Hiding in Plain Sight: The Production of Heteronormativity in Medical Education

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Abstract
Mounting evidence that sexual minority status is linked to stigma, stress, and health disparities necessitates critical analysis of medical sex education. In this article, I use ethnographic data to show how normative understandings of sexuality were produced at a top twenty medical school in the United States. Although non-normative sexualities were never overtly denigrated within the curriculum at Buena Vista Medical School, a hidden curriculum of heteronormativity repeatedly positioned some sexualities as normal, natural, and obvious, while others were quietly excluded. 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 of egalitarianism that discourage overt homophobia and sexuality-related discrimination. This research also demonstrates possibilities for closer communication between the sociological subfields of medicine and sexuality.

Keywords
sexuality, medical education, heteronormativity, inequalities, hidden curriculum

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Introduction

What do medical students learn about human sexuality within their professional training, and how do they learn it? We know that North American medical schools have provided some human sexuality education for decades, although its prevalence and scope are not well understood (e.g., Coombs 1968; Marcotte et al. 1976; Dunn and Alarie 1997; Solursh et al. 2003). But there has been very little sociological analysis of the content, delivery, and reception of medical sex education—whether by such education we mean a concerted, self-conscious set of efforts intentionally geared toward educating doctors-in-training about human sexuality or the largely unintentional processes through which messages about and understandings of sexuality may be constructed and transmitted within medical schools. The lack of sociological analysis of medical sex education is doubly surprising. First, there is a long tradition of ethnographic inquiry into many other aspects of medical education and the professional socialization of doctors-in-training (e.g., Merton, Reader, and Kendall 1957; Becker et al. 1961; Good 1995). Second, 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). We might therefore have predicted that social scientists would have paid much closer attention to medical sex education than in fact they have done.

Medical sex education is a complicated subject to approach because there is little indication that medical educators themselves have a collective sense of what medical education “is,” that is, what it looks like or should look like in practice, what it should be or include, or what “sex” and “sexuality” mean within the medical context (e.g., Coombs 1968; Coleman 2012). Although empirical research demonstrates that patients consider sexuality to be important to their health and experiences of health care encounters in a broad range of ways, we know little of how medical professionals collectively construct their understandings about sexuality and its relevance to their work. Sexuality is not an arcane subject and medical students and doctors alike may develop understandings about sexuality from messages within our ever-more-sexualized culture (Attwood 2006), but it makes sense to study the collective production of medical understandings about sexuality within medical education because medical school has been recognized as a particularly potent, transformative site of professional socialization (Freidson 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 will reshape or even supplant whatever preexisting knowledge or beliefs they may possess.
An exhaustive list of ways in which sexuality might be relevant to doctors’ work and thus to medical education is difficult to establish, in no small part because “sex” and “sexuality” are notoriously difficult to define. Sociologists agree that what sexuality means or includes is always a historical construction, involving a host of mental and physical capacities, desires, and experiences that gain their meaning within social relations (Weeks 1986, 15). Even if we acknowledge that what counts as sexuality varies, it remains difficult to draw distinctions between what is sexual and what is not. “Sex” might denote “erotic body work” (Plummer 2003, 527) or “carnal acts” (Jackson 2006, 106), and “sexuality” may be usefully understood as 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). But both “erotic” and “carnal” are synonyms for “sexual,” indicating, as Jackson acknowledges, that sexuality has no fixed boundaries.

This definitional ambiguity makes it particularly important to examine medical understandings of sexuality, which have the potential to impact patients’ experiences of health care, and with them, patterned health outcomes including health disparities (Matthews et al. 1986). Although sexuality intersects with medical practice in some ways that seem obvious—for instance, the diagnosis and treatment of sexually transmissible infections—patients experience sex(uality) to be relevant to their health and well-being and to their experiences of health care encounters in a broad range of ways. Some patients come to their doctors seeking general information or counsel about sexuality (Berman et al. 2003). Others have questions about how a medical procedure will affect their sexual functioning (Manderson 2005; Hordern and Street 2007). Other patients experience sexuality’s relevance to health care upon encountering sexuality-related stigmatization in the doctor’s office. Persons with HIV/AIDS have negotiated discrimination from doctors and other health care providers (Weitz 1990; Emlet 2006), 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 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, German, and Kerrigan 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).

Here I attempt to address only a small portion of the questions that could usefully be asked about the collective construction of medical knowledge about
sexuality, namely, questions about what might happen within medical education to contribute to the production, reproduction, or contestation of sexual stigma. These sorts of questions are particularly timely within 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) titled “The Health of Lesbian, Gay, Bisexual and Transgender People: Building a Foundation for Better Understanding” that 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 and medical educators ponder curricular interventions to prepare doctors to work with sexually diverse populations, questions about the production of normative understandings about sexuality within medical education are particularly salient.

In this article, I discuss the processes by which a hidden curriculum of heteronormativity was produced at Buena Vista Medical School at the level of the formal curriculum, or the officially offered, required classes and related activities (Hafferty 1998). In doing so, I contribute to the extant literature on medical sex education in three key ways. First, I provide thick description (Geertz 1973) of formal, sexuality-related medical curricula-in-action, something that previous research has not done. Second, 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 ([1990] 1999) argued that the cultural intelligibility of persons, or the extent to which a person 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.

Third, I 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. Unlike previous research that 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, Dibble, and Robertson 2011; Obedin-Malevir et al. 2011), this analysis shows how the reproduction of heteronormativity was accomplished unintentionally through practices that seemed unremarkable. 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, Lambert, and Baker 2009), or a lack of curricula devoted specifically to sexual minorities, which can be measured objectively.

This research demonstrates the particular utility of ethnographic methods for revealing how sexuality-related stigma can be produced and reproduced through subtle mechanisms. 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.

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 nonnormative sexualities in particular to the medical establishment (Foucault 1978; Weeks 1986; Epstein 1996; Irvine 2003). Drawing upon the work of scholars such as Michel Foucault, Gayle Rubin ([1984] 1993) argued that the medical profession had much to do with the development and maintenance of “sex negativity,” or the idea that sex in general is guilty until proven innocent, and nonnormative sexuality is by definition especially harmful to participants and threatens the stability of society. 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 toward 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. 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 (Klamen, Grossman, and Kopacz 1999).

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 may bear little resemblance to the overtly hostile processes that Rubin described, since 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 toward sexual minorities are less acceptable (Seidman 2009; Jenkins, Lambert, and Baker 2009). Many medical schools are among the institutions that include sexual orientation clauses in their antidiscrimination and antiharassment 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 toward 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). What might be happening within medical schools today to produce medical understandings about sexuality that ultimately contribute to some patients feeling stigmatized within health care encounters?

Medical Sex Education and Training for LGBT Cultural Competence

Questions of this nature have generated a heightened degree of interest within medical institutions in the last few years, along with discussion of curricular interventions to better prepare doctors to work with sexually diverse populations. More specifically, LGBT-specific medical education or training for “LGBT cultural competence” has been conceptualized as the solution to the
problem of sexuality-related stigma and health disparities (Curry 2011). Following the publication of the IOM report on LGBT health in 2011, the Journal of the American Medical Association (JAMA) published an article detailing the results of a survey of the LGBT-specific curricula provided in North American medical schools. The median number of hours devoted to LGBT topics by the medical schools who responded to the survey was 5. Some schools reported that they devoted more than 5 hours to LGBT-specific training, but 9 reported that they did not devote any time to LGBT content (Obedin-Malevir et al. 2011). Obedin-Malevir et al. framed their article by citing the 2011 IOM report’s call for doctors to better understand the social stigma and unique health risks that LGBT persons experience and a 2007 survey of California physicians which revealed that 18.3% of responding doctors were “sometimes” or “often” uncomfortable providing care to gay patients (Smith and Matthews 2007). Their discussion implied what others have argued more explicitly: that “many physicians feel uncomfortable working with LGBT patients because their formal education has not challenged the negative attitudes in society about LGBT people” (Eliason, Dibble, and Robertson 2011, 1358).

At the Annual Conference of the Gay and Lesbian Medical Association (GLMA) in 2011 in Atlanta, Georgia, numerous presenters referred to the IOM report’s recognition of sexuality-related health disparities and Obedin-Malevir et al.’s findings about LGBT-specific curricula (i.e., the lack thereof) as evidence of the need for training for LGBT cultural competence, or more of it, within medical education (author’s field notes). Training for “cultural competence” emerged as a strategy for preparing practitioners to work with ethnically and racially diverse populations in the interest of eliminating racial and ethnic health disparities (Betancourt et al. 2003; Tervalon 2003), and its use has been extended to sensitizing professionals to work with sexually diverse populations to some extent (Van Den Bergh and Crisp 2004).

This attention to sexuality-related health disparities and medical education geared toward sensitizing doctors to provide “culturally competent” care to sexually diverse patient populations is historically significant within medical education. Although at least a limited group of medical educators recognized the “commonplace occurrence of sexual problems in medical practice and the poor preparation of physicians to deal with them” (Golden and Liston 1972, 761), and advocated for the provision and expansion of medical sexuality education as early as the 1960s (e.g., Woods and Natterson 1967; Lief 1970), both past and current observers of medical sex education have described its presence as limited or neglected, relative to its importance to patient care (e.g., Coombs 1968; Parish and Clayton 2007; Coleman 2012). The limited picture of the recent state of medical sex education (as opposed
to LGBT-specific education) in the United States is based primarily from a
survey conducted in 1999 by Solursh et al. Approximately 94% of the North
American medical schools that responded to their survey provided at least
one or two hours of sexuality-specific training, and approximately 30% of
their respondents provided more than ten hours. However, not all of these
course offerings were required, and approximately 6% of these schools did
not provide any sexuality-specific training. Some of the topics covered most
frequently included: causes of sexual dysfunction and the treatment thereof,
“altered sexual identification,” issues of sexual functioning in conjunction
with illness or disability, sexually transmitted diseases, infertility, and sexual
abuse (Solursh et al. 2003, S43). Although the content of these courses as
they were transmitted in practice is largely unknown, there is little evidence
that medical sex education programs have historically made concerted
attempts to be inclusive of sexual minorities.

Particularly if it has been absent from medical education in the past, it
seems reasonable to expect that the addition of LGBT-specific content would
have distinct benefits. There are some important medical reasons to talk
about the particular health needs of sexual minority patients (Mayer et al.
2008), and medical efforts to highlight the specific needs of LGBT patients
seem like a significant step toward making sexual minorities more visible
within sex education. Sex education programs in junior high and high schools
(Fields 2008; Elia and Eliason 2010; Kendall 2013) have also been criticized
for their lack of representations (or positive representations) of nonhetero-
sexual persons and sexuality, so the prioritization of coverage of LGBT issues
within medical education may represent an important development within
sex education across contexts.

However there are also critical questions about the provision of LGBT cul-
tural competence that are worthy of consideration as we seek to understand the
meanings of sexuality that are transmitted within medical education and how
they may eventually shape the production of sexuality-related inequalities
within medical care. Critics of cultural competence argue that this approach to
teaching about diversity often presents a reductionist, categorical view of
human differences (whether “racial,” ethnic, or otherwise) and fails to
acknowledge the power differentials that undergird health disparities (e.g.,
Wear 2006). Suggesting that the provision of LGBT cultural competence is the
recipe for preparing doctors to provide equitable care to sexually diverse pop-
ulations implies that “LGBT” is a category that encompasses all forms of
sexual diversity and represents a clearly defined set of persons whose experi-
ences are relatively static and can be easily taught about, which may serve to
ghettoize sexual minorities or reinforce stereotypes of particular populations.
The exclusive emphasis on LGBT-specific curricula, isolated from education
about “sexuality,” more broadly conceived also implies an unproblematic separation between “sexual minorities” and “everyone else” that may contribute to an understanding that it is only necessary to teach or learn or know about sexuality when it is the province of the minority. Furthermore, it may lead to the impression that only LGBT persons experience sexual stigma. Although heterosexuality is usually understood to be the status of the majority and a category that requires little explanation, experiences of heterosexuality are neither homogeneous nor equally privileged (Seidman 2009). For example, persons who identify as heterosexual but practice BDSM (an umbrella term for persons who engage in bondage, domination and submission, or sadism and masochism) are often stigmatized—both within biomedicine and society (Bezreh, Weinberg, and Edgar 2012).

Finally, it is important to think beyond the presence or absence of LGBT-specific curricula because messages about LGBT sexuality (or any other aspect of sexuality) may be transmitted during curricular moments that are not officially designated as “LGBT” or “sexuality”-specific. In one of the few mentions of sexuality within ethnographic studies of medical education, Smith and Kleinman (1989) found that sexuality can become salient within medical education when students learn to examine the naked human body—living or dead—and negotiate their emotional responses, particularly those that accompany the examination of body parts that are commonly understood to be “sexual.” Smith and Kleinman (1989) found that medical students and faculty alike experienced discomfort when examining the sexual body, and rather than providing curricular interventions to address or mitigate this discomfort, faculty members’ actions combined with the unwritten rules of the medical school allowed this discomfort to persist. Smith and Kleinman’s research demonstrates that sexuality may indeed become germane within medical education even when it is not the designated teaching topic per se—and that the spontaneous relevance of sexuality may not generate equally spontaneous discussion of sexuality or recognition of the messages that are being transmitted about it.

**Heteronormativity**

A nuanced understanding of the construction of messages about sexuality within medical education that may contribute to the production of sexual inequalities requires attention to the subtle processes by which “a heteronormative social fabric is unobtrusively rewoven, thread by thread, persistently, without fuss or fanfare, without oppressive intent or conscious design” (Kitzinger 2005, 478). 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) and the myriad ways in which heterosexual privilege is insidiously and pervasively woven into the fabric of everyday life (Jackson 2006, 108). Complicity with heteronormativity need not be predicated upon prejudice or antipathy toward sexual minorities, nor a conscious desire to marginalize anyone (Kitzinger 2005). It may exist in the absence of overt homophobia or entrenched heterosexism, and may coexist easily with a few hours of training for LGBT cultural competence.

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 remain 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 (e.g., Fields 2001; Jackson 2006).

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 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, Beagan, and Goldberg 2012). Nonheterosexual 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, German, and Kerrigan 2013).

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, Eagan, and Parker 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, that is, 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 training than is commonly recognized, and how a hidden curriculum may be produced solely within the formal curriculum, not only between the formal curriculum and other levels of curricular processes.

Field Site and Methods

This analysis is drawn from a larger research project concerning medical education and sexuality, for which data were obtained through participant observation and in-depth qualitative interviewing at Buena Vista Medical School. I also collected ethnographic data from GLMA’s Annual Conference in 2011,
which I referenced earlier. Buena Vista is a top twenty medical school in the United States. It has a history of excellence in research and the basic sciences and does not have a history of defining itself as placing a strong emphasis on humanistic medicine, but did, at the time of my research, require its students to complete of 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 multipart 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 that 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, that is, even when it was not the officially designated 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 any of the “hard science” classes as it would within a discussion of 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.

I participated in the SAM course sequence for the 2009–2010 academic year, and served as a “faculty facilitator” for the Physician-Patient Dynamic and Stages of the Life Course. Normally, the role of faculty facilitator was fulfilled by medical school faculty members, 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 classes, and the Institutional Review Board at my home institution also approved my participation in this
Taking on this role enabled me to attend lectures and seminars, and also to participate in faculty facilitators’ meetings and of course, cofacilitate students’ small group discussions—components of the medical school environment that were normally off-limits to anyone other than their designated participants, that is, Buena Vista students and faculty. Students and faculty alike were aware that I was not a medical doctor, as faculty facilitators usually are, and that I was conducting research on medical sex education and using my observations from classes as data.³ My participant observation in this fashion totaled approximately one hundred 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.

I interviewed a total of seventeen Buena Vista faculty members, nineteen students, one staff member (the director of medical student affairs), and two psychologists who lectured within the SAM course sequence. Twelve of the faculty interviewees were male and nine were female. Ten of the students were male, and nine were female. 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, German, and Kerrigan 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. Medical students too have many demands on their time. I recruited most of my student interviewees 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 could not spare the time.

My in-depth, semistructured 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. Previous literature has discussed homophobia within medical education, the subtle production of “everyday inequalities” in medical education (Beagan 2001), heteronormativity within curricula (Sumara and Davis 1999), and the importance of examining multiple levels of curricular processes within medical education (Hafferty and Castellani 2009), but the particular salience of heteronormativity within the formal curriculum at Buena Vista presented itself inductively.

The broader research project addresses questions about the content and production of the total sex(uality) “curricular universe” (Flinders, Noddings, and Thornton 1986) at Buena Vista, student and faculty understandings of what “sexuality” fundamentally is and their beliefs about its relationship to medical professionalism, and the role of informal relationships between medical students and among students and faculty in shaping what students learned about sexuality and its place within medical practice. In keeping with this article’s emphasis on the processes by which heteronormativity was produced through collective, public processes, most of the data I reference here comes from the lecture portion of SAM classes, which I supplement with data from interviews, seminars, and small-group discussions.

**Background: Sexuality Education at Buena Vista**

A comprehensive discussion of the Buena Vista’s approach to medical sex education and the context in which it was developed (including the extent to which they conceived of “medical sex education” as a distinct endeavor at all) and received is beyond the scope of this article. However, three points are important for providing context for my analysis and suggesting the implications of the curricula I describe. First, Buena Vista did not have a coherent, collectively planned sexuality curriculum. Most Buena Vista faculty members whom I spoke with described their sexuality-related curricula as “limited,” and one described it as “haphazard.” Faculty were free to include sexuality in the curricular segments that they were responsible for if they chose, and they were also free to not address sexuality. There were several
curricular moments officially devoted to sexuality at Buena Vista, but sexuality also became salient at times when it was not the officially designated topic of discussion, meaning that sometimes messages about sexuality were transmitted even when faculty did not intentionally set out to teach about sexuality.

Second, like medical educators decades earlier, Buena Vista faculty referred to their own lack of expertise and the general dearth of experts on sexuality as reasons why it was difficult to provide sexuality-specific instruction. In the 1960s and 1970s, medical school faculty cited their own lack of formal sexuality education as the explanation for their ignorance of sexuality, which in turn served as justification for avoiding teaching about sexuality themselves (Coombs 1968; Marcotte et al. 1976). The result was “a circular system” in which sexuality remained “devalued” within medical curricula (Marcotte et al. 1976, 117). There were indications at Buena Vista that such a circular system might still be occurring. Most of the Buena Vista faculty who I interviewed told me that they had received little formal sexuality education themselves, within or outside of their own medical training, and had a hard time defining “sexuality” when I asked them to do so during interviews. Given sexuality’s inherent ambiguity, this is not surprising, but even if sexuality is difficult to define, the absence of collective, institutional attempts to define it is significant. When sexuality is collectively unknown, as it so often is within organizations (Hearn and Parkin 1995), it is nearly impossible for an institution to become aware of the messages it may be transmitting about it.

Third, Buena Vista students came into medical school with varying amounts of formal knowledge about sexuality, varying degrees of personal exposure to sexuality as a dimension of human life, and varying amounts personal experience with sexuality. Previous research has pointed out that medical students are likely to come to medical school having devoted much of their prior time and energy to studying the natural sciences (Smith and Kleinman 1989). While this point may seem obvious, its implication is that even though medical students may have theoretically had the opportunity to have their own sexual experiences, or learn about human sexuality through formal study in high school or college, or gain exposure to some sort of messages about sexuality (even of dubious accuracy or questionable value) through depictions of sexuality within popular culture (Attwood 2006), in practice, their lives, prior to coming to medical school, may have had very little to do with sexuality at all.

Such was the case for many of the Buena Vista students I interviewed. The average age of the students was 23, and many of them had come directly into medical school after completing their undergraduate education. When I asked students about their sources of knowledge about sexuality, many had a hard
time identifying what these were. Most student interviewees reported they had never talked about sexuality with their families when growing up. Asian students often explained this as an “Asian thing,” saying that their families didn’t talk about sex because they were “conservative and Asian.” Nearly half of the students at Buena Vista were Asian, so these impressions likely were not isolated, but a lack of familial discussion may not have been attributable to ethnicity. White students, who comprised approximately the other half of the student body, also reported an absence of familial talk about anything sex-related.

Some students did have a little more experience with or exposure to sexuality. Two students had taken human sexuality classes as undergraduates. Several mentioned that they had learned about sexuality from MTV, or *Cosmopolitan* magazine, or from the Internet. Three older students who had a little more life experience than those who had come to Buena Vista straight out of college expressed a very different set of notions about sexuality’s relevance to medicine than their younger peers. Several students reported having dated and having learned about sexuality from those experiences, but just as many students that I interviewed spoke of their lack of sexual experiences. A couple of students told me that they had not “had sex” and had never dated, and had maintained friendship networks throughout high school and college with similarly abstinent peers. Some told me that they were very surprised to learn, upon arriving to medical school, that new friends they made were sexually active at all.

Thus, however little formal sexuality education Buena Vista faculty may have received, the sexuality curricula they crafted and delivered comprised, for many Buena Vista students, their most substantial source of information about or exposure to sexuality up to that point in their lives. I now turn to an in-depth examination of these curricula.

**What Counts as “Sex”? Defining the Parameters of Sexual Diversity**

One of the meetings of the Physician–Patient Dynamic (PPD) course was officially and completely devoted to the subject of sexuality—one of the few instances were sexuality was the planned, sustained focus within the formal curriculum. Dr. George Sorin, the course director, started off the day’s “lecture” by telling the students that he was going to ask them a series of questions, which they were to answer honestly and anonymously, using a push-button polling system to submit their responses, which would then be tabulated and displayed on a projector screen for all 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 handling the male students’ question about the meanings of dating in the way that he did, Dr. Sorin quietly destabilized the assumption that dating, for a man, would necessarily involve “a girl.” He went on to ask the auditorium full of students more questions about their own sexual experiences, and their understandings about sexuality. In quick succession, he queried, “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 Dr. Sorin 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 queried the class. 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 a move toward 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, frames 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.

The sexual possibilities that were excluded—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
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).

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 the 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.

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. They 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 nonheterosexuals, and the poll had contained a nod to nonheterosexual practices, including the question, “Have you had sex with a person of the same gender?” But even the queer students did not have 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.

**Isolation vs. Integration of Nonnormative Gender and Sexuality**

Immediately after Dr. Sorin’s poll and discussion about sexuality, 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 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 nonheteronormative identity in a similar fashion.

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, the curriculum at Buena Vista might not have contained any transgender-specific content.

However, the transgender 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 guest speakers, Gloria and Jackson, told the audience a bit about themselves, and told the students stories about the “awful, awful” experiences they had had with medical professionals. They had come
to speak to the group, they said, because they wanted to prevent such things from happening in the future. By all indications, their talk made a strong impression upon the students. Many students told me later that prior to the panel, they had never “seen” a transgender person before. Others mentioned the transgender speakers immediately when I asked them what they had learned about sexuality from their medical education thus far. But their comments often took the tone of describing a sighting of something exotic, rather than an expanded view of the intelligible possibilities of humanity.

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 SAM the course directors, lecturers, or faculty facilitators were transgender, and perhaps more significantly, transgender persons were absent from other panels of guest speakers with these courses. Other panels within SAM courses 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. As the transgender-specific panel clearly demonstrated, transpersons are candidates for having challenging experiences with medical professionals. They also form families and parent children, they grow old and become senior citizens, and they come from an array of cultural backgrounds. Transgender persons could have been included in the panels that pertained to aspects of the life course more generally instead of only the transgender-specific panel, but they were not. David 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 thus obscures the diversity within the category known as “transgender.” Such a reductionist presentation of transgender provides doctors-in-training with a very limited, circumscribed understanding of how these patients’ health needs may differ from—or overlap with—the health needs of cisgender patients.

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, reinforcing 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 other panel discussions in the SAM classes that ostensibly pertained to aspects of human experience also contributed to the hidden curriculum of heteronormativity through the exclusion—however inadvertent—of transpersons and other sexual minorities. For instance, the “families with young children” panel was composed entirely of heterosexual couples and their infants, and throughout their comments, the
parents made casual references to their biological relationship to their children. These panel discussions quietly and repeatedly portrayed healthy human development as inherently, unremarkably heterosexual.

**Heteronormative Family Relationships**

In addition to prescribing a certain way of being sexual, 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 is thus 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 significant 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, and 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.”
Dr. Bentson never hinted at how sexual “restraint” might apply to couples who cannot or choose not to marry. 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, 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 a lecture to these topics and their relationship to human health—however, these topics could have been addressed without focusing exclusively on heterosexual coupleings.

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, 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 well 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 sexual diversity 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 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. A 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. True to the definition of heteronormativity, Dr. Jun’s comments were made “without oppressive intent or conscious design” (Kitzinger 2005, 478), and the same could be said about the other curricular moments I have analyzed. Rather than suggesting a concerted effort to exclude nonheterosexual 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 to 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 nonheterosexual 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.

Discussion

If taken in isolation, each of the curricular moments described here might look fairly innocuous. But in the aggregate, these and other moments like them served to repeatedly bring heterosexuality into the realm of the visible, familiar, and knowable, while at the same time, a lack of regular references to nonheterosexual sexualities rendered much sexual diversity far less visible, familiar, and intelligible. Further research is needed to develop an understanding of how sexuality-related curricula (formal, hidden, or otherwise) shapes what doctors actually do in practice, and how patients experience their care. But for now, we might reasonably imagine that if the broader range of human sexual diversity is unknown to doctors, many patients may be unintelligible to them. When a patient is not intelligible to a doctor, the doctor’s knee-jerk response may be confusion or discomfort, which may 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 be scarcely aware of their own behavior or its potential impact in these situations, but even so, the patient on the receiving end of these sorts of actions may find them profoundly upsetting.

Although Buena Vista is a single case and unlikely to be completely representative of all other medical schools, we might expect to find a hidden curriculum of heteronormativity in other medical schools because heteronormativity is prevalent in society, not just medical education. This analysis demonstrates the strength of ethnographic methods for revealing heteronormative embedded messages and the “unremarkable” processes through which they are transmitted, and further ethnographic research of medical sexuality education is needed to develop a better understanding of the contemporary production of medical knowledge about sexuality—heteronormative or otherwise. 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”—also impacts patients’ experiences of medical care (Berman et al. 2003). In this article, 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 toward a more integrated style of teaching and away from stand-alone courses devoted to particular topics (Coleman 2012). 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).

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 medical educators. Addressing embedded messages about sexuality that educators are scarcely aware that they are producing is no small task—especially when collective understandings about what sexuality means or is are underdeveloped, as they were at Buena Vista. It may be very difficult to recognize something that is collectively unknown or underdefined. Heteronormativity within medical education is a reflection of heteronormativity within the surrounding society, and it is often difficult to denaturalize that which seems unremarkable—if it is even noticed at all. 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, Krebs, and Axtell 2002). This approach also provides a path toward easing the need for distinctions between “LGBT-specific” curricula and curricula that pertains to sexuality, more broadly defined.

Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

Notes

1. “Buena Vista” is a pseudonym, as are the names of all research subjects mentioned in this article.

2. One of the many things we do not know about medical sex education is when medical students “should” learn about human sexuality, and Buena Vista faculty members held very different positions on the ideal placement and timing of sexuality education within the broader trajectory of medical training and professional development.

3. The question of whether or not my status as an unusual participant in the small-group discussion settings may have caused the students and the cofacilitators of my small discussion groups to act differently than they might have had I been replaced by a faculty facilitator of the usual (i.e., medical) variety is an important one that I take up elsewhere. However, because this article is not primarily concerned with data from these small group discussions or meetings with faculty facilitators, consideration of this question is beyond the scope of the present discussion.

4. “Transgender” is not necessarily best understood as a manifestation of sexuality. However, transgender does form the “T” in “LGBT,” and is understood by many as having much to do with sexuality, not just gender. At Buena Vista, questions about whether transgender is fundamentally “about” sexuality or gender or both—or what the dynamic between these dimensions of experience might look like—were not explored within the formal curriculum.
5. Following Schilt and Westbrook (2009), I use the term “cisgender” to refer to persons who have a match between the gender they were assigned at birth, their physical bodies, and their current gender identities.

References


Murphy


**Author Biography**

Marie Murphy earned her PhD in sociology from the University of California, San Diego in 2014. Her research interests include the production of knowledge about sexuality, stigma, and sexuality-related inequalities.