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The relationship between medical education and trans health disparities: a call to research

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Abstract

According to the National Transgender Discrimination Survey, 28% of trans respondents reported postponing medical care due to discrimination, and 28% reported being harassed by providers when they did seek out care. Scholars have proposed that what is taught (or not) in medical schools might play a role in the unequal health care experienced by many trans people. As medical education becomes a site of intervention for reducing transgender health disparities, it presents opportunities for sociologists to study and explain the processes by which medical training creates, reinforces, and potentially challenges stigma-related health disparities. In this paper, we propose three areas of inquiry that might help explain this situation: the hidden curriculum, patient health movements and consumerism, and medical competency. By employing these concepts, we argue that sociologists can develop more comprehensive explanations for the relationship between medical education and transgender health inequalities and offer solutions to address this disparity.

KEYWORDS

health disparities, hidden curriculum, medical competency, medical education, patient health movements, Transgender health

1 | INTRODUCTION

In August 2015, a new hashtag started trending on Twitter: #transhealthfail. Using this hashtag, trans people¹ shared stories about their negative experiences with doctors and other healthcare providers. These experiences ranged from being asked to fill out non-inclusive intake forms and questionnaires to physicians using incorrect names and pronouns. Taken together, #transhealthfail reveals the unfortunate realities that many trans people face when seeking and receiving health care. These tweets are not isolated incidents; they reflect an empirical pattern regarding trans people's experiences in the healthcare system.

Trans people face mistreatment in a variety of institutions, including the workplace, housing, and education (Monro, 2005; Schilt, 2010), as well as in everyday interactions (Dworkin & Yi, 2003; Lombardi, Wilchins, Priesing, & Malouf, 2002; Nadal, Skolnik, & Wong, 2012). Experiences with prejudice and discrimination extend into health

care. Research consistently finds that trans people experience a disproportionate risk for poor physical and mental health as a result of inequalities in health care access and treatment (De Santis, 2009; Kenagy, 2005; Lawrence, Meyer, & Northridge, 2007; Xavier, Hannold, Bradford, & Simmons, 2007). Several studies link the persistence of transgender health disparities with inadequate clinical training, suggesting that a lack of preparedness and comfort among healthcare professionals hinders effective diagnosis and treatment for trans patients. In fact, a recent survey of 150 deans of medical education found that a majority of medical schools do not incorporate transgender health issues into their curriculum (Obedin-Maliver et al., 2011). This recognition has prompted numerous calls to develop training programs in medical schools that explicitly address transgender health (Lombardi, 2001). The Association of American Medical Colleges (AAMC, 2014), for example, developed a set of competency guidelines to improve health care for people who are lesbian, gay, bisexual, transgender (LGBT), gender nonconforming,² or born with disorders of sex development (DSD).³ The University of Louisville School of Medicine became the first program to pilot these new guidelines in Fall 2015.

As medical education becomes a site of intervention for reducing transgender health disparities, it presents opportunities for sociologists to study and explain the processes by which medical training creates, reinforces, and potentially challenges stigma-related health disparities. Sociologists have a long history of research on medical education that examines not only the formal curriculum but also the everyday, seemingly mundane moments in which medical students learn what it means to be a healthcare provider (Hafferty, 1998; Hafferty & Franks, 1994), as well as more recent work on transformations in medicine resulting from patient consumerism and the rise of evidence-based medicine (Timmermans & Oh, 2010). Despite these contributions, Hafferty and Castellani (2009) have noted that a gap between sociology and medical education literature persists. In addition, although sociologists have examined stigma-related health disparities (Link & Phelan, 2001), relatively little sociological scholarship has systematically investigated how medical education (re)produces health disparities for marginalized groups in general and for trans people in particular.

We begin this manuscript by providing a brief overview of research that documents the inequalities experienced by trans people in terms of adverse health behaviors and conditions, as well as health care access and treatment. We review research that demonstrates how stigma influences encounters between trans patients and their healthcare providers and the quality of treatments they access and receive. Next, we consider the question: What is being taught about trans patients in medical schools? We review the literature on transgender-related content in medical education, as well as recent calls to intervene in medical training to reduce transgender health disparities. We argue that sociological perspectives can push us toward some answers about how and why medical education creates and reproduces transgender health inequalities, even as it increasingly attempts to address these disparities through new pedagogical initiatives. In particular, we consider how sociological frameworks might help us identify and explain the socialization processes through which transgender disparities are produced and maintained in medical school, as well as the transformations in medicine that have contributed to the growing demand for clinical training in transgender care. Finally, we recommend that sociologists consider the medical education literature on competency in order to examine the construction of transgender competencies in pedagogical interventions and their potential effects on reducing stigma-related health disparities.

2 | TRANS HEALTH AND BIOMEDICAL ENCOUNTERS

Drawing on Goffman (1963), numerous studies have documented the important connection between stigmatized identities and population health disparities (Hatzenbuehler, Phelan, & Link, 2013; Krieger, 1999, 2012; Link & Phelan, 2001; Meyer & Northridge, 2007). Stigma carries health consequences by constraining "access to resources that could be used to avoid or minimize poor health" (Link & Phelan, 2001). Similarly, minority stress theory argues that stress resulting from socioeconomic (Dohrenwend, 2000), racial and ethnic (Williams, Yu, Jackson, & Anderson, 1997), gender (Hendricks & Testa, 2012), and sexually (Meyer, 1995) marginalized identities negatively impacts health and well-being.

More recent work has established a link between stigma and health outcomes for trans individuals in particular (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013; Gamarel, Reisner, Laurenceau, Nemoto, &

Operario, 2014; Huft, 2008; Operario, Yang, Reisner, Iwamoto, & Nemoto, 2014; Spicer, 2010; White, Jaclyn, Reisner, & Pachankis, 2015b; Xavier et al., 2013). This research finds that, compared to the general U.S. adult population, trans people experience a disproportionate risk for mental illness, suicide and attempted suicide, HIV infections, and health-harming behaviors such as smoking and self-injury (De Santis, 2009; Kenagy, 2005; Lawrence et al., 2007; Xavier et al., 2007). Data from the National Transgender Discrimination Survey report HIV rates of 2.64% among trans respondents compared to an HIV infection rate of 0.6% for the general U.S. adult population (Grant et al., 2011). The same survey found that 41% of trans participants had attempted suicide in comparison with 1.6% of the general population (Grant et al., 2011). Eight percent of trans participants reported currently using alcohol and drugs to cope with discrimination, compared to National Institute of Health estimates of 7.3% for the general population (Grant et al., 2011). Gender (non)conformity played a significant role with regard to substance use. Miller and Grollman (2015), for example, found that trans participants who were gender conforming were less likely to currently smoke (27%) than those who were gender non-conforming (37%).

Although this research demonstrates that stigma can result in adverse health effects, countless studies also show how stigma operates in clinical encounters. In fact, several studies suggest that the poor health outcomes among trans individuals can be traced to inequalities in access and treatment in the healthcare system. Health care access refers to the "timely use of personal health services to achieve the best possible outcomes" (IOM, 1993, 4). Levesque, Harris, and Russell (2013) explicate five aspects of accessibility of health care, including approachability, acceptability, availability, affordability, and appropriateness. Research finds that trans people face difficulties on all aspects of healthcare accessibility.

Trans individuals, for instance, are slightly less likely than cisgender people to have health insurance coverage: 19% lacked health insurance compared to 17% of the general population (Grant et al., 2011). The situation is even worse for transgender African Americans, who report the lowest coverage of any racial group (Grant et al., 2011). Lacking access to affordable health insurance prevents trans individuals from accessing medical care, yet even with insurance, barriers to receiving medical treatment remain. For example, many insurance plans do not cover gender affirming medical treatments, often dismissing them as "pre-existing" or "medically unnecessary" (Khan, 2013). Without insurance coverage, "some resort to use of street hormones acquired through friends or online" (Grossman & D'augelli, 2006; Sanchez, Sanchez, & Danoff, 2009), which can put users at significant health risks (Coleman et al., 2012; Nemoto, Luke, Mamo, Ching, & Patria, 1999; Williamson, 2010). Xavier et al. (2007) found that "half of hormone-experienced study participants obtained hormones from someone other than a doctor, and nearly 46% injected themselves with hormones or received an injection from someone other than doctor," with that number being significantly higher for trans men (71%) than trans women (37%).

Regardless of insurance coverage, trans individuals face dilemmas when they seek medical care. For example, trans people may postpone seeking care not necessarily as a result of affordability but because of past negative experiences with medical providers. Whereas an estimated 20% of cisgender people postpone medical care (Cunningham & Felland, 2008), Cruz (2014) found that nearly 50% of trans participants delayed seeking medical care, with about 28% indicating their decision to postpone was the result of a fear of negative experiences (Grant et al., 2011). Using data from the Trans PULSE Project, Bauer, Scheim, Deutsch, and Massarella (2014) found that 33% of trans respondents reported needing to use emergency department services in the previous year. Due to a self-reported fear of negative encounters with providers, however, 21% of these respondents indicated that they avoided seeking needed emergency care. This fear is not unfounded, as 52% reported negative experiences when they did receive emergency department care.

Even when trans people access medical care, they often report receiving inadequate, insensitive, and inappropriate treatment by healthcare providers and institutions. Such mistreatment can happen as soon as trans patients step into waiting rooms and are asked to complete intake forms. For example, a survey of over 500 healthcare facilities in the United States found that only 13% explicitly designed their health records to allow patients to indicate whether their current gender identity differs from the gender listed on their birth certificate or their insurance card. Despite the small percentage of healthcare organizations offering options for patients to self-identify in their health

records, over 40% of those surveyed indicated that they were interested in revising their forms to include such options (Hanneman, 2014). Nonetheless, the absence of inclusive health records in many healthcare facilities represents a form of discrimination that can communicate a lack of acceptance and support for trans patients.

Experiences with discrimination often continue as trans patients enter examination and emergency rooms. Nearly 27% of transgender participants in one study reported being outright denied care by medical providers, and another 35% report that their providers refused to touch them (Lambda Legal, 2010). Another national survey of transgender individuals reported similar results: 19% of the sample were refused care due to their trans or gender non-conforming status (Grant et al., 2011). Perhaps this is why some trans patients avoid disclosing their transgender status to their healthcare providers. According to the National Transgender Discrimination Survey, only 28% of respondents disclosed their transgender status to all of their healthcare providers (Grant et al., 2011), with 21% reporting not being out to any medical provider. In fact, being out to medical providers is associated with an increased likelihood of experiencing discrimination. Twenty-three percent of respondents who reported being out to providers were denied service because of their transgender status compared to 15% of those who were only "partly" or "not at all" out to their providers (Grant et al., 2011).

A shortage of properly trained healthcare providers also creates obstacles when seeking and receiving quality transgender medical care (Gardner & Safer, 2013; Snelgrove et al., 2012). In a recent Lambda Legal survey (2010), 90% of trans participants believed that there were not enough trained providers to address their medical needs. As a result, 50% of trans patients surveyed by the National Transgender Discrimination Survey reported having to educate their providers about transgender issues and care (Grant et al., 2011)—particularly trans men (62%) and those who have transitioned (61%). This lack of provider knowledge leaves many trans patients feeling frustrated and alienated—even in their interactions with well-intentioned medical providers. For example, Lurie (2005) found that even those providers who "were committed to providing high-quality and culturally sensitive care" felt unprepared to treat their trans patients. Such a lack of comfort and preparedness creates uncertainty for both patients and providers: Patients approach medical encounters with feelings of uncertainty about provider competence, and healthcare providers experience feelings of uncertainty because of their lack of knowledge. Poteat, German, and Kerrigan (2013) argue that this mutual uncertainty "challenges traditional clinical relationships in which the doctor is expected to be a knowledgeable authority, while the patient acquiesces to the provider's knowledge."

All of these factors, from a lack of health insurance to unprepared medical providers, create a situation in which many trans patients avoid or delay seeking preventive and emergency care. This reluctance to seek medical care can translate into the poor health outcomes reported among trans people. Next, we will consider how the problem and solution are intertwined in how medical students are trained.

3 | WHAT MEDICAL STUDENTS DO AND DON'T LEARN ABOUT TRANS PATIENTS

Given that these findings on the major health disparities experienced by trans patients indicate that bias and discriminatory behaviors on the part of healthcare providers are often to blame, it is important to consider how the culture of medical education might contribute to the disparity. Medical school is a space in which students learn not only the technical and scientific information required of practicing physicians but also the norms, values, and beliefs of the profession (Hafferty & Franks, 1994; Brosnan, 2009; Underman, 2015). Medical students are socialized through formal and informal encounters with their peers, patients, and faculty members (Hafferty, 1998; Hafferty & Franks, 1994; Brosnan, 2009). Sociologists have long pointed out that what is explicitly taught in the curriculum is just as important as what is omitted (Hafferty & Franks, 1994). As such, we argue that the overwhelming lack of curricular interventions that address trans patient care and health issues leads to a culture of silence and discrimination.

Studies show that very little attention is paid to LGBT health in medical school curriculum. In addition, transgender health is often undifferentiated from gay, lesbian, and bisexual health in these studies, making it difficult to know

how much space in the curriculum is dedicated to topics specifically about transgender health. A 2011 national survey of medical schools found that the median number of hours spent on LGBT topics in the curriculum was five (Obedin-Maliver et al., 2011). Two-thirds of medical students in a national survey rated their school's curriculum as fair, poor, or very poor (White et al., 2015a). Third-year clerkships and residency programs, during which medical students are exposed to or select a specialty, also do not address these gaps in the curriculum. Specialties with high levels of patient contact, such as pediatrics, family medicine, or internal medicine, do not spend much time, if any at all, working with medical students on transgender care. For example, a survey of family medicine departments found that only 49.4% reported spending any time on LGBT health (Tesar & Rovi, 1998). The average amount of time spent for those that did address LGBT health was 2.5 hr *over four years* (Tesar & Rovi, 1998). Likewise, electives and dual-degree programs are not preparing medical students to address what is left out of their curriculum. A survey of public health schools in the U.S. found that only 41% reported having at least one faculty member studying LGBT health and that most research and teaching on LGBT health centered on HIV/AIDS (Corliss, Shankle, & Moyer, 2007). Only 9% of schools surveyed offered a course about LGBT health extending beyond HIV/AIDS (Corliss et al., 2007).

Despite these major gaps in medical school curriculum, medical students do encounter LGBT patients during their training. A survey found that 91.5% of third- and fourth-year medical students reported at least one encounter with an LGBT patient⁴ (Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006). Studies have found that regular contact with trans and queer patients has positive effects on medical students. For instance, those with more frequent clinical contact with this patient population were more likely to have more positive attitudes and be more knowledgeable about LGBT health issues (Sanchez et al., 2006). Such findings suggest that there is a great need for more explicit attention to transgender health in medical education.

In addition to a lack of explicit training on transgender health, the treatment of trans students may contribute to a culture of bias and discrimination in medical school. Trans medical students face fear and discrimination during their undergraduate medical education and residency programs. A recent study found that 0.6% of medical students did not identify as cisgender (Mansh et al., 2015).⁵ Of these students, 60% were not "out" about their gender identity, and many cited fear of discrimination and lack of support as the reasons they chose not to disclose their trans identities (Mansh et al., 2015).

Despite the absence of transgender health in the curriculum and the hostile institutional climate experienced by some transgender medical students, many medical educators are pushing to develop more inclusive curriculum on LGBT health care. The AAMC, for example, recently released a 300-page report that identified medical education as a key site for eliminating health disparities among people who are LGBT, gender nonconforming, or born with DSD (AAMC, 2014). The report recommended the development of eight competency domains in medical school curricula to improve the quality of treatment for these patient populations. Some medical schools have started to integrate such recommendations into their curriculum. For example, at Tulane University, students participated in a series of three optional 1-hr didactic sessions and one standardized patient encounter to increase their knowledge and comfort about LGBT health care (Sequeira, Chakraborti, & Panunti, 2012). Some schools are already reporting positive results from these curricula changes. The medical school at the University of California at San Francisco, for example, developed a three-part intervention, including a syllabus, 1-hr patient panel, and 1-hr case-based discussion that was shown to be effective in increasing students' comfort and knowledge (Kelley, Chou, Dibble, & Robertson, 2008). A standardized patient case designed to increase students' comfort communicating with trans patients at the University of Illinois at Chicago was also recently piloted with positive results: Over 80% of medical students surveyed agreed or strongly agreed that the trans patient scenario increased their ability to effectively provide care for trans patients (Underman, Giffort, Hyderi, & Hirshfield, 2016).

Nevertheless, these interventions are still few and far between. Gaps in the curriculum, and indeed, in the culture of medical education have profound impacts on how medical students—and later, residents, and physicians—interact with and treat trans patients. Next, we discuss ways in which sociologists can unpack the relationship between medical education and transgender health disparities through utilizing the concepts of the hidden curriculum, patient health movements and consumerism, and medical competence.

4 | EXPLAINING THE LINK BETWEEN MEDICAL EDUCATION AND TRANS HEALTH DISPARITIES

4.1 | The hidden curriculum in medical education

How future practitioners are socialized into the culture of the medical profession is important for thinking about knowledge and attitudes toward trans patients. Through formal curriculum, interactions with peers and faculty, patient encounters, and other educational activities, medical trainees learn to adopt the values, attitudes, ethics, and dispositions of their field (Brosnan, 2009; Hafferty & Franks, 1994; Underman, 2015). Within this literature, the concept of the hidden curriculum (Hafferty, 1998; Hafferty & Franks, 1994) can help explain why what is included in medical education is just as important as what is not. The concept of the hidden curriculum was adapted from work in the field of education more broadly to help explain the reproduction of the culture of medicine (Hafferty, 1998; Hafferty & Franks, 1994). The hidden curriculum refers to “an undercurrent of norms, values, and regulations embedded within the training process that students are to assume and embrace in order to function effectively in a social role” (Michalec & Hafferty, 2013, 4). It is used to consider both interactions and structural factors (Hafferty, 1998).

The hidden curriculum has been studied in a number of ways with regard to medical education. For example, the concept of the hidden curriculum has been used to demonstrate gender bias in curricular content (Phillips, 2009). It has also been used to understand mismatches between explicit curriculum that espouses patient-centered values and educators' discriminatory words or actions, which often demonstrated bias against women, people with mental illness, overweight people, and LGBT people (Phillips & Clarke, 2012). Other studies examine the hidden curriculum in relationship to career expectations (Phillips, 2009; Hill, Bowman, Stalmeijer, & Hart, 2014) and professional identity development (Gaufberg, Batalden, Sands, & Bell, 2010).

Despite numerous studies on the hidden curriculum in medical education (Michalec & Hafferty, 2013), very little attention has been paid to transgender issues in the hidden curriculum. One notable exception is Murphy's (2016) study on how the hidden curriculum in medical education reinforces heteronormativity.⁶ Murphy argued that the “reproduction of heteronormativity was accomplished unintentionally through practices that seemed unremarkable” (Murphy, 2016: 261) in the medical school that she studied. Education about sexuality was a key site where heteronormativity was reproduced. Despite a lack of organized, formal curriculum on sexuality and sexual health, medical students still absorbed stigmatizing messages about LGBT patients. For example, the only place in the curriculum where trans patients were visible was during a panel about trans people's experiences with health care. Murphy concluded that:

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 (Murphy, 2016, 276).

Thus, the visibility of trans patients in some areas of the curriculum and their stark absence in others reinforces notions of heteronormativity and gender normativity in medical education.

We argue that sociologists concerned with health inequalities among trans populations should consider the hidden curriculum and other aspects of socialization in medical school and health professions education more broadly. Understanding explicit messages about gender and sexuality, as well as silences and exclusions, can shed light on the attitudes and behaviors that healthcare providers will later adopt with trans patients. These attitudes may affect whether trans patients decide to seek health care again in the future, thus potentially shaping health inequalities. As such, we suggest several areas of inquiry that may be fruitful for sociological research on the hidden curriculum.

First, given that curricular content on sexuality has been identified as a key site where discriminatory attitudes and behaviors regarding trans patients may be introduced, what *are* medical students learning about trans patients

in these kinds of lectures? What kinds of words are being used to discuss trans health, and how is gender identity being presented? Second, clinical skills are taught in various types of classes and workshops, and students are tested within their medical schools and on national licensing examinations on their ability to communicate in an empathetic and sensitive fashion. How trans-inclusive (or not) are the skills being taught in such workshops? What assumptions about gender identity are embedded in the teaching of such skills as taking a sexual history? Third, given that role-modeling during clinical rotations is a key area where medical students learn about clinical authority and attitudes toward patients, what kinds of interactions with trans patients are medical students seeing their faculty and mentors have? What kinds of attitudes and behaviors about gender identity occur “backstage” at the clinic? Such avenues of additional research may help to uncover how medical training contributes to the discriminatory behaviors that prevent trans people from seeking care and receiving appropriate care when they do seek it out.

4.2 | Patient health movements, consumerism, and medical education

Another lens through which sociologists can examine the relationship between medical education and transgender health disparities is through research on patient health movements and consumerism. The increasingly important role of consumer advocacy in the scope and demand for medical services has reshaped the provision of health care in today's society (Conrad, 2005). The recent attention in medical education to providing sensitive care to trans patients may be linked to broader transformations in which patients place pressures on the healthcare professions in various ways. We argue that studying the impact of trans patient health movements and consumerist practices on medical schools can provide insight into the causes of and potential solutions for transgender health disparities.

Patient health movements can refer to any patient group, health social movement, disease constituency, or other forms of health activism in which patients and those acting on their behalf organize to change, resist, or intervene in medical knowledge and practice (Brown & Zavestoski, 2004; Epstein, 2007). This literature is sometimes also framed as biological citizenship (Petryna, 2004; Rose, 2006), in which individuals attempt to make claims of rights or belonging based on some illness, injury, or bodily state. The literature on patient health movements and biological citizenship is too vast to adequately summarize here, but for our purposes, it is important to note that it demonstrates how organized groups of patients are able to intervene in the provision of health care, whether by demanding or accessing new treatments, shaping provider practices, or changing knowledge. For example, Mary C. Burke (2011) shows how trans activists challenged the medical establishment with regard to gender identity disorder as a diagnostic category. For activists, the gender identity disorder diagnosis was both stigmatizing and normalizing. Some rejected the diagnostic category as pathologizing gender variance, and others found it to be a means through which they might receive care. Framing transgender health as a medical condition rather than a psychiatric one may be a strategy through which patients and providers are able to access hormones and gender-affirming surgery, while at the same time producing gatekeepers and barriers for trans patients to navigate (Dewey & Gesbeck, 2015). In this way, trans activists and patients selectively resist or leverage medical understandings of gender in order to obtain necessary health care. These recent efforts may be viewed as a patient health movement or as a form of biological citizenship and may offer an explanation for the recent surge in attention to transgender health in medical education. We argue that it is important for sociologists to consider how medical schools have responded to trans activists' demands for change.

Market-based challenges also exist within medicine and may provide an avenue of potential research about attempts to address trans health disparities. Consumerism refers to the ways in which healthcare becomes a commodity and patient choice becomes analogous to spending power (Timmermans & Oh, 2010; Tomes, 2016). Although consumerism is frequently associated with transformations in medicine since the 1980s (Clarke, Shim, Mamo, Fosket, & Fishman, 2003), the roots of the patient-as-consumer go back to the early 20th century and the origins of the for-profit healthcare system (Tomes, 2016). Consumerism goes hand-in-hand with shifts toward a neoliberal economy of health care in which health has become a moral obligation that the patient must manage through self-monitoring and self-advocacy (Rose, 2006). Or, put another way, the option to exercise one's freedom of choice as a patient through purchasing power has become an obligation; seeking and maintaining health (rather than avoiding or treating

disease) has become a moral requirement for individuals. Consumerism most heavily benefits middle-class Whites (Tomes, 2016), who possess the necessary forms of capital to engage in such monitoring and advocacy practices.

One of the results of consumerism is the new emphasis on patient satisfaction in health care (Sitzia & Wood, 1997). Advocates of using patient satisfaction scores cite their success in the business world: "Marketing studies clearly show that high satisfaction levels have a positive impact on customer loyalty, repeat patronage, and more extensive and favorable referrals" (Dang, Westbrook, Black, Rodriguez-Barradas, & Giordano, 2013:2). Patient satisfaction is measured in a number of ways, including in relationship to outcomes (Fenton, Jerant, Bertakis, & Franks, 2012) and as a proxy for quality of care (Cleary & McNeil, 1988). Patient satisfaction is linked to physician compensation (Fenton et al., 2012). "Patient satisfaction is important because it means the physician has provided comfort, emotional support, education, and considered the patient's perspective in the synthesis of the clinical decision-making process" (Kupfer & Bond, 2012, 139). As such, the provider-patient relationship has come under scrutiny as a key element in patient satisfaction. In this new regime, producing more culturally sensitive healthcare professionals becomes linked to economic security for the medical profession.⁷ In this way, there has been an intensification of emphasis on professionalism as a "third pillar" in medical school (Underman & Hirshfield, 2016) and a heightened interest in teaching empathy as a form of emotional labor (Larson & Yao, 2005; Underman & Hirshfield, 2016). Simply put, due in part to consumerist pressures, medical schools now focus more time and energy on the doctor-patient relationship and emotional socialization.

Understanding the ways in which trans health movements and consumerist pressures transform medical school curricula is important for sociologists concerned with solutions to trans health disparities. Little research exists on how patient demands affect medical education, which makes this a key area of investigation. MyTransHealth.com and other similar examples of patient-led databases can be seen as a result of consumerist pressures in healthcare, as well as patient health movements putting pressure on their healthcare providers to alter their practices. In such databases, patients are encouraged to "shop around" for providers who are knowledgeable about transgender health issues and who interact with sensitivity and care. The existence of such databases depends on an organized social movement of trans patients. However, such databases are not the only places to see consumerism and patient health movements in action. Patient groups inside and outside of medical institutions are actively working to reform health care for trans people. Examples of such movements inside medicine include LGBT student groups and professional associations, as well as the actors involved in AAMC and other similar recommendations for reform. As such, we suggest three potential areas for research.

First, given the rise of patient satisfaction metrics and provider databases like MyTransHealth, how are medical schools responding? Are there increased efforts to collect data on trans patient encounters, and (how) are these data being used to make curricular transformations? Second, given the interest of organizations like the AAMC in incorporating LGBT health more fully into the curriculum, how are these changes occurring? Who is advocating for changes within medical schools, and what are the links to broader trans advocacy movements? Third, given the presence of LGBT student organizations in medical schools and in the AAMC, what changes, if any, are such organizations able to make? What kinds of events and resources do these groups receive? How do medical students make demands of their institutions, and how do stakeholders respond? Such areas of inquiry may help elucidate whether and how patient-led efforts to address discrimination in healthcare impact medical education.

4.3 | Cultural competency in medical education

In the previous sections, we recommended that the sociological concepts of the hidden curriculum, patient health movements, and consumerism should be applied to research exploring the relationship between medical education and transgender health disparities. With the recent push to change how doctors are educated about transgender health, questions arise regarding the content and form of such pedagogical interventions. Therefore, in this section, we suggest that sociologists might benefit from engaging with the medical education literature on competency-based medical education (CBME). In doing so, we argue that sociologists can better understand how competency discourses

and practices in medical school shape how providers learn how to care for their trans patients and might affect stigma-related trans health disparities.

In recent decades, the field of medical education has witnessed a proliferation of CBME with significant time being devoted to discussing and debating such programs in seminars, workshops, and the pages of academic journals (Hodges & Lingard, 2012). Sociologists have studied this historical uptake of competency discourse within the health professions. For example, some scholars have examined how the push for medical competency has been used historically as a resource in the boundary work practices of health professionals as they struggle to assert their jurisdiction over new domains of health and illness (Gieryn, Bevins, & Zehr, 1985; Witz, 1992). More recently, Leung (2002) and Sullivan (2011) highlighted the importance of rising accreditation standards as motivating the uptake of competency discourses in medical schools.

Developing and assessing medical competencies is not a new idea; such debates can be traced back to the mid-20th century (Grant, 1979; McAshan, 1979; McGaghie, Miller, Sajid, & Telder, 1978). But the idea of employing a competency framework to address stigma is relatively recent. In the 1980s, cultural competency emerged as a strategy for educating health professionals to effectively communicate with and care for an increasingly diverse U.S. population (Allen, 2008; Cross, Bazron, Dennis, & Isaacs, 1989). Cultural competency refers to the “trained ability to identify cross-cultural expressions of illness and health, and to thus counteract the marginalization of patients by race, ethnicity, social class, religion, sexual orientation, or other markers of difference” (Metzl & Hansen, 2014, 126). The goal of training medical students in cultural competency is to prevent unconscious bias and overt discrimination from impacting providers’ interactions with patients. Although there is evidence that cultural competency training can reduce health disparities (Betancourt, Green, Carrillo, & Park, 2005; Brach & Fraserirector, 2000), scholars have made several (sometimes scathing) critiques of cultural competency. First, medical anthropologists have criticized the idea of cultural competency for assuming that culture refers to fixed, intrinsic characteristics of a homogenous group (Kleinman & Benson, 2006). Consequently, in addition to treating culture as static, cultural competency also ignores differences within groups. Second, scholars have criticized the concept for focusing on individual attitudes and beliefs, therefore overlooking the role of structural factors in shaping health and illness (Abrams & Moio, 2009; Metzl & Hansen, 2014). Finally, despite acknowledging that the cultural backgrounds of patients and providers shape clinical encounters, medical sociologist, Renee Fox (2005), points out that cultural competence does not address how medicine itself has a culture and how this culture shapes interactions.

Despite such critiques, cultural competency training is seen as having an important role in medical education. Some medical educators have explicitly tied the adverse health outcomes experienced by many trans individuals to the lack of cultural competency training in medical schools (Corliss et al., 2007). Although cultural competency training in medical schools has been proposed as a strategy for combating LGBT health disparities (Kenagy, 2005), no formal or widely accepted curriculum currently exists (Bonvicini & Perlin, 2003; Feldman & Goldberg, 2006). A 2014 report released by the Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development of the AAMC, however, represents a major effort to develop a formalized, competency-based curriculum on LGBT, gender nonconforming, and DSD health with the explicit purpose of using medical education to reduce the negative health impacts of stigma. Drawing on Englander et al.’s (2013) Reference List of General Physician Competencies, the AAMC report proposes a list of 30 professional competencies needed to effectively address the needs of this patient population. These competencies fall into eight broader domains including patient care, knowledge for practice, practice-based learning and improvement, interpersonal and communication skills, professionalism, systems-based practice, interprofessional collaboration and personal and professional development. In August 2015, the University of Louisville School of Medicine became the first program to pilot the AAMC competency-based framework.

Despite the recent calls for cultural competency in trans health, little is known about how these pedagogical interventions are playing out in medical education departments.⁸ We recommend two areas of inquiry for research on cultural competency training aimed at reducing trans health disparities. First, given that scholars have critiqued cultural competency for homogenizing groups, we suggest that sociologists employ an intersectional lens to examine curriculum materials and teaching practices for trans competency: Do they reproduce homogenous categories? Do

they normalize certain trans experiences and render others invisible? If yes, what effects might this have on the ability of these interventions to address trans stigma in healthcare? Sociological insights from intersectional analyses of competency teaching materials may help educators improve the effectiveness of these emerging pedagogical interventions and their ability to redress trans health inequalities. This is particularly important given that research shows that trans people of color experience worse health outcomes (Grant et al., 2011).

In addition to examining the content of competency interventions, we encourage sociologists to attend to the processes by which medical educators come to agree upon the criteria for trans competency. For example, who is involved in the development and evaluation of such criteria? Do medical educators seek out and involve trans people? In other words, who is considered an expert on trans competency and allowed to develop the curricula that will be used to teach medical students how to deliver care to trans people? And what, if any, resistance emerges from this process, and from whom?

While social scientists have studied shifting ideas of transgender within and outside of biomedicine (Valentine, 2007), little work has examined how this category is reconfigured in educational initiatives for cultural competency and the consequences for access to and quality of health care. Just as medical categories of sex and gender have shaped the lived realities of transgender individuals, arguably so do the competencies that medical students learn through their training. By tapping into the medical education literature on CBME in general and cultural competency in particular, we argue that sociologists should consider studying the unfolding developments in medical schools as more programs move toward integrating trans health into their curriculum, as well as assessing their potential to lessen trans health disparities. In addition, this avenue of research could bridge the already-noted gap between sociology and medical education research (Hafferty & Castellani, 2009).

5 | CONCLUSION

The health disparities experienced by transgender individuals have been documented both anecdotally, through #transhealthfail, and empirically, through interviews and surveys. More recently, scholars have proposed that what is taught (or not) in medical schools might play a role in the reproduction of unequal health care for transgender people. The increasing recognition that medical education contributes to transgender individuals' poor access to and quality of healthcare provides opportunities for medical sociologists in general and those who study sex and gender in particular to develop research into how and why medical education creates and reproduces transgender health inequalities.

In this paper, we proposed three areas of inquiry that might help us identify and explain this situation. First, using the concept of the hidden curriculum, sociologists can examine how future physicians are socialized into the culture of medicine and how explicit and implicit messages about gender might shape physician knowledge and attitudes toward their transgender patients. Discriminatory behavior prevents trans people from getting necessary and even routine health care. Second, we encourage sociologists to consider insights from the literature on patient health movements and medical consumerism to untangle the factors contributing to the growing demand for clinical training in transgender care and how medical schools are responding. Finally, we recommend that sociologists tap into the medical education literature on CBME to examine the emerging pedagogical interventions into transgender health disparities, focusing on the emergence and trajectory of transgender competencies and their potential effect on trans health care. By employing these literatures, we argue that sociologists can develop more comprehensive explanations for the relationship between medical education and transgender health inequalities and potentially offer solutions to address this disparity.

NOTES

¹ In this paper, we use the terms *transgender* and *trans* to "refer to individuals whose gender identity and expression do not normatively align with their assigned sex" (Miller & Grollman, 2015, 810).

- ² Miller and Grollman (2015) define gender nonconforming as a "gender expression [that] breaks cultural expectations for normatively 'doing gender' " (810).
- ³ Disorders of sex development is a contested medical term for intersex traits (Davis, 2015).
- ⁴ The study did not differentiate among gay, lesbian, bisexual, and transgender patients.
- ⁵ Schilt and Westbrook define cisgender as "individuals who have a match between the gender they were assigned at birth, their bodies, and their personal identity" (Schilt & Westbrook, 2009, 461).
- ⁶ "Heteronormativity refers to the innumerable ways in which heterosexuality is posited as the natural, normal, unproblematic, taken-for-granted way of being" (Murphy, 2016: 264–265).
- ⁷ Critics have pointed out, however, that patient satisfaction does not always mean better care, because physicians must balance appropriate care with what patients want (Mol, 2008; Kupfer & Bond, 2012). For example, when prescribing opioids, physicians balance the risk of addiction with patient demands (Zgierska et al., 2012).
- ⁸ Some research, however, does exist on the effectiveness of competency trainings in nonprofit health centers, demonstrating an increase in health professionals' awareness of the healthcare barriers of trans individuals, as well as their knowledge and skills to care for this patient population (Hanssmann et al., 2008; Thomas & Safer, 2015). That said, we advocate studying not only the potential effectiveness of these programs but also the content, process, and consequences of cultural competency discourses and practices on trans health.

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