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Queering Healthcare: Why Integrating Cultural Humility into Medical Education Matters for LGBTQ+ Patients

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Abstract

The medical field is still grappling with how to understand and situate LGBTQ+ patients within healthcare settings. The medicalization of LGBTQ+ identities and the legacy of heteronormativity in the medical field has situated these patients within narrow understandings of gender and sexual orientation. In this paper I outline how the medicalization of queerness and medical management of breast cancer have marginalized LGBTQ+ breast cancer patients as they proceed through diagnosis, treatment, and survivorship. Next, I link medicalization to the broader process and context of medical education, specifically the patient-provider relationship, where cross-cultural communication strategies, such as cultural competency training, are being utilized in an effort to understand LGBTQ+ health disparities. However, this approach has limited clinicians' abilities to examine how their own cultural standpoints influence the care of LGBTQ+ patients. In response, I discuss how an alternative approach, cultural humility, motivates clinicians to examine their own cultural biases and assumptions as well as the power imbalances inherent in the patient-provider relationship. Data collection included reviewing studies related to cultural humility, LGBTQ+ health disparities, and how medical education approaches LGBTQ+ health. Using an integrative analysis of the literature, I outline how these studies suggest cultural humility is efficacious in equalizing patient-provider relationships and generating growth through awareness of how identity is relevant to health and healthcare. In conclusion I explore how this change in medical education revolutionizes our understanding of LGBTQ+ individuals' health both by centering and privileging the voices of LGBTQ+ patients and examining how the patient-provider interaction is shaped by sociocultural context.

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Why Integrating Cultural Humility into Medical Education Matters for LGBTQ+ Patients

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The medical field is still grappling with how to understand and situate LGBTQ+ patients within healthcare settings. The medicalization of LGBTQ+ identities and the legacy of heteronormativity in the medical field has situated these patients within narrow understandings of gender and sexual orientation. In this paper I outline how the medicalization of queerness and medical management of breast cancer have marginalized LGBTQ+ breast cancer patients as they proceed through diagnosis, treatment, and survivorship. Next, I link medicalization to the broader process and context of medical education, specifically the patient-provider relationship, where cross-cultural communication strategies, such as cultural competency training, are being utilized in an effort to understand LGBTQ+ health disparities. However, this approach has limited clinicians' abilities to examine how their own cultural standpoints influence the care of LGBTQ+ patients. In response, I discuss how an alternative approach, cultural humility, motivates clinicians to examine their own cultural biases and assumptions as well as the power imbalances inherent in the patient-provider relationship. Data collection included reviewing studies related to cultural humility, LGBTQ+ health disparities, and how medical education approaches LGBTQ+ health. Using an integrative analysis of the literature, I outline how these studies suggest cultural humility is efficacious in equalizing patient-provider relationships and generating growth through awareness of how identity is relevant to health and healthcare. In conclusion I explore how this change in medical education revolutionizes our understanding of LGBTQ+ individuals' health both by centering and privileging the voices of LGBTQ+ patients and examining how the patient-provider interaction is shaped by sociocultural context.

Keywords: Queering | Breast cancer | Medicalization | Cultural humility | Intersectionality | Medical education | Patient-provider relationship

The medical field is still grappling with how to understand and situate LGBTQ+ patients within healthcare settings. The medicalization of LGBTQ+ identities and the legacy of heteronormativity in the medical field has situated these patients within narrow understandings of gender and sexual orientation. In this paper I first outline how the medicalization of queerness and medical management of breast cancer have marginalized

LGBTQ+[1] breast cancer patients as they proceed through diagnosis, treatment, and survivorship. More specifically, I explore and expand on feminist literature documenting how aspects of medicalization and medical management of breast cancer, such as advancing biotechnology, shape definitions of self, sexuality, womanhood, and (dis)ability. Next, I link medicalization to the broader process and context of medical education, specifically the patient-provider relationship, where cross-cultural communication strategies, such as cultural competency training, are being utilized in an effort to understand LGBT health disparities. Though cultural competency training may be viewed as an advancement in medical education, this educational program has shortcomings, including limiting clinicians' abilities to examine how their own cultural standpoints influence the care of LGBTQ+ patients. In response, this paper elaborates on how an alternative model, cultural humility, motivates clinicians to examine their own cultural biases and assumptions as well as the power imbalances inherent in the patient-provider relationship. Further, cultural humility highlights an intersectional viewpoint of a patient's identity and health. Taken together, intersectionality[2] and cultural humility are necessary frameworks to understand the social determinants of LGBTQ+ health care, disease risks, and access to care (Damaskos et al., 2018). Lastly, I propose that the integration of cultural humility enables a queering of healthcare that involves changing the structure of how we understand LGBTQ+ individuals' health both by centering and privileging the voices of LBGTQ+ patients and examining how the provider-patient interaction is shaped by sociocultural context. I specifically bring in conversation about LGBTQ+ breast cancer patients in reference to queering healthcare. This paper calls for a reimagining of how we conceptualize the intersections of identity, breast cancer, and health equity.

Setting the Context: Homophobia, Transphobia, and Medicine

LGBTQ+ health disparities are shaped by sociocultural mechanisms that have ostracized "other" sexual and gender identities that fall outside the norm of heterosexual and cisgender** identity. The intersections of homophobia, transphobia, and medicine and how these affect LGBTQ+ breast cancer patients specifically are highly understudied, though a review of the literature reveals that historical understandings of LGBT patients have followed a biomedical model (Fredriksen-Goldsen, 2014, 654; Lev, 2013;

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[1] I use variations on LGBT as it aligns with the literature's descriptions. Otherwise, I suggest we expand our view to include LGBTQ+ individuals in our conversations about healthcare.
*Trans is used to recognize and include all transgender, non-binary, and gender nonconforming identities.
**Cisgender refers to an individual whose gender identity aligns with their given sex at birth.

[2] The term intersectionality references interlocking systems of power and oppresssion, originating within the context of unique challenges of intersecting sexism and racism facing black women (Crenshaw, 1989). This paper reflects on how an intersectional lens enhances our ability to deconstruct the multiple systems of power and oppression in our healthcare system contributing to the devaluation of LGBTQ+ patients.

Silverstein, 2009). Until recently (1973) homosexuality was categorized as a disorder within the *Diagnostic and Statistical Manual of Mental Disorders*, and sexualities and genders, other than being heterosexual and cisgender, have been studied and understood within medicine and biology as a deviation from the normal (Drescher, 2015; Silverstein, 2009; Rosario, 1997). Scientific studies and research have historically not benefitted these communities but instead sought to explain the homosexual body, such as its "naturalness," on a genetic and molecular level (Rosario, 1997). Biomedical science, particularly genetics, has become one of the most trusted expert sources responsible for governing the naturalization of human behaviors and ailments (Rosario, 1997, 8). Medicalization works at many levels in this instance by biologizing identities "not only in the cultural phenomenon of 'gayness' as a construct, but genes themselves and the 'molecular visions of life' are an elaborate socio-historical construct" (Rosario, 1997, 9). Using science as a mechanism to categorize and ostracize certain sexualities, bodies, and genders has created a context wherein accessing medical care is difficult in both a material and psychological sense for LGBTQ+ individuals.

The histories of homophobia and medicine are closely intertwined, where medical science functions as an objective source of knowledge that legitimated the construction of homosexuality as a sin, crime, and result of sickness and insanity that could be cured and controlled through the practice of medicine (Rosario, 1997). Medicinal techniques, such as castration, hypnotherapy, psychoanalysis, drugs, and aversion therapy, contributed to and perpetuated a hierarchical social order through construction of homosexuality as deviant. Because homosexuality has been historically regarded as biologically, psychologically, genetically, morally, emotionally, and sexually inferior to heterosexuality, LGB interactions with the medical system are socially, psychologically, and financially complex (Fish, 2006, 9). Though many individuals of the LGBTQ+ communities have difficult healthcare experiences, they all vary greatly and are intertwined with different life experiences and unique identities that are more than just biological. The studies of medical management of identities and experiences and the ways in which research from a biomedical standpoint limits the overall wellness and potential of so-called deviant communities provides context for this research. While the works within Rosario's collection do not specifically highlight breast cancer, they convey a queer understanding of social constructions and the way in which the medical system has sought to generate and maintain certain bodies and identities while stigmatizing others. Therefore, the healthcare system has distorted health and healthcare by reinforcing heteronormativity, and, consequently, failed to provide adequate healthcare to meet the genuine needs of LGBTQ+ individuals.

The Medicalization of Queerness: Healthcare For LGBTQ+ Breast Cancer Patients

In "The Shifting Engines of Medicalization" Peter Conrad contends that the apparatus of medicalization has shifted according to the changing medical technologies, practices, and markets now available. His definitional account of medicalization focuses on "defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it" (Conrad, 2005, p. 3). Similarly, Erik Eckhert defines medicalization as "the (often unconscious) process by which organisms, tangible objects, or social constructions are rendered into biomedical terms" (Eckhert, 2016, p. 239). In this paper I bring Conrad and Eckhert's conceptualizations of medicalization into conversation with the gendered nature of medicalization of LGBTQ+ patients and their intersecting diagnosis with breast cancer. This analysis of heteronormativity prevalent within and perpetuated by practices of medicine and medical research is furthered by the point that many of the ways that trans* people have to function in their daily life, such as using gender-neutral bathrooms or possessing the proper identification documents, need the approval of the medical establishment (Spade, 2003, 1-3). Spade describes the medicalization of trans* identities as a way for their gender identification and presentation to be policed and expected to fit within the dominant gender binary. I extend Spade's description of this medicalization to the medicalization of breast cancer. In the context of this paper, the medicalization of breast cancer means the insistence that breast cancer patients adhere to certain regimes within Western medicinal ideology and practices, such as maintaining their bodies and identities in a way that can be categorized, organized efficiently, and fit within a narrow medical model and narrative. Spade's examination of the intersection of medical and legal frameworks brings to light how LGBTQ+ patients may be dehumanized and traumatized by the categorization and definition of identities and bodies alongside moderation of access to medical treatment and care. Additionally, the intersection of trans* identified bodies and breast cancer presents the medical practice with a complex situation in which heteronormative practices that already isolate a trans* individual from medical care may be further compounded by physicians' assumptions and biases in breast cancer care.[3] Accordingly, I draw from the literature the insight that LGBTQ+ breast cancer patients represent a queer narrative that defies the dehumanizing nature of our current healthcare system. Heterosexism and pathologizing queerness by medical professionals have detrimental effects on patient care by either intentionally or unintentionally ignoring these social contexts and perpetuating ignorance of specific needs and life experiences.

There's no "I" in breast cancer: self and subjectivity

Women suffering from the disease of breast cancer, such as Audre Lorde, Susan Sontag, and Rachel Carson, explored their diagnoses in differing ways and present us with

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[3] For example, physicians' assumptions about transgender men (such as the lack of presence of breast tissue) may eclipse opportunities to inquire about overall breast cancer risk through family history, genetic testing, and self-breast examinations, and other screening mechanisms. In a cervical cancer risk context: "if a white transgender man presents to a HCP [healthcare provider] with…[pelvic pain, abnormal bleeding, and pain upon urination]…it is important to include a psychosexual history because a transgender man may still have a <u>cervix</u> and could be at risk for developing cervical cancer. In both instances, assumptions by the HCP about the LGBT person could lead to missed diagnoses, incomplete assessments, inadequate care, and poor survival" (Damaskos et al., 2018).

complex narratives of self and breast cancer. The metaphors and myths surrounding cancer, as well as other illnesses, serve as a barrier to patients searching for and obtaining the quality care they need, adding discomfort and extra burdens to an already difficult situation. These accounts also illustrate how medicalization shapes their experiences of self as they proceed through breast cancer diagnosis and treatment. Susan Sontag's account attempts to deconstruct some of these barriers and render cancer as a disease rather than a negative and disheartening connotation and testimony to the character of the woman experiencing it (Sontag, 1977). The myths and metaphors of cancer disrupt and silence patients who are unable to formulate and express the meaning of their experiences. Defying the patient's "cancer personality,"[4] Sontag's examination of the medical industry's tendency to blame the victim and attribute failure to overcome to the patient's lack of responsibility for their health and well-being is a prime example of the neoliberal ideology used in breast cancer care that marginalizes many thoughts and voices. By deconstructing homogenized and mainstream accounts of breast cancer, Sontag's work informs the study of LGBTQ+ breast cancer patient's experiences by providing alternative narratives and de-stigmatizing illness.

Subjecthood, womanness, and representation are examined "in terms of the biopolitical management and organization of subjects and femininity for the well-being of the nation" and provide an expansion for the evaluation and treatment of breast cancer in the US context (Ehlers and Krupar, 2012, p. 2). Through prioritization of health, social movements, and environmental activism and the body in breast cancer, Ehlers and Krupar recognize the importance of feminist scholarship's incorporation of the complexities of bodily experience, how bodies are portrayed and normalized, and the corporeality and materiality of breast cancer. The material experiences of the body can be imagined on multiple levels and are incredibly crucial to providing quality care to LGBTQ+ breast cancer patients and redefining the limited and rigid definitions of subjecthood. Queer breast cancer healthcare demands allowing a multiplicity of experiences of the body as well as recognition that cancerous and queer bodies are severely regulated at societal and biomedical structural levels. Due to the intersection of various identities in one body for breast cancer patients, quality healthcare for queer-identified individuals requires acknowledgment of the multiple material violences patients are subjected to and willingness to advocate for equitable and compassionate care.

In addition, conceptions of breast cancer and selfhood are linked with so-called biotechnological advancement of medicalization, often creating divisive rather than

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[4] Lawrence LeShan, psychologist and psychotherapist, claimed "'there is a general type of personality configuration among the majority of cancer patients'and a world-view that cancer patients share and 'which pre-dates the development of cancer'…'The cancer patient,' LeShan writes, 'almost invariably is contemptuous of himself, and of his abilities and possibilities.' Cancer patients are 'empty of feeling and devoid of self'"(Sontag, 1977, 51). The cancer personality, according to LeShan and O. Carl Simonton, renders the cancer patient unable to have meaningful relationships and plagued by despair, thereby attributing a cause of cancer to the emotional state of the individual patient. Sontag's account defies this cancer personality by deconstructing how cancer is not the result of individual patient's lack of responsibility.

holistic healthcare. Specifically, the distinction between mind and body is disrupted and challenged by breast cancer, and, consequently, we see that the "self is never separable from its own materiality" (Ehlers and Krupar, 2012, p. 3). Rather, through this feminist discourse, LGBTQ+ breast cancer patient's experiences can be examined and healthcare can be reimagined to recognize the necessity and redefinition of holistic care. Currently, "the medical arena depersonalizes representations of the body with breast cancer, from medical pamphlets to medical studies, [and] the body generally appears passive, injured, damaged, and divorced from subjectivity" (Ehlers and Krupar, 2012, p. 5). Navigation of this complex and multilayered environment requires "a material politics that recognizes the body/self as always contingent and always in the process of becoming" (Ehlers and Krupar, 2012, 8). Attention to detail and active engagement by medical professionals and providers as well as breast cancer organizations is necessary in order to provide LGBTQ+ breast cancer patients with quality care that includes holistic analysis and expansion of the material self, including with biotechnology, immersed in an ever-changing environment.

Acknowledging that feminist scholars and activists have explored sexist and heterosexist assumptions in medical management of breast cancer, Rubin and Tanenbaum (2011) further address the lived experience of mastectomy and breast reconstruction through the qualitative interviewing of lesbian women who were faced with the decision to undergo breast reconstruction; many of the women's decisions were influenced by their physician's framing of reconstruction and their consequent concerns about the stigmatization of illness. "Women chose reconstruction for reasons such as desiring symmetry, avoiding external prostheses, wanting to feel 'whole,' and wanting to look 'normal'" (Rubin and Tanenbaum, 2011, 403). Wholeness and abnormality have been examined within previously on a molecular and political level, and these views of self given by self-identified lesbian women have implications for what it means to be healthy and fully oneself. "Western culture's emphasis on ‘‘seeming’’ over ‘‘being’’ (Bourdieu, 1984)—or rather ‘‘being’’ by ‘‘seeming’’—encourages the use of breast reconstruction to create a body that represents wellness, even if the surgery itself is linked with further bodily risk and degradation" (Rubin and Tanenbaum, 2011, p. 406). Exploring the nature of what constitutes "womanhood," through gender policing and medicalization, is relevant to LGBTQ+ breast cancer communities, and deconstruction of these frameworks may reveal potential interventions for improving ways that physician's and care providers address illness and bodily modifications as well as other concerns.

Their language of feeling less than whole has important links to disability. Disability has been historically perceived as lacking the "normal" bodily experience. "Disability theorists emphasize the socially constructed nature of disability, namely, that it arises from the interaction between bodies (and embodied differences) and an unaccommodating physical and social environment," placing queer bodies with breast cancer at the intersection of this discourse (Rubin and Tanenbaum, 2011, p. 410). "Although many women post-mastectomy will face minimal, if any, functional impairment, disability theory's challenge to notions of the 'normal' body make it particularly useful for understanding the experiences of women who have undergone mastectomy for breast cancer" (Rubin and Tanenbaum, 2011, p. 410). Disability studies in conjunction with feminist frameworks expand the current views of breast cancer by creating space for redefinition of queer selfhood and provide analysis that has the potential to transform healthcare's framing of holistic healthiness. Ultimately, "breast loss raises questions about identity and what it means to be a woman, and although the simplest antidote may be a cosmetic one—to replace the lost breast(s)—perhaps, it really calls for a redefinition and expansion of what it means to be a woman" (Rubin and Tanenbaum, 2011, p. 412).

Biopower and Medical Management of Breast Cancer

Feminist principles understand healthcare as a socially constructed mechanism that should recognize and address human bodies and illnesses in a way that overcomes and resists inequality as well as marginalization based on race, class, or gender (Morgen, 2006). Conceptions of health and illness change depending on historical period and are susceptible to regulation by physicians as well as challenges from breast cancer movements. Examining Michel Foucault's notions of biopower reveals that cancer research is about more than scientific discovery and entails broader structures of politically and historically-rooted mechanisms of knowledge-power. Rather than supporting Francis Bacon's conception of knowledge and truth as separate, Foucault argues for the conception of knowledge-power, where knowledge production is intertwined with power relations and reflexively interacts with society (Foucault, 1978, p. 139). When conceiving of how the knowledge produced about breast cancer is circulated and introduced into broader society, Foucault's notion of knowledge-power asks the question of whom the funding and knowledge benefits. Furthering this, biopower is useful in analyzing the public health system as a form controlling, monitoring, and classifying life.

Cancer is a major health concern, yet it has the potential to be shaped and regulated so as to produce a certain quality of bodies in the population. Breast cancer is an already gendered practice, where the body is an avenue for constructing health aims around female-bodied individuals. According to Foucault, "at the juncture of the 'body' and the 'population,' sex became a crucial target of a power organized around the management of life" (Foucault, 1978, p. 147). Anatamo-politics is a deeper look into biopower that consists of optimizing the capabilities of the body and increase of its usefulness and docility, and it reflects a view of cancer research as a mechanism for shaping bodies to support systems of efficient and economic controls (Foucault, 1978, p. 139). Through this lens, the individual is pictured as an autonomous unit to be controlled and managed to produce a certain kind of life, mainly that which is a certain version of a healthy human. In the case of any cancer, including breast cancer, biopower is not necessarily a negative structure in terms of looking at cancer as a dangerous invasion of the body and the positive health outcomes that result from proper treatment and care from health care professionals. Yet Foucault's contributions of biopower, knowledge-power, and anatamo-politics highlight how cancer research is not only an arena for greater biomedical health advances but also a piece within the public health system that can be used to produce a certain dynamic with certain types of bodies.

Medical research and development of biomedical technology have provided a resource that has saved many lives. However, the benefits of this research are inevitably intertwined in power relations, where those who receive the proper treatment, in both a biological and social sense, are more privileged in some cases. Not only does continued medical management reinforce a hierarchical binary between clinicians and patients, patriarchal structures determine who is of value in society and control bodies through health care, sexuality, heredity, blood, hygiene, and well-being. Only certain populations are allowed to have access to the knowledge provided by the cancer research industry. The intersecting nature of the medicalization of queerness and the medical management of breast cancer renders LGBTQ+ breast cancer patients subject to isolation and marginalization as they proceed through diagnosis, treatment, and survivorship.[5] The definitions of self, sexuality, womanhood, and (dis)ability for these patients are dynamically intertwined with biotechnology and other aspects of medicalization and medical management of breast cancer. Recognizing how heterosexim, homophobia, and transphobia interact uniquely with breast cancer within our healthcare system is necessary for us to reimagine healthcare that incorporates intersections of identity and breast cancer to provide quality care for these patients.

The Limitations of Cultural Competency Training in Medical Education

Cultural competency training is now often incorporated into health system design as a way to measure quality of patient-provider interactions, provide individualized care, and incorporate aspects of patient identity. Yet cultural competency, with its focus on attainment of knowledge about patients' cultural identities, is limited in its reach in enabling providers to connect with patients and understand their own cultural positionality. The lack of understanding of their own sociocultural positionality limits clinicians' abilities to untangle the power dynamics within their relationships with their patients. Additionally, there are difficulties in measuring cultural competency, especially when these measurements contain hidden assumptions about the identities of clinicians and patients as well as conflate the meanings of culture, race, and ethnicity (Kumas-Tan et al., 2007). More specifically, these instruments tend to conceptualize culture as an attribute possessed by the ethnic or racialized "other," and the development of the instruments is predicated on understandings of white, middle-class, and educated patients with no feedback from patient populations (Kumas-Tan et al., 2007). Yet in developing these quality measures, the healthcare system should, as mentioned by Berwick (2009) in "What 'Patient-Centered' Should Mean: Confessions of an Extremist," center patient voices and shift the nature of what quality means. The element missed by Berwick is how

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[5] Refer to Sarkin (2015) for preliminary case study on the unique barriers faced by lesbian and transgender breast cancer survivors on their journeys through diagnosis, treatment, and survivorship.

patient voices need to be centered with specific relation to how clinicians may be culturally sensitive and exercise humility in practice. For example, how do we incorporate aspects of patient and clinicians' identities to improve quality of care for patients? Who ultimately determines which pieces of their identity are salient to patient care?

It seems critical that new definitions of patient-centered care incorporate the necessity of integrating cultural sensitivity and humility into patient-provider communication, interactions, and quality measures. In a sense, measuring cultural competency seems futile because it still implies that quantitative analysis and knowledge of patient experiences is enough to provide quality services to marginalized populations. While it is still incredibly important to have knowledge of who the patient population encompasses, it takes more than acquired knowledge to have a connection with patients and promote culturally sensitive interactions. As mentioned above, part of patient-centered care involves analyzing the power relations that shape the patient-provider relationship. These power relations are connected to larger social structures that hierarchically order clinicians as superior in expertise of health and illness compared to patients. Therefore, assuming that individual knowledge is enough to create change misses the greater opportunities for structural changes in patient-centered care that go beyond "individualizing" a status quo that is already culturally insensitive for many patients.

In reshaping health system design to be more patient-centered, we should be gravitating toward intersectional understandings of patient identity as defined by the patients themselves. Kumas-Tan et al. (2007) prompt that the meaning of culture in medical encounters needs to expand to include gender, age, sexual orientation, income, ability, and faith, in addition to race and ethnicity. Furthering Berwick's point, new definitions of patient-centeredness allude to changing the structure of how we understand patients' health by privileging their often marginalized voices. In advocating for patient-centered design, Berwick mentions how "evidence-based medicine sometimes must take a back seat," so patients may, at times, override "professional judgment" (Berwick, 2009, p. 561). Yet Berwick's note also highlights the gap missed in his analysis: Aspects of patient and providers' identities moderate and filter who may override professional judgment. Therefore, patient-centeredness needs to expand to highlight how patient-provider interactions are shaped by sociocultural context. Further, patient-centered care should incorporate cultural sensitivity and awareness of how identity mediates interactions in patient-provider relationships.

Within medical education, healthcare, which has its own language, values, and practices, is reinforced as an invisible cultural system. The stigmatization around LGBTQ+ identities remains "influential in the education of health care providers, the quality of health care they deliver, their comfort in interacting with clients, and the institutional policies under which they work" (Fee and Krieger, 1994, p. 244). This perpetuates a "culture of no culture," which obfuscates the role that a clinician's cultural standpoint has in patient care (Robertson, 2013, p. 26). Heteronormativity, then, becomes ingrained within clinicians' approaches, which constrain LGBTQ+ patients' sense of power and agency. Power dynamics exist between professionals and patients due to the social and institutional hierarchies that attribute success and value to the formalized knowledge obtained through education and academia as opposed to life experiences. Heteronormative sociocultural assumptions become internalized as authoritative knowledge and reinforce policy decisions about LGBTQ+ individuals that drive health disparities (Robertson, 2013). In response, intersectional feminist researchers propose that we integrate a multiplicity of ways of knowing and knowledge production generated by patients into healthcare (Brisolara, 2014). Knowledge and ways of knowing include “perception, intuition, conceptualization, inference, representation, reflection, imagination, remembrance,” and recognition of this knowledge shared by these patients is a form of giving voice to those who are usually silenced or ignored (Brisolara, 2014, p. 16). Alongside this, we should continue to question historically ingrained uneven relations of power that have marginalized and are currently marginalizing LGBTQ+ identities and experiences. Cultural humility, then, is a useful intervention within medical education and healthcare.

Cultural Humility: Definitional Accounts and Bioethical Relevance

Definitional Accounts of Cultural Competency and Cultural Humility

As mentioned above, the “culture of no culture” becomes reproduced through cultural competency education, which operates based on lack of acknowledgment of clinicians’ cultural standpoint and fixed knowledge about a patient’s culture and identity. The nature of cultural competency limits its integration into an already intense medical curriculum that emphasizes the prominence of hierarchy, emotional neutrality, and knowledge acquisition, among other factors. In contrast, cultural humility encourages clinicians to be highly sensitive to their cultural biases and maintain a dynamic view of the patient and culture. Cultural humility leads providers to examine their own assumptions, thereby drawing attention to the fact that the providers’ views are not objective and within “a culture of no culture.” While cultural competency may imbed cultural stereotypes, cultural humility works to privilege the perspective of the patient. By centering the patient more in the dialogue and giving each party more space to communicate, cultural humility works to dismantle the power hierarchy in the patient-provider relationship. Rather than focusing on acquiring set quantities of knowledge about LGBTQ+ patients, as cultural competency does, we may do better by encouraging reflective skills and communication strategies that take seriously patients’ narratives of their health and illness.

Ethical Elements of Cultural Humility

Provider-patient relationships are morally central to how we conceive of healthcare. Cultural humility is directly connected to a clinician’s ethical duty and responsibility. When clinicians are in charge of the care the patient, read as “the other” in medical encounters, this responsibility requires “a sense of receptivity, humbleness, and learning from the other, as well as bringing ‘into check the power imbalances that exist’” (Ucok-Sayrak, 2016, p. 123). We are all, in some sense, implicated by others, sometimes beyond our own will, thereby establishing our ethical relation to others. In the context of healthcare, clinicians should “make sense of the other on her own terms” (Ucok-Sayrak, 2016, 124). Similarly, Judith Butler also offers that our human physicality and social vulnerability is a site of connection and ethical responsibility towards one another. (Ucok-Sayrak, 2016, p. 129). In the context of cultural humility, clinicians should prioritize centering the patient and learning about “the other” based on “her cultural resources and frameworks rather than taking the ‘teaching perspective’” (Ucok-Sayrak, 2016, p. 124). This work advances responsibility as ethically relevant alongside rights in the bioethical literature. Medicine is tied directly to communities and social identities through cultural humility, where responsibility is a foundation of a commitment to social justice.

Cultural humility is modeled on a "journey of growth, development, action and struggle," and competency is not enough to give future physicians the tools to become agents of social justice, in part because clinicians should reflect on their own biases, culture, and identity in order to begin to understand those of the patient (Stone, 2010, p. 505). Healthcare experiences related to identity are morally significant, and often times, moral principles or rules posited for the abstract, generic person erase aspects of an individual’s identity. Yet cultural humility grounds our moral experiences in healthcare by opening us up to examining the power and biases that shape health outcomes. In this way, cultural humility revives the moral meanings behind healthcare. It elucidates that the marginalization and oppression of LGBTQ+ populations are moral wrongs, and within healthcare, clinicians have an imperative to oppose this oppression and instead create space for patients to become part of the ethical conversation.

The Intersection of Cultural Humility and Intersectionality in LGBTQ+ Healthcare

Cultural humility recognizes the intersectional nature of a patient’s identity and health. One understanding of intersectionality posits that “racism and sexism, as well as other forms of oppression such as homophobia, ageism, and ableism, operate as mutually reinforcing systems of inequality” and intersect with associated health risks, healthcare delivery, and health and well-being (Geiger, 2006, p. 273). I believe intersectionality and cultural humility are necessary frameworks to understand the social determinants of LGBTQ+ health care, particular disease risks, and access to care (Damaskos et al., 2018). Clinicians should be able to reflect on the multiple contributions to what “health” is. Recognizing how various cultural identities and backgrounds moderate various definitions of “health” requires flexibility and humility. In the context of the patient-provider relationship, then, internal and external contexts, such as social and economic factors as well as environmental influences, need to be considered in how they shape how illness originates and how the patient and physician are able to communicate about what actions (or inactions) to take (Helman, 2007, 154). Cultural humility provides common ground for these interactions.

Intersectional training within medical education would be sensitive to who is producing and represented in the curriculum and would insist upon inclusion of research done by and about individuals with marginalized identities (i.e., scholarship produced by and for people of color, individuals with disabilities, LGBTQ+ people, etc.). Furthermore, the idea of becoming culturally *responsive* (rather than *culturally competent*,) would be viewed as a life-long process of continual self-reflection and critical engagement with cultures that differ from one's own, not a skill to be mastered (Bain et al., 2018). In terms of educating for social responsibility, John Stone offers that educational approaches should "aim to give physicians much more grounding in what respect and social justice demand in light of their social contract and reciprocity" (Stone, 2010, p. 505). This dovetails with my vision of how cultural humility is relevant to medical education and can help physicians reflect on how social justice is part of their professional duty. Health assessments that are inclusive of all aspects of an individual's psychosocial and medical histories will allow for a comprehensive understanding of their cancer risks, screening behaviors, treatment adherence, and adjustment to survivorship (Damaskos et al., 2018).

Moving Forward: Cultural Humility and the Necessity of Queering Healthcare

The embrace of cultural humility is a way of enabling a queering of medical education, healthcare, and bioethics. This queering involves changing the structure of how we understand LGBTQ+ individuals' health both by centering and privileging the voices of LBGTQ+ patients and examining how the provider-patient interaction is shaped by sociocultural context, including cultural mechanisms of homophobia, sexism, racism, transphobia, and ableism. An applicable instance where this may be engaged is with LGBTQ+ breast cancer patients or potential breast cancer patients. LGBTQ+ breast cancer patients and survivors' experiences are rarely discussed in healthcare literature, yet LGBTQ+ health inequities, specifically with relation to breast cancer, are of striking moral concern. In many ways, the marginalization of LGBTQ+ patients in healthcare is further compounded by health conditions, such as breast cancer, which are described as inherently abnormal. Cultural factors, among others, shape beliefs about breast cancer risk and response to/by LGBTQ+ patients. Furthermore, different cultural conceptions of what causes breast cancer and how it should be treated involve moral elements and judgments (Helman, 2007, 133). As mentioned above, holistic health assessments will allow for a comprehensive understanding of cancer risks, screening behaviors, treatment adherence, and adjustment to survivorship. With a cultural humility lens we can also see how cultural biases, such as heteronormativity, drive cancer inequities.

My perspective is that a cultural humility approach to LGBTQ+ health care incorporates cultural reflection, community engagement, and moral action. To work toward the elimination of LGBTQ+ health and breast cancer disparities, clinicians have an ethical responsibility to engage with cultural humility. Clinicians are morally implicated in their responsibility to their LGBTQ+ patients and whether they question their moral judgments of patients and their health. With this in mind, when bioethics discourse includes LGBT persons but does not change the frame in which to advocate for healthcare, this can simply maintain the status quo. Queering the bioethical lens means to include the perspectives, histories, and feelings of LGBTQ+ persons. Queering the ethical analysis means taking a non-normative approach when focusing on what is standard. The queering of medical education is essential for: (1) actively creating space for patients to become part of the ethical conversation around healthcare and (2) alleviation of health and breast cancer disparities. Medical education should take these concepts as imperative to improving the nature of LGBTQ+ healthcare.

Authors Notes

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