A PIECE OF MY MIND

The Labor of Representation

Aliya G. Feroe, BA
Harvard Medical School, Boston, Massachusetts.

In college, a professor cautioned me that future patients would feel "much more comfortable" if I dressed and acted more "femininely." One medical school interviewer found 4 different ways to ask if I thought it would be awkward to interact with female patients as a queer woman in obstetrics. A friend warned me not to be "out" in medical school after he spent his first year tokenized as one of the few openly gay students who was consistently asked to help fill in the many curricular gaps regarding health issues affecting the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community.

None of these encounters were vicious, bigoted attacks, but together, these experiences did suggest that being visibly "out" in medicine might come at a cost. Despite spending four years in college slowly emerging from the confines of the proverbial closet, I found myself facing what I saw as a clear choice upon matriculation into medical school: I could stand up and assert my queer identity, potentially compromising my medical education and career prospects, or hide my identity to ensure approval of professors, peers, and patients, but pay for it with the loss of self.

I agonized over this choice in the months before medical school, with each day bringing increasing anxiety. I thought that if I could pass as straight, I could protect myself and my burgeoning career. So that's what I decided to do. The calculations ran unrelentingly through my head, and I convinced myself that while imperfect, this plan was doable: it would be 4 years of medical school, 4 years of residency, and another few years of fellowship. I envisioned remaining distant from my colleagues, dressing and acting "straight," and biting my tongue at any talk of my partner—diving into medicine feeling alone. Maybe later, a decade into my medical career, I would feel the consolation of acceptance. But how could I estimate the magnitude of damage to my self-esteem and to the LGBTQ patients that sought care from me, and who might be denied comprehensive care by physicians who were inadequately prepared?

> Medical school faculty—not just a handful of students—should be adequately prepared to teach and model LGBTQ-informed care....

Unexpectedly, within the first few weeks of medical school, I found myself immersed in a community that welcomed and celebrated diversity. This appreciation for diversity manifested in several ways: faculty members asked for our pronouns, such as "she/her/hers," trainings during orientation helped us to identify and curb implicit biases as we approach colleagues and patients, and an LGBTQ student organization announced its presence, making clear that visibility and fostering a supportive community were priorities not only for the group but for the entire school. This foundation of acceptance convinced me to gauge the reaction of new colleagues to my queer identity. With positive initial results, I nervously dropped subtle indicators into conversations: sharing my prior LGBTQ-related work and referring to my partner as "she" rather than an ambiguous "they." With great relief, I did not experience any negative backlash; instead, my peers either engaged me with warm, curious questions about my life, or nonchalantly carried on the conversation as if these disclosures were routine.

Those hesitant trials morphed into confident conversations, and I quickly joined the LGBTQ medical group that welcomed me. The comfort with being openly queer grew with the strength of relationships I began forming with classmates and faculty; when I could share my truth, I could more fully connect and grow amidst the multitude of thought, experience, and beliefs around me. In part because the first-year clinical encounters carried few evaluative consequences, I felt safe to publicly advocate for greater LGBTQ content in the curriculum, improve recruitment efforts, and advocate for a nongendered hospital dress code.

However, this increasing visibility and empowerment brought its own challenges and exhaustion in the form of tokenization. As one of the few publicly queer women in my class, I am frequently called upon to facilitate conversations about LGBTQ populations and looked to as a guide for respectful exploration of LGBTQ culture. Attending a 1-hour presentation by transgender patients included in our preclinical curriculum—an academic experience itself unthinkable just a decade before, but still insufficient—ballooned into countless hours of me fielding questions from peers. While these conversations felt important and interesting, they could also be draining. I worry my peers look to me with an expectation that any LGBTQ person is automatically equipped with complete knowledge to teach the history, experience, and culture of our varied communities. As a result, I felt as though I was constantly shortchanging my peers, since I am just a medical student who happens to identify as queer, able to speak only from personal or relayed experiences—far from an expert that this important topic certainly deserves.

One year later, I am now preparing for my clinical rotations and considering, yet again, how I will continue to navigate the role of my LGBTQ identity in medicine. I still worry how colleagues and patients will treat me and how this might affect the care of my patients. Will a patient seeing the rainbow pin on my white coat donned over less traditionally feminine attire refuse

Corresponding Author: Aliya G. Feroe, BA, 107 Ave Louis Pasteur, Vanderbilt Box 274, Boston, MA 02115 (Aliya_Feroe@hms.harvard.edu).

Section Editor: Preeti Malani, MD, MSJ, Associate Editor.

my care? To whom can I turn if this does happen? Will my attending feel uncomfortable letting me see certain patients? Or will this small symbol of my identity encourage supportive relationships with colleagues and expand comfortable spaces for LGBTQ patients, students, and physicians, alike, to feel understood? Will visible activism empower others to advocate for themselves and the increasingly visible LGBTQ community?

Evidence suggests that similar thoughts are on the minds of other LGBTQ medical students. A survey of US and Canadian medical students found that 30% of students who identified as a sexual minority concealed their identity, predominantly due to fears of discrimination and existing social and cultural norms.[1] Another survey of LGBTQ students at one medical school found that 42% of the responding students experienced anti-LGBTQ jokes, bullying, or discrimination by fellow medical students and other members of the health care team.[2]

This culture does not vanish after medical school. In a 2009 analysis of 427 LGBTQ physicians, 15% reported they were harassed by a colleague, 22% had been socially ostracized, 27% witnessed discriminatory treatment of an LGBTQ coworker, and 65% heard derogatory comments about LGBTQ individuals.[3] A follow-up study from the 2015-2016 academic year demonstrates that these behaviors continue.[4] While progress has been made to advance the basic rights of LGBTQ people, including marriage equity, employment, and housing protections, more research is needed to understand how these cultural shifts are mirrored in medicine. Being a visible queer woman is more than self-revelation and sharing the gender of my partner. Increased acceptance carries the message that LGBTQ physicians deserve an equal standing in the medical community and that LGBTQ patients deserve the same quality of care awarded to anyone else.

Actualizing this goal requires that LGBTQ issues are included in the broader efforts to advance, support, and celebrate diversity in medicine. From a structural standpoint, medical school faculty—not just a handful of students—should be adequately prepared to teach and model LGBTQ-informed care within a curriculum that dedicates sufficient space for these lessons. Culturally, definitions of professionalism need to be updated to reflect nonbinary and gender diversity. For instance, guidelines around business casual attire for patient care in training hospitals should be inclusive of all gender expressions; hospitals ought to dismantle the expectation of pants, button-up shirts, and ties for "males" and dresses or blouses for "females." These structural and cultural shifts fuel recruitment efforts that help remedy the many LGBTQ and other underrepresented students lost along the pipeline to medical school with the reassurance that diverse identities have a real place in medicine[5]—students who are crucial to the development of a workforce that reflects the diversity of our patients.

The culture within a medical school has the potential to evolve rapidly. Every 4 years, there is an entirely fresh set of students to mold norms of acceptance and compassion. Each year can further open space for subsequent waves of students to feel comfortable within their own skins and accepted by colleagues—their community and lifelines along a rigorous journey. Such cultural transformation should not be constrained to medical school but ought to continue through residency and fellowship.

A transformed medical school culture can be achieved by ensuring that there are appropriately trained faculty to teach medical students about the unique health care needs of a large and growing population in the United States. This development would relieve the pressure and fatigue that students, like myself, often face when trying to address the concerns affecting LGBTQ populations that all physicians must understand. As a more inclusive culture can grow, more stories of acceptance and respect will enable the recruitment of additional LGBTQ students—whether they are already "out" or they are still exploring this aspect of their identities. I ask that the medical community help us advance and strengthen this cultural transformation so that we slowly disassemble the medical school closet and let the rainbow of diversity shine onto the care we provide to all patients.

Conflict of Interest Disclosures: No disclosures were reported.

Additional Contributions: I thank Chana Sacks, MD, MPH, Carl Streed Jr, MD, MPH, Jessica Halem, MBA, and Dana Vigue, BA, for editorial guidance and feedback, for which they did not receive compensation.

1. Mansh M, White W, Gee-Tong L, et al. Sexual and gender minority identity disclosure during undergraduate medical education: "in the closet" in medical school. *Acad Med*. 2015;90(5):634-644. doi:10.1097/ACM.0000000000000657

2. Nama N, MacPherson P, Sampson M, McMillan HJ. Medical students' perception of lesbian, gay, bisexual, and transgender (LGBT) discrimination in their learning environment and their self-reported comfort level for caring for LGBT patients: a survey study. *Med Educ Online*. 2017;22(1):1368850. doi:10.1080/10872981.2017.1368850

3. Eliason MJ, Dibble SL, Robertson PA. Lesbian, gay, bisexual, and transgender (LGBT) physicians' experiences in the workplace. *J Homosex*. 2011;58(10):1355-1371. doi:10.1080/00918369.2011.614902

4. Eliason MJ, Streed C Jr, Henne M. Coping with stress as an LGBTQ+ health care professional. *J Homosex*. 2018;65(5):561-578. doi:10.1080/00918369.2017.1328224

5. Hughes BE. Coming out in STEM: factors affecting retention of sexual minority STEM students. *Sci Adv*. 2018;4(3):eaao6373. doi:10.1126/scinadv.aao6373