes twinkled as he proclaimed, “EXACTLY. That’s how I knew I was a man. I was just born that way.” He said this with relish and certainty, carefully enunciating the words in the last portion of his statement. His story referenced this theme again and again: people don’t make a choice to be lesbian or gay or bisexual, they are just born that way. People do not make a choice to be transgender, they are born that way. Both speakers made a point out of emphasizing that transgender and sexual orientation are two different things, but they never defined either of these aspects

of experience, nor did they explain the differences between them. At one point Jackson said, “You know the difference between sexual orientation and gender, right? There are two choices for gender, and three choices for sexual orientation: gay, straight, and bisexual.” Gleefully he declared that “Heterosexuals are born heterosexuals, and that’s just the way it is. THERE’S NOTHING THEY CAN DO ABOUT IT.” Again, his eyes twinkled as he spoke. He recounted his own history of being a woman, married to a man, then coming out as a lesbian then realizing that that wasn’t right and coming out as transgender. Throughout the chronicles of his revelations and transitions, he never explained what “wasn’t right” for him about being a lesbian or how for him, the issue was not sexual orientation but gender transition.

Like the preceding lecture, this panel presentation was filled with ironies. In a sense, the panel served a tremendous purpose simply by introducing students to the presence of transgender persons in the world around them, by giving them the opportunity to hear their stories and their experiences of receiving medical care, and by giving them the chance to ask questions. Even this brief introduction may have been significant – research indicates that exposure to oft-stigmatized sexual minorities does much to reduce ignorance and thus, reduce prejudice and hostility (Herek 1984; Kelley et al. 2008). In this regard, the panel was probably a lot better than nothing. But while brief encounters may take students from a place of zero exposure to transgender to a state of some baseline awareness or familiarity, they may not go very far towards alleviating the discomfort that may come along with interacting with patients, i.e., persons, who are unfamiliar and bringing them to the point of being intelligible as a “normal person just like me.”

Later developments suggested that my impression was correct - during the question and answer period with Gloria and Jackson and then later in my small group

discussion, some students spoke up to say that they had never met or “seen” a transgender person before. This comment was echoed by medical students I interviewed long after this panel. For example, when I asked Cindy how medical school had shaped her understandings about sexuality, the first thing she said to me was, “I thought the presentation with the transsexuals was very interesting. Cause I hadn’t, you know, I hadn’t met any, and like, heard from them up close, you know, before, so that was, that was interesting. I think that helped me appreciate their situation more.”

Cindy’s remarks – and the extent to which she stumbled through their formulation - illustrate the fact that for her and other students, transgender persons were foreign and unfamiliar both as individual persons and as a social category. Perhaps ironically because of the implied relationship between persons that fall under the “LGBT” umbrella, this was true of students who identified as gay as well as students like Cindy who identified as straight. One gay-identified student named William told me that the transgender panel provided much-needed education and exposure for himself and his classmates. But while there were ample indications that the transgender panel made a strong impression on the students, their comments, as they told me about their experience of the transgender panel, often took the tone of describing a sighting of something exotic, rather than an expanded view of the intelligible possibilities of humanity. Thus, although Gloria’s and Jackson’s talk provided some beneficial exposure to the very existence of transgender people and made it clear that they have been subject to inappropriate treatment from medical professionals, it also in many respects put the cart before the horse: it was pretty clear that many of these students did not have the faintest idea what the possibilities of “transgender” might include, what it would mean exactly to treat these persons “with dignity,” or what specifically they needed to be respectful of.

Furthermore, whatever impression the transgender speakers made on the students during this curricular event, the absence of transgender persons from other curricular moments within the SAM courses was just as important as their presence on this isolated occasion. None of the SAM course directors, lecturers, or faculty facilitators were transgender, and perhaps more significantly, transgender persons were absent from other panels of guest speakers with the SAM classes. Other SAM panels included groups of speakers who had had challenging experiences with their medical care providers, families with young children, panels of seniors, and a “cross-cultural” panel. Transgender persons certainly are candidates for having challenging experiences with medical professionals (as the transgender-specific panel clearly indicated), they form families and parent children, they grow old and become senior citizens, and they come from an array of cultural backgrounds. In other words, transgender persons could have been included in these panels which pertained to issues other than transgender, but they were not. Valentine (2007) points out that the tendency to consider transpersons only through the framework of transgender elides other dimensions of their identities that shape life chances and experiences, such as race/ethnicity, class, etc., and variation in these dimensions of experiences contributes significantly to diversity within the category known as “transgender.” Moreover, transpersons visit the doctor for a range of reasons, some which have everything to do with being transgender and some which do not (Dewey 2008). Being able to recognize a transperson as a *person* who happens to be transgender may be a critical component of providing transgender patients with care that they experience as both respectful and medically effective (for discussion see Dewey 2008).

The point is not that transgender persons were intentionally or maliciously excluded from the formal curriculum at Buena Vista, rather, it is that the faculty members

who convened the panels likely did not think to include transgender persons or did not personally know any to include. But whatever the intentions behind the composition of the panels of guest speakers, limiting the appearance of transgender persons to transgender-specific panels and excluding them from panels devoted to general aspects of life experience created a dual dynamic of hypervisibility and invisibility, serving to define transgender persons by one aspect of their being. Even though it was not done maliciously, the segmentation of transgender experience reinforced heteronormativity by implying that those who disrupt normative arrangements of sex-gender-sexuality cannot be integrated into the realm of normal life experience, but rather must be treated as a separate category of persons or experiences.

The composition of panel discussions contributed in other ways to the hidden curriculum of heteronormativity. In addition the isolation of transgender persons within the transgender panel, the “families with young children” panel was composed entirely of heterosexual couples and their infants. The couples on the panel made casual references to their status as biological parents of their children, and although the panelists mentioned that they were coping with less sleep and other lifestyle changes, it was clear that they had abundant resources at their disposal to care for their children’s well-being. In other words, the picture this panel presented was that healthy, normal, standard families are composed of a heterosexual couple and their biological children. (A further implication was that healthy, normal, standard families are upper middle class, and frequently white.) Not only did the “families with young children” panel reinforce a heteronormative conceptualization of what “families” entail, the exclusion of sexual minorities from all of the other panels ostensibly pertaining to *aspects of human experience* served to reinforce the idea that all aspects of healthy human development are inherently, unremarkably *heterosexual*. The lack of representation of sexual

minorities from these panels was not an act of overt discrimination and likely was not the product of intentional exclusion. But the absence of overt hostility and ill will is the very essence of heteronormativity: through actions that seem innocuous and fair, the reproduction of a normative order is accomplished. In this instance, the absence of sexual minorities from these panels meant that the normalcy of heterosexuality was seamlessly reproduced, and the normalization of sexual identities other than heterosexuality was never accomplished.

Heteronormative family relationships

In addition to prescribing a certain way of being sexual and a certain relationship between sex, gender, and sexuality, heteronormativity shapes expectations of concomitant social arrangements such as family configurations (Fields 2001; Kitzinger 2005; Jackson 2006). Heteronormativity presumes that heterosexual attraction between appropriately-sexed and appropriately-gendered women and men comprises the basis of the procreative, nuclear family –the “natural” family unit (Fields 2001; Ryan and Berkowitz 2009; Schilt and Westbrook 2009). Although family is usually considered “unsexual,” marriage is the nexus of family rights, and marriage has historically been predicated upon heterosexuality – and still is, in many parts of the United States. Family thus is better understood as *heterosexualized* rather than unsexual (Sumara and Davis 1999). Both offhand and intentional references to family were ubiquitous within the SAM course sequence, and within this context the hidden curriculum of heteronormativity flourished.

A major example of this occurred within the class meeting of Stages of the Life Course devoted to the topics of “marriage, family, and divorce” as major components of human growth and development. The stated health-related themes of the talk were the implications of marriage (or its absence) for happiness and health, and how the benefits

of marriage accrued differentially to women and men, but many points within the lecture were not explicitly linked to health outcomes. The lecturer, Dr. Jonathan Bentson, presented an array of statistics pertaining to marital trends, including how long marriages last, the predictors of divorce, the likelihood that characteristics of a first spouse will predict characteristics of a second or third spouse (very high).

Dr. Bentson used the word “partner” as he talked about marriage, but when speaking of *persons* he referred to “guys” and “gals.” When referring to a hypothetical man, Dr. Bentson said “wife” when speaking of the man’s hypothetical partner. When female students asked a question, the speaker referred to these students’ hypothetical partners as “he” in his responses. When talking about the increased average age at first marriage, Dr. Bentson brought up the advent of birth control, which, he said, made it so that “marriage and sex and children don’t have to be a package deal anymore.” When he enumerated the factors that lead to divorce, Dr. Bentson said, “Living together before marriage predicts divorce, however, doing this is becoming the norm. It’s pretty exceptional when we hear about people who have the restraint not to live together before marriage, not to mention having sex, or whatever.”

These comments, and the entirety of Dr. Bentson’s lecture, underscore the importance of being attuned to heteronormativity in curricula rather than more overt forms of sexual stigma. He never uttered an ill word about sexual minorities, and never directly suggested the superiority of heterosexuality over other forms of association or desire. However Dr. Bentson said absolutely nothing about forms of association or relationship beyond the realm of normative heterosexuality. For instance, he never hinted at how sexual “restraint” might apply to couples who cannot marry – or, for that matter, *choose* not to. How might the idea of waiting until marriage to live together as a buffer against divorce apply to their forms of commitment? Dr. Bentson did not say, but

later he asked, rhetorically, “What’s the problem with conflating the categories of ‘divorced, widowed, never married, and separated’ within the category of ‘unmarried’?” After some guesses from the audience, he told the class that the strain of marital dissolution may undermine health, creating meaningful differences between the never-married and the divorced. Neither Dr. Bentson nor the students pointed out that same-sex couples were not legally able to marry in that state (at the time the research was conducted), and that lack of access to the rights and privileges associated with marriage might also cause stress. Given the prevalence of heterosexual marriage and divorce, it was not unreasonable to devote attention to these topics and their relationship to human health – however, this lecture could have addressed these topics without focusing *exclusively* on heterosexual couplings.

In the small group discussion that I facilitated immediately following this lecture, the students were puzzled. “What does all of this stuff have to do with being a doctor?” they wondered aloud. This was not an infrequent question posed after SAM lectures – as I discussed in Chapter 3, students, and some faculty too, took a dim view of the SAM classes – but often, this question was posed rhetorically or sarcastically and after the “marriage, family, and divorce,” lecture it was expressed with genuine concern. “If marriage has health benefits, do we tell our patients to get married?” one asked, sounding deeply perplexed. “We do consider marriage,” another student said. “When we do our patient interviews, we always ask, ‘are you married?’” During my interviews with medical students, many told me that they were taught and frequently reminded to ask patients if they have sex with ‘men, women, or both’ during patient interviews, but the curriculum did not provide any clear links between the awareness they were supposed to have of the awareness of sexual diversity they were supposed to have in one context, and the potential for relationship or family diversity in another. This small

group discussion suggested that students were not likely to automatically make such connections on their own. Even if the instructions to ask patients if they “have sex with men, women, or both” were explicit, their cumulative impact on students’ understandings of sexual diversity was drowned out by the consistency and prevalence of heteronormative embedded messages.

The heteronormativity of body parts and their functions: ‘It hurts for him and it hurts for her too’

Sociologists have noted the tendency for doctors to view human genitalia through a heteronormative lens. In their studies of medical responses to the birth of intersex children, Suzanne Kessler (1998) and Katrina Karkazis (2008) found that cultural understandings of what sexual acts are or should be undergird medical decision making. Doctors’ decisions about when to perform genital surgery on intersex children rested upon their estimations of what constituted a “too-large” clitoris or a “normal-sized” penis, within the overarching presumption that the reconstructed genitalia needed to be suitable for penile-vaginal intercourse when the child grew older. As a team of clinicians in Kessler’s study put it, surgically (re)constructing genitalia that were not functionally and aesthetically sound for heterosexual genital sex was the most serious mistake that could be made when assigning a gender to an intersex baby (Kessler 1998). Heteronormative understandings of what “sex” is and what body parts are involved and what these body parts should do and how they should look or feel have been shown to also shape doctors’ approaches to erectile dysfunction (Potts et al. 2003) and female genital cosmetic surgery (Braun 2005).

The contents of Dr. Arnold Jun’s lecture on the male reproductive anatomy reflected a heteronormative understanding of genitalia and their functioning. An

urologist, he gave the first-year students their lecture on the male reproductive anatomy, and the students found him a memorable speaker. I learned of Dr. Jun's reputation before I met him. "He's incredibly sexist," one student named Arthur told me. "All of the girls hate him. But the guys who want to go into urology idolize him." I was not able to observe Dr. Jun's (in)famous lecture in person, so he talked me through it and showed me each of the lecture's PowerPoint slides on his laptop when I interviewed him. His slides included photographs of penises that were malformed due to disease or congenital abnormality, and he paused to talk about a slide that showed a picture of a curved penis. He told me that when this picture would come up during his lecture he would ask the students in the audience, "What is this?" and they would respond by saying, "It's a penis." Dr. Jun described the rest of the typical exchange in the following manner:

So, obviously, this picture is of a penis, but then I ask the students, "Okay, what is *wrong* with this picture [of the penis]?" So this is called Peyronie's Disease, you know, where you have a curvature of the penis and it hurts. Sometimes not just for him but also for her, you know. It could be a painful situation. I think the kids get the gist of it.

These comments seemed to imply a certain set of understandings about what a penis is for, and assumptions about what the medical students would "get the gist" of. I asked Dr. Jun if this might be the case.

Interviewer: Based on what you just said it seems like there is an assumption that a penis is for sexual intercourse.

Dr. Jun: Yeah.

Interviewer: Or more specifically that a penis might be for certain types of sexual intercourse.

Dr. Jun: I'm not getting your question.

Interviewer: So at a couple of points you said, 'this doesn't work for the guy or for the girl involved.' So that suggests heterosexual penetrative intercourse, no?

Dr. Jun: Oh yeah. Yeah, yeah, yeah. Okay.

Interviewer: So there's a certain embedded assumption that a penis is for sex and for certain kinds of sex and if that if the penis doesn't work then sex doesn't work.

Dr. Jun: Yeah, yeah.

Interviewer: Is that talked about at all?

Dr. Jun: You know, being – probably being a heterosexual and being a married guy, yeah, there's a lot of – a lot of the background to my discussion is heterosexual. There's no question about it. There may be some introduction to homosexual, but... I've not had that experience and that not being my orientation, that's not usually the default frame of reference in my imagination.

Interviewer: Okay, so do you think that matters?

Dr. Jun: I don't think that the purpose of the lecture...the goal of my discussion is to get through how to do a physical exam. And so a lot of the heterosexual background to my discussion is more for jokes, truthfully. It doesn't have to do with the goal of the lecture which is to discuss how to perform the male exam. So, yeah, I don't think it's an obstacle. It's just simply a tool for me to get to that point.

Dr. Jun's comment that the curvature of the penis associated with Peyronie's disease "hurts for him but also hurts for her too" relied on the ubiquity of the understanding that penile-vaginal intercourse is the default reference point for what "sex" *is* (Jackson 2006) and thus was obviously what he was referring to. And of course, penile-vaginal intercourse is hardly an uncommon practice, and Dr. Jun had no intention to marginalize other sexual practices by omitting mention of them. Rather than suggesting a concerted effort to exclude non-heterosexual sexuality, Dr. Jun's lecture exemplified how heterosexual privilege allows heterosexual persons the freedom to be unaware of their own privileged status, and freedom from any obligation to become aware of other groups' experiences in society (Simoni and Walters 2001). From his perspective, he was simply trying to provide students with a humorous, memorable

lecture, and in order to do that, he felt it was most appropriate for him speak authentically from his own frame of reference. Given his privileged heterosexual status, it is possible that he had never had much impetus to consider the potential value of making reference to non-heterosexual sexual possibilities in addition to heterosexual ones. As we talked he seemed to be negotiating unfamiliar territory, and at the end of our interview he thanked me for giving him the opportunity to think about things in ways that he never had before.

The implications of the hidden curriculum of heteronormativity

True to its definition, heteronormativity was produced at Buena Vista without “oppressive intent or conscious design” (Kitzinger 2005: 478). What I observed of the formal curriculum was free of any kind of explicit or obviously intentional denigration of non-normative sexuality, and similarly, there were no indications of any systematic efforts to exclude sexual minorities. If taken in isolation, the curricular occurrences described here might look fairly innocuous. But even though it occurred quietly, the sexual possibilities that were repeatedly put forth and rendered visible, familiar, and knowable included some and excluded others. Even though heterosexuality was never explicitly privileged over other sexualities, it was routinely cast as the implicit standard and the possible alternatives to heterosexuality that were presented were both extremely narrow in scope and only sporadically referred to. This hidden curriculum existed in conjunction with the provision of some LGBTQ-specific content, and it is hard to imagine that simply adding a few more hours of material specific to sexual minorities (and particularly, a narrowly-defined group thereof) would automatically or necessarily inhibit or counterbalance the production of heteronormative latent messages.²⁰

²⁰ My intention is not to speculate too far beyond my data, and indeed, it might be that there is some sort of threshold effect that occurs after a certain amount of focused attention on non-heterosexual sexuality is in place: within the context of greater “forced awareness” to or formal

For the purposes of thinking about what how what happens within medical training that might impact patients' experiences of health care, we might reasonably imagine that if the broader range of human sexual diversity is unknown to doctors, many patients may be unintelligible to them. Even in non-medical settings, not being able to determine the gender of a person that one is interacting with tends to provoke confusion, or even extreme discomfort (West and Zimmerman 1987). Uncertainty about a person's sex, gender, or sexuality and the coherence (or incoherence) between these aspects of their identity does not constitute a mere point of curiosity about one (or some) of many personal attributes, it translates into uncertainty about how fundamentally human a person is recognized to be (Butler [1990]1999). When a patient is not intelligible to a doctor, the doctor's knee-jerk response might be confusion or discomfort, which could translate into avoidance, awkwardness, brusque treatment, or passing the patient off to a colleague without explanation – or a host of other behaviors. Health care providers may not recognize the degree to which they regard a patient as embodying an intelligible way of being, nor how this assessment shapes their behavior toward a patient, but even so, the patient on the receiving end of the providers' responses may find them profoundly upsetting. However vaguely-defined normative behavior or personhood may be, the power of normative categories to set the parameters for “appropriate” actions, such as doctors' responses to patients, is not dependent upon explicit delineations between who fits in and who does not.

Although Buena Vista is a single case and cannot be completely representative of all other medical schools, there are reasons to suspect that a hidden curriculum of heteronormativity operates in other medical training programs too. The definitional

inclusion of sexual diversity, a heightened sensitivity to the nature and content of representations of sexuality might develop.

ambiguity combined with the discomfort associated with sexuality – not to mention the perennial problem of time constraints within already-packed programs of training - set the stage for instruction pertaining to sexuality to be fraught with complexities, contradictions, and unintended consequences in cases beyond Buena Vista. Since it appears that many North American medical schools offer fairly little sexuality education (Solursh et al. 2003; Obedin-Malevir et al. 2011), it may be the case that many medical schools have not devoted significant efforts to designing their sexuality curriculum, exploring definitions of sexuality and its relationship to medicine, and thinking about health-related sexual inequalities and the roles medical professionals may play in producing or addressing them. Schools lacking a well-developed sexuality curriculum may be likely to unconsciously reproduce understandings of sexuality that are the default in society at large – such as notions about the “naturalness” of heterosexuality as an “obvious” frame of reference.

The invisibility of heteronormativity

Not only does it seem likely that heteronormativity might operate at medical schools beyond Buena Vista, a broader problem may be that heteronormativity not only “hides in plain sight” in medical schools as it is produced, but that educators concerned with representations of sexual diversity or the teachings about sexual minorities are not attuned to it either. At the GLMA Annual Conference in 2011 there were many indications that heteronormativity was off of the collective radar. This conference followed close on the heels of the publication of Obedin-Malevir et al.’s article in *JAMA*, and talk about the IOM report published earlier in 2011, the *JAMA* article, the dearth of LGBT curricula in medical education, and what to do about it permeated the conference

and served as focal points within many presentations.²¹ Numerous conference presenters showcased LGBT-specific curricula that they had developed and implemented at their home institutions. Some of these curricula were supplementary or optional while some were integrated into required courses. Some presenters spoke of the need for “LGBT cultural competence” while others referred to “LGBT” or “LGBT curricula” without calling these curricula “cultural competence” per se. Nearly all of the conference presenters that I observed referred to “LGBT” or “LGBT persons,” while a small minority used different language, such as “queer.” Who exactly fit within these categories and what “LGBT curricula” might pertain to was left implicit in presentation after presentation. Thus a number of definitional questions hung in the background. What exactly is the objective of LGBT curricula? Who needs to know what about whom? These and other related questions were never broached, much less answered, within the presentations I observed. Although most conference presenters were clearly motivated by the problems of LGBT health disparities, the stress associated with sexual minority status, and the need for medical schools to address these issues, many of them did not clearly define the specific aspects of these problems that their solutions were designed to address.

Benjamin Cox’s and Nicole Rosendale’s presentation reflected these tendencies. Both fourth-year medical students at NYU, they gave a presentation on the supplementary LGBT curricula that they had developed and implemented. Like many others, they began their presentation by citing the IOM’s call for more LGBT cultural competence and communication training for medical professionals. They said that in response to the IOM’s call to action, they had created a four-part dinner lecture series on

²¹ My comments about the GLMA 2011 Annual Conference come from my field notes that are based upon my ethnographic participation in this event. Because their presentation was a public event, Benjamin’s and Nicole’s names are not pseudonyms.

LGBT health, and gained the dean's approval to turn the program into a credentialed certificate on LGBT health to attract participants. They emphasized that the dean had been particularly interested in doing this because of the "buzz" about the "Stanford survey" (i.e., the Obedin-Malevir et al. article in *JAMA*) which came with increasing recognition of "how little is taught." How little was taught about *what*, specifically, they did not say. They continued to describe their "interventions" as being supplemental to the "standard" curriculum, which is "what you would get if you went to lecture." The presenters made little mention of the possible benefits or drawbacks of offering supplemental curricula instead of integrating their material into required lectures, incentivized as their particular supplement may have been. What happens when important matters – be they LGBT health or something else – are offered in the form of an optional dinner lecture series? The potential for participants to be a very particular, self-selecting audience, for instance, was not touched upon. Nor was the possibility that lecture itself might be a complex set of processes, containing multiple layers of messages, both manifest and latent.

Benjamin and Nicole emphasized the importance of evaluating dinner series participants with pre- and post- tests to see what they had gained from the experience. The lengthy surveys they had created for these purposes included questions such as, "I assume a patient is heterosexual unless they tell me otherwise." On a 5 – 1 Likert score, students could strongly agree, agree, disagree, strongly disagree, or be unsure. While assessing pre- and post- course knowledge is important and a questionnaire format was probably the most practical means of doing so, this question attempted to measure something directly that might have been better measured indirectly. The Obedin-Malevir et al. (2011) found that 97% of the medical schools that responded to their survey instructed students to ask patients if they had sex with "men, women, or

both,” when obtaining a sexual history, thus it might seem that one of the things medical students are most likely to know about LGBT issues is that they need to ask about the gender of sexual partners. Throughout my participant-observation at Buena Vista, this instruction was repeated frequently, even outside of the context of discussions about taking a sexual history: rather than making assumptions about a patient’s sexual orientation, faculty regularly reminded students to ask patients if they have sex with “men, women, or both.” When I interviewed students and asked them what they had learned about sexuality within their medical training to date, this – and sometimes only this - was an answer they came to readily. In other words, it seems likely that in the context of taking a test, students would know that there was a “correct” answer to the question “I assume a patient is heterosexual unless they tell me otherwise.” However, whether or not the student might assume heterosexuality in another context is a very different question.

Another question within Benjamin’s and Nicole’s pre/post-test was, “Which of the following terms are NOT identities found within the LGBT community?”

- a)bear
- b)butch
- c)baller
- d)top”

The audience laughed when they heard this question. In a grave tone, Nicole told the listeners “You’d be surprised by how many people get this wrong, it’s really shocking.” The correct answer to the question was c) baller, but she did not explain why the tendency for students to get this question wrong was so “shocking,” nor did she tell the audience anything more about these terms to clarify their contextual significance for anyone who might not have known the correct answer to the question or understood anything much about the terms. The implication seemed to be that a certain amount of

knowledge about LGBT life, culture, and terminology should be obvious to anyone in medical school, and moreover, that this knowledge is the goal in and of itself - rather than, for instance, achieving a certain kind of approach clinical care that might or might not be readily measured through a pre/post-test. However, after describing the tendency for students to get this question wrong as “shocking,” Nicole immediately went on to say that “attitudes may matter more than knowledge.” An audience member quickly raised their hand and asked, “So if it’s attitudes that matter, and since homophobia has become less cool and people tend to hide it more, how do you target people who are homophobic?” “Well they need special attention,” Nicole replied. “We need to work on them specifically, we need to target and identify these students in small group discussions who have doubt so they can be worked with individually.”

In locating the perpetration of sexual stigma within problematic individuals who could be easily identified and targeted for specific remedial attention, Nicole’s and Benjamin’s concluding comments reflected the problems that scholars have argued are inherent to the concept of homophobia. Sexual stigmatization does not arise from a few aberrant individuals, scholars argue – it is entrenched within society as a whole. And although they did not say so specifically, Benjamin’s and Nicole’s comments implied that sexual stigma is matter of heterosexuals expressing hostility towards “LGBT” persons. There was no indication within their presentation that sexuality-related stigma might be much messier and more diffuse than heterosexual antipathy towards LGBT folks, nor was there any mention of the ways that heterosexual privilege might be perpetuated through seemingly neutral, collective practices – as opposed to the actions of a few prejudiced or ignorant – or simply naïve - individuals. In other words, there was no suggestion that the issue might be heteronormativity rather than limited pockets of hostility towards or ignorance concerning LGBT persons.

Like other presentations at the conference, their comments also suggested that the acronym “LGBT” is both self-explanatory and simultaneously an appropriate residual category for all forms of sexual diversity. The repeated, un-explicated use of the acronym “LGBT” as the category that is supposed to represent diversity suggests that the category “LGBT” speaks for itself – when it actually represents a great swath of persons with diverse experiences that may have little similarity to or relationship with one another. This use of the “LGBT” acronym also implies that *all* sexual diversity can be neatly situated within this category, and that the persons who fit within it are *either* lesbian, gay, bisexual, transgender,²² and that these options of personhood are self-explanatory and consistent categories. By contrast, in addition to the great diversity (and the potential for marginalization) within the supposedly homogeneous category of “heterosexuality” or “heterosexuals,” much sexual variation outside of the scope of heterosexuality does not fit neatly within the confines of “LGBT.” And these distinctions are not simply a matter of academic hair-splitting or identity politics. They have everything to do with the ways in which patients experience medical care, and the ways in which doctors are able to recognize their patients as familiar, intelligible sorts of persons, with familiar, intelligible sorts of needs – or not.

Like others at the conference, this presentation isolated “LGBT”- related curricula from curricula pertaining to “sexuality” more broadly defined. None of the presenters who referenced the results of the Stanford survey discussed them within the context of other relatively recent surveys polling the number of *sexuality* – related hours of curricula within medical training, and the question of whether or not it might make sense of consider “LGBT” medical curricula and “sexuality” medical curricula as similar or related

²² As an earlier segment of this chapter indicates, transgender is not necessarily best understood as a manifestation of sexuality. But transgender does form the “T” in “LGBT,” and is often implied to be one of four options under the umbrella of sexual diversity.

topics – or not – was not raised. Isolating “LGBT” issues from a consideration of “sexuality” is may be useful within some contexts,²³ but completely decontextualizing LGBT health or LGBT sexuality from a broader consideration of sexuality has important consequences that were not part of the conversation at GLMA. Implying a total separation between LGBT sexuality and sexuality in general runs the risk of suggesting that sexuality only “matters” if it differs from the norm. And the parameters of the norm itself remained unspecified within the discourses circulating at GLMA 2011 (and in the *JAMA* article). Although there may be a tendency to consider it “obvious” that “heterosexuality” is the norm, this further reifies the notion that heterosexuality is itself a monolithic entity that requires no explanation – or any consideration within medical training. Such an assumption does a disservice to the pursuit of understanding not the unique needs of sexual minorities by reaffirming the hegemony of the implied “standard,” and it precludes discussion of what sexuality fundamentally is and how it matters within medical practice more generally.

Conclusion

Recognizing the potential for normative understandings of sexuality to be created within the hidden curriculum of a medical school presents unique opportunities and challenges for further research and practice. Addressing embedded messages that educators are scarcely aware that they are producing is no small task.

Heteronormativity within medical education is a reflection of heteronormativity within the surrounding society, and it is often difficult to denaturalize that which seems

²³ As the IOM report, the *JAMA* article, and a multitude of other sources indicate, LGBT persons and other sexual minorities do have unique experiences and thus have unique health needs that are associated specifically with their sexual identity, which are well worth discussing in their own right. But these health needs themselves are often the product of complex factors which intersect with other aspects of a person’s identity and life circumstances. The disaggregation of LGBT sexuality from sexuality in general is most useful when the specific reasons for the distinction are made clear within the context of any particular discussion.

unremarkable – if it is even noticed at all. Moreover, heteronormativity may occur in conjunction with substantial efforts on the part of medical educators to integrate more teachings about LGBT persons and their health needs into medical education – which is, in many respects, a major historical development and an effort based on excellent intentions.

While it may well be the case that more sexuality or LGBT curricula in medical education would be beneficial in some respects, advocates for more of this sort of curricula regularly ignore the perennial problem of too much to learn and too little time to learn it within medical education, and also bypass the possibility for shifting the content of even the most offhand mentions of sexuality. However, addressing latent messages also provides a way out of the age-old and ever-increasing problem of too much to teach and learn and too little time for it within medical education, for it presents the opportunity to make changes to existing content without necessarily adding more material to an already-full course of training. Simply marking unmarked cases is disruptive of heteronormativity: instead of only talking about sexual orientation when discussing sexual minorities, sexual orientation can be mentioned in every case. Naming heterosexuality as a sexual orientation instead of letting it remain the default assumption turns the normative category into a particular one; into one instance of sexual orientation rather than the natural standard (Turbes et al. 2002). This approach also provides a path towards easing the need for distinctions between “LGBT specific” curricula and curricula that pertains to sexuality, more broadly defined.

This chapter demonstrates the strength of ethnographic methods for revealing heteronormative embedded messages and the unremarkable processes through which they are transmitted – and suggests the utility of further ethnographic research on medical sexuality education. Further sociological study of medical sexuality education is

particularly important at this historical moment in which the medical profession seems to be devoting an unprecedented amount of attention to medical issues pertaining to sexual minorities. When a substantial emphasis is placed on a particular kind of sexuality education, what happens to understandings not only of this particular “part” of sexuality, but also to understandings of the “whole,” or sexuality more broadly defined? Sexuality is an important concern to almost all patients (Parish and Clayton 2007), and doctors’ knowledge about sexuality - beyond “LGBT cultural competence” – potentially impacts all patients’ experiences of medical care (Berman et al. 2003). In this chapter I have suggested that an emphasis on LGBT specific medical education outside of a broader sexualities education may pose the risk of eliding conversation of what sexuality, in general, fundamentally means or includes – but whether or not this happens in practice, and what its effects are for medical understandings about any aspect(s) of sexuality are empirical questions that future research might usefully explore.

Findings from ethnographic research on medical sex education may also be particularly useful to medical educators concerned with LGBT-specific content or other curricular interventions designed to alert students to health disparities and the physician’s potential role in (re)producing them. This analysis demonstrates how important it is to look beyond the sheer number of hours devoted to LGBT-specific training and consider the messages about sexuality and LGBT sexuality that are produced in curricular moments that may or may not be officially devoted to these topics. Being attuned to both formal and hidden curricular messages about sexuality is particularly critical as medical education shifts towards a more integrated style of teaching and away from stand-alone courses devoted to particular topics (Coleman 2012) – a transition that Buena Vista was making at the time of my research. Because sexuality is potentially relevant to patients’ health in a range of ways, discussion of

sexuality may arise spontaneously more frequently within integrated models of medical education, and thus teaching time devoted to sexuality or LGBT health more specifically may be even harder to identify, quantify, and study than it has been in the past (for discussion of these challenges see Solursh et al. 2003). Under these circumstances the hidden curriculum of heteronormativity may be likely to effectively remain hidden.

This chapter hints at daunting questions about the production of inequalities and the potential for the processes that contribute to inequalities to be recognized and addressed. If the essence of heteronormativity is that it occurs through processes that appear not only innocuous but unremarkable to the point that they are unlikely to be noticed or recognized at all, just how exactly might heteronormativity be effectively disrupted? Questions about the identification of subtle processes by which inequalities are maintained apply to other dimensions of inequality, not only sexuality. If, as Eduardo Bonilla-Silva (2002; 2006) argues, color-blind racism is so insidious because it occurs through practices that seem fair or neutral to dominant members of society (i.e., whites) but are experienced negatively by those it disadvantages (i.e., blacks), the fundamental question is about who gets to determine what counts as inequality or marginalization or exclusion. Even as overt, legalized forms of discrimination (directed towards sexuality or race or any other dimension of human experience) are increasingly recognized as unacceptable, inequalities may be produced through practices that are not – or not yet – recognized as unjust. The question for institutions that are devoted to the worthy pursuits of helping others (whether through medical care or other works) may be how to stay attuned to the possibility that the production of inequalities may occur through subtle processes that are hard to conceive of even as the institution expends considerable energy attending to the forms of inequalities that are already recognized as problematic. But if we are concerned about being able to identify the processes by

which inequalities are produced before they become so entrenched that they are more obviously, unavoidably problematic, it is necessary to ask questions about how the frontiers of inequality production come to be recognized – rather than simply identifying their consequences.

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CHAPTER 5
MEDICAL PROFESSIONALISM AND THE NULL CURRICULUM OF SEX
NEGATIVITY

Sexuality's special status and medical professional jurisdiction

If sex negativity is pervasive in society, doctors may remain as likely as anyone else to be influenced by it in belief and action unless specific efforts are made within medical education to attenuate it. Sociological studies of medical education and the professional socialization of medical students tell us much about the transformation medical students go through as they make the journey through medical school and eventually become doctors, but we know less about the ways in which medical students, and the doctors they become, remain similar to laypersons. Although there is, as one Buena Vista faculty member put it, “alchemy in the transition” from layperson to medical student to physician, physicians may remain, despite the particularly intense process of professional socialization they go through, similar to other members of the society they are part of.

In this chapter I am concerned with the ways in which sex negativity – or the understanding that anything that is related to sexuality is subject to a disproportionate amount of hostility, suspicion, or discomfort (Rubin [1984] 1993) – is reproduced, recognized, and negotiated within medical education. We know that patients experience sexuality to be relevant to health and clinical encounters in a broad range of ways, and that the scope of doctors' professional jurisdiction makes dealing with sexuality if not inevitable, at least not entirely avoidable. Patients' accounts of their experiences of health care indicate that sex negativity operates within medical care – at least from their perspective. How do doctors experience sex negativity themselves, and conceive of its

impact on patients and health care encounters? These questions are particularly significant within the context of the medical profession's emphasis on high standards of professionalism, treating patients with "respect and dignity," as "whole persons," and so forth.

We know little about how professionals whose scope of practice encompasses sexuality negotiate sex negativity. We actually know little about how the place of sexuality within the jurisdiction of various professions, or how professions conceive of their duties or professional responsibilities pertaining to sexuality. Perhaps because sexuality and work are often considered antithetical (Hearn and Parkin 1995), the sociology of sex and work has largely been limited to the study of sex work, or the provision of sexual services. This gap in the literature is surprising in a sense because there is a well-developed sociological literature on "dirty work" (e.g., Hughes 1958; Ashforth and Kreiner 1999; Drew, Mills, and Gassaway 2007) that examines the ways in which workers whose duties include stigmatized or tainted or "dirty" activities negotiate their jobs and manage the taint associated with them. We would think that if sexuality is particularly stigmatized it would feature more prominently within the dirty work literature – but perhaps this is exactly the reason why it does not.

Even if there has been little study of how professionals collectively negotiate sex negativity, we see indications that sex negativity is a social fact (Durkheim 1895) with broad implications. The idea that sex per se is harmful has been chiseled into shared attitudes about child-rearing, medical practice, sex law, and police practices (Rubin [1984] 1993: 4), and as I discussed in Chapter 1, it shapes the transmission of knowledge in school-based sex education (Irvine [2002] 2004; Fields 2008; Kendall 2013). The stigma associated with sexuality has constrained scientific research on sexuality and the legitimacy of sexual knowledge (Kinsey et al. 1948; Gagnon and

Simon [1973] 2005; Rubin [1984] 1993; Irvine 2003; Epstein 2006; Irvine 2014), and conferred a “courtesy stigma” (Goffman 1963) upon individual scholars who study it (Irvine 2003; Irvine 2014) – if they are able to study it without interference at all.

Recently, Janice Irvine has taken up the subject of sexuality research as a form of dirty work, and has articulated some of the institutional and cultural mechanisms through which sexuality research is constructed as dirty (2014). Irvine argues that sex research is indeed – true to the definition of dirty work – socially necessary yet marginalized, and confers taint upon its workers. However, it would seem that part of the problem is that sexuality research is not necessarily deemed socially necessary.

The prevalent notion that sex(uality) is “private” (Hearn and Parkin 1995; Wallis and VanEvery 2000; Moon 2008) may be considered analogous to sex negativity because it has served as justification for quashing sex research even within very recent history. In the latter part of the twentieth century and the early twenty-first, federally funded research pertaining to sexuality was subject to attacks from congress and conservative advocacy groups such as the Traditional Values Coalition. These actors charged that the study of sex would promote undesirable sexual behaviors or problematic attitudes towards sex and sexuality, and that, moreover, sex research constituted an unjustifiable invasion into private matters (Epstein 2006). The argument that sex research should be shut down because it is an “improper intrusion into the private lives of Americans” relies upon and reinforces the shared understanding that sexuality is shameful or harmful and needs to be kept hidden, or contained (Epstein 2006: 4). Thus it seems necessary to ask how the appeal to privacy as a strategy for keeping sex(uality) unknown or unknowable operates within medical education and medical practice. The doctor’s office is paradoxically a private space wherein that which

is private elsewhere becomes “unprivate” – although not exactly public – within it. How are doctors trained to negotiate sexuality, privacy, and sex negativity within this space?

Even in the absence of an exhaustive list of the ways that sexuality intersects with medical practice or a definitive set of understandings about when sexuality sits squarely within doctors’ professional responsibilities (and when it might be avoidable), it is evident that at least some routine aspects of doctoring have unavoidable sexual implications. For example, even basic examinations of the naked physical body may be laden with sexual meanings, particularly when the genitals – parts of the body understood as fundamentally “sexual” in nature – are the subject of the examination (Smith and Kleinman 1989; also see Wear et al. 2006). Sexual identity, which may be deemed a private matter in many contexts, can have unavoidable pertinence to health care encounters regardless of whether the medical issue at hand directly related to sexuality or not. As I have noted elsewhere, patients perceive doctors to be primary resources for sexual health care and sexuality information and education (Lieblum 2001; Berman et al. 2003). Although these professional service obligations are not totally exclusive to doctors – nurses too perform physical exams, of course – sexuality becomes un-private and unavoidable within many routine aspects of doctoring. How do doctors negotiate the unique stigma associated with these relatively unique professional responsibilities? How does sex negativity affect them, and what do they do in response?

In this chapter I am concerned with the following questions. Is sex negativity produced, reproduced, or contested within medical education? If sex negativity is prevalent in society we would expect that it manifests itself in some ways within medical education. What do these manifestations look like? Within medical education, is sex negativity recognized as a social fact, or a thing in itself, that might have implications for medical practice, within medical education? If so, how is it regarded and negotiated?

Whom is it imagined to affect, and how, and under what circumstances? If sex negativity is not recognized, what does this non-recognition look like?

Sex negativity

Gayle Rubin argued that in Western societies, sex is guilty until proven innocent, and sexual acts and conflicts over sexuality are saddled with a disproportionate amount of symbolic weight ([1984] 1993: 11). Following Christian traditions which considered sex negative, dangerous, destructive, and sinful, Western societies have tended to treat all things sexual with suspicion (Rubin [1984] 1993). “Virtually all erotic behavior is considered bad unless a specific reason to exempt it has been established...the most acceptable excuses are marriage, reproduction and love,” Rubin wrote ([1984] 1993: 11). While the “acceptable” justifications for erotic license may have expanded since Rubin’s time of writing, we still see indications that sex remains a “special case” in American society as Rubin claimed. Although Rubin noted that Western culture subscribes to a hierarchical system of sexual valuation that stigmatizes some sexual possibilities more than others, she also emphasized that *anything* sexual, including not just sexual identities or behaviors or desires, but also the parts of the body that are often considered sexual in nature, is potentially suspect, not only the “outer limits” of sexual variations that are understood to be “bad, abnormal, unnatural” (Rubin [1984] 1993: 13).

Within this chapter, I refer to these elements of erotic discourse that Rubin identifies as “sex negativity.”²⁴ Rubin considers these trends in erotic discourse elements of thought patterns that comprise ideological formations which have had such

²⁴ Rubin herself considers these elements of erotic discourse as components of six ideological formations, of which sex negativity is only one (but the most important one, in her estimation). Namely, these ideological formations are sexual essentialism, sex negativity, the fallacy of misplaced scale, the hierarchical valuation of sex acts, the domino theory of sexual peril, and the lack of a concept of benign sexual variation. I use “sex negativity” as shorthand for referring to all six of the ideological formations she identifies because while they have distinct features, all pertain to the negativity accorded to sex(uality), and thus for the purposes of simplicity and clarity within this chapter it makes sense to refer to them by one name.

a strong grip upon sexual thought that we need to identify their presence in order to avoid remaining enmeshed within them ([1984] 1993: 11). Rubin identifies these ideological formations as part of a set of conceptual tools that provide the means for developing a radical theory of sex that can identify, explain, describe, and denounce erotic injustice, using a critical language that can convey the “barbarity of sexual persecution” ([1984] 1993: 9). Here I employ elements of her conceptual toolkit without suggesting that barbarous sexual persecution is exactly what I am identifying. I assume that sex negativity usefully pertains to discomfort, anxiety, avoidance, and nervousness, not only sexual repression and extreme social and legal sanctions. For my purposes, the strength of Rubin’s work is her emphasis on sex negativity as pervasive and potentially associated with anything that has to do with sex, and her insistence that its identification is essential to fully understanding sexual dynamics in social life. My intention in this chapter is to provide thick description (Geertz 1973) of what sex negativity may look like in practice, and to show that the construction of sexuality as a special case or a marked category may occur through processes that do not appear to be barbarous or extreme. However, whether or not sex negativity is the most useful term for describing all of the ways that sexuality-related discomfort is manifested and deemed particularly special is an open question, and I will revisit it later in the chapter.

Rubin’s insistence that *anything* sexual – not *only* non-normative sexuality – may be subject to taboo, hostility, sanction, or discomfort is another reason why her concept of sex negativity is particularly useful, even if the enactment of sex negativity occurs through processes that are sometimes subtler or gentler than those she describes. Although sexual minorities, i.e., non-heterosexuals are subject to particular sexual stigma (Herek 2009), there is evidence that medical students and doctors experience sexuality-related discomfort in ways that are not specific to sexual minority patients or

non-normative sexualities (Smith and Kleinman 1989), and that even sexual “majority,” i.e., heterosexual, patients perceive that doctors are uncomfortable discussing their sexuality-related health concerns (Berman et al. 2003; Hordern and Street 2007). We need a better understanding of the range of ways in which sexuality-related discomfort manifests itself and is negotiated within medical education, in part because it is not only sexual minority patients who have sexuality-related health needs. Furthermore, distinctions between “minority” and “non-minority” sexuality are sometimes ambiguous. There are of course critical empirical distinctions between the experiences of sexual minorities and those of the “norm” or the “majority” – some of which are germane to medical care and medical education. But making these distinctions also runs the risk of implying that the line between minority and non-minority sexuality is obvious or concrete, and suggests that sexual stigma and sexuality-related inequalities are only experienced by sexual minorities. Heterosexuality is a heterogeneous category and not all heterosexualities are particularly or equally privileged. But moreover, sexuality-related discomfort or negativity or hostility is not simply a matter of sexual behavior or identity and where these sit within a majority-minority continuum. Sexuality-related discomfort also adheres to the body and its parts that are understood to be fundamentally sexual in ways that matter within medical practice, and Rubin’s formulation of sex negativity encompasses this without neglecting the particular stigma associated with non-normative sexuality.

Rubin and other social scientists who study sex sexuality have argued that in the past, medical professionals played a substantial role in the active production of understandings about sexuality that comprise sex negativity as we know it today (Foucault 1978; Weeks 1986; Weeks 1987; Stein 1989; Rubin [1984] 1993; Epstein 1996; Terry 1999). But while this is taken as a truism, empirical research has not

examined the ways in which medical professionals are subject to sex negativity themselves. Whatever their historical origins, notions that sex(uality) is private, taboo, suspect, or particularly likely to provoke discomfort are pervasive within American society, and it is reasonable to imagine that persons who happen to be medical professionals encounter these shared understandings just as anyone else does (Kelly et al. 1987). Any sexuality-related beliefs and biases that physicians share with other members of society may impact their interactions with patients (Kelly et al. 1987; Hunter and Ross 1991; Street et al. 2007) and these dynamics are important to our understanding of the production of sexuality-related inequalities such as health disparities. But sexuality-related discomfort also impacts medical students' and doctors' experiences of their work, and the negotiation of sex negativity within medical education may also impact medical students' personal lives outside of school (Smith and Kleinman 1989). We lack a comprehensive understanding of how sex negativity operates as a social fact within the arena of medical education.

Questions about the negotiation of sex negativity are particularly salient in the context of the substantial emphasis on professionalism, humanism, and patient-centered care within medicine and medical education. Both the medical profession in general and Buena Vista Medical School in particular have emphasized the imperative to treat patients as “whole persons,” with “respect and dignity.” How is the discomfort associated with sexuality in general and non-normative sexuality in particular in the United States (Epstein 2007) acknowledged, ignored, transformed, or reproduced within education for medical professionalism?

Medical professionalism: service, altruism, and the “total needs” of patients

In the last several decades, attention to medical professionalism has burgeoned within the academic medicine literature. This came about as a result of medicine's self-

perceived “crisis of professionalism” which began, depending on one’s viewpoint, somewhere between the 1960s and the 1990s (Hafferty and Castellani 2009). Mounting evidence that the consuming public no longer perceived medicine as having an unwavering commitment to public service prompted medical educators to reframe the nature of their work, and put a new spin on the not-so-new mission of producing excellent physicians (Hafferty and Castellani 2009). In 1998 the Association of American Medical Colleges (AAMC) launched its Initiative on Professionalism in response to growing concerns – both on the part of the public and within the profession itself – that physicians long-venerated commitment to professionalism was waning (Cohen 2000).

Despite the enthusiasm for promoting professionalism, there has been little consensus about what “professionalism” itself means (Swick 2000). Perhaps it is like pornography, some say - difficult to define, but one knows it when they see it (Swick 2000; Arnold and Stern 2006). Most definitions of professionalism emphasize excellence, humanism, accountability, and altruism. Others refer to service, compassion, dedication, humility, accountability to patients and society, honesty, integrity, respect, self-regulation, commitment to ethical and moral standards, and the like (Hafferty 2000). Since disease is universal, physicians should be guided by humanism, or “a sincere concern for or interest in humanity” in all of their interactions with patients, Arnold and Stern argue (2006: 22-3). “Humanism,” in this sense, combined with the “core values of the profession” form professionalism, in their view (Arnold and Stern 2006: 17). The “Function and Structure of a Medical School” published by the Liaison Committee on Medical Education states that physician should have a “dedication to service,” and also stipulates that “medical schools should educate physicians who will

meet the ‘total needs of patients’ and gain the ‘trust and respect of patients, colleagues, and the community’” (Hafferty 2000: 16).

Sociological perspectives on the professions and professionalization take a critical view of professions claims to prioritize service to the public. While professions – including but not limited to medicine – may well have a service orientation to a certain extent, they are also defined and motivated by other orientations that are not necessarily congruent with public service, such as, in the case of medicine, relative freedom from lay evaluation and control (Friedson 1970). A commitment to service is not necessarily an empirical description of a profession’s members’ motivations or actions, but an imputation that the profession has successfully won from the public through its leaders’ efforts to secure autonomy (Friedson 1970: 82). Ironically, the achievement of this autonomy may lead the profession to stop responding to the particular public needs that enabled its development, cohesion, and acquisition of authority in the first place (Freidson 1970: 330-1). While professions may well perform essential public services, Freidson argued, it must also be remembered that expertise sometimes functions as a mask for privilege and power (1970: 337).

But the nature of the medical profession’s power and prestige have become increasingly complicated since the 1970s, in the context of broad changes in the social, cultural, economic, and political climates that reshaped the relationship between doctors and the consuming public, and the relationship between medical professionals (collectively and individually) and other entities (Light and Levine 1988; Hafferty and Light 1995). Corporate control of medicine shifted the nature and dynamics of physicians’ relationship to their work in the abstract, as well as their relationships with individual patients and the public at large (Light and Levine 1988). For instance, the rise of managed care complicated understandings of who exactly doctors’ clients were.

Were they the patients seeking services, or the insurance companies, who paid their claims (Light 2010)?

Hafferty and Light (1995) argue that since the 1970s the medical profession's claims to a service orientation have contained as much rhetoric as fact, but the broader point may be that - particularly within the complex ecology of countervailing powers - what constitutes a "service orientation" may be difficult to define. Donald Light points out that we "cannot expect professionals to act too differently from the market structure and institutional framework in which they practice" (2010: 274), and when doctors are under pressure to achieve certain quantities of results, it seems inevitable that the quality of their efforts will be affected (e.g., Hafferty and Light 1995). The temporal and bureaucratic exigencies of managed care place a burden upon physicians to maximize their impact in terms of outcomes and minimize the time and cost of procedures it takes to do so. What does medical commitment to service and altruism mean, under these circumstances? In the context of increased protocols that impose technically-oriented norms of practice upon clinicians, consumers may end up receiving care for routine conditions that are handled expeditiously, but patients presenting unusual concerns may receive less satisfactory care (Hafferty and Light 1995). Although Hafferty and Light wish to avoid "Pollyanish sentiments" that suggest a lost paradise of a romanticized vision of doctors' former commitment to service and altruism, their argument implies that "meeting the total needs of patients" as the Liaison Committee on Medical Education advocates remains the idealized outcome of an orientation to service and altruism (Hafferty and Light 1995: 145).²⁵

²⁵ Alternative conceptions of the "service orientation" might recognize that, for instance, medical schools tend to provide medical services to some patients on a charity basis, or at a significantly reduced cost (Light 1988). Medical schools also create large numbers of jobs of various types (Light 1988). These functions constitute a certain sort of public service, even if they are not

In addition to the constraints upon clinical practice that managed care imposes, meeting the total needs of patients may also be complicated by physicians' quest for intraprofessional status. Andrew Abbott (1981) argues that intraprofessional status may have little to do with what the public wants from a particular profession, or what it venerates the profession for (Abbott 1981). The public tends to esteem the profession for bringing order to disorder and making sense out of human complexity. Professionals tend to shy away from the realm of human messiness and complexity because problems of this nature present threats to their professional purity, i.e., their capacity to work with problems that are solely relevant to their specialty, and to solve them using the tools and information within their domain. Drawing upon the work of Mary Douglas, Abbott argues that unresolvable problems, or problems that present threats to professional purity and status usually find one of two fates. They may either be demoted to residual status or referred to an outcast, low status specialty, as was the case with some medical problems relegated to psychiatry. Or, they may be given special status as anomalies whose "unresolvability symbolizes the fundamental ambiguities of internal professional inference" and whose resolution presents the "possibility of yet further [professional] purification" (Abbott 1981: 827). What counts as resolvable or unresolvable disorder, and thus what constitutes a threat to professional purity and what does not are judgments that evolve within the profession over time (Abbott 1981). For Abbott, the point is that the aspects of the medical profession's work that the public venerates are very different from what medical professionals themselves respect and reward – which would seem to pose regular challenges to the achievement of altruism and service, or at least, to occasion a closer examination of their definitions.

usually what are meant within discussions of medicine's commitment to "service and altruism" – or the need for it.

Unless the definitions of “meeting the total needs of patients” are more circumscribed than “total” usually implies, it would seem the aforementioned features of the medical realm might pose challenges to the achievement of service and altruism, if not frequently then at least regularly. Yet within the medical professionalism literature there is little discussion of how factors such as structural constraints on the provision of health care and the negotiation of intra-professional status might complicate the meanings of professionalism or interfere with its accomplishment, collectively or individually. “Physicians have a duty to do right and to avoid doing wrong,” Herbert Swick wrote, unironically (2000: 614), suggesting that there is a clear line between “right” and “wrong” that is objectively discernable. When professionals fail to be “professional,” individual-level explanations for these lapses are often provided, with references to the inevitability of a few “bad apples” (Hafferty 2006).

In the context of questions about the negotiation of sex negativity within medicine, it is important to point out that medical discussions of professionalism rarely acknowledge that physicians are members of society, and as such, may well share whatever prejudices towards or negative beliefs about certain groups or types of persons that are common within their society at any given time. Does the profession recognize the possibility that biases or prejudices that are common to members of society might impact doctors’ capacity to meet the total needs of their patients – whether some of their patients, based on their demographic status or group membership, or a set of health needs that are potentially shared by all patients? This is not an individual-level problem, it is a question of how the profession recognizes broader systems of social inequalities and their place within them, and the extent and contours of their conceptualization of their professional obligations to redress those that they recognize. Is the enactment of altruism predicated upon an assumption that physicians somehow transcend the biases

that are common to other members of society, or does medical education attempt to explicitly transform doctors' attitudes towards persons or aspects of human experience that are negatively valued within prevailing social norms? What *counts* as “doing right” and “doing wrong,” and what social forces shape the understandings of these parameters? More specifically, how do physicians collectively learn how to “do right” and avoid “doing wrong” as they encounter sexuality, which is so tightly bound up with notions of taboo, sin, taint, and discomfort, within their training and work? The relatively recent medical professionalism literature does not say anything about sexuality nor any particular challenges that may be associated with addressing it.

Conceptualizing sex negativity within medical education

However, advocates for medical sex education in the 1960s and 1970s recognized sexuality-related discomfort as both prevalent and important for medical education to address. Woods and Natterson (1967) found that medical students experienced discomfort discussing sexuality with patients – particularly when they felt that they had sexual problems of their own. This discomfort pertained to examinations of the genitals and rectum and to hearing about patients' sexual concerns – particularly masturbation, homosexuality, and infidelity or impotence within marriage – and led students to avoid physical examinations and withdraw from discussions in which patients attempted to express their sexual concerns. Woods and Natterson argue that the “anxiety, guilt, and shame *in students own sexual lives*” were the cause of their “phobia” of addressing sexuality in the clinical context (1967: 327; emphasis mine) and propose that students should be able to share their anxieties about sexuality in small-group discussion settings and have access to psychiatric treatment in order to resolve the problem. They also recommended fact-based sexuality education to provide the students with a knowledge base, but in the absence of access to psychiatric services,

any formal knowledge of sexuality would not enable students to become physicians capable of taking patients' sexual concerns seriously.

Interestingly, although Woods and Natterson (1967) recognized social consequences of doctors' sexual discomfort, they suggested that the discomfort originates from individuals. Other advocates of medical sex education hint at the potential influence of social sources of discomfort, and affirm the social consequences of addressing this discomfort or neglecting to do so. Golden and Liston (1972) suggested that students needed to resolve concerns about the *propriety* of asking patients about their sexual problems before they could adequately treat them. Marcotte and Logan (1977) found that medical sex education courses at the University of Minnesota not only enabled students to develop a more "liberal" view of sexual behaviors, including higher degrees of tolerance towards the sexual behavior of others, but also decreased the "dogmatism" in students' attitudes towards a range of sexual and nonsexual behaviors. On the other hand, Coombs argued that if medical education does not address human sexuality, the medical student will "leave school with the same misinformation and rigid attitudes he brought with him [sic], and his ability to render service to patients with sexual problems will be seriously impaired" (1968: 275).

These and other medical educators of this era agreed that sexuality was likely to arouse discomfort and that medical education needed to address the discomfort associated with sexuality in order to prepare medical students to address even the most routine sexuality-related issues that were sure to arise within the average medical practice. There is little evidence that a clear set of curricular initiatives within medical education have emerged to accomplish this, and recent research and comment on medical sex education that considers discomfort tends to conceive of sexuality-related

discomfort as being associated with sexual minorities specifically (Kelley et al. 2008; Eliason et al. 2011).

What do the manifestations of sex negativity within medical experiences include? Discomfort related to sexual minorities or non-normative sexuality is certainly an issue. In the next section I explain how complicated even that sub-type of sex negativity might be, and elucidate a few others.

Experiences of sex negativity within medical care

As this dissertation has reiterated, patients have reported a variety of experiences of feeling stigmatized on the basis of their sexuality or sexuality-related health condition within health care encounters (Smith et al. 1985; Weitz 1990; O'Hanlan et al. 1997; Beehler 2001; Herek and Capitanio 2002; Schuster et al. 2005; Kinsler et al. 2007; Dewey 2008; Poteat et al. 2013). Lesbian and bisexual women have reported that providers responded inappropriately (i.e., proposing voyeurism or referral to a mental health professional), with embarrassment, or by getting up and leaving the examination room upon disclosure of their sexual orientation (Smith et al. 1985). Rose Weitz describes a gay man who “realized” he had AIDS when during a hospital stay his hospital care team suddenly disappeared, only to be replaced by an all-gay set of doctors (1990: 30). One trans patient in Dewey’s study reported this of their experience in the emergency room: “There was nobody in the ER and they just didn’t help me. My girlfriend overheard doctors and nurses talking shit about me and she asked them for help and they started to laugh” (2008: 1348). As I have also noted elsewhere, we know that experiences of sexual stigmatization and the perception of the likelihood for sexual stigmatization to occur within health care settings has prompted patients to avoid health care entirely or to carefully limit their encounters with health care providers, constraining

the care that they are able to receive (e.g., Epstein 2007; Kinsler et al. 2007; Poteat et al. 2013).

But patients also experience sex negativity as relevant to clinical encounters in ways that are not related to sexual minority status or sexually transmissible diseases. Even sexual “majority” patients have reported the experience of wanting information or resources from their doctor and feeling like the provider was uncomfortable with talking about sex.

Typical reactions [to patients voicing sexual complaints in a medical setting] of a physician unprepared to hear sexual complaints include embarrassed silences, misinformation, the imposition of one’s own personal values, a surprised or shocked expression, apparent boredom or preoccupation, personal discounting, and belittling (Berman et al. 2003: 573).

Patients may feel particularly dependent upon their doctors for information about sexuality when they experience a major medical event, such as surgery or treatment for a serious illness. An Australian study of cancer patients found that patients really wanted information from their doctors about their sexual health in the context of their cancer treatment and future quality of life (Hordern and Street 2007). The doctors, who were also included in this study, felt embarrassed to talk about sexuality with patients because they perceived that doing so was “risky” business, and justified their avoidance of the topic by saying that for the patients, survival was the most important priority (Hordern and Street 2007). While it is perhaps unsurprising that patients were focused on their overall well-being while their doctors were more focused on the medical details of ensuring their survival, it might be reasonable for patients to presume that doctors are better suited to answer questions about sex during chemotherapy than are any other possible sources of information, even if the doctors themselves did not see themselves as such.

Although there are ample indications that patients experience sex negativity to be salient to clinical encounters, less research has examined doctors' and medical students' experiences of sexuality-related discomfort (or embarrassment or antipathy) within clinical encounters – whether their own discomfort or their perceptions of patients'. Discussions of medical students' initial encounters with human bodies, both living and dead, which note that these experiences have sexual connotations for some students (Lella and Pawluch 1988; Smith and Kleinman 1989) are an exception. Perhaps encountering the naked body and particularly, body parts that are considered "sexual" in nature, is the place within medical practice where sexuality is the most obviously, immediately relevant to the medical student or health care provider. In their ethnographic study of emotion management within medical education, Smith and Kleinman (1989) analyzed the discomfort that both students and faculty associated with examining the naked human body and its "sexual" parts, in the context of cadaver dissection or breast, pelvic, and rectal exams on live patients. Although students privately acknowledged the struggles they faced as they came into contact with human bodies in new ways, no formal opportunities for discussing the discomfort associated with the anatomy lab and physical exams were provided, and students quickly learned from the unspoken rules of the medical school that talking about their affective responses – whether revulsion or attraction, disgust or discomfort – was taboo. Similarly, Lella and Pawluch observed that the dissection of cadavers' genitalia was characterized by an undercurrent of "sexually related anxiety" (1988: 129), but say little about the measures, formal or informal, taken to address or even acknowledge it.

Particularly telling were the actions of the medical school faculty members that Smith and Kleinman (1989) observed. Although they did not acknowledge the affective significance of physical exams for those performing them, nor offer students strategies

for negotiating their personal responses to these duties, they indirectly affirmed the discomfort associated with examining certain body parts and offered a strategy for its avoidance. Students learned that it was acceptable to defer pelvic, rectal, and breast exams through witnessing residents and attending physicians defer them, and through the discovery that they would not be reprimanded for doing the same. The possible medical consequences of skipping physical exams, along with the reasons for doing so, were not discussed at the medical school Smith and Kleinman studied.

Professionalism, the construction of sex negativity, and the null curriculum of sex negativity and its effects

Buena Vista did not have a distinct set of teachings that pertained to the relationship between sexuality and professionalism, but sexuality was sometimes considered in conjunction with professionalism, or matters related to the achievement of professionalism, at Buena Vista. Like the sexuality education that took place at Buena Vista, the teachings pertaining to professionalism were not confined to a tightly-bounded curricular space and there was not a self-consciously established “professionalism curriculum,” but many teachings related to medical professionalism as it has been conceived of within the academic medicine literature were presented. Sustained moments of teaching about professionalism-related topics occurred within the Social Aspects of Medicine (SAM) classes, but teachings about professionalism also arose spontaneously and in conjunction with varied subject matter. Substantial emphasis was placed on “humanism” and “being professional” and discussions of – or at least, references to – the need to “treat patients with respect and dignity” were common. Faculty regularly urged students to follow the “platinum rule” rather than the golden rule – meaning, to do unto others as they themselves would want to be done onto, rather than as one would want to be done onto themselves. Not quite as frequent, but still

regular, were references to the potential difficulties associated with doing this. Buena Vista's teachings on professionalism sometimes contained considerable nuance, presenting the complexity of the human endeavor of doctoring with its myriad grey areas and unanswerable questions. Yet these teachings were not without their contradictions, and sexuality's place within these contradictions contributed to the construction of its special status.

In the rest of the chapter I elucidate how sexuality was constructed as special, different, particularly funny, uniquely capable of provoking discomfort, or an exception to the rules of professionalism. Although these practices were a far cry from actively labeling sex(uality) in general or any of its specific forms sinful or bad, the effect of these comparatively subtle practices had the effect of keeping sexuality removed from the realm of the ordinary. At the same time, a set of teachings about how the special status of sexuality might interfere with the provision of effective, equitable medical care was not present. Given that most aspects of the sex education endeavor at Buena Vista were nebulous, it is not surprising that there was not a curriculum specifically designed to alert students to sexual stigmatization within medicine and its potential to impact patients' experiences of health care and ultimately, shape patterns in health outcomes. But considered from the perspective on the emphasis on medical professionalism and the inextricability of sexuality from routine aspects of medical care, it is reasonable to analyze the absence of a set of teachings about the potential impact of sex negativity through the lens of the construct known as the "null curriculum."

The concept of the null curriculum is as promising as it is problematic. Simply put, the null curriculum refers to what a curriculum does not teach. Some educational theorists argue that looking at what a given educational system or institution does not teach is just as important as examining what it does teach, if not more important,

because knowing what a school excludes tells us much about what sorts of ignorance it may produce (Eisner 1985; Flinders et al. 1986). The problem, of course, is that every curriculum necessarily excludes more than it includes, and many curricular exclusions are considered obvious or reasonable. No one would claim that omitting advanced calculus from kindergarten classes counts as a null curriculum, Flinders et al. (1986) point out.

One way of making the concept of the null curriculum more useful is to apply it to material that has been deemed important or even mandatory within a given “curriculum universe” but has been excluded from the executed curriculum (Flinders et al. 1986). Clearly, if something that is collectively and internally determined to be important is left out, this omission counts as an exclusion that is recognized as an exclusion within the realm of that educational institution. The problem, of course, is that the concept is most useful for examining curricular exclusions that have not been conceived of by a given set of curriculum planners as exclusions. In other words, the concept of the null curriculum can usefully draw attention to content that is not part of a given curricular universe and whose absence constitutes meaningful exclusions – from the perspective of the outside analyst or observer. The “nothing” or the “nullness” that the null curriculum then points to is subjectively established. For this reason, Flinders et al. (1986) argue, the concept of the null curriculum may have more promise for curriculum developers than for empirical researchers although they concede that the concept may be useful within empirical research for drawing attention to the values and interpretations and preferences of curriculum planners. Here I employ the concept of the null curriculum to draw attention to the absence of teachings about how to transform sexuality-related discomfort or sexuality’s special status, which were acknowledged, into the achievement of professional behavior, which was prescribed.

Locating sex negativity at Buena Vista: Physicians' biases and their implications

The topic of physicians' biases came up regularly within SAM lectures and was discussed to varying degrees of depth. Sometimes lecturers simply acknowledged that physicians have biases, or told the students that it was important for them to recognize their own biases. One discussion of physician's biases came within the context of an introduction to psychiatric interviewing. Dr. Salvador Molina, a psychiatrist, modeled psychiatric interviewing to the students by showing the class a film of himself interviewing a patient. After the film, Dr. Molina told the students "As a psychiatric interviewer, you perform the role of barometer, and you are assessing the patient against what you consider normative. Therefore, the better know yourself and your biases, your idiosyncracies and problems, the better you can perform an objective analysis of the patient." He spoke seriously and enthusiastically, and this assertion could have been a very compelling opening to a longer discussion. But Dr. Molina's mention of the need for physicians to develop this self-awareness didn't go any further, and he offered the students no guidance as to how they might come to understand their own biases, idiosyncracies, and problems.

During another lecture, Dr. Margaret Walter from Buena Vista's professional development center also briefly touched upon the need for doctors to recognize their biases when she delivered a lecture on patient interviewing. Dr. Walter told the class that 85% of patients choose or rate their doctors based on how they feel about the doctor as a person, rather than where they went to medical school or other objective factors. Patients, she told the students, just want to feel like they're being listened to, empathized with, and respected, and as such, physicians' skills need to include more than just technical competence, but also presence, focus, listening, body language, and the capacity to acknowledge patients' emotions rather than trying to "solve problems."

To do this, she said, “You need to get in touch with your own feelings, responses, and biases within clinical encounters. Patients can feel your judgment even if it is not explicitly stated.” Although she did not say exactly what would happen if patients did feel judgment from their doctor, her tone made it clear that the consequences of this were not likely to be good. But like Dr. Molina, Dr. Wallace did not say anything about how students should go about getting in touch with their own feelings, responses, and biases, and I did not observe nor hear of structured activities designed to help students do these things.

Not only did the teachings about bias recognition and self-awareness seem to lack traction, another type of remarks about physicians’ biases sent a contradictory, if subtle, set of messages. During a Psychopathology lecture on personality disorders, the lecturer of the day remarked, “I’m comfortable with my own biases, I picked them up during medical school, and they’ve served me pretty well throughout my career.” His delivery was dry, and he said nothing more about his biases – his own or anyone else’s – so it was never clear how seriously he meant for his remarks to be taken. Similarly, during a brief mention of “culture” within one lecture within the Physician-Patient Dynamic class, Dr. George Sorin told the audience “sometimes, as doctors, we have to stereotype patients.” This remark, like the one during the Psychopathology lecture, was made in passing, and I perceived a bit of irony in his delivery. But if the irony was there, it was subtle. It struck me that his statement could just as easily been interpreted as “Go ahead and stereotype your patients, kids. That’s what we do. We’re busy, we have to make decisions quickly, and that’s just the way it goes.” And of course, physicians are busy and do have to make decisions quickly, and stereotyping patients is probably an inevitable byproduct of these arrangements. But does that matter? Is that something

that physicians need to think about or try to address? These sorts of questions were not raised alongside the acknowledgements of physicians' biases.

At one point during the lecture/discussion/poll/curricular event known as “sex day” that I described in detail in Chapter 4, Dr. Sorin told a story of a patient he encountered years ago. She was a “cute” high school student, and he asked her if she was having sex. She told him yes. He asked if she was using birth control. She said no. He asked if she was trying to get pregnant, and she said no. He pointed out to her that if she was having sex and didn't want to get pregnant it might be a good idea to think about using birth control. Ultimately, the point of the story was that the patient was a lesbian, and years ago when this incident occurred, he had not recognized the possibility that a young woman who was reasonably nice-looking by his standards might be gay. Now, he told the students, this kind of a situation would be very different, but at the time, the possibility that this patient was a lesbian was totally outside of his radar. In a sense, Dr. Sorin's telling of this story reflected a certain amount of humility – after all, he was telling the audience that he had made an assumption about a patient, and he had been incorrect. But the recounting of this anecdote was significant in other ways too.

In Dr. Sorin's telling of the story, the patient had a fair amount of control within the encounter. As Dr. Sorin asked question after question about her sexual activity and contraceptive use, the patient, he said, was “totally winding him up, knowing exactly what she was doing” by answering his questions in a straightforward manner, while also forcing him to come to his own realization of the particularities of her situation and recognize his assumptions for what they were. In this scenario, there were not any negative consequences for the doctor or the patient by virtue of this assumption being made. The patient was unperturbed, the doctor got to learn a lesson from a “cute” high

school student, and no one suffered along the way. The patient was comfortable enough with her own sexuality to have a little fun with the slightly ignorant doctor. In some ways this anecdote served to disrupt the typical understanding of the balance of power in the doctor-patient relationship, by putting the patient, and in this case, a young, female, non-heterosexual patient, in control. However, this anecdote could also have served as a point of departure for talking about the very unpleasant, very difficult experiences that many patients have had due to their doctor's assumptions about their sexuality, and the medical consequences of these assumptions. While this particular patient might not have been fazed by Dr. Sorin's assumptions about her sexual orientation, research shows that lesbians often perceive their doctors to be ignorant, insensitive or prejudiced towards them (Stevens 1992). Many report experiencing humiliation or nonempathetic care from health care providers, and reported feeling risk of harm (Stevens and Hall 1998). Putting off health care until the last minute or avoiding care entirely was a frequent result (Stevens 1992; Stevens and Hall 1998). Of course, lesbians are not the only patients – sexual minority or otherwise – who have had such experiences of health care and avoid it as a result, but in the context of Dr. Sorin's story, it is worth noting that lesbians have repeatedly suffered from what they perceive to be doctors' insensitivity or prejudice. Doctors' assumption of their heterosexuality is a common complaint made by queer patients (Beehler 2001; Harbin et al. 2012). The potential for patients to have these sorts of experiences was not discussed on this occasion, nor considered elsewhere.

Sexuality as exception to the rule of treating all patients who come to you

In another lecture that pertained, in part, to physician's biases, sexuality was singled out – albeit, perhaps unintentionally – as an exception to the rule that doctors should treat any patient who comes to them for help, and to treat all of their patients with

compassion. During the lecture entitled “The Physician as Person,” Dr. Nora Fischer, a family physician, told the students that it was important to have compassion for all patients, no matter who they are. “If you’re dealing with ex-convicts, people that have killed someone, you have to show regard for them even if you might dislike them or not respect what they have done. Once they come to you for treatment, and you are their physician, you have to help them,” she said. In response, a student raised his hand and shared an example from his own experience. He was working in an emergency room, and a patient came in who turned out to have swastikas tattooed all over his body. The student said that it was really hard for him to work on the patient because he was Jewish. Later, he shared the story of his experience with his Jewish father, who told him “When you’re a doctor, you have to show compassion for all of your patients, no matter who they are and what they bring to your office.” The student said he had been moved by his father’s response, and had learned a lot from the whole situation.

Dr. Fischer thanked the student for sharing, and concurred with his sentiments. When a patient comes to you, it is your duty to serve their needs, she agreed. But then later she backpedaled a little bit. She told the class that there might be times when a patient comes along that makes the physician feel uncomfortable, and in those instances, sometimes the doctor just has to tell the patient, “You know, it really would be better for both of us if someone else were your doctor.” The example she used to illustrate a potential cause for physician discomfort was sexual orientation. Sometimes a patient’s sexual orientation might be something that the doctor just can’t deal with, Dr. Fischer told the class. In situations like this, she went on, “You have to practice social tai chi. You have to be centered enough in yourself to know how you feel, and in certain situations, you need to step aside. You may have to extricate yourself from working with certain patients because of your own feelings and biases.”

Dr. Fischer did not acknowledge that she had just introduced a caveat to her edict that doctors should help all patients that come their way – or perhaps even contradicted herself. Nor did she explain why she had chosen sexual orientation as her example of something that a patient might present to make a doctor so uncomfortable that they would be compelled to step aside. It is entirely possible that Dr. Fischer was formulating her thoughts on these matters as she made her remarks, and that under different circumstances, she might not say that sexuality necessarily constituted an exception to the rule of treating the patients who come to you, whoever they are. But even if her remarks were not carefully formulated, their implication was that Jewish doctors must find compassion for patients covered in swastika tattoos, but sexual orientation, on the other hand, provided an exemption from the rule of doctors' duty to demonstrate compassion to all. Dr. Fischer's comments suggested the legitimacy of the notion that sexuality per se is different from other types of human difference, or other forms of human behavior, and that it is justifiable to draw distinctions on the basis of sexuality that would not be acceptable otherwise. Gayle Rubin argues that the notion that erotic variety is dangerous might well be called the "last socially respectable form of prejudice if the old ones did not show such obstinate vitality, and new ones did not continually become apparent" ([1984] 1993: 12-3). Nazis may be regarded as bad seeds, but they are familiar characters. Persons who deviate from normative sexuality and gender may be far less intelligible (Butler 1999) than the Nazi or the convict, whose crimes may taint them, but in a familiar way. Shared societal understandings of the badness of criminal actions also provide a clearer framework for action. The Nazi has clearly veered off track, but the doctor, by treating the tainted patient, takes the high road. Patients whose sexuality is the issue may present a more complex challenge to the doctor within the context of shared understandings that unfamiliar sexual variations

are negative, and little cultural impetus to challenge these assumptions because of the threat of incurring a courtesy stigma.

Although Dr. Fischer's message about sexuality being the exception to the rule of treating all patients who come a doctor's way may have been subtle and sent unintentionally, it may still have sent a powerful message, particularly because it was in line with a conclusion that students sometimes came to themselves. For example, during the small-group discussion after "sex day" within the Physician-Patient Dynamic class, the topic of conversation turned to inappropriate sexual behavior on the part of patients. Students agreed that if a patient was sexually harassing a doctor, it would be appropriate for the doctor to stop treating the patient. The conversation shifted to the matter of dealing with HIV-positive patients who are having unprotected sex. One student offered that when patients receive an HIV diagnosis, it is not uncommon to get angry and depressed and act destructively, such as by having unprotected sex. Another student quickly responded, "That's pathological behavior!" Others shook their heads and expressed disgust and indignation, saying, "That's totally irresponsible and unacceptable." I asked the students how they would respond if they had a patient who was behaving in this manner, and one said, "Well, I would try to educate the patient, but if they wouldn't change their behavior, I would have to cut them off and not see them anymore." Then a student made a comparison to a patient who won't stop smoking, or a diabetic patient who won't change their diet. As soon as this analogy was made, a student named Diana jumped in. "My grandfather smokes, and he isn't doing too well, but he won't stop smoking," she said. "But I'd be pissed if a doctor told him that they wouldn't help him anymore just because he smokes. You can't just cut patients off because they don't do what you say." Her voice wobbled with emotion, and a few of the other students looked down and mumbled "Yeah, I guess that's true." But they did not

return to the topic of inappropriate sexual behavior and did not collectively discuss how Diana's revelation might apply to situations with patients concerning sexuality.

While there are certainly valid medical reasons to be concerned about patients – regardless of their HIV status – having unprotected sex, the line between medical concern and moral disapproval was blurry in both Dr. Fischer's equivocal discussion of having compassion for patients, and the students' differential responses to different instances of patients contravening doctors' orders. The line between medical concern and moral disapproval – or even a response that is murky, barely conscious, and difficult to define – may be fundamentally grey. But the exploration of this grey area - of how doctors' medical and moral responses to patients may come together - may be essential to understanding how patients may end up feeling like a doctor is judging them, and such exploration did not occur in conjunction with these curricular moments. In these cases, sexuality was the third rail that automatically challenged the ideals (or tropes) of treating patients with equal regard – and this was not a topic of discussion in and of itself.

How do biases matter? The invisibility of discrimination

Buena Vista's teachings about biases were full of contradictions. It is significant in itself that attention was regularly devoted to encouraging students to recognize their biases. After all, the medical professionalism literature does not systematically acknowledge the possibility that physicians might have biases, much less the need for them to be recognized, and many critics of training for cultural competence argue that one of the problems with training for cultural competency is that it does not do enough to address physicians' biases and prejudices (e.g., Wear 2006). Simply by explicitly naming biases as something that physicians need to be aware of, Buena Vista introduced nuance into the emphasis on treating all patients with respect and dignity, by

acknowledging a possible impediment to this process, and hinting that physicians' social selves might shape their medical practices.

But in addition to the contradictions and exceptions within these teachings that I have already discussed, Buena Vista's teachings about biases were isolated from a broader discussion of discrimination and patterned marginalization of patients. The possibility that physicians' biases might adversely affect individual patients was barely hinted at, and there was no discussion of how physicians' biases might overlap with or contribute to patterned, repeated discrimination against or exclusion of certain groups of patients. Should the absence of discussion of these topics be considered a null curriculum? Put differently, did Buena Vista need to provide specific teachings concerning the ways that physicians' biases might have an impact on patients? If Buena Vista, or any other medical school, or medical schools in general, wants their students to become physicians who treat their patients with "respect and dignity," what sort of reflexive understanding of physicians' biases is required? Is it enough to recognize their existence? These questions escape easy answers, in part because they not only have to do with the ways in which educational objectives and curricula are conceived, but also the ways in which these curricula shape students' actions and patients' reception of them. Putting aside questions about the relationship between content of curricula and medical students' eventual actions (and patients' experiences thereof), here I suggest that the absence of teachings about why and how biases matter constitutes an important curricular omission – i.e., a null curriculum. Buena Vista students who had not personally witnessed discrimination had a hard time believing that it could actually exist,²⁶ and demonstrated little awareness of the potential for physicians' beliefs or

²⁶ Beagan (2003) observed similar tendencies in a study of medical students' attitudes toward social and cultural differences.

biases to translate into actions that a patient might experience adversely. In the absence of a set of teachings about how and why physician biases could matter for patient care, students did not necessarily come to an understanding of their potential impact on their own.

Many of the students I interviewed, even those who were in their first year in medical school, knew from firsthand experience that “unethical” behavior was a clinical reality, or had heard stories of isolated instances of unethical behavior on hospital floors. Yet most were less aware of – or perhaps less able to conceive of or acknowledge – reoccurring discriminatory behavior towards particular groups of patients. Buena Vista students typically implied that “unethical” and “discriminatory” behavior are distinct sorts of practices, and the professionalism literature says little about where discrimination and ethics intersect. Students regularly expressed disbelief that doctors might treat patients disrespectfully on the basis of their identity or membership within a particular social group, however unintentionally. A student named Doug, who identified as queer, told me about a time in one of his small group discussions where they considered a case study in which a patient was discriminated against because they were gay. “Everyone in my group thought this was a joke,” Doug told me. “They were laughing, and they did not believe that this would happen. They didn’t understand that this kind of thing happens. And I had to tell them, ‘No, you guys. You do not understand. This happens. I have seen this happen many times.’” Doug’s sense was that his classmates could not believe that such discrimination actually occurs because, as he put it, “...they’ve either lived in a bubble of political correctness their entire lives, or [the discrimination] is at a frequency that they just can’t hear.” Doug’s sense was that many of his fellow students hadn’t experienced discrimination themselves – particularly related to their sexuality – and thus didn’t believe that it existed. “How do you make someone who isn’t queer understand

what it's like?" he wondered aloud during our interview. Perhaps a partial answer to this question would be to teach about the existence of discrimination and its effects, but to the extent that this happened at Buena Vista, even when discrimination was acknowledged directly, students still had a hard time taking its potential significance seriously.

During the class meeting of Stages of the Life Course devoted to cultural competence²⁷, a film was shown during lecture that featured white doctors yelling at Mexican patients who did not speak English. In order to try to make the patients understand them, the doctors continuously raised their voices. The students in the auditorium laughed uproariously, and the lecturer told them that they would see this kind of thing over and over again as they began their work as doctors. The students did not show any signs of believing her during lecture, nor during the subsequent small group discussion that I facilitated. During the small group discussion one student named Nadav became very excited, saying that he didn't understand why immigrants, like the Mexican patients in the film, couldn't *just learn* the language of their new homeland. "Why can't they just learn English?" he asked excitedly and repeatedly. Other students said that they felt the film was unrealistic, and a few rolled their eyes. One student named Kenneth disagreed. "No guys, you don't understand," Kenneth said. "I was that guy, I was just like that doctor one time." In quick reply, Nadav repeated his conviction that people should be able to pick up the language of their host country quickly, and Kenneth responded, "Not everyone can do that! Not everyone can pick up a language that easily! They're working all the time, they don't have resources!" Nadav became even more agitated as he reiterated his conviction that "they should just learn the

²⁷ Although training for cultural competency sometimes encompasses sexual diversity in addition to diversity on the axes of ethnicity/race, national origin, language, and "culture," this lecture on cultural competency focused primarily on "culture" as a proxy for ethnicity/race and made no mention of sexuality.

language,” and Kenneth shook his head. “You’re from a wealthy family, Nadav! It’s different for you!” he protested adamantly yet wearily. Shaking his head, he let the matter drop there, and looked down at his desk. The other students in the group laughed, but their laughter was easy and bore no traces of tension or discomfort, and Nadav smiled as he looked around and met his classmates’ gazes. A couple of students said that they didn’t think that any of them would really act like the doctors in the film, so they didn’t have anything to worry about, and the discussion moved on. Kenneth remained quiet, and the possibility that doctors in general, rather than a few isolated bad apples, might indeed be capable of treating patients rather poorly was never addressed. Nor was there any discussion about how or why this might happen – or how even the most well-intentioned doctors or medical students might unintentionally treat their patients in ways the patient could experience as discriminatory.

Without situating the discussion of biases within the context of systematic discrimination and health disparities, there may be little impetus for student to recognize patterned stigmatization and health inequalities at all, much less the role their biases could play in perpetuating them. The lack of acknowledgement and discussion of the potential for the relationship between biases and discrimination and sexuality to be particularly tricky is interesting because Buena Vista students and faculty alike readily recognized sexuality as being special in other respects – namely, they recognized that sexuality was a topic that was associated with particular discomfort, and because of this, served as especially good fodder for jokes.

Joking, sexuality, and professional behavior

The sociological literature on the professional socialization of medical students and the work of doctors recognizes the prevalence of joking within medical work. Sociologists note that joking is hardly unique to medicine, and note that humor serves

important functions within most occupational groups (Drew, Mills, and Gassaway 2007), particularly those who perform work that is considered “dirty.” Sociologists argue that “dirty work” is work that is essential to society but confers taint upon those who execute it. Dirty work usually involves duties that are likely to be perceived as disgusting or degrading (Hughes 1951; Drew, Mills, and Gassaway 2007); that deals with “difficult” or “distasteful” aspects of social experience (Bolton 2005); involves contact with stigmatized persons, danger, or a servile relationship to others (Ashforth and Kreiner 1999). Interestingly, even though close physical contact with others and proximity to matters that are usually considered private are (partial) criteria for “dirtiness” (Bolton 2005), sexuality does not feature prominently within the dirty work literature. In a sense, this is not surprising – the fact that sex and paid work are so often seen as antithetical (Hearn and Parkin 1995)²⁸ coupled with the stigmatization of those who study sex (Irvine 2003; Irvine 2014) and the more recent suggestion that sexuality research should be considered a form of dirty work (Irvine 2014) are likely reasons why sexuality’s intersections with work have not been studied extensively, even if it is particularly “dirty.”

Much of the dirty work literature examines occupations that are relatively low status, and focuses on examining the ways in which dirty workers negotiate the taint they are accorded as a result of the nature of their jobs (e.g., Ashforth and Kreiner 1999; Drew, Mills, and Gassaway 2007). But how does “dirtiness” affect higher status jobs and workers? Ashforth and Kreiner (1999) note that in higher prestige occupations, the workers’ status may mitigate the stigma their dirty work might accord them, to some degree. “[B]ecause prestige is associated with a status shield, the salience of social

²⁸ Hearn and Parkin (1995) and others acknowledge that sexual interactions – both wanted and unwanted – are commonplace in workplaces, even if these interactions challenge Weberian notions of rational, bureaucratic organizations (Williams et al. 1999). Here I am concerned with sexuality’s place within professionals’ duties, rather than within workplace dynamics and relations between colleagues.

perceptions may be reduced,” they write (Ashforth and Kreiner 1999: 430). Everett Hughes pointed out that in the case of doctors, work that might be considered dirty in other cases, namely, the intimate handling of the human body, may be an “intimate part of the very activity which gives the occupation its charism” (Hughes 1958: 52). Thus, in the case of doctors, it may be that *they* are able to avoid incurring taint themselves even if some of their work counts as dirty, but does that mean that the stigma disappears from the work and its context entirely? And if it does not, what are its effects?

It is clear that even if doctors are not usually considered dirty workers in the strictest sense, they, like other dirty workers, tend to relieve the stress associated with the “dirty” aspects of their work through joking. Medical sociologists have recognized gallows humor as a frequent response to the strains associated with confronting human suffering and death on a regular basis, and routinely violating strong cultural norms that prohibit looking at, touching, and probing naked human bodies – not to mention coming into contact with their various excreta - and analyzed its place within the process of emotion management as doctors confront difficult aspects of their work (Bosk 1980; Leiderman and Grisso 1985; Anspach 1988; Hafferty 1988; Wear et al. 2006). Gallows humor frequently includes derogatory characterizations of patients, particularly those who are of low social worth, have illnesses that are perceived to have been brought upon by their own behaviors, or both (Anspach 1988; Wear et al. 2006). Elaborate descriptive terminology pertaining to such patients has been developed – “crock” and “gomer” are two of the more common terms applied to patients who vex doctors’ efforts to treat them or are otherwise frustrating (Leiderman and Grisso 1985).

Sociologists of medicine tend to take one of two perspectives on the implications of doctors joking about patients. One is that joking about patients constitutes a healthy coping mechanism for dealing with the uncertainty associated with medical diagnoses

and the stress and sorrow of dealing with terminally ill patients, and may facilitate the achievement of professionally-appropriate affective neutrality, or “detached concern” (for a review of the relevant literature see Anspach 1988). Physicians experience stress from the structural features of their work such as perpetual time constraints, and from the idiosyncratic challenges of dealing with patients, thus remarks that belittle or degrade patients are important or at least justifiable insofar as they allow the physician to blow off steam and deflect the anger and disgust that they experience in the course of their work (for discussion see Wear et al. 2006). Joking about patients allows medical students and doctors to talk about challenging experiences without having to confess weakness, and the support that they receive from sharing in this manner helps them understand that they are not alone and that their problems are not unique (Smith and Kleinman 1989). Although this perspective does not necessarily take into account the implications of doctors’ joking upon the patients they are supposedly caring for, its strength is its recognition of doctors’ humanity. “Professional” or not, joking about patients is an expression of the very real human emotions that doctors experience as they go about their work. And after all, the use of humor as a coping strategy is not limited to one particular occupational group, but common to many. Why should doctors be any different?

The second perspective on doctors’ practices of joking or making derogatory remarks about patients is that these behaviors, in addition to being “interesting,” also “troubling” insofar as they indicate that physicians are “departing from the ‘ideal’ norms and values of respect for the patient and for professional role prescriptions” (Leiderman and Grisso 1985: 223; Anspach 1988). Although medical educators commonly recognize that medical students experience “ethical erosion” and heightened degrees of cynicism as a result of their medical training (Wear et al. 2006), referring to patients as

“crocks” or “gomers” or “brain stem preparations” still seems like an egregious contradiction of the medical training’s goals of imparting humanitarian values or a service orientation (Parsons 1951; Anspach 1988). There is probably an important distinction to be made between the jokes of workers whose duties include the direct care of humans – particularly those who are ill or otherwise vulnerable – and workers whose dirty work involves little interaction with clientele, but the dirty work literature has not yet explored this distinction.

While the tension between joking as necessary for professionals’ humanity and joking as barrier to respecting patients’ humanity has clear implications for the negotiation of sexuality within medical practice, my intention here is to not to argue that looking at sexuality brings a new perspective to this debate, but rather to show how joking about sexuality reinforced its “special status” and validated the notion that sexuality “naturally” provokes discomfort. Most of the sociological literature on joking among medical students and doctors does not consider sexuality-related jokes specifically nor the ways in which sexuality-related joking may be similar to or different from other jokes. In a striking exception, Frederic Hafferty (1988) recognizes the manipulation or mutilation of “sexual” organs as a specific type of “cadaver story.” Cadaver stories are a particular macabre form of prank-playing (or storytelling) among medical students wherein the perpetrators confront an unsuspecting victim with a manipulated cadaver or pieces thereof with the intention to cause shock or distress. For example, in one story a cadaver’s penis is stuffed into another cadaver’s vagina and when an unsuspecting medical student happens upon this scene, they are surprised and probably upset or disturbed. Hafferty refers to “sexual organs” unproblematically, suggesting that this category of body parts is self-evident, and does not explain how the

manipulation of these “sexual” body parts might be different from the manipulation of the “non-sexual” parts.

At Buena Vista, students and faculty alike reported that joking about patients was commonplace, but were quick to point out that the jokes did not always pertain to sexuality. “I can assure you that [joking about patients] happens, and it’s not just related to sexuality. It may not always be appropriate, but sometimes we do joke around about patients as a way of alleviating stress...we’re always laughing and telling stories about patients and encounters with patients, not making fun of the patient, but because it’s funny,” Dr. Janet Norton, an OB/GYN told me. Yet many of the jokes I heard or heard about did indeed pertain to sex. At Buena Vista, joking about sexuality was sometimes recognized as a necessary tool for diffusing the discomfort associated with sexuality, but far from transforming sexuality-related discomfort into something else, it seemed that joking about sexuality reinforced the notion that sexuality is different, special, or uniquely funny. As I discussed in Chapter 2, Dr. Arnold Jun, the urologist who gave the lecture on how to do an exam on the male genitals described his lecture as being “kind of fun because it’s about male anatomy.” He went on to explain that sexuality is a funny subject for most people, because it makes them nervous, and thus, joking about sexuality helps lighten the discussion and makes the subject matter a little easier to approach. As I argued in Chapter 2, even if Dr. Jun’s intention was not to teach students that sexuality can only be dealt with through the use of humor, the tone and content of his lecture reinforced the idea that sex provokes discomfort, and this discomfort can best, or perhaps only, be allayed with humor. “There’s something about sexuality that’s uncomfortable for people,” Dr. Jun told me, “so once I make it facetious then it’s easier for them to digest the factual information I present.”

Patients who came to the doctor with an object stuck in an orifice were a frequent subject of joking. During the discussion of the gastrointestinal system within an anatomy lecture, a student named Jalil told me, the lecturer showed a slide of a coke bottle stuck in a patient's rectum. Not only did the students in the class laugh, but the lecturer did too, and made a few "snide remarks" about the man's sexual practices, according to Jalil. The jokes "got a little out of hand," Jalil said, and the course director (who had not been present for the joking when it occurred) heard about what had happened and addressed the issue in their next class meeting. "Sometimes it's helpful to joke around and make light of things," Jalil recalled the course director saying, "but we also have to remember that when we're dealing with actual patients it's not appropriate to do this." But although the course director addressed the issue of joking about actual patients, he did not address the nature of the subject that had provoked the joking, or more specifically, he did not challenge the idea that a patient with a foreign object stuck in one of their orifices could be considered anything other than humorous. Given the prevalence with which patients presented with foreign objects stuck inside of them, this might have been a matter worth talking about.

Stories about a patient coming to the emergency room with something stuck in their rectum or vagina were common. Even the students who hadn't observed this firsthand had stories about peers who had. "My old roommate saw this happen twice within the span of three weeks," a student named Don told me. Most of the stories involved joking about the patient and their predicament. A student named Arthur told me that some of his classmates had been on rotations when a patient came in with a sex toy stuck inside of him, and I asked Arthur if he'd heard of any jokes or derogatory remarks being made by anyone present. Arthur said that he wasn't sure, but speculated that there probably were. "I definitely guarantee that my classmates would make jokes or

snicker in the background [in that situation]. For sure, it's guaranteed. I would try to be a good person, but I would probably laugh too," he told me. Arthur's inclination to laugh and predictions about his classmates' responses were more likely representative of the rule rather than the exception in such situations. As a medical student in Wear et al.'s study put it, "There's nothing potentially funny about a sinus infection or an earache...But...if somebody comes in with an object lodged in their anus, that's entertaining" (2006: 457).

These jokes about patients with foreign objects stuck inside of them likely had the effect of facilitating in-group bonds among students and doctors, and perhaps resolved any awkwardness or embarrassment that they might have felt in the witnessing of patients in this predicament. But these jokes were not accompanied by discussion of the patient's experience of awkwardness in this situation, nor mention of the role the doctor could play in putting them at ease. Nor was there any indication that the jokes about sex toys facilitated greater comfort with talking about sex toys and the possibility that they might get stuck. The humor associated with the patient's predicament, or the discomfort that the physician experienced upon encountering it, was never fundamentally challenged or even acknowledged. Don told me about a time that he was on rotation and a patient came to the hospital with a dildo stuck in his rectum. "He was incredibly uncomfortable," Don told me. "And the attending physician was really weird about the whole thing... she never even said the word 'dildo,' she never actually talked about the object...she just asked the patient how he was after the 'procedure,'" Don remembered. The attending physician did not initiate a teaching-related discussion on the subject, and Don's impression was that the situation was incredibly awkward for doctor and patient alike.

Despite the prevalence of stories about patients coming in with objects stuck in their orifices, I did not observe the coverage of this topic within any formal teaching, and aside from the incident that Jalil told me about, students did not recall hearing it mentioned during classes, either. Thus, it seemed that the *only* way that this situation was discussed was in jest. The jokes were not complemented by serious discussion of any kind, so patients with sex toys or other objects stuck inside of them were *only* considered within the context of humor – and humor that was not necessarily benign. While we can't be sure what the results of this are, the incident that Don described at the Navy hospital, where the doctor kept her discussion with the patient with a sex toy in his rectum to a bare minimum, suggests that one implication is that it may be difficult to find ways of talking about this (and other) subjects with patients if their consideration is usually limited to the range of crass jokes.

The point is not necessarily that there was a null curriculum of sex toys per se at Buena Vista, but rather, that meaningful discussion about the discomfort that sexuality-related situations might produce was absent. In other instances there were also indications that joking about something was not necessarily a bridge to integrating that subject into a physician's or a student's comfort zone, but rather a way of keeping the uncomfortable at arm's length. Dr. Janet Norton told me a story of her first encounter with transgender patients.

I was new to this part of the country...there's a little less diversity where I come from and where I did my residency, and one of the first patients I had after I got [to Buena Vista] always came with another woman. They always wanted to be together in the room when they had their exams. They both used to be men, and they had had surgery and everything, but they came in wanting pap smears. I was young and I had never seen this as a resident, and they wanted to be in the exam room together and take turns getting their pap smears. Well, I tried to explain to them that they didn't need pap smears because a pap smear is a screening test for cervical cancer and they didn't have a cervix, but they wanted pap smears because they wanted to have the experience that every woman

has. I felt really awkward, and they came back all the time! One time they came back complaining of decreased libido and I thought to myself, 'Well, *yeah*. You used to have really high levels of testosterone and now you don't! Welcome to being a woman!' I just didn't know what to do and it was just funny. I remember telling lots of my friends about it and laughing because it was just so awkward. I wasn't laughing *at* them, but I was laughing because it was funny.

Dr. Norton was candid about her own discomfort in this situation, and said that ultimately, she felt like she had "done okay" with her transgender patients, and had treated them well despite the awkwardness she experienced. But even if her encounters with these patients had been relatively successful from her perspective, they had not led to a shift in her overall understanding of transgender as a set of experiences, nor an integration of transgender patients' needs into her conceptualization of what her work included. "I think there's a pretty specialized group of physicians who takes care of them," she said of transgender patients. "I think they would benefit from going to practitioners who know more than the average gynecologist. We don't generally manage those patients. They really need specialists who can take care of them," she told me. Dr. Norton referred to transgender patients' need for their hormones to be monitored, and, in the case of male-to-female patients, their need for prostate exams, which she, as an OB/GYN, did not normally do.

But Dr. Norton's comments also reflected more than a practical concern that transgender patients' specific medical needs be met by physicians who were trained to address them. Early in our interview, Dr. Norton had proclaimed that much of the reason why she chose her specialty was because of the huge variety of things that OB/GYNs do on a given day. She spoke enthusiastically of her enjoyment of talking with patients and forming relationships with them. "We get to know our patients really well and we share intimate things," she said. Part of doing this, according to Dr. Norton, included at least some discussion of the patient's sexual history and sexual activity, and any concerns

about gender identity that they might have. Yet most of the examples she gave about her interactions with patients pertained to heterosexual women and their relationships and their sexual practices. After some discussion, I pointed out that it seemed that heterosexuality seemed the default frame of reference for most of her description of her work, and she agreed that it often was, although she always asked patients about “what kind of a partner they have.” Her telling of her encounter with the transgender patients who wanted pelvic exams implied that the variety and intimacy that she appreciated within her work had certain limits. Anything beyond these limits provoked discomfort which joking helped alleviate, but, at least in the case of the transgender patients she described, the joking did not facilitate their integration into the realm of what she considered the routine, or particularly enjoyable, elements of her job.

Thus, joking served the purpose of diffusing the discomfort associated with sexuality, but it did not fundamentally transform its affective charge, and reinforced, however subtly, the notion that sexuality is inherently associated with discomfort and humor. It might be fair to say that the processes by which students might digest or transform the sexuality-related discomfort that necessitated the joking were part of a null curriculum. I will examine the matter of discomfort in greater depth later in the chapter, but first I consider students’ understandings of the relationship between their personal responses to aspects of their work, such as joking, in one moment and displaying appropriately professional behavior in the next.

From joking to altruism: translating backstage impulses into frontstage professionalism

Ample evidence of joking about patients at Buena Vista and elsewhere indicates a tension between the ideals of conduct the medical professionalism literature puts forth and the potential obstacles it recognizes to their achievement. More specifically, the

professionalism literature does not acknowledge the discomfort doctors and students may experience as they are confronted with aspects of their work that are unfamiliar or perplexing, or that would likely be considered disgusting or repulsive in any other circumstance. It assumes doctors' and medical students' capacity for altruism yet it does not allow that doctors and medical students might experience discomfort or a need for its relief. It does not acknowledge that doctors might joke about or judge their patients, or respond to them in other ways that the patient ultimately experiences negatively. If doctors and students are capable of behaviors that are unprofessional, how do they translate impulses towards unprofessional responses into appropriate professionalism? Putting the question this way is somewhat awkward because "professionalism" is not only a social construction, but relatively under-defined within the medical professionalism literature. But questions about how medical professionals conceptualize the relationship between their personal responses to patients and their sense of what behavior is appropriate to deliver to patients are important.

The sociological literature on professional socialization has explored questions of this nature to a limited extent. Previous research has found that students and doctors are quite aware that certain behaviors may be acceptable outside of the presence of patients – i.e., backstage – but certainly are not appropriate in frontstage settings (see for instance Smith and Kleinman 1989; Wear et al. 2006). This was also true at Buena Vista, where students and faculty alike referred to the importance of keeping a "straight face" around patients, even if they found things funny and made jokes outside of the patient's presence. But is keeping a straight face the whole point? Renee Anspach points out that whatever positive functions joking and making derogatory remarks about patients may serve, they may also reflect a "blunted capacity to care and a deeply dehumanizing orientation to patients... which jeopardizes their care" (1988: 359). Is the

successful maintenance of a “straight face” around patients a reflection of the doctor’s ability to transition between joking about patients in one moment and providing them with compassionate, altruistic care in the next? Is such a transition really possible, or is joking about patients, as Anspach suggests, an indication that the care patients ultimately receive will be less than ideal? If this translation process, by which students and doctors transform their discomfort and its various manifestations into behaviors that patients experience to be neutral or positive, is successful, what does the process look like on the student’s or the doctor’s end? Are they formally trained in how to achieve this – after all, it would seem that such training would facilitate the achievement of professionalism, or is it something that students learn either from informal cues within the medical environment (as described by Smith and Kleinman 1989) or some other means? These questions belong to a larger subset of questions: how do medical students and doctors conceive of the relationship between their personal self and their professional self? How do they conceive of the relationship between their personal responses to the social world and their professional responses to it? Moreover, how do medical schools conceive of this sort of a negotiation process, and the need for teachings to address this topic? Should the absence of these sorts of teachings – or considerations about whether or not to offer such curricula – be considered a null curriculum? These questions are relevant to many aspects of medical practice, not only sexuality, but if sexuality is particularly likely to produce discomfort and if that discomfort is understood to be best or only resolved through humor, these questions have particular implications for our understanding of how doctors respond to sexuality within clinical encounters.

Although the potential contradiction between joking (as a normal part of what physicians do) and professionalism (as something that physicians must enact at all

times) was never explicitly addressed, Buena Vista students got the clear message that certain standards of professionalism were expected and certain ways of interacting with patients were unacceptable. “The essence of the practice of medicine is that it’s patient-centered medicine,” Arthur told me. “The patient needs to be comfortable in your care. If they’re not comfortable in your care, then you’re not an effective doctor, period,” he said. “You’re not supposed to have prejudice,” a student named Nicole told me. “You’re not supposed to make the patient feel uncomfortable, or use a negative tone of voice when you talk to them,” Nicole said. These instructions are reasonable enough, and simply emphasizing these guidelines constitutes attention to patients’ experiences of doctors’ care. However, when I discussed these sorts of teachings with students it was clear that while they had at least a superficial understanding of what they should and should not do or convey when interacting with patients, they did not necessarily know how to achieve “professional” conduct and at times doubted that meeting the standards of professionalism was even possible. While joking about patients was something that doctors and students acknowledged fairly readily, the question of how joking contradicted or fit into norms of appropriately professional behavior was rarely explored beyond recognizing the need for the doctor to keep a straight face in situations that might provoke a giggle or a grimace. Arthur, who had acknowledged that in the context of a sex toy stuck in a patient’s rectum he would “try to be a good person but would probably laugh,” had this to say:

Interviewer: Often I’ve heard students say that they’re told, ‘Don’t cheat,’ or, ‘don’t make your patients feel uncomfortable.’ But how do you do that? When you have that human reaction to laugh. When you have a strong relationship with your colleagues and part of that relationship involves joking. What is the bridge between wanting to joke and also wanting to make your patients feel comfortable?

Arthur: I don’t know. I don’t know.

Interviewer: Is that ever talked about?

Arthur: No, it isn't. I guess I would personally try to set up a really strict wall between the patients' and the colleagues' worlds.

What that "really strict wall" would have looked like in practice for Arthur, and how he might cross from one side of the wall to the other, he could not say, and I never observed or heard of any specific instruction about how students and doctors should negotiate the potential tension between personal responses and the achievement of professionalism.

Furthermore, I heard little formal or informal discussion of *when* it might be necessary to keep a straight face and when laughing or joking might be acceptable. What counted as something that could be joked about, and what counted something that should not be joked about in front of patients was implied to be obvious. And it may well be "obvious" that it is not appropriate to joke about some things – for instance, Wear et al. (2006) found that medical students at the Northeastern Ohio Universities College of Medicine had a clearly-defined set of internal rules about which patients were fair game for joking and which were off-limits, and when and where it was appropriate to joke. Within this context, medical students learned fairly quickly where the line between acceptable and unacceptable joking was drawn. But what are the criteria for an "acceptable" joke? Dr. Bruce Stevens, a Buena Vista faculty member who had attended medical school himself in the 1970s and thus had seen a few decades of change, noted that when he was a resident, it was very common to hear homophobic jokes made in frontstage settings.

You know, right in front of patients, in patient care areas, when a gay person would come into the emergency room with a suicide attempt there would be snickering and laughing about it, and you know, if you were a closeted medical student, you just wanted to crawl into a hole and die. Back in those days, it was considered okay to make homophobic comments, but now, I think, as the culture has started to change and more people started to come out, there's more of a sense that that isn't acceptable.

Dr. Stevens thought that this historical change was similar to making racist or sexist comments in public: although it might have been acceptable once, most people knew that it wasn't acceptable anymore. Dr. Stevens' view may have been a little optimistic - scholars argue that although homophobia may have declined it is far from extinct (Jenkins et al. 2009), and my interviews with students and other faculty members suggested that homophobic, sexist, and racist comments were not totally absent from backstage settings at Buena Vista. But more importantly, Dr. Stevens' points elide a broader question: if medical professionalism espouses respect and dignity for all patients, how does it conceptualize its relationship to broader social norms that shape what counts as an "acceptable" joke?

While the professional socialization literature has examined the potential for tension between joking and the provision of compassionate, effective care, there is a need to look beyond joking and examine other aspects of types of physicians' personal responses to patients and how they, and their potential to impact the care of patients, are conceptualized within medical education. Joking about patients is one way that physicians' or students' personal responses to their work may manifest. But such personal responses may also take other forms, such as imposing one's own views on a patient, or judging them. The student named Arun suggested that this sort of occurrence might be unavoidable at times.

Interviewer: You mentioned a minute ago that there's always the tension between your personal feelings and opinions and your professional work – how do you feel like medical school has trained you to negotiate this tension?

Arun: I don't think we're trained to negotiate that. I feel like most of the faculty assume that you just don't let your personal beliefs get in the way. I definitely think it should be taught about because I'm sure there will be views that are imposed on a patient and even though I don't think it would necessarily lead to lying...it might end up affecting treatment, whether it's

conscious or subconscious for the physician. You can't control it sometimes.

Other students shared Arun's impression that faculty simply assumed that students understood the need for a distinction between personal beliefs and professional duties and could adjust their behaviors accordingly. The student named Darcy also sensed that faculty assumed that students knew what it meant to be "nonjudgmental."

Darcy: We learn how to take a sexual history, and they tell you that you want to be non-judgmental, but to get as much information as possible to assess risks.

Interviewer: What does it mean to be non-judgmental?

Darcy: I don't know.

Interviewer: How do your instructors teach you to be non-judgmental? How is that presented?

Darcy: I think they assume that we know what it means to be non-judgmental. I think the implication is to watch your tone of voice, don't say anything that would be perceived as judgmental. It's funny, sometimes we joke that SAM is all about people skills, and I think, well, I have people skills! There are a lot of people who don't have people skills, but I don't think you can necessarily teach that kind of thing. I don't think you can teach someone not to be judgmental.

Ironically, Darcy's tone of voice was harsh as she told me that it was important for a physician to watch their tone of voice to avoid conveying judgment. Later in our interview, Darcy backpedaled a little bit on her earlier statements about not being judgmental, saying that patients deserve their doctors' judgments if they do not follow doctors' orders:

If a patient comes to me and has repeated STDs and still doesn't use contraception or whatever, I would have to say, "But I *told you* [emphatically]. I *told* you to use protection." [Faculty] say, "Don't be judgmental," but at some point everybody's judgmental and... the thing is, we're the doctor, and we're trying to help the patients and they have to listen to us.

Darcy's tone was more acerbic than any of the other students I interviewed, and she was the only student who professed a conviction that patients should be prepared for

consequences if they failed to comply with doctors' advice. Whether or not her forcefulness was a passing phase within her professional development is impossible to know, and it may be that Darcy was simply more honest than her classmates who presented a gentler demeanor and a different version of commitment to "patient-centered care."

But her comments were also representative of the contradictions within many students' understandings of professionalism. They generally believed that doctors were supposed to help patients and in order for this to happen, patients would need to be comfortable in their care. But students also expressed the belief that they had authority and knowledge that laypersons, i.e., their patients, did not, and that they, as doctors, couldn't realistically be sensitive to their patients' needs all of the time. "I can't do everything the SAM classes tell me to do," Darcy told me at one point during our interview. "And you know what, it's fine if the *New York Times* or whatever popular sources want to criticize doctors for not being humanistic enough. But they don't know what it's like. *They* aren't doctors, they don't know," she said. Again, while Darcy's positions may evolve or have evolved as she progressed through her training, what may be important about the content and tone of her remarks is that she delivered them in one breath then, in the next, and told me that she had "people skills" and was socially liberal and comfortable with persons from all sorts of backgrounds.

Darcy's comments point to a tension within the curriculum at Buena Vista that is probably relevant to teachings about professionalism both within other medical schools and in other professional training programs. Although, as I discussed earlier, some lecturers emphasized the need for physicians to become aware of their own biases because patients could perceive their judgment and were likely to choose their doctors based on how they felt about them, and although faculty frequently reminded students

that their first responsibility was to refrain from doing harm, students and doctors alike may have only vague understandings of what it means to do harm, and how patients might experience harm within clinical encounters – even when the doctor acts with the best of intentions. Students' conceptualizations of the relationship between their personal responses to patients (such as joking or judgment) and the professional behaviors that they exhibit are particularly worthy of interest given Buena Vista students' general incredulity about the existence of discrimination.

Sexuality's place within the selective recognition of discomfort

As the preceding discussion illustrates, there was a certain amount of indirect acknowledgment that sexuality could provoke discomfort on the part of medical students and doctors. Although sexuality-related discomfort was often hinted at or talked around, if it was explicitly mentioned at all, this was not always the case: sometimes discomfort related to sexuality was explicitly expressed or acknowledged. In this segment I explore the construction of discomfort at Buena Vista in greater depth and detail. When was *sexuality*-related discomfort explicitly acknowledged? Whose discomfort mattered – the doctor's or the student's, or the patient's? Discomfort was not always difficult to talk about, and was actively discussed as something that naturally occurs within some contexts, due to certain stressors. Finally, although talk of sexuality provoked discomfort in many contexts, it did not always. At the end of this segment I discuss the instances in which students and faculty alike talked about sexuality enthusiastically rather than reluctantly.

Other studies of medical education have found that discomfort associated with any topic is generally off-limits from discussion. Smith and Kleinman (1989) argue that an important element of professional socialization is the development of "appropriately controlled affect." Medical professionals must learn to develop an unemotional persona,

or “affective neutrality” (Parsons 1951) even in the face of situations which, outside of the context of medicine, would be likely to evoke strong personal responses. In their ethnographic study of a well-established medical school, Smith and Kleinman (1989) found that the ideals of affective neutrality prohibited discussion of feelings of discomfort, leaving students to figure out individually how to transform their “inappropriate” feelings into appropriately professional behavior. No courses within the curriculum dealt with emotion management, but the hidden curriculum provided ample indication that students must learn to manage their emotions on their own through sheer willpower (Smith and Kleinman 1989: 57).

Although Smith and Kleinman (1989) focus on the norms of affective neutrality within the context of students’ early encounters with the human body, they suggest that these norms are so pervasive that there is no place for the acknowledgement of discomfort anywhere within medical training. At Buena Vista the situation was not quite this extreme. Emotions that did not fit into the norms of affective neutrality were acknowledged and even expressed, at times. Within lectures, small-group discussions, and interviews, faculty and students at times spoke freely about the grief and helplessness they experienced in the face of death. During a small-group discussion after a lecture on death and dying, both students and the faculty facilitator shared stories of the loss of loved ones. Tears were shed, the difficulties of negotiating emotional responses to death were discussed within joking, and no one suggested that these emotions didn’t have anything to do with a doctor or didn’t have a place within medical school.

It also important to note that students got the distinct impression that faculty were concerned about their general comfort as medical students, in the form of their stress levels and overall well-being. Students got the message that the administration felt their

“happiness was first and foremost,” and several of the students that I interviewed described specific accommodations that the administration had made for them to better tailor their medical school experience to their needs, goals, or frustration with certain aspects of Buena Vista (I briefly described the student named Doug’s experience with this in Chapter 3). Students believed that faculty recognized that medical school was a stressful experience capable of provoking all sorts of discomfort, and students appreciated the concern that they perceived from faculty. I too observed faculty members demonstrating their interest in students’ experiences of medical school and the challenges it presented, and acknowledging the stress inherent to the pursuit of a medical career. Given that discomfort was sometimes acknowledged and allowances were made for emotion to be collectively expressed and negotiated, the place of sexuality-related discomfort at Buena Vista was all the more complicated.

Discomfort related to physical exams

Several Buena Vista students told me they were a little nervous as they performed their first pelvic, rectal, or breast exam. As the student named Miguel said of his first rectal exam, “I was a little uncomfortable at first...I mean, I hadn’t really stuck my finger in a lot of butts before, to do prostate exams.”²⁹ Other students concurred, telling me that either they themselves were nervous when they had done their first pelvic exam (or were nervous as they anticipated it, if they hadn’t yet done it), or sensed that their classmates were. Faculty acknowledged student nervousness, too. Dr. Jun, the urologist who taught the male urinary/rectal exam, had this to say:

²⁹ But on the other hand, Miguel told me that he had had enough sexual experience with women in the past to feel relatively comfortable performing the female pelvic exam the first time. An Australian study found that female and male medical students who had experienced “sexual intercourse” were more likely to feel unintimidated by performing a female pelvic exam and confident that they could put the patient at ease during the procedure than their sexually inexperienced peers (Abraham 1996). As I discussed in Chapter 2, students’ personal sexual experiences may constitute a form of sexuality education that is worthy of further study.

Yeah, I do perceive that some of the students are a little nervous, and so I try to talk them through the [male urinary/rectal exam]. I think the most important thing – like in any relationship – is communication. So I slow down, demonstrate [for the students]. You've heard the adage 'see one, do one, teach one,' and I show students how to do something, let them try to do it, and if they still can't get it then I tell them, 'okay, we're working together to get this done.' I diminish the nervousness by facilitating the skill set experience. And I tell them that it's something that will come with time.

Dr. Jun cracked jokes and throughout much of our interview, his voice had the tone of barely-contained mischievous glee, but as he spoke these words he sounded kind, understanding, and patient.

Both students and faculty believed that the key to resolving students' discomfort with the pelvic or rectal exams lay in learning how to facilitate the student's technical competence with the procedure in order to make the patient comfortable. Students acknowledged, and faculty observed, that students wanted to make the patient comfortable, but were concerned about hurting them. Similar to the dynamics that Smith and Kleinman (1989) observed, most Buena Vista students thought that the way to resolve the patient's imagined discomfort, and with it, their own, was to achieve technical competence. As they learned to conduct the exam correctly and talk the patient through it systematically, letting them know what to anticipate, they felt that they were making the patient comfortable and thus they began to feel more comfortable.

Yet sometimes even the faculty who emphasized that the acquisition of technical competence reduced any discomfort that might be associated with physical exams contradicted themselves and suggested that there might actually be a certain amount of discomfort inherent to examinations of the sexual body parts. Dr. Jun's comments were particularly interesting in this regard. As I have discussed elsewhere, Dr. Jun repeatedly stated or implied that sex is a funny subject for some people during our interview, and that joking about sexuality helped displace the nervousness the topic provoked. But

when I asked him directly about the sexual connotations of medical work he was more equivocal.

Interviewer: How do you address the possible sexual connotations of doctoring? For instance, prior to coming to medical school, many students might have associated genitalia with sexuality. And now they start to deal with naked people in a way they never have before.

Dr. Jun: You know, that thought doesn't even cross my mind because I know they're on such a rigorous path, with the goal of achieving medical knowledge, so I've always presumed that... Now that you mention it, I have to admit that I've never really thought about this before. To me it's like any other metric they're trying to achieve, like learning about chemistry. They've never done biochemistry before, but they're going to do it in med school. You've never done pharmacology before, but you do it here. To me it's all the same.

With these comments, Dr. Jun implied that contrary to his other remarks about sexuality as a potential source of nervousness and the need for humor to dispel the nervousness, the medical context actually took the humor, or the specialness, out of anything related to sex. As soon as medical school starts, learning about anything related to sexuality is just like pharmacology, perhaps. But a few moments later still in the interview, Dr. Jun revealed his own visceral responses to the sexual body. "I always teach students to tell the patient to pull their own foreskin back during an examination," he said. "I don't want to pull some guy's foreskin back. It's nasty, you know," he explained.

How the "nastiness" of foreskin fit within his estimation that learning to perform exams on the sexual body parts was just like learning biochemistry, Dr. Jun did not say. Dr. Jun's comments were characterized by contradictions: on the one hand, learning how to do a male genital-rectal exam was just like learning anything else that medical students encountered for the first time, and had no more affective weight than biochemistry. But on the other hand, Dr. Jun knew that students were a little nervous about learning this exam and doing it for the first time, and he was well aware that anything related to sex could provoke nervousness and he intentionally employed humor

to dispel that nervousness. Although he suggested that comfort with the physical exam would come with time and experience and the achievement of competence and confidence, by deeming foreskin “nasty,” Dr. Jun also suggested that there is a certain amount of discomfort with particular body parts that never goes away, no matter how much experience in examining them is gained, and no matter how much technical competence is achieved. He made no mention of how the student’s or the physician’s feelings about the patient’s body – such as, for instance, feelings about foreskin being nasty – might shape the doctor’s behavior toward the patient and ultimately impact the patient’s experience of the health care encounter.

Dr. Charles Benjamin, a doctor of internal medicine, also indicated that learning how to do exams on the breasts, genitals, and rectum was different from learning to examine other body parts, and different in a way that could provoke a particular sort of discomfort. “We use paid models for the pelvic and breast exam,” he told me. “Most other medical schools do the same thing, and [the models] have been trained to take them through the procedure and give the students instruction and feedback, and...hopefully [the models] don’t traumatize [the students] too much!” I asked Dr. Benjamin to tell me what he meant about the models not traumatizing the students, and he told me that when he had performed his first pelvic exam on a model when he was a medical student, he was extremely nervous, and the model, rather than putting him at ease, had chided him for fumbling around. Dr. Benjamin freely shared his own feelings of discomfort and his experience of having been “traumatized” by his pelvic exam model, but when he spoke of the models themselves, his tone turned harsh. “Everyone comes to everything with an agenda,” he told me. “So you have to ask, what is the agenda of someone who’s being a pelvic exam model? Do they get paid pretty well? I don’t know.” He sounded irritated and critical, and referred again to the vulnerability of young

medical students who are “through-the-roof anxious” when they perform their first pelvic exam, and the need for the models to be sensitive to the students’ discomfort.

Dr. Benjamin was visibly agitated as he recounted his own experience of performing a pelvic exam for the first time and as he talked about the need for models to be sensitive to the anxious students they were responsible for coaching. But he implicitly placed both the responsibility for addressing this discomfort and the blame for its very existence upon the models themselves. I asked Dr. Benjamin if there was any explicit discussion of discomfort within teachings prior to sending the students to work with the models, and he said that he wasn’t directly involved with those teaching segments. The discomfort should at least be recognized as “the elephant in the room,” he said, but he wasn’t sure that any particular teaching segment was tasked with at least acknowledging the elephant.

In these instances, it was the student’s, or the doctor’s discomfort within the exams that was conceptualized, and the patient, or the model, is seen as the source of the discomfort, whether through their actions (the model was too chiding) or by virtue of the presence and nature of their body parts alone (foreskin is nasty). Within these discussions of physical exams, discomfort was acknowledged, but in a manner that suggested its inevitability. The specific reasons for or nature of the discomfort were not quite on the table for consideration, and were not discussed in a way that might change its nature or the implications of its presence. How might this matter for the doctor’s capacity to relate to the source of the discomfort – which happens to be the patient? This is an element of (potentially) “dirty” work that the dirty work literature has not considered. When the source of the taint is the client – or patient – who is dependent upon the dirty worker for essential care (and along with that, to put it in the language of medical professionalism, the accordance of “respect and dignity”), how do those

performing the work negotiate the dirtiness in conjunction with their obligation to provide treatment for the patient that is in line with professional standards of care?

Here we see an intersection between the dirty work, medical professionalism, and “emotion work” (Hochschild 1979; [1983] 2012) literatures that has not yet been explored. Emotion work refers to the effort expended in the attempt to change the degree or quality of an emotion in order to achieve comportment and actions that are acceptable within a given context (Hochschild 1979: 561). Doctors, Arlie Russell Hochschild points out, are expected to try to produce an emotional state in their patients through control over their own affect – as Hochschild puts it, they are supposed to be both “trusted and trusting” ([1983] 2012: 151) – but they are also free from supervision of the emotion work that they do or, as the case may be, do not do. While the emotion work performed within some occupations (e.g., flight attendants) is directly evaluated by workers’ higher-ups, doctors supervise their own emotional labor through their awareness of professional norms and patient expectations (Hochschild [1983] 2012: 153). Thus we might ask how doctors understand the latent feeling rules within clinical encounters in which sexuality becomes salient. How do doctors understand what is “owed” and what is “owing” (Hochschild 1979: 572) in terms of the emotional management within clinical encounters in which sexuality – for which there are few readily available cultural resources for the resolution of discomfort – becomes salient?

Discomfort related to sexual practices

While the discomfort related to performing physical exams on the sexual body parts could be at least partially or theoretically alleviated through the achievement of technical competence with the procedures involved, discomfort related to other manifestations of sexuality did not have the same sorts of readily-available solutions.

Asking or hearing about people's actual sexual practices was something that students and faculty alike sometimes found unnerving. Students were frequently instructed to ask patients, "Do you have sex with men, women, or both?" but students admitted to me that depending on the patient's answer, they might not know what to do with the information they received, and did not know how to take a conversation about sexual practices beyond that initial question. When I asked my student interviewees if they thought they would feel comfortable talking with patients about sexuality, many of the responses I received were circular or equivocal. "Yeah, I would feel comfortable," some would say, and then become silent or quickly change the subject. Cindy's response revealed a rare awareness of and willingness to talk about one's own discomfort. Although she had been trained to ask patients about their sexual behavior, she told me, she did not want to hear their answers.

I would not really want to talk about sex, even with my peers. I wouldn't want to talk about sexual practices or that kind of thing. Maybe about, sexual identity, sexual orientations, you know? That's all I could talk about, I think. I don't want to know if someone is thinking about anal sex or something - I don't want to know about specific sexual practices. That's not something I feel comfortable talking about. With people I don't even know. And not even with a patient. I mean, after training, in a clinical setting, I could ask if the patient is sexually active, and the gender of the partner or if they have multiple partners, but I think that's it, I don't know if I could handle talking about more than that.

A few students told me that they felt that they were comfortable talking about sexuality with patients, but that they were pretty sure that some of their classmates were not, but all the same, they were confident that these very same classmates would be able to "be professional" and "keep a straight face." Yet there were some indications that this prediction might be optimistic, or at least, underestimated a hypothetical patient's need to actively discuss their sexual experiences with a doctor. The student named Emily got the impression that many of her fellow medical students were

uncomfortable discussing anything related to sexuality, based on her own experiences of attempting to contribute to small-group discussions where sexuality-related matters were the topic at hand:

Emily: I feel like [sexuality] has largely been absent and almost ignored in a way. I feel like it's that way because it's been pushed off to the side, kind of, it's something that people aren't comfortable talking about...I'm pretty open about myself and I don't really have any problems sharing things and I have said things to other students and I felt like they were uncomfortable. They were like, "Whoa! That was way too much information for me!"

Interviewer: Can you give me an example of such an exchange?

Emily: I had relationships with a female a few different times and I mentioned that in an SAM small group discussion, and I got the impression that my comments were not welcome at all. Like that information wasn't something they wanted to know about.

Interviewer: How did you get the message that they weren't interested?

Emily: From their body language, and from the fact that no one wanted to take the conversation any further.

Emily's classmates' reluctance to respond to her disclosures of sexual experiences may have been symptomatic of particular discomfort with non-normative, i.e., non-heterosexual sexuality, or it may have reflected a more general discomfort with talking about sexual practices in detail. As a participant observer in SAM small group discussions, I regularly observed students talking openly, if not extensively, about heterosexual relationships – their own and those of their classmates. I also observed non-heterosexual students referring to their significant others in gender-neutral terms in these situations, while students in heterosexual relationships spoke much more freely about their partner's gender and the existence of the relations. However, while these discussions were explicit about *relationships*, they made little reference to sexual *practices*.

Some faculty members spoke directly to the difficulty of talking with patients about sexual practices. In the seminar portion of two meetings of the Physician-Patient Dynamic class, approximately a third of the medical students met as a group with a model patient. Under the supervision of a faculty member, the students practiced asking the model patient questions about his health and his concerns about his current health situation. The model patient was an older man preparing for heart surgery and brought his “wife” with him on his second visit. With his model wife by his side, he spoke of his fears about his upcoming procedure, including concerns about what his “interactions with his wife” would be like after the heart surgery. The patient mentioned these concerns multiple times, but the students did not pick up on the subject, and instead, pressed the model patient to come up with a plan for a healthier lifestyle, post-surgery. “Are you going to exercise more?” they asked. “What about changes to your diet?” Finally, the faculty member who was supervising the seminar stepped in and asked the students, “Okay, so what do you think the patient is talking about here, when he refers to his worries about how his interactions with his wife might change after surgery?” The students were silent, and the faculty member let them squirm for another long moment before he said, loudly and clearly, “Sex! He’s talking about sex, and this is something that you have to get comfortable asking about. This is a subject that needs to be dealt with respectfully, and age differences may be barrier to communicating, but you have to address these issues.” The facilitator’s delivery of these instructions was empathetic yet firm, but he did not follow up with any sort of suggestions for *how* students might get comfortable asking about sex, nor did he model the kinds of questions that students might ask by engaging with the model patient directly himself. This sort of curricular moment points to the promises and the pitfalls of the concept of the null curriculum. The fact that the faculty member explicitly instructed the students to ask patients about sex

and to get comfortable doing so was incredibly significant. He could have avoided the issue too, after all. But the absence of demonstrating asking the model patient questions about sex himself, and the lack of discussion of strategies for achieving comfort with talking to patients about sex were probably meaningful omissions.

However, other SAM classes provided or attempted to provide the opportunity for students to practice talking about sex or asking model patients directly about sex. As I described in Chapter 3, one class meeting of Stages of the Life Course theoretically gave students with the opportunity to practice interviewing high school students about a range of topics, including sexual health. However, as I discussed, this did not necessarily work out as planned. As I described in Chapter 4, Dr. George Sorin devoted an entire “lecture” within the Physician-Patient Dynamic to talking about sex(uality), based on the recognition that sexuality can be difficult to talk about, and with the intention of de-sensitizing the subject to some extent. And students’ responses to this curricular event indicated that it did indeed meet these goals to some extent.

However, it is worth noting that Dr. Sorin did not make these objectives clear in his remarks within that lecture/discussion/poll. Despite his recognition that sex was difficult for many people to talk about, Dr. Sorin did not develop the possible implications of this difficulty for either the doctor – or the medical student – or the patient when it came to talking about sex within clinical encounters. The atmosphere within this curricular event was boisterous and markedly different from any other “lecture” within the course. Allowing students to respond to the discussion as they did, without trying to constrain them or keep the proceedings “serious” was perhaps very useful: it met the students where they were, and allowed them to respond without having to censure themselves. But the rowdiness of the discussion also reflected and reified the notion that talking about sex is different from talking about other topics – and perhaps not just

slightly different, but sensational and provocative in a way that other topics are not. While the experience students gained from talking about sex publically during this curricular event may have been significant for many of them, the tone of this curricular event was very different from the tone that would probably need to be adopted when talking one-on-one with a patient about sexual practices. Whether or not the opportunity to talk excitedly about sex in public facilitates the ability to talk seriously and openly with a patient about sex in a much more private setting is an open question. But even if the ultimate impact of Dr. Sorin's approach to "sex day" is unknown, it is worth pointing out that a lecture designed to desensitize sexuality indirectly reaffirmed that talking about sexuality is very affectively different from talking about other topics. Nor did that "lecture" or any other explicitly address the affective challenges associated with talking about sex and how they might impact a clinical encounter, and what a student or physician could do to negotiate this sensitivity or discomfort – whether it manifested on their end or their patient's.

Might it be that talking with patients about sexual practices becomes routine, over time, and that whatever discomfort the prospect of talking about sex causes medical students in their early years of training simply fades away over time, as they gain experience and learn on the go? This is likely to happen to at least a certain extent. As I discussed in Chapter 2, some Buena Vista faculty reported that although they had received little or no formal sex education themselves, they had gained knowledge about sexuality and comfort talking with patients about it on the job. But to assume that this happens automatically is probably a mistake, and even if there were indications of an automatic dissipation of sexuality-related discomfort, whether or not physicians' subjective experiences of comfort with sexuality equate with patients' experiences of

comfort in their care is an empirical question.³⁰ In Chapter 2 I discussed Dr. Bernard Lumumba's experience of being confronted by a resident's discomfort when he asked her if she had asked her patient who was experiencing recurring bladder infections about the specifics of her sexual activities. The resident's obvious embarrassment, combined with Dr. Lumumba's concern about getting sued for sexual harassment, led him to end the discussion quickly, and thus, there was no "learn as you go" moment for the resident, either in terms of learning about the specific medical implications of particular sexual practices or working through some of the discomfort associated with talking about sexuality. These sorts of instances suggest that the absence of discussion of sexuality-related discomfort and how to handle may be reasonably considered a null curriculum: in the case of Dr. Lumumba's resident, the resident's discomfort with sexuality prevented her from asking the patient questions that would have helped resolve the immediate medical issues.

Finally, there were indications that even after their own formal training and years of learning on the go themselves, faculty did not necessarily come to see patients' sexuality-related disclosures or questions as totally appropriate. Dr. Norm Gallo told me this story:

There is this gentleman who is in his seventies, and his sexual practices aren't of the norm. He and his wife have another partner join in and they sometimes engage in what he calls kinky sex, and I can't remember if he was swinging, if he and his wife were swingers, but I think they were. But anyway, he's in great shape. He works out and he has a personal trainer, and one day, he was feeling really fatigued after a strenuous workout, so he came in to see me. It turned out that he had a complete heart block and we rushed him to the hospital and he had a pacemaker put in. Well, after that, a student came to see him to check up on him, and he asked about how [the pacemaker] would affect his sexual activity. And he was really open about bringing it up, he's not shy about bringing up those

³⁰ For discussion of the trouble with taking physicians' self-reported levels of comfort with potentially discomfort-provoking aspects of medical practice, see Harbin et al. (2012), who also argue that the acknowledgement, rather than the eradication of discomfort, may be more effective for increasing patient satisfaction with health care encounters.

kinds of issues at all, and I think he tries to get a little shock value out of it. Especially if it's a female student, I think he brings it up just to get a rise out of them.

Dr. Gallo shook his head as he finished the telling of this anecdote, and explained that the situation had provoked “a little giggling” on the student’s part, and that he felt that the patient’s questions had pushed the limits of what a third-year medical student could reasonably be expected to answer. Why exactly this question might be unreasonable for a student to answer, Dr. Gallo could not say, and he admitted that in a sense, the answer was very straightforward: yes, the patient would be healthy enough for sexual activity, even with the pacemaker.

How do we determine what counts as an appropriate or inappropriate question about sexuality? Perhaps this patient was indeed trying to provoke a reaction from the medical student who checked on him. There are certainly lines to be drawn between acceptable and unacceptable behavior in the doctor’s office – both on the part of the patient and the doctor. But in Dr. Gallo’s example, the patient at least ostensibly had a medical reason for asking sex-related questions. If the patient had been equally open about his interest in ballroom dancing, and equally concerned about his ability to continue dancing after having the pacemaker put in, would Dr. Gallo have gotten the impression that the patient was trying to get a “rise” out of the medical student?

Without examining sex negativity as a social fact, as a thing in and of itself that shapes doctors’ and patients’ experiences of medical encounters, it may be difficult to figure out what constitutes “legitimate” discussion of sexuality within a medical context and what might be inappropriate. In the absence of collective consideration of sex negativity and the absence of opportunities to both recognize and renegotiate the discomfort so often associated with sexuality, physicians’ collective comfort levels with talking about sexuality may be relatively low. And while physicians have the right to their

own personal boundaries, we need to examine their collective comfort levels with sexuality and acknowledge the possibility that the discomfort associated with sexuality may circumscribe both the medical treatment patients receive, and doctors capacity to regard their patients as whole persons. As I have illustrated, students and doctors demonstrated very different understandings about and comfort levels with sexuality. Without some explicit negotiation of sex negativity, some doctors might well deem nearly any question about sexuality inappropriate.

The absence of explicit negotiation of sex negativity may also make it difficult for medical students and physicians to thoughtfully develop their own professional boundaries pertaining to the discussion of sexuality, and firmly adhere to them if pushed. Just as it seems important that doctors be able to regard sexuality as a routine part of patients' health and personhood, and something that can be talked about frankly and openly, surely it is also important that doctors feel confident in handling a patient's inappropriate sexual behaviors if necessary. If Dr. Gallo's patient had raised the questions that he did in the hopes of provoking a reaction for his own titillation, might this possibility – and the more general possibility that patients might regard the clinical encounter as a sexually arousing experience – have been addressed with the student as one of many potential situations that a doctor might need to be prepared for? Learning how to draw lines between appropriate and inappropriate sexual questions may be an important subject for medical training to cover. Although I did not observe any discussion of how to handle sexual harassment from a patient (or how to determine what *counted* as sexual harassment, i.e., where or how to draw the line between questionable and inappropriate behavior), Buena Vista faculty members occasionally hinted to students that sexual harassment scenarios or accusations thereof were something to be concerned about, and a couple of faculty members told me stories of situations of

questionable propriety – such as walking into an examination room and finding a patient naked and posed provocatively.

Within the examples that I have considered here, it was the doctor's and the student's discomfort that was of primary concern – and the patient, or the model, was regarded as the source of discomfort. The possibility that patients might experience sexuality-related discomfort within a clinical encounter did come up, but infrequently and I discuss some of the instances in which it did next.

Conceptualizing the potential for patients to experience sexuality-related discomfort

The possibility that patients might experience discomfort related to sexuality – and more specifically, related to their doctors' responses to their sexuality – was illustrated in vivid detail during the panel discussion featuring transgender guest speakers, which I described in Chapter 4. These panelists spoke at length about the discomfort they had experienced within medical encounters, and their visit made an impression on many medical students I spoke with. However, their talk was the only instance in which sexuality-related stigmatization in health care was explicitly discussed that I observed or heard of, and I as I noted in Chapter 4, this panel may have done more to isolate the issues faced by transpersons than integrate consideration of their particular needs *or* the broader issues that their talk raised into the mainstream concerns of the curriculum.

Students and faculty alike sometimes mentioned that female patients might feel uncomfortable during pelvic exams, but the patient's discomfort was usually conceptualized in relation to the doctor's or student's technique, or lack thereof - if the student or the doctor did not bungle the exam and communicated with the patient about the procedure and let them know what they could expect to feel, the patient would be

comfortable. A couple of interviewees noted other potential sources of discomfort during a pelvic exam. One student, Norman, said that when he had learned to do the female pelvic exam, some of his classmates brought up the possibility that patients might feel uncomfortable exposing private parts of themselves that they aren't used to putting on display for strangers, and raised the possibility that a history of abuse might make patients particularly sensitive to a physical exam. Norman didn't recall the discussion going beyond the initial mention of these issues, however. Dr. Janet Norton, too, noted the possibility that experiences of abuse could make the pelvic exam very difficult for patients.

There was some talk of the discomfort patients might experience in situations that had little to do with sexuality. Malpractice came up with some regularity, and within these discussions, patients' discomfort was recognized very distinctly, and the need for doctors to respond and respond appropriately was clearly articulated. The importance of apologizing to patients if a procedure went awry was emphasized, as was the potential for a doctor's apology to thwart a lawsuit. But interestingly, in these situations when the patient's discomfort was explicitly recognized, the doctor's discomfort was not discussed. The possibility that doctors might be very uncomfortable when forced to confront the consequences of their own errors and summon the humility and courage to apologize to a patient was not explicitly recognized within the discussions of malpractice that I witnessed.

When sexuality does not provoke discomfort: the topic of doctor-patient dating

As the discussion thus far indicates, there were both direct and indirect indications that sexuality was a subject that could provoke discomfort or unease on the part of both students and faculty. But there was one sexuality-related topic which did not seem to provoke discomfort at all, that students and faculty were comfortable if not

enthusiastic talking about: the subject of doctor-patient dating. Doctors who identified as gay and as heterosexual volunteered leisurely stories of patients who had come onto them, colleagues who had had relationships with patients, or even stories of their own romantic dalliances with patients. The faculty, including those who reported that they had had some sort of romantic engagements with patients in the past, agreed that dating patients was not a good idea, but recognized the possibility for the lines between pragmatism and propriety and reality to get a little blurry. “If you live in a small town and you’re the only doctor...” was a caveat I heard more than once. One physician, Dr. Terry Olsen, suggested that a sexual relationship between doctor and patient could be part of the patient’s healing process. “Who knows, perhaps that’s part of what the patient needs at the time to heal,” she mused. Although I heard this specific possibility expressed only once, other faculty members acknowledged that sexual relationships between doctors and patients were not uncommon.

Students discussed the subject of doctor-patient dating with singular enthusiasm in the meeting of the small-group discussion that I facilitated on “sex day,” the day devoted to the topic of sexuality within The Physician-Patient Dynamic class. The subject of doctor-patient dating (among other sexuality-related topics relevant to the doctor-patient relationship) was discussed in the assigned readings for that day, but none of the students made explicit references to the content of these readings (the “required” readings were rarely referenced by students or faculty facilitators) throughout the course of their unusually lively discussion. Raj, a student who rarely spoke up, was pretty sure that doctor-patient dating was acceptable. Particularly if you’re a surgeon, Arun agreed, doctor-patient dating shouldn’t be a problem. “I know you’re not supposed to date patients,” Darcy said, “but what if you meet *the one*?” During this discussion I probed with a few questions. Was dating patients their intended, overall strategy for

dating? Students laughed, but no one answered the question. What will you DO if you experience persistent attraction to a patient, and the strategy of “just dealing with it” doesn’t quite seem to work? Raj, in sarcastic response, said that he would only treat male patients, or patients that he wasn’t attracted to. Another student said, “I’ll just deal with it as a professional.” I asked the group what “dealing with it as a professional” meant in practice. “What will you actually DO if you find yourself attracted to your patients on a regular basis?” I persisted. “These are good questions,” someone said, but no one suggested any answers, and then Raj and Arun turned the discussion towards a consideration of whether or not it was okay for doctors to date nurses.³¹

Seasoned faculty members would have considered the content of this discussion fairly typical. “When they enter medical school, they all think doctor-patient dating is acceptable,” Dr. Nancy Green told me. “But later they start to understand why it isn’t a good idea.” What I found most interesting about the students’ discussion of doctor-patient dating was their level of interest in it and willingness to talk at length about it, not so much whether or not they thought that doctor-patient dating per se was a good idea or not. The students demonstrated a degree of enthusiasm in their discussion of doctor-patient dating that I rarely saw within small-group discussions in general, and displayed more willingness to talk about a sexuality-related topic than I witnessed in any other context. Although this discussion did not include explicit consideration of sexual practices or sexual identities or sexual desires, the students indicated and expressed their potential to experience attraction and their desire to date and form relationships. In so doing, they demonstrated their own personal needs and their humanity within their (future) professional role to a degree that I did not witness to the same degree in other instances.

³¹ This discussion continuously and exclusively referenced heterosexual relationships.

“We’re not social workers” : sexuality and the parameters of doctors’ work

This chapter suggests more questions than it answers regarding the place of sexuality within doctors’ work. If the goal is to treat patients as whole persons, with respect and dignity, what do doctors need to know or be able to respond to, when it comes to sexuality? This is a difficult question to answer for many reasons. Sexuality’s relevance to medical encounters is amorphous and unpredictable, and likely to be salient to patients’ and doctors’ experiences of these encounters in very different ways. The structural factors that shape the context of health care delivery are also important to take into account as these questions are considered – including the ever-present challenge of time constraints.

As I discussed in Chapter 2, Buena Vista students and faculty alike tended to recognize, at least nominally, that sexuality was relevant to health. But as we have seen, this recognition did not translate into a clear set of understandings about doctors’ sexuality-related professional responsibilities. Students often deflected their responsibilities to address sexuality by saying things like, “well we’re not social workers” and “we don’t have time.” Even when they were in the first year of the program, students were quite preoccupied with the time constraints faced by doctors. “When you only have fifteen minutes, what can you really expect to do?” they would say. Dr. Nancy Green believed students typically subscribed to this sort of thinking early in their training but changed their mind as they progressed into their career and started to recognize that it was necessary to talk with patients about their lives, and delve into subjects like sexuality, in order to build the trust with patients that is necessary for the sorts of good relationships that ultimately lead to the desired health outcomes.

But time constraints are an ongoing reality within both medical education and practice, and for that matter, doctors are not social workers. But what does that mean in

practice for a profession that subscribes to ideals of humanism and treating patients as whole persons? This question has many implications, and I here I address only one. Even the Buena Vista physicians who believed sexuality was important to address, despite having received little formal sexuality education themselves and even in the face of time constraints, did not mention that discomfort or stigmatization related to sexuality might impact patients' experiences of medical care. For instance, Dr. Janet Norton told me that she didn't really feel that she had been trained to talk to patients about sexuality, but given that so many patients came to her with sexuality-related concerns, it had become clear to her that talking about sexuality was part of her job as an OB/GYN, and she had better do it as best as she could. "Sometimes I don't know what to offer them," she told me. "But so often I'm the first person they tell when their husband has an affair, or whatever... they come in and they want to get tested for STDs, and there's so much they've had on their minds that goes with the whole situation, and I'm the person that gets to hear it. And we've got fifteen minutes."

Two points about time constraints are important. First, even the doctors, such as Dr. Norton, who recognized that talking with patients about sexuality was part of their work regardless of whether or not they felt like they had time or had been adequately trained to do it, did not recognize sexual stigmatization as an issue within health care. Although some Buena Vista faculty considered sexuality important to patient care, they did not indicate awareness of sexual stigmatization, sexuality-related inequalities, or the potential implications of the very sorts of discomfort surrounding sex that made their patients turn to them first when they had questions about sexuality. Second, the broader issue of time constraints as a potential barrier to treating the patient not the disease, to treating patients as whole persons, and to treating patients as they would want to be treated was not a subject that I observed or heard of consideration of. The tension

between the reality of time constraints and the achievement of professional, compassionate care is relevant to more than just the negotiation of sexuality within clinical encounters, but might, in the case of topics that provoke discomfort, be used as ready justification for why the subject cannot be negotiated at all.

Conclusion

In this chapter I have shown that sexuality-related discomfort was present at Buena Vista, but this discomfort was not addressed as something that might present a challenge to achieving appropriately professional behavior. Sex negativity as a social fact that might shape both doctors' and patients' experiences of clinical encounters, and that might need to be negotiated in order to enact professional behavior, was not the subject of consideration. Does the absence of teachings about sex negativity – i.e., acknowledging it as a social fact, talking about how it may impact both doctors' and patients' experiences of clinical encounters, and how it may ultimately shape patterned health inequalities – constitute a null curriculum? It certainly seems that the absence of teachings about sexuality-related discomfort and how to mitigate it are curricular omissions that matter, because as this chapter indicates, sex negativity may not automatically resolve itself within medical training and medical practice.

Even though doctors encounter sexuality throughout the course of their work in ways that those outside of the medical profession do not, the discomfort associated with sexuality is not necessarily resolved even as doctors gain the technical skills necessary to perform procedures that have sexual connotations. In some respects, doctors' relationship with sexuality is very different from laypersons', but in others it may not be very different at all. Although Dr. Jun, the urologist, examined male genitalia in a manner and frequency that most laypersons do not, he still found sex to be funny and foreskin to be nasty – responses to aspects of the body and human experience that

seem contradictory to the ideals of medical professionalism. For Cindy, the medical student, learning to ask patients basic questions about sexual activity or orientation did not translate into comfort with hearing their answers. Although doctors' work brings them into contact with the realm of the sexual, there was little indication that the meanings associated with sexuality were subject to explicit consideration at Buena Vista, and little indication that broader social understandings about sexuality were substantially transformed or reshaped. Doctors may be just as subject to sex negativity as laypersons are, but may not be aware of their unique capacity to enact and reproduce it within clinical encounters.

A null curriculum of sex negativity and a null curriculum of doctors' capacity to enact it and cause their patients discomfort in doing so creates the conditions in which sexual stigmatization may occur. Without explicitly acknowledging patients' experiences of sexuality-related stigmatization within clinical encounters, it may be very difficult for the conditions that give rise to these sorts of experiences to change.

These observations are similar to the frequent critique of training for cultural competence programs that attempt to address health disparities associated with race/ethnicity/national origin by teaching medical students and doctors about supposedly categorical cultural differences between different "cultural" or "racial" groups. Instead of teaching about *races* (or "races"), critics argue, we should be teaching about *racism*, and the power differentials that are entrenched in American society and contribute to inequalities such as health disparities (Taylor 2003; Tervalon 2003; Wear 2003; Wear 2006). Teaching about sexuality and sexuality-related discomfort is different from teaching about ethnicity, culture, and race in some respects, but the parallel question may be, what do doctors need to know about the broader social forces – such as racism or sex negativity – that impact providers' and patients' experiences of health care? And

what are they expected to do with this knowledge? This chapter indicates a need for further research on how the discomfort associated with sexuality may be produced, reproduced, recognized, and negotiated within medical education, and how medical educators conceive of the effects of doing this or not doing this. What sorts of knowledge about sex negativity is produced within medical education, or what sorts of ignorance?

Developing a better understanding of the manifestations of sexuality-related discomfort and its negotiation is important for our knowledge of both patients' and doctors' experiences of health care. Just as the avoidance of sexuality circumscribes the treatment of patients as "whole persons," leaving the discomfort associated with sexuality intact or unacknowledged may prevent the doctor from feeling comfortable within their job (for related discussion see Smith and Kleinman 1989). If sex negativity is a potent social force, we need to better understand doctors' sexuality-related discomfort as well as patients' (or patients' perceptions of their doctors' discomfort). In order for doctors to treat patients as whole persons, surely their humanity needs its own recognition – even when that includes "unprofessional" emotions or sentiments.

Is "sex negativity" the best term to use to capture the sexuality-related discomfort at Buena Vista, and is it appropriate terminology for future studies that might consider the various manifestations and implications of sexuality's "special status"? Rubin's language is extreme, and her definition of sex negativity suggests that it may be inescapable. And while a subtler, more nuanced conceptual framework and sociological vocabulary for talking about the discomfort, unease, or stigma that surrounds sex(uality) may be needed, this chapter suggests that Rubin's conceptualization of sex negativity remains relevant. Without explicit recognition of sex negativity as a social fact, the effects of sex negativity may be reproduced. In other words, if we do not recognize sex

negativity we run the risk of becoming enmeshed within it, as Rubin suggests ([1984] 1993). For this reason Rubin's terminology remains useful, and we need a better understanding of how sex negativity manifests itself and is negotiated within medicine and other professionals' work.

CONCLUSION

As the first ethnographic, inductive, comprehensive study of medical sex education, this research makes important contributions to the literature and also points to many questions that future sociological research might explore. I began this dissertation by asking the question, “What do doctors know – or need to know – about human sexuality, and how do they learn it?” Through this study of the teaching and learning about sexuality that took place at Buena Vista, I have demonstrated just how complicated these questions themselves can be, and how complex their answers are in practice. By examining the production and transmission of understandings about sexuality through multiple levels of curricular processes, this study has expanded the parameters of conversation about medical sex education, and in doing so, raises questions for future sociological research and sheds new light on the opportunities and challenges associated with the provision of sexuality education within medical training. Here in the conclusion I summarize my key findings and their implications for the evolution of medical sex education efforts, then move on to considering the broader sociological significance of my findings and questions that future sociological research might usefully explore.

The teaching and learning about sexuality that occurred at Buena Vista provide important insights into the ways in which the need for sexual knowledge is conceptualized by medical students and medical educators, and the ways in which sex negativity (Rubin [1984] 1993) may constrain sexual knowledge production. It demonstrates the ways in which normative understandings about sexuality which privilege some and marginalize others may be produced through processes that seem innocuous and thus may be very difficult to recognize. In my ensuing discussion of the

bearing my findings have upon the evolution of medical sex education efforts, I attempt to keep in mind both the real challenges associated with implementing curricular changes, and the fact that the impact or efficacy of curricular innovations is always an empirical question. Moreover, the criteria for efficacy of medical sex education have neither been established, nor extensively explored by medical professionals. Thus my normative agenda, if anything, is to generate impetus for such conversations - rather than to impose a set of ideas of my own device.

As Judith Butler notes, identifying and critiquing normative arrangements – as I have in this dissertation - can be delicate business. The analysis of normativity runs the risk of implying another normative alternative in place of the first (Butler [1990] 1999: xxi). Perhaps obviously, I do take the position that medical sex education matters and that the study of medical sex education matters – not only for our understandings of medical knowledge about sexuality and eventually, its impact on health care practices, patients' experiences, and patterned health outcomes, but also for our understandings about the production and transmission of formal sexual knowledge in society more generally. In proposing that medical sex education matters and in examining the production of normative understandings about sexuality, I may have risked implying my own normative vision of what medical sex education should be – starting with the presumption that medical sex education should be a priority at all. My ensuing recommendations for the future of medical sex education are based upon a deep appreciation of the challenges that may be associated with its provision, along with a belief in its importance.

Historical continuity: we (still) don't know what medical sex education is

Although our knowledge of current trends in the sexuality education provided by North American medical schools is limited, two things seem reasonably clear. Many

North American medical schools report that they provide *some* sexuality-related curricula (e.g., Solorsh et al. 2003; Obedin-Malevir et al. 2011). However, a shared set of understandings about what medical sex education should include, how and when it should be taught, and what students should take away from such curricula has yet to emerge and become institutionalized within medical education (Coleman 2012).

In practice, the sexuality education that was intentionally provided at Buena Vista was representative of both of these patterns. Buena Vista faculty did not share a clear set of understandings about what sexuality fundamentally meant, or how it could become salient within medical practice, and there was no collective effort to examine these questions and deliberately create a sexuality curriculum with a consistent set of messages or a specific set of learning objectives. But even in the absence of an internally-generated or externally-imposed set of guidelines about what to teach about sexuality and when and how, a fair amount of teaching about sexuality took place at Buena Vista, which is perhaps surprising and admirable considering the significant obstacles faculty members perceived to be associated with the provision of sexuality-related curricula. While the moments of deliberate, sustained consideration of sexuality were not uncomplicated success stories, as I have discussed, they were indicative of the possibility that some nuanced, dedicated attention to sexuality can emerge in the absence of a mandate to teach about sexuality, through particular faculty members' agency. One practical consequence of this is that in the absence of a collectively established set of guidelines, what faculty members teach about sexuality may be the result of their experiences and perspectives about what sexuality is or what is important about it. In other words, the medical sex education that does occur outside of collectively-determined initiatives may be the result of faculty members' idiosyncratic perspectives.

In addition to the moments of deliberate, sustained teaching about sexuality within the formal curriculum (Hafferty 1998) at Buena Vista, there were also moments within the formal curriculum in which messages about sexuality were transmitted unintentionally. Dr. Jonathan Bentson's lecture on the topics of marriage, family, and divorce did not explicitly engage sexuality, but the content of his lecture was predicated upon heterosexual desires and heteronormative relationships. Dr. Arnold Jun's lecture on male anatomy featured jokes about penises and their purposes that reinforced heteronormative understandings of the functions of particular body parts as well as the notion that anything related to sexuality is likely to provoke a particular form of discomfort that is best alleviated through humor. During my interviews with these lecturers, it became clear that not only did neither of them set out to teach about sexuality per se, but also neither lecturer was aware that they might inadvertently be transmitting a set of messages about sexuality.

There were also a number of brief, offhand mentions of sexuality within the context of lectures primarily devoted to a wide range of topics, in which sexuality was explicitly referred to but not explicated. These sorts of curricular moments present a set of opportunities and challenges for medical educators that have not previously been identified as such. On the one hand these sorts of off-the-cuff references to sexuality are likely to be difficult to systematically recognize or influence, and their impact hard to assess. But on the other hand these brief mentions of sexuality in conjunction with a diverse array of topics provide an organic, empirical illustration that sexuality is relevant to many dimensions of health and demonstrate that teaching about sexuality can be integrated into discussions of other topics – perhaps so easily that it is scarcely recognized when it is happening. While it may be a sociological truism that sexuality intersects with multiple domains of human experience, the effortless and perhaps

unintentional links made between sexuality and other topics within the formal curriculum at Buena Vista are worth emphasizing in the context of persistent uncertainty about the best format for medical sex education (Curry 2011; Coleman 2012). But it is just as important to note that, in practice, these passing mentions of sexuality at Buena Vista may have effectively contributed to the notion that sexuality is either undefinable, knowable through its unknowability (Hearn and Parkin 1995), or self-explanatory.

It is also important to emphasize that many of the lectures in which sexuality was mentioned quickly and without explication – for instance, the potential for “sexual side effects” were noted in a discussion of pharmaceutical drugs designed to treat depression – ended early. Taking a few more minutes to talk even slightly more extensively about sexuality’s meaning and significance in this context would have been *possible*, at least in terms of the sheer amount of time that was available for the given class meeting. This discovery belies the assessment, made by medical educators decades ago (e.g., Coombs 1968) and Buena Vista faculty members today, that the problem of time constraints was a major obstacle to teaching about sexuality. However, the literal availability of time within lectures to talk about sexuality is not the whole point. Figuring out what sexuality means takes time too. Even if there was time within some lectures to expand brief mentions of sexuality into fuller discussions, this does not mean that faculty members’ perception of the problem of too much to teach and too little time was totally off base. Conceptualizing sexuality takes time, whether done collectively or individually, and faculty members’ belief that there was insufficient time available to teach about sexuality may have reflected the slightly different, but related, challenge of not having the time to determine what to teach about sexuality.

Recognizing that the topical integration of sexuality into curricular moments that are primarily devoted to other subjects may not necessarily include the explication of

sexuality nor lead to the spontaneous thematic coherence of a set of messages about sexuality is important as medical education moves away from a curriculum that features stand-alone courses and toward a more integrated style of teaching (Coleman 2012). Buena Vista was making this sort of transition at the time of my research, and a few faculty members, including one of the deans, speculated that there might be more opportunities to teach about sexuality within the new, integrated, systems-based curricular model. The fact that a de facto integrated sexuality education of sorts was already occurring at Buena Vista in the absence of conscious efforts to achieve this suggests that the opportunities for teaching about sexuality that new curricular models present may not be that different from the opportunities to discuss sexuality in conjunction with other topics that have already existed. Whether the *perception* that new teaching formats provide new opportunities to teach about sexuality will foster meaningful changes in the way sexuality is taught about in medical education is an open question. It seems likely that the presence or absence of a shared set of understandings about what sexuality is, how it matters to medicine, and what needs to be taught about it and when and why may have more of an impact on the sexuality teachings a medical school puts forth than the overarching structure of the curriculum. In the absence of a collective sense of what medical sex education should be, any new opportunities to teach about sexuality may just as likely function as opportunities to *not* teach about sexuality, or to provide a set of messages about sexuality that are inconsistent at best.

Buena Vista is particularly instructive in this regard because some faculty members did devote time to the nuanced consideration of sexuality's meanings and how the definitional ambiguity associated with sexuality could have bearing upon clinical encounters and medical outcomes, even in the absence of any shared understanding that this needed to be included in the curriculum. The extant literature on medical sex

education has not even emphasized the potential utility of exploring definitions of sexuality in medical education, much less examined the prevalence of efforts to do so – thus we might imagine that Buena Vista’s efforts in this regard are perhaps unique. But as I have discussed, these isolated moments of defining sexuality or confronting its definitional ambiguity did not permeate the curriculum, and moreover, there were no attempts made to explore the range of ways in which sexuality is relevant to medicine, nor to suggest the extent to which the potential relevance of sexuality to medicine dictates a clear set of professional responsibilities for doctors. In other words, at Buena Vista it was never made clear whether or when doctors have an unavoidable duty to deal with sexuality – whatever sexuality is understood to mean.

Historical change: Teaching about sexual diversity

There are indications that some aspects of medical sex education have changed little since the 1960s and 1970s. Shared understandings about what it is or should include remain elusive, and barriers to teaching about sexuality that Buena Vista faculty members perceived were strikingly similar to those articulated by medical educators decades ago (e.g., Coombs 1968; Marcotte et al. 1976). However, the move toward the explicit, systematic inclusion of LGBT sexuality represents a significant break from the past. Often, discussions of medical sex education efforts from earlier decades reveal a heterocentric focus or an absence of consideration of the potential need to consider sexual diversity, or both. The relatively recent, concerted push to incorporate LGBT-specific training or “LGBT cultural competence” into medical education is indicative of a new relationship between medical professionals and sexuality. Medical professionals historically contributed actively to the understanding that sexual variations were pathological (e.g., Foucault 1978; Weeks 1987; Martin 1993); in the nineteenth century they were prominent advocates for legislation penalizing various forms of sexual

behavior (Starr 1982: 28). Instead of designating sexualities that diverge from procreative heterosexuality as pathological (Weeks 1987), mainstream biomedical institutions such as the Institute of Medicine are now recognizing the adverse health outcomes associated with sexual stigma (which the medical profession may have been historically responsible for producing), and there seems to be an unprecedented degree of awareness forming around the need for medical education to devote specific attention to sexual minorities (e.g., Institute of Medicine 2011; Obedin-Malevir et al. 2011).

Training for “LGBT cultural competence” has come to be seen as a strategy for addressing sexuality-related stigma within health care and sexuality-related health disparities (Curry 2011). The presentations and discussions at the Annual Conference of the Gay and Lesbian Medical Association in 2011 in Atlanta illustrated the extent to which current thinking about teaching about sexual diversity conceives of this diversity and the ways to teach about it in narrow terms. In September 2014, California Governor Jerry Brown signed into law a bill stipulating that all continuing medical education courses include “...as appropriate, information pertaining to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities” (California Assembly Bill 496). Although the wording of the California Assembly Bill extends consideration beyond the confines of “LGBT” to include intersex persons, this bill is still an indication of the momentum of the cultural competency approach to teaching about sexuality in medical education. Certainly, making LGBT health – however it is conceptualized – more visible in medical education is a step toward a more inclusive approach to teaching about sexuality, but a narrow focus on this “group” (or “groups”) and “their” sexualities or health needs may present not only a reductionist conceptualization of LGBT persons, but also a very narrowly bounded scope of human sexual diversity.

Within this context, Buena Vista's teachings about sexual diversity are particularly worthy of scrutiny. In some respects, Buena Vista's teachings about sexual diversity were – perhaps inadvertently – relatively progressive. Within the only moment of teaching that might have reasonably counted as “LGBT-specific,” Dr. Michelle Thompson delivered a lecture on adolescence and sexuality that was not only explicit about sexual diversity but also situated it within a broader continuum of sexual possibilities, and a more general discussion of what sexuality meant, and how it mattered within stages of human growth and development. Within Dr. George Sorin's “sex day” lecture/discussion/poll, he pushed students to define sexuality and he illustrated some of the empirically-occurring sexual diversity within the medical school cohort. While some elements of these lectures were worthy of critique, they were progressive at least insofar as they presented sexual diversity as a complex rather than straightforward matter, and avoided reductionist presentations of particular sexual groups or populations. Without setting out to do so, Buena Vista's teachings about sexuality indicated how possible it is to teach about “sexuality” and “sexual diversity” as related topics, and to consider sexual diversity both within and outside of the scope of LGBT sexuality.

Competing messages within multiple levels of curricular processes

My comments in the preceding pages pertain to the sexuality education within the formal curriculum. But the understanding that curriculum is produced through multiple levels of simultaneously occurring processes that often complicate the messages intentionally put forth in the formal curriculum is shared within the sociology of medicine and academic medicine (e.g., Hafferty and Franks 1994; Hafferty 1998; Maudsley 2001; Suchman et al. 2004; Hafferty and Castellani 2009). Despite this recognition, previous research on medical sex education has not extensively examined

the transmission of messages about sexuality outside of the formal curriculum, and this study's analysis of the messages produced through informal, hidden, and null curricular processes is a distinctive contribution to the literature. The analysis of multiple levels of curricular processes provides new insight into the challenges that are likely to be associated with teaching about sexuality across cases, the similarities and differences between teaching about sexuality and other forms of human difference or other reasons why social sensitivity is important in medicine, and fresh perspectives on opportunities for educators to innovate.

However we might evaluate Buena Vista's intentional teachings about sexuality – progressive or heteronormative, nuanced, essentialist, or perhaps a little of all of these things and more - students did not necessarily receive this content or take it particularly seriously because of the competing influences within the informal curriculum. The veneration of bioscience within Buena Vista's culture impacted the Social Aspects of Medicine (SAM) classes in several distinct, yet mutually-reinforcing ways. Students, believing that their other courses were more important, tended to consider the SAM classes as “BS” or as requirements to simply get through, rather than invest energy into thinking about. Faculty members who were involved in the SAM classes had to defend the allocation of time to social topics against attack from colleagues who also considered social curricula a waste of time. The combined faculty and student disregard for the SAM classes made their structure vulnerable to student complaints about the “fairness” of evaluation techniques. While the content of the SAM classes might have been taken more seriously by students if they were tested every week on their content, as they were in other courses, this was virtually impossible for SAM course directors to implement because the social sciences were held in low regard by many. As I described in Chapter

3, student and faculty protest led to an evaluation system in the SAM classes that was less than rigorous.

This sort of disregard for social content is by no means unique to Buena Vista, nor is it only relevant to teachings about sexuality. Others have observed that an institutional culture of reverence for biomedicine impacts medical students' reception of social science curricula, or curricula designed to promote social sensitivity (e.g., Beagan 2003; Tervalon 2003). The question for medical educators concerned with teaching about sexuality and sexual diversity is what to do about this. Advocates for the integration of social or cultural topics in medicine, including attention to diversity and difference, sometimes present curricular initiatives while leaving their implementation "to be worked out by creative leadership within each institution" (Tervalon 2003: 571). As the difficulties experienced by the SAM course directors at Buena Vista indicate, even creative leadership cannot necessarily surmount all of the challenges posed by informal curricular processes that devalue certain types of teachings – including but not limited to sexuality.

The critical questions for educators to consider may be how to ensure that teachings about sexuality gain optimal traction, not how much time is devoted to them. Even if Buena Vista had devoted another six lectures to the elaboration of sexuality and sexual diversity, these lectures might not have "counted" unless students were tested on their content – and of course, whether or not weekly tests would have changed the students' regard for and reception of the SAM material is an empirical question. The point is that for educators struggling with the practical realities of curriculum planning, the circumstances that shape the reception of curricula may matter as much if not more than the amount of time devoted to sexuality within the formal curriculum.

The hidden curriculum of heteronormativity

The ethnographic methods employed in this study revealed that a hidden curriculum of heteronormativity coexisted easily with the teachings that explicitly considered sexual diversity at Buena Vista. True to its name, the hidden curriculum of heteronormativity was not recognized by faculty or students, because by definition, heteronormativity is comprised of practices that seem unproblematic, or seem to simply reflect the natural order of things – if the routine positioning of heterosexuality as the obvious standard is even noticed at all (e.g., Kitzinger 2005).

Recognizing the existence of heteronormativity is in some ways analogous to recognizing the “culture of medicine” (Taylor 2003; also see Beagan 2003) insofar as it requires attention to a form of privilege that is usually invisible and may not seem problematic even if it is made visible. Social scientists argue that medicine has its own culture but resists recognizing it as such, preferring instead to regard other forms of knowledge as cultural and medical knowledge as *real* (for discussion see Taylor 2003). Similarly, heterosexuality is often understood as the standard way of being, rather than as one sexual possibility out of many (e.g., Sumara and Davis 1999), and heterosexuals have the freedom to not recognize their privilege for what it is (Simoni and Walters 2001). In other words, there may be very little impetus for a heterosexual majority of educators to recognize the ways in which heterosexual privilege is repeatedly reified within curricular moments where it seems like nothing special is going on – that is, within moments that seem to be unsexual but are actually *heterosexualized* (Sumara and Davis 1999; Kitzinger 2005). Within a heteronormative curriculum, regular representations of heterosexuality construct its normalcy or neutrality, and even if other sexual possibilities are not completely excluded, they never achieve familiarity or intelligibility. Heterosexuality becomes the obvious, standard way of being, while other sexualities are not made familiar as livable, legitimate, intelligible ways of being (Butler

[1990] 1999). How – or if - embedded, normative messages about sexuality shape doctors' actions and patients' experiences thereof is an important area of future inquiry.

Moving education concerning sexual diversity forward

How might heteronormativity be addressed within medical education? This specific question is new, but it is related to a broader set of concerns about medical efforts to teach about human difference that social scientists have explored at length. Originally designed in an effort to address race and ethnicity-based health disparities, training for cultural competency initiatives are geared toward “sensitizing” students from the dominant culture to “minority differences” – which are often understood in static, categorical terms (Wear 2006). These programs have been criticized for their reductionist conceptualizations of difference, and for their lack of recognition of the broader social and political dynamics of power, oppression, and inequality (for discussion see Wear 2006). Instead, some argue, medical schools should teach – for instance - about race and racism, not “races.” (Or sexuality and sexual inequalities, rather than particular, supposedly distinct “sexualities.”) A better strategy would entail giving students the opportunity to recognize the particularity of their own perspective or position as well as their capacity to act in ways that reproduce social inequalities even if they are nominally committed to principles of equality, some suggest (e.g., Beagan 2001). These sorts of recommendations imply that the best way to address heteronormativity is to talk about heterosexual privilege and attempt to make it routinely visible. And this is probably a worthy goal, but the features of heteronormativity that make it pernicious are the same features that may make it very difficult to disrupt. Making heterosexuality repeatedly visible through, for example, faculty members' casual references to their own heteronormative family arrangements, may seem like a demonstration of faculty members' lived realities and their capacity to speak

authentically from their own frames of reference, rather than practices that contribute to heterosexual *privilege*. One way of slightly shifting the valence or significance of these mentions is to actively mark heterosexuality as a sexuality, rather than mentioning sexuality only when a patient is not heterosexual (Turbes et al. 2002). This is an example of a practice with the potential for broad application, and while naming heterosexuality will not eradicate heterosexual privilege nor necessarily make heteronormativity immediately or completely visible, there may be cumulative power in the routine marking of cases that are usually unmarked.

Destabilizing heteronormativity and making sexual diversity visible are not quite the same thing, and both are important components of achieving more equitable representations of sexuality within medical training. Just as disrupting heteronormativity may be difficult, questions about how to make sexual diversity visible within an educational context that has typically placed little positive emphasis on diversity, sexual or otherwise (e.g., Beagan 2001; Wear 2003) and prided itself on its “culture of no culture” (Taylor 2003) also present familiar challenges. On the one hand, medical educators argue, medical students need exposure to sexual diversity because it facilitates awareness of and comfort with patient populations that are often stigmatized and misunderstood (e.g., Kelley et al. 2008; Eliason et al. 2011), and there is evidence that heterosexual antipathy toward sexual minorities is reduced through interpersonal contact (Herek and Glunt 1993). In practice, however, curricular interventions designed to give medical students exposure to the diversity they may encounter in their future patient populations often takes the form of “pop up lectures” or “safari experiences” (Wear 2003: 553) where isolated moments of hypervisibility contrast with the relative invisibility of diversity within the rest of the curriculum. I described in Chapter 4 how the panel of transgender guest speakers exemplified this dynamic at Buena Vista.

One question for medical educators and researchers to consider seriously is whether it is worse to make sexual diversity visible in isolated, petting zoo-type moments, or not at all. The panel of transgender guest speakers made a tremendous impact on some Buena Vista students, after all. Isolated, somewhat artificial exposure to sexual diversity, however problematic, may be better than none at all – and this may be an area of empirical inquiry with substantial practical and theoretical significance.

Another set of questions concerns the extent to which medical schools can support the visibility of sexual diversity that occurs naturally among students and faculty members. Buena Vista students' informal interactions with their peers were a powerful source of their understandings about sexual diversity. A perceived absence of sexual diversity led some students to believe that sexual diversity was not present at Buena Vista, and that this absence was not really remarkable and did not have discernable consequences. However the students who encountered sexual diversity among their peers often found these experiences to be an eye-opening source of exposure to the sheer presence of sexual diversity as well as the ways in which sexuality can be salient within experiences of social life. The extent to which heterosexual students came to be aware of the presence of non-heterosexual students in their class was to some degree dependent upon the extent to which non-heterosexual students felt comfortable disclosing their sexual identities and participating in the culture of Buena Vista. Non-heterosexual students' calculations of whether they could be open about their sexuality without fear of repercussions were based in part upon their perception of sexual diversity among faculty members – of which they could detect very little. This was taken by some to mean that being openly gay could be a risk to one's medical career. In the absence of clear examples to the contrary, it was hard for some of them not to worry.

Buena Vista students were predictably concerned about their success and anxious about the evaluations and opinions of their superiors. Within such a context, one of the most significant moves that a medical school might make toward not only making sexual diversity visible but also according legitimacy to its existence would be to make sexual diversity more visible among faculty members. Sociologists of medicine and medical educators alike recognize the powerful influence of faculty role models on students' experiences of medical training (Hafferty and Franks 1994; Maudsley 2001), but advocates for medical sex education have yet to emphasize that one of the most powerful forms of teaching about sexuality may come from the messages that faculty members send simply by virtue of being who they are, and through the elements of their personhood that they name and claim through the course of their participation in the medical school environment. Of course, non-heterosexual faculty members' choices about whether and when and how to out themselves may also be informed by their perception of the climate of institutional support for their minority position (Bowen and Blackmon 2003), potentially making top-down efforts to promote a climate that is hospitable to the visibility of sexual diversity particularly important. This study has demonstrated that the impact that informal interactions with peers and superiors have upon what students, in their own estimation, learn about sexuality within medical training – suggesting the potential value of both future study of and educational interventions targeting these sorts of curricular processes.

Sex negativity

While the recent attention devoted to sexual inequalities within mainstream biomedicine (e.g., IOM 2011) has focused on LGBT sexuality and the stigma that may adhere to persons in this category, it is important – *especially* in the context of heightened interest in LGBT-specific training - to keep in mind that “sex negativity” may

be associated with *anything* sexual, whether it is normative or not (Rubin [1984] 1993). In other words, sexual diversity is an important component of medical sex education and in some respects, questions concerning medical sex education are similar to questions about medical teachings about other forms of diversity. But sexuality is not only salient to medicine in terms of diversity, and *all* aspects of medical sex education need to be examined in conjunction with sex negativity.

Gayle Rubin argues that within Western societies, anything and everything that has to do with sex is liable to be considered a “special case,” a domain of experience that is saddled with a disproportionate amount of negative significance (Rubin [1984] 1993: 11). Whether we talk about sexuality’s special status in terms of taboo, stigma, discomfort, privacy or sensitivity, the point that sexuality is rarely understood to be neutral or mundane is evident. We know that sex negativity has shaped the production of formal knowledge about sexuality (Epstein 2006; Irvine 2014), and the transmission of knowledge about sexuality, particularly in public schools (Haynes 2003; Irvine [2002]; 2004; Fields 2008). In this study I have examined how sex negativity was manifested at Buena Vista, and have argued that there was little collective awareness of how discomfort associated with sexuality or the understanding that sexuality is sensitive or special or funny might interfere with the achievement of medical professionalism.

The medical profession in general places substantial emphasis on medical “professionalism,” defined usually as some combination of altruism, humanism, being dedicated to service, committed to caring for the total needs of patients, and treating patients as whole persons (Cohen 2000; Hafferty 2000; Swick 2000; Arnold and Stern 2006). Buena Vista emphasized these themes within their teachings about professionalism that, like their teachings about sexuality, were not organized into a self-conscious curriculum but were fairly substantial in their composite. While some of these

messages about professionalism were nuanced and emphasized not only the need to treat patients as whole persons and with respect and dignity but also the difficulties sometimes associated with doing so, the ways in which sex negativity might pose a particular challenge to the accomplishment of professionalism were not considered. This is particularly noteworthy because there were moments in the curriculum in which sexuality was deemed “sensitive,” or uniquely funny, or capable of provoking a particular kind of discomfort. But the admission that sexuality could provoke nervousness or discomfort on the part of the medical student or the doctor did not lead to a recognition of a potential threat to the achievement of professionalism, and was not accompanied by consideration of how patients might be uncomfortable in the doctor’s care if the doctor was uneasy during a clinical encounter that in some way bore relevance to sexuality. Nor was there serious discussion of how students might transform whatever affective responses they might have to sexuality-related aspects of doctoring, aside from the presumption that with time and experience, students would either become less sensitized to sexuality or more technically competent and thus comfortable with procedures such as pelvic or rectal exams that had immediate sexual connotations. Yet there were indications that even experienced faculty members had affective responses to sexuality, suggesting that years on the job did not necessarily reconfigure sex negativity into a fundamentally different set of understandings about sexuality and its significance.

These findings demonstrate that even if medical students and faculty members do not actively construe sexuality – in general, or any specific dimensions of it – as taboo or dirty or sinful or *negative*, broadly shared societal understandings that sexuality is different, suspect, or private are not necessarily mitigated within the medical realm, either. In some respects this is surprising, since it seems likely that doctors are

compelled to confront sexuality within their work to a greater extent than other professionals (aside from sex workers, or workers who provide sexual services, of course). Whether or not doctors actively embrace the fact that interfacing with sexuality is a byproduct of their professional authority, it seems plausible that perhaps they might be motivated to confront sexuality and sex negativity through necessity. There was little indication of this being the case at Buena Vista, and moreover, there were indications that sex negativity was a factor that shaped the overall approach to teaching about sexuality at Buena Vista – and may well inform sex endeavors in other medical schools, too.

In 1976 Marcotte et al. noted a “circular system...where medical teachers who received their medical education devoid of sex education determined curriculum and all too frequently devalued [sexuality’s] importance,” but optimistically predicted that newfound attention to medical sex education would reverse years of negligence and stimulate the widespread adoption of medical sex education programs (117). Decades later, Buena Vista faculty did not exactly devalue medical sex education, and as I have discussed, a few faculty members turned their conviction that sexuality was important to teach about into the delivery of curriculum. While these efforts were important, so too was the absence of a collective effort to treat sexuality as a topic that warranted sustained attention, and the absence of collective attempts to figure out what to teach about sexuality, and how, and when within the overall course of medical training. Robert Coombs observed this tendency among medical educators in the 1960s. Coombs reported that a common attitude among faculty he surveyed was “Sex education is important and should be an integral part of the curriculum – *but* someone else should do it, not me” (1968: 273; emphasis in original). Buena Vista faculty members expressed the very similar sentiment that medical students needed to learn about sexuality, but the

ideal place for such learning was somewhere other than their particular point of influence within the longer pipeline of medical training. Faculty who developed coursework believed that medical students could really only understand why sexuality mattered to patient care and thus, learn about it effectively, when they were residents and were more mature and had more contact with patients. Conversely, faculty who worked with residents complained that medical students could make it through school without being able to ask even basic questions about sexuality. I never learned of any attempts among faculty to bring these concerns to the table for collective consideration, nor did I hear of any external pressure upon faculty to devote time to doing so.

Early observers of medical sex education argued that anxiety about sexuality underlay the provision of medical sex education (Woods and Natterson 1967; Coombs 1968; Golden and Liston 1972; Dunn and Alarie 1997), and this anxiety was evident at Buena Vista years later. Experienced Buena Vista doctors expressed concern that medical students or even residents might find talk about sexuality inappropriate – even when they were dealing with a patient presenting sexuality-related health issues – and potentially complain or sue them for sexual harassment. A few faculty members also acknowledged – or demonstrated – their own capacity to experience discomfort when discussing sexuality with patients.

The persistence of anxiety related to teaching about sexuality on the part of medical school faculty members suggests that sex negativity may be a formidable obstacle to the provision of medical sex education – more significant, perhaps, than the problem of time constraints. Sex negativity may be a reason why “social change,” so often cited as a reason why medical sex education is necessary (e.g., Marcotte et al. 1976; Leiblum 2001; Kuritzsky 2006), has not automatically resulted in the appearance of a clearly-defined home, or protected space, for medical sex education efforts to

germinate. While historical change has certainly shifted social norms concerning sexuality and sexuality's place within social life, sexuality continues to occupy a social position that is at best complicated. As Janice Irvine writes about sex research, it is tempting to assume that historical change has brought about cultural liberalization that has made sexuality less controversial (2014). However, a notion of linear progress in which sexuality is increasingly accorded legitimacy or is at least increasingly free from repression is too simple (Foucault 1978; Irvine 2014), and as Irvine demonstrates, even the potentially legitimizing context of scientific research and scholarly inquiry is not necessarily enough to imbue the production or transmission of formal knowledge about sexuality with credibility. Sexuality research, Irvine argues, is socially necessary, and "many people are eager for the knowledge that sexuality researchers produce" (2014: 633). It would seem that this is even truer of the sexuality-related work that doctors do: the public wants or even expects their help or advice or compassion or sensitive awareness (Beehler 2001; Leiblum 2001; Berman et al. 2003; Parish and Clayton 2007). But it also seems that neither the scope nor the social *necessity* of the sexuality-related components of doctoring is collectively understood by doctors themselves. Although Buena Vista faculty and students alike at least vaguely embraced the relationship between sexuality and health and believed at least theoretically that doctors had responsibilities to address their patients' sexual health concerns, there was little evidence of a shared understanding that sexuality was *essential* to learn about and deal with, either generally or with regards to a particular set of potential patient concerns.

Humanizing the doctor as well as the patient

Addressing sex negativity within medicine might start with an explicit recognition that sex negativity exists, that it is a "social fact" (Durkheim 1895) with broad implications for patients' and doctors' experiences of receiving and providing health care. Certainly,

teaching about the stigma sexual minorities experience is an important component of this. But so too is allowing medical students and doctors the opportunity to name and claim their own experiences – of discomfort, nervousness, desire, embarrassment, or whatever else - as they encounter the naked bodies of strangers, learn to talk about sexual practices, encounter sexual diversity, and confront sexuality in ways they were never called upon to do as laypersons. If patients' experiences related to sexuality within health care encounters are to be taken seriously, medical students' and doctors' experiences of sexuality within medicine need to be taken seriously too. In a society where there are few opportunities for the formal, thoughtful consideration of sexuality and few spaces that offer a respite from sex negativity as a framework for understanding sexuality writ large, it may be very difficult for medical students and doctors to assume professional responsibility for any dimensions of sexuality in the absence of training designed specifically for that purpose.

Medicine, social science, and the limits of doctors' professional capacities

Many recommendations for curricular changes to promote heightened social and cultural sensitivity within medicine offer a list of content and competencies that medical schools might *add* to their course offerings in order to produce improved student-physicians – from the latest perspective of what sort of social sensitivity is essential to the delivery of equitable medical care (e.g., Betancourt et al. 2003; Tervalon 2003; Sequeira et al. 2012). While the motivations behind these recommendations may be hard to impugn – the goals of reducing health disparities or preparing student-physicians to treat all patients who come their way respectfully and effectively are certainly worthy of pursuing – attempting to effect change by adding more training for social and cultural sensitivity to medical education may not be successful (Beagan 2003).

Social scientists continue to insist that the social sciences have an important role to play within medicine, particularly where sexuality is concerned (Roberts 2011). Celia Roberts argues that medicine does not have the skills or the resources to provide adequate accounts of the complexity of human behavior, so the “uneasy relationship between medicine and social science will continue into the foreseeable future,” particularly for the sake of providing “adequate accounts of the complexity of human [sexual] behavior” (2011: 74). While this may be a valuable point, the benefit of the relationship between the social sciences and medicine may depend upon the recognition of the structural factors that constrain medical education and shape the place of humanism within it in all of their current complexity (see for instance Bloom 1988; Conrad 1988). As technical, scientific knowledge continues to expand exponentially, the amount of bioscientific material that medical students must master to gain entry into the position continues to grow. At the same time, expectations of the “cultural” competency doctors should have also increased. In 1988 Peter Conrad noted that “To be a humanistic doctor in our technical world of medicine is to swim against the stream” (329). Not only have the requirements for entry into the technical world of medicine increased since Conrad’s time of writing, new forms of cultural competency continue to clamor for attention within medical education.

At what point do we start to reconceptualize the limits of doctors’ capacities in the most literal sense? How much material can they be expected to master or even absorb within medical education, and how many things can we expect them to do well as doctors? These questions are relevant to more than just sexuality, but they are particularly salient to sexuality because of sex negativity which makes sexuality a difficult, uncomfortable thing to confront in just about any of its manifestations. If we want medical responses to sexuality to change, we need to think critically not only

medical sex education in isolation but also its place within the total contents of medical education –and the limits of doctors' professional capacities. In other words, discussions about how best to change medical sex education may need to take a closer look at the broad factors that constrain – or enable – medical schools' capacities to teach about sexuality in ways that students are most likely to absorb, and the factors that shape students' receptivity to sexuality-related teachings.

In his op-ed piece on physician suicide in the *New York Times* in September 2014, Dr. Pranay Sinha ruminated upon the pressure doctors feel to project the equanimity that Sir William Osler prescribed. Doctors' internalized expectation to be imperturbable and steady in the midst of tense situations may lead to dire distress on the physicians who subscribe to these ideals, Dr. Sinha argues. The statistics on physician suicide that he refers to bring the need to humanize the doctor as well as the patient into sharp relief: if we do not acknowledge the stress that doctors experience in medical encounters, pursuing curricular interventions to facilitate patients' wellbeing may narrowly focus on patient-centered goals without considering the health of the health care provider.

Suggesting that doctors' professional authority be thought about in different ways is not to suggest a separation between humanism and technical competence. It might as conceivably remove some technical, bioscientific material from medical education and doctors' repertoires as anything else – and this shift is as much about reconfiguring the public's expectations of doctors as it is about the boundaries of doctors' professional jurisdiction. In terms of sexuality more specifically, the questions have to do with the spaces and opportunities for the legitimate consideration of sexuality as an important dimension of human health and well-being. Are doctors the only professionals who can

serve as sexual health resources? If this is currently the case, how might it be otherwise? These questions might usefully be taken up in future sociological research.

Questions for future sociological research: understanding the conceptualization, delivery, reception, and consequences of medical sex education

The complexity of the teaching and learning about sexuality that took place at Buena Vista indicates that further ethnographic research is essential to advance the sociological study of medical sex education. Although past discussions of medical sex education have referred to patterns in the amount of teaching time officially devoted to sexuality-related topics within the formal curriculum, my research demonstrates how important it is to look beyond the formal curriculum in order to develop a comprehensive, nuanced understanding of the processes and substance of medical sex education.

This study shows that even the seemingly simple question of “how much” sexuality curriculum a medical school provides can be incredibly complicated. The intentional teachings about sexuality within the formal curriculum may contain latent, embedded messages. The official teachings that are presented may or may not be received by students in the manner they are delivered. What is not taught may matter just as much as what is taught. Students may learn more from their peers and from the messages that faculty present through the sexual diversity they display than they learn from their classes. Messages about sexuality may be unintentionally provided within the formal curriculum. How might we reasonably quantify the messages about sexuality that emerge from medical training? Even if we were to separate the question of what medical schools *teach* about sexuality from the question of what medical students *learn*, my findings from Buena Vista point to the need for parsing these questions into more specific sub-questions.

As I discussed in Chapter 3, informal curricular processes had the potential to nullify the sexuality-related content that presented within the formal curriculum. What are we concerned with measuring, the sexuality-related curricula that are delivered, or received? Some of the teaching time in which messages about sexuality were intentionally transmitted was not officially billed as time devoted to sexuality. Dr. Michelle Thompson, who delivered a lecture on LGBTQ youth that seamlessly integrated discussion of sexual diversity within consideration of what sexuality is or means more generally, had been tasked with lecturing on the topic of *adolescence*. Would a medical school leader, accustomed to frequent requests to complete surveys of curricular content (Curry 2011) have counted her lecture as an hour of teaching time devoted to sexuality? Or to LGBT issues? Simply studying the content of the formal curriculum turns out to be more complicated than survey research reveals. Even if we forego questions about the production of latent messages within the formal curriculum, ethnographic study of Buena Vista indicates that formal curricula devoted to sexuality may be much more diffuse in practice than has been recognized to date.

It seems reasonable to expect that the processes by which teaching and learning about sexuality are accomplished at other medical schools could be as complex as they were at Buena Vista. After all, medical educators and sociologists of education – medical or otherwise – alike recognize that curriculum is multifaceted. And it seems reasonable to imagine that the combination of sex negativity and a tendency to valorize the bioscientific, technical aspects of medicine over its social aspects could lead to avoidance of or disregard for sexuality-related curriculum in medical schools beyond Buena Vista. But it would also be inappropriate to assume that the particular ways in which sexuality education was complex at Buena Vista will be found elsewhere. A medical school that is recognized for excellence in patient care, or is known for

emphasizing humanism within the curriculum, may produce a different sort of regard for teaching and learning about the social aspects of medicine in general or sexuality in particular. Geography may affect the faculty and students that a medical school attracts – or the extent to which students and faculty feel supported in being open about their sexuality - and with that, the extent to which sexual diversity is visible or knowable within the medical school environment. Faculty understandings about the relevance of sexuality to medical practice may be informed by the patient populations they have the most exposure to. All of these factors and more are likely to vary across medical schools, and may inform the intentional and unintentional teachings about sexuality a medical school puts forth, in ways that need to be explored further.

This study also demonstrates that students' backgrounds may influence their reception of the sexuality-related messages that are available within medical school, whether these messages are the result of faculty efforts or the influences of their peers. Research on the understandings about sexuality that students bring with them to medical school would provide data that could inform the development of medical sexuality curricula, and also stands to provide sociological insights what constitutes sexual knowledge, and the processes by which it might be developed. Does personal experience with dating or romance or erotic bodily practices – all potential components of what has come to be understood as “sexuality” – comprise sexual “knowledge”? Does exposure to sexuality as an aspect of human experience that is “out there”; part of the social world and other persons' experiences of it matter? If so, how do we measure these experiences and their impact on the development of “sexual knowledge,” or, eventually, student-physicians' professional behavior and their patients' experiences of it? What about formal sex education? Sociologists argue that school-based sex education has potential consequences beyond its impact on high school students' sexual

behaviors, such as students' understandings of power and inequality in the world around them, and their capacity to recognize and respect a diverse range of human experiences (Fields 2008; Kendall 2013). Empirical research might take up the question of how school-based sex education shapes medical students' understandings about sexuality, and, subsequently the extent to which the messages within school-based sex education shape their responses to sexuality as they encounter it in their work (and, for that matter, other "downstream" effects of school-based sex education). And what about the influence of formal sexuality education that medical students might have received in other contexts, such as college courses? What counts as knowledge or knowing about sexuality, and what are the consequences of its different types? These questions have particular significance within medical education, but are broadly relevant in an era where meanings of sex and sexuality are, paradoxically, increasingly elusive even as sexuality is becomes more and more visible and integrated into mainstream culture (Attwood 2006).

As attention to sexuality education – or at least, LGBT-specific education – within medical training grows, we might expect that shared systems for measuring medical students' knowledge about sexuality (or LGBT cultural competence, perhaps) will emerge. Sociological study of the evaluation methods that may emerge also stands to tell us much about the construction of medical knowledge about sexuality. The study of student learning outcomes of medical sex education would usefully pay close attention to the dimensions or aspects of sexuality that students are aware of, and recognize as salient to medical practice. Sociologists of sexuality recognize that sexuality is inherently ambiguous and that a wide range of experiences could be considered "sexual." This study, along with previous sociological research, illustrates that sexuality may mean many different things, or be understood as salient in a variety of different

ways in medical contexts. Key questions for sociologists of sexuality concern the meanings of sexuality that are presumed or explicated within medical education, and the conditions under which particular definitions become shared or particular dimensions of sexuality come to be understood as what sexuality fundamentally means or is about. For example, although recent sociological research has recognized Viagra and other drugs designed to treat erectile dysfunction as an instance of the medicalization of sexuality (e.g., Mamo and Fishman 2001; Loe 2004; Conrad 2007), I heard very little discussion of Viagra or topics related to sexual functioning or sexual desire (e.g., Irvine 1995), at Buena Vista, and faculty and students rarely mentioned these topics during interviews. The range of ways in which sexuality is made visible or deemed salient to medical practice within medical education are worthy of study, as are the consequences of this scope.

Just as future sociological research might usefully examine the production, contents, and consequences of medical sex education within the first four years of medical training in greater depth and detail, so too would it be useful to systematically examine what doctors learn over time and through experience. Questions about what doctors learn “on the go” have practical bearing upon the development of medical sex education, particularly if they are examined in conjunction with patients’ experiences of health care. Sociological analysis of the relationship between what doctors learn about sexuality and how and when, and patients’ experiences of their care would also advance our understanding of the processes by which sexuality-related stigma may be produced within health care encounters.

Professional jurisdiction and the place of sexuality within other professionals’ education

Throughout this dissertation I have presumed that sexuality is relevant to the work that doctors do, and demonstrated that students and faculty at Buena Vista tended to believe, at least vaguely, that this is the case - without attempting to exhaustively catalog the specific range of ways in which sexuality was understood to be salient to medicine by students and faculty at Buena Vista. It might be useful for future research to look closely at the range of ways in which doctors understand sexuality to be germane to their work, and the sources of these understandings. Dr. Paul Offit's *New York Times* op-ed cited in the introduction to the dissertation implied that the relevance of sexuality to medicine may be negotiable, from doctors' perspectives. Yet we know that patients expect doctors to be able to talk about sexuality. Figuring out who has the responsibility or authority – or thinks they have it – to talk about or treat or otherwise address sexuality has practical implications for public health, and also stands to tell us much about when and where and why sexuality is deemed a legitimate public concern, worthy of professional attention in our society.

In other words, in addition to developing a better understanding of sexuality's place within the medical profession's jurisdiction, we also need to ask questions about the place of sexuality within other professionals' scopes of practice. Although sociologists have studied sex work, i.e., the provision of sexual services, extensively (e.g., Bernstein 2007), they have devoted less attention to the ways in which sexuality intersects with the work of professionals whose duties are not primarily understood in sexual terms. Psychologists consider sexuality to be very relevant to their professional duties (Wiederman and Sansone 1999), and social workers understand sexuality's intersections with their work in a range of ways (McPhail 2004). But these professions' (or professionals') understandings about sexuality have not been subject to sociological inquiry, which would enable analysis of both what sexuality means in the estimation of

different professions, as well as the range of ways professions conceive of sexuality as relevant to human health and wellbeing; to private experience and public life. (And, for that matter, how the line between “public” and “private” experiences is socially constructed by these professionals.) And of course, a better understanding of the range of professions that encounter sexuality within their professional duties would point to a range of other contexts in which the production and transmission of formal knowledge about sexuality may be constructed. Examination of sexuality-related education within other professional training programs beyond medicine would advance the study of sex education – so often presumed to that which occurs in junior high and high schools - considerably.

Sex negativity, dirty work, emotional work, and professionalism

This research has shown that sex negativity may pose a unique obstacle to the achievement of professionalism – and that sex negativity may not be explicitly recognized as an achievement to appropriately professional behavior. I argued that sexual stigma may be reproduced by a null curriculum of sex negativity. If student-physicians do not become aware of their capacity to enact sex negativity, they may unwittingly behave towards patients in ways that the patient experiences adversely. Sexual stigma is usually associated with non-normative sexuality and particularly non-heterosexual sexuality (Herek 2004) but anything related to sexuality is vulnerable to suspicion (Rubin [1984] 1993) or, in the language of the dirty work literature, “taint.”

Can dirty work be reconfigured into something else? Some of the dirty work literature implies that “dirtiness” is if not inherent then immutable – even while simultaneously acknowledging that taint is a social construction (Ashforth and Kreiner 1999; Tracy and Scott 2006). Many studies of dirty work have employed microanalyses

of the taint management strategies of individual dirty workers (or small groups of dirty workers). These studies consider the reframing that dirty workers engage in to transform the meanings of the stigmatized aspects of their work, so that the workers themselves refashion their contact with taint into a badge of honor (even if only they and their coworkers recognize this transformation as such), or workers' efforts to establish distance from the tainted aspects of their work and proximity to the socially valued aspects of their work (for discussion see Tracy and Scott 2006: 9-10). But the fundamental dirtiness of the work, whether it is associated with bodily fluids, marginalized individuals, dangerous conditions, etc., remains unchallenged.

Studies of dirty work might consider the circumstances in which dirty workers transform or seek to transform the understanding that the work they do is dirty. That is, instead of claiming their dirty work as a badge of honor or attempting to distance themselves from the dirty aspects of their work, do dirty workers ever seek to challenge the dirtiness itself? Perhaps this question has unique relevance to sexuality-related work. Because of the entrenched nature of sex negativity (Rubin [1984] 1994), we might imagine that work that is unambiguously about sexuality is the dirtiest work of all.

Until recently, the dirty work literature has not specifically considered questions of sexuality-related dirty work, and has not yet entertained the question of whether or not it is particularly tainted. This may be in part because we know little about the ways in which sexuality intersects with the duties of various professionals – and this may be in part due to the taint accorded to sexuality and the study thereof. Although Janice Irvine (2014) has recently examined sex research as a type of dirty work, she does not consider why sexuality might make dirty work especially dirty – but her work indicates that posing that question is a form of dirty work in and of itself. When is sexuality-related work considered necessary or essential to society, and how do these workers negotiate

the tension between the necessity of their work and the taint associated with it? This question indicates the utility of exploring emotion work in conjunction with dirty work.

Smith and Kleinman (1989) argue that medical students experience stress when they come into contact with the sexual body in their medical training, and that the coping methods they employ for dealing with this stress ultimately impact their emotional experiences of their personal lives. The depersonalization strategies they use for approaching patients' "sexual" body parts as unsexual objects threaten their ability to engage in physical intimacy with their partners, outside of the medical setting, Smith and Kleinman (1989) argue. Smith and Kleinman do not go so far as to argue that there is something special about the emotional management related to sexuality that students undertake, but their analysis suggests that learning to engage in intimate physical contact with patients' sexual bodies is inimical to interactions that are intentionally sexual in nature within the student-physician's personal life. They speculate that "the professionalization of private emotions may help to explain some of the health problems associated with medical practice" (Smith and Kleinman 1989: 67).

This perspective evokes a well-rehearsed argument about another form of work that involves sexuality: prostitution.³² Because sex as a relational practice is understood to be the most intimate expression of connection, most reflective of individuals' authentic emotions and most essential to personal truth, the selling of sexual services is often understood to be a corruption of a person's most fundamental self (e.g., O'Connell Davidson 1996; for discussion and critique of these notions see Chapkis 1997). Although prostitution and other forms of sex work might not seem to bear any similarities to doctoring, there are some important parallels to consider. Both may involve contact

³² Within this discussion I am referring strictly to *voluntary* engagement in prostitution or other forms of sex work.

with the naked human body and its sexual parts, and physical contact with strangers in ways that are considered to be private and personal, and usually reserved for intimate encounters between persons who are engaged in a certain sort of relationship – that is, one that is defined at the minimum by its freedom from commercial exchange. Although we typically think of selling the service of sexual gratification as the primary form of sexual commercial exchange, the payment that doctors receive for treating a sexually transmissible infection or talking about sexual functioning or prescribing Viagra represents a commercial exchange of which sexuality is a part. Some argue that because we live in a society that shares the ideas that love cannot be bought and sex(uality) is a part of love, the selling of sexual services transforms the seller into a person who is not a person, fundamentally alienated from their self (O’Connell Davidson 1996).³³ While the objectification or use of the seller’s body is part of what anti-sex work advocates decry, part of the problem is the separation of sexuality from the context of love, mutual pleasure, and a certain type of relationship (Chapkis 1997). From this perspective, medical professionals’ contact with sexuality is also dubious, as Smith and Kleinman’s (1989) argument about the relationship between professional work and private life suggests.

Like anti-prostitution activists who argue that engagement in commercial sexual activity “destroys the ability to experience *real* sexual intimacy even outside of the

³³ It is worth pointing out that O’Connell Davidson argues that “sexual services are not generally exchanged across a market...sexual acts are not typically viewed as commodities, and sexuality is not regulated by the ideology of the market” (1996: 193). This line of thinking may be more reflective of normative understandings about sexuality and its relationship to a pre-social self (or soul – see Chapkis 1997 for discussion) than empirical reality. Sexual services are indeed exchanged as market commodities, and by most estimates, the sex industry is a multi-million if not multi-billion dollar industry (e.g., Coopersmith 2000; Bernstein 2007; Jeffreys 2008). Might sex be as regularly a part of work that is not usually considered “sex work”? It seems possible that assumptions similar to O’Connell Davidson’s about the nature and place of sex(uality) may have constrained the sociological study of where and when and how sexuality appears in other occupations.

marketplace” (Chapkis 1997: 77; emphasis mine), Smith and Kleinman (1989) argue that the achievement of affective neutrality in the professional realm may interfere with the achievement of intimacy in the personal realm. Although Smith and Kleinman acknowledge that dealing with patients as sexual beings – or at least, as sexual bodies – is in some respects similar to other emotionally challenging aspects of medical work, they do not explicitly refute the notion that sexuality is special in some regards, or particularly subject to the perils of emotion management. “Particularly in the sexual domain,” Smith and Kleinman write, “the progressive neutralization of the body threatens personal meanings that the students have long attached to physical intimacy...some students fear that the special power of intimacy may be lost as they neutralize the body for medicine” (1989: 66). In this sense, their argument is not that far afield from that of anti-sex work advocates: there is something essentially special about sexuality that make it difficult (at best) to deal with outside of the context of the particular sorts of relationships in which it belongs.

What Smith and Kleinman do not consider is the potential stress associated with negotiating a subject that is not only off the table from consideration within and outside of medical training, but associated with a formidable amount of heavy baggage – taboo, taint, sin, and discomfort. As I argued earlier in the conclusion, asking doctors to address sexuality may be stressful not only because it is another complex, ambiguous matter to heap upon their already-full plates, but because society in general and medical training in particular offer few resources for renegotiating the stigma associated with sexuality, or for shedding the shroud of privacy that so often cloaks talk about sex. The tension between encountering sexuality as a professional – whether as doctor or prostitute – and engaging in sexuality in one’s personal life may have more to do with the stress associated with the social norms that deem sexuality private, intimate, and

appropriate within the context of particular sorts of interpersonal relationships, rather than anything inherent to sex per se that makes it difficult to negotiate across contexts.

Smith and Kleinman (1989) argue that engaging in emotion management, whether in relation to sexuality or other aspects of medical work that have affective weight, may be detrimental to student-physicians' own lives – although they acknowledge that it may be the *specific character* of the emotion management *strategies* that are the problem. Indeed, Arlie Russell Hochschild's conceptualization of emotional management does not pose a rigid distinction between emotional labor and “natural” emotion, nor does she see emotional labor as an inevitably destructive practice (Hochschild [1983] 2012; Chapkis 1997). Hochschild argues that emotion work may help the worker develop perspective upon the relationship between their sense of self and their role, allowing for the development of a healthy separation between worker and work. Wendy Chapkis finds that prostitutes find the emotion work their jobs require to be an important part of setting professional boundaries. The emotion work that prostitutes do is integral to both attending to their clients' needs and their own.³⁴

Future research might explore the ways in which professions understand emotion work to be a part of professionalism, and the training for *engaging* in emotion work that accompanies (or does not accompany) training for professionalism. The emotion work associated with sexuality requires the recognition and negotiation of sex negativity, which may require considerable resources – theoretical, conceptual, and material – to address. But while sexuality may be a particularly stigmatized aspect of human experience and while the societal resources for understanding it outside of the context of

³⁴ In the *Lancet*, Dr. Michael L. Rekart asserts that “sex work is an extremely dangerous profession,” but notes that much of this danger is due to the stigma associated with sex work and its associated effects (2005: 2123). Perhaps ironically, Dr. Rekart recommends that sex workers develop a healthy separation between their professional work and their private lives, build their self-esteem, and seek social support. He also notes that social understandings about sex work need to change for sex workers' safety and well-being to change.

taint may remain very limited, sexuality is not the only aspect of medical work that is associated with taboo or discomfort or taint. Understanding how doctors incorporate the dirty aspects of their work into their understandings of professionalism has the potential to tell us much not only about sexuality and medicine, but also to shed light on the relationship between stigma, the provision of equitable, compassionate professional services, and the (re)production of social inequalities more generally.

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