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Commentary

Lesbian, Gay, Bisexual, and Transgender Medical Students and Their Ethical Conflicts

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There are some studies of the ethical conflicts medical students face generally, but there are no studies that describe the ethical conflicts lesbian, gay, bisexual, and transgender (LGBT) students face by reason of their sexual and/or gender identities. Given the demonstrated presence of hostility toward homosexuality and transgenderism in medical schools, it cannot be assumed that conflicts about sexual and/or gender identities leave no impact on the personal moral development of future physicians or their views of the integrity of the profession as a whole. There is considerable need for study of the effects of homophobia and unsupportive educational environments on the values and ethical commitments of LGBT medical students. This study is important in its own right and not merely in terms of the improvement of patient care, which has usually been the justification for attention to sexual identity in medical school curricula.

KEY WORDS: lesbian; gay; transgender; medical school; homosexuality; ethics; medical students.

INTRODUCTION

Given the way in which medicine once treated homosexuality as pathological and given continuing social hostility toward same-sex eroticism, it is not surprising that there are still unresolved tensions regarding the place of lesbian, gay, and bisexual students in the medical profession. Moreover, given medicine's unsettled debate about transgenderism, it is even less surprising that self-identified transgender students are uncommon in medical schools. While psychiatry accepts gender interventions if all else fails, it nevertheless still considers those claiming opposite sex identities as mentally disordered (1). While the matter is not well studied, lesbian, gay, bisexual, and transgender (LGBT) students sometimes do face hostile or discriminatory environments in medical school.

Studies in the 1980s showed that some physicians would refuse admission to LGB applicants to medical school, though the prevalence of that view seems to be diminishing (2). It is also clear that physicians in key academic positions—directors of residency programs—hold negative views of homosexual orientation. In fact, one 1994 survey showed that one in four residency directors in family practice "might rank" or "most certainly" would rank an applicant known to be gay lower than a heterosexual applicant (3). Some of these directors reported that they would not rank applicants for acceptance if they knew them to have a homosexual orientation. Once in school, some medical students witness or directly experience discrimination related to their sexual/gender identities (2). Other students encounter not blatant discrimination but uncomfortable silences about LGBT issues or discouragement from pursuing these issues because they might get in the way of professional advancement (4). The status of transgendered students may be complicated in ways that magnify the worries facing LGB students, though this conclusion is speculative because there are no systematic studies in this area. There is, though, enough anecdote and intuitive

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sense to conclude that hostility and discrimination toward LGBT matters are still live concerns.

Medical schools have not been blind to these concerns. In most medical schools, efforts to deal equitably with homosexuality have gone forward largely as educational programs *with improved patient care* as their focus. Some analysis explicitly says as much: "The primary purpose of teaching about homosexuality is to improve the health care of gay men and lesbians" (5). Toward this end, many medical schools now offer a range of panel discussions, lectures, meetings with LGBT persons, and films in their curricula (5–7). These programs are designed to familiarize students with various aspects of same-sex erotic behavior as well as LGBT identities. Other efforts involve teaching students how to conduct histories and physical examinations without presuming the heterosexuality of patients. These efforts are aimed largely at making medical students more comfortable with homosexuality in general and LGBT patients in particular. While it appears that these interventions—and personal acquaintance with a lesbian or gay man—do help in reducing hostility toward homosexuality (8), they do not eliminate it entirely (9–11).

Some schools do more than modify the curriculum in the name of patient care, they offer social services to LGBT students. Some schools sponsor student groups, offices of LGBT concerns, or liaison officers concerned with l/g/b issues, and these services can be helpful for students generally even if they do not transform an educational institution into an ideal place for students (12, 13).

Yet there is a conceptual limitation to the way in which most medical schools have tried to improve the profession's record on sexual and gender identities. While efforts to serve LGBT patients sensitively and to offer academic support to LGBT students are all to the good, they are still only part of the story. The untold part of the story is the *effect* of hostile educational experiences on students themselves. This is a extremely poorly studied area. Even in the most sympathetic studies, the effect of anti-LGBT hostility is mostly construed as a problem *for patients*, as against medical students themselves. That is, educators worry primarily about homophobic interactions with patients (and especially patients with HIV and/or AIDS) rather than with medical students and/or residents (14).

For example, one undated study of students at a Midwestern medical school showed that some medical students either agreed or strongly agreed with statements that 1) homosexuality is immoral, 2) homosexuals should not be allowed to work with children, 3) homosexuality is a mental disorder, 4) those in favor of homosexuals tend to be homosexuals themselves, and that 5) they themselves avoid homosexuals whenever possible. This same study also showed that some medical students disagreed with statements that 1) they enjoy the company of homosexuals, 2) they would feel comfortable working with a fellow medical student who is homosexual, and that 3) homosexuals should have equal opportunity employment (15). For all the good it does in outlining the extent of resistance toward homosexuality, this study—and virtually every other one like it—theorizes the importance of confronting and undoing these views in order to improve patient care. It is as if students are somehow assumed to be capable of weathering any animus from their peers and instructors, and that only patients are in need of protection from anti-LGBT hostility. It is not to be doubted that many LGBT students prove resilient in the face of hostility; it is simply that we do not know what price these students pay for that hostility in terms of moral compromise and missed opportunities.

Another commentary in the literature laments the lack of attention to LGBT issues in the curriculum because this inattention promotes the idea that "gay-specific patterns of illness and wellness do not exist" (16). To be sure, if medical students are not sensitized to the possiblity of specific health risks of LGBT people, they may well overlook these dangers in their practice and do a disservice to their patients. But, again, this focus overlooks students entirely. Even among the most sympathetic studies, *commentators have consistently failed to address the impact for students of hostility based on sexual orientation and gender identity.*

What is known about the effect of hostility in medical schools is that LGBT students do report objectionable experiences, and that they take tolerance and climate into consideration when choosing which residency training to pursue (2). Beyond that, nothing is known about the significance of students' ethical conflicts for their personal and professional moral development. The overall ethical development of LGBT medical students is terra incognita. There is nothing in the literature to describe the ethical conflicts LGBT students face in regard to their sexual/gender identities, nothing that describes the effect of these conflicts on their moral development, and nothing that describes the impact of these conflicts on their

professional moral values or the view they take of medicine's core values.

Ethical conflicts and their moral resolution can be all the more influential for students who are coming to grips with their sexual and gender identities *during* medical school. It is a mistake to assume that students have fully formed sexual and gender identities during medical school *or* that they have fully formed moral characters, which are more or less immune to the challenges of medical education. The assumption of an LGBT identity—let alone a moral identity—is a continuous process; it may well be that the ethical conflicts LGBT students face are significant because they take place during a time in which their personal and professional values are being shaped in fundamental ways, at times when their moral identities are being consolidated. An ethical conflict can have lifelong repercussions. This ethical impact is all the more significant with LGBT medical students since they may have to face their ethical choices alone, without readily identified friends and mentors with whom they could discuss options and the meaning of various choices for their professional lives.

OPENING AN AREA OF INQUIRY

The literature shows that medical students raise different ethical questions than those debated by their elders who are immersed in public policy, resource allocation, and various hot button topics of the day. Whereas professional analysts may revel in commentary about the ethics of human cloning, genetic experimentation, national health insurance, and other questions emblazoned in news headlines, medical students report ethical questions that are more closely related to their immediate experiences. For example, one study showed that medical students reported ethical conflicts related to their ability to carry out procedures, to conduct patient education, about their place in the hierarchy, about the adequacy of their knowledge, about the proper use of their knowledge, and the extent to which they should challenge objectionable practices (17). These questions bear on moving into a professional role, preparedness for that role, and responsibility for personal improvement. While these day-to-day worries of junior professionals are almost never studied in-depth by professional ethicists, they are nevertheless important as introductions to moral engagement and educational practice, and it is eminently reasonable to address these questions in the medical curriculum.

It is also reasonable to expect that LGBT medical students face not only the foregoing kinds of ethical conflicts but also conflicts related to their sexual/gender identity. That is, in addition to ethical questions faced by *all* medical students, LGBT students face *an additional* set of questions associated with their sexual/gender identity. These questions are rooted in various patterns of social hostility toward homosexuality or in the *expectation* of this hostility. These patterns of anti-LGBT hostility can cause worries among students even if there is no explicit condemnation of homosexuality or LGBT persons in the educational environment. In other words, unless there are cues to the contrary, students may expect medical school to be no different from the culture at large where hostile sentiments often hold sway in important ways over the lives and fates of LGBT people. At the very least, LGBT medical students must be ever alert to the possibility that some adverse experience may come their way by reason of their sexual/gender identity.

At this point, there is more to learn about the meaning of ethical conflicts faced by LGBT students than is known at present. In view of the variety of possible ethical conflicts and their far-reaching implications, I believe it is important to know—at the very least—whether and to what extent LGBT medical students report ethical conflicts in instructional settings and educational relationships. These conflicts could include deciding how to respond to belittling accounts of homosexuality offered by an instructor, inaccuracies about sexual minorities in assigned reading, or observation of discriminatory behavior toward patients. The conflicts might also involve hesitation about raising questions of sexual and gender identity in classroom discussion or clinical instruction. The conflicts could also include generalized fears about the students' acceptance in medical school—what to say during interviews for medical school—and the medical profession itself. The conflicts would also include worries about whether to disclose one's sexual/gender identity in classroom settings, applications for scholarships, applications for residency, and so on. The conflicts might also involve being assigned time-consuming duties in preference to married peers with children, on the theory that LGBT people have fewer familial responsibilities and may therefore bear a disproportionate share of the work. In each case, of course, the key element at stake is the ethical conflict *as the students experienced it*, whether or not the sexual

and/or gender identity of the student was known at the time to the people whose actions precipitated the ethical conflict. The LGBT student may be the only one in the situation, after all, who perceives an ethical conflict at hand.

Over and above a catalogue of answers to the question of "what happened?" it would also be interesting to know whether ethical conflicts promote or work against moral development. By moral development I mean the acquisition of a core set of values and a logic of decision-making. It would be instructive to know, for example, how medical students understand their ethical identities as they respond to sexual/gender identity hostility. For example, if they choose not to disclose their sexual identity during conflicts, do students interpret this choice as a moral lapse or as a protective strategy having a situational integrity of its own? Other responses to ethical conflicts might include doing nothing, talking privately with an instructor later, complaining to a student service group, consulting a counseling service, writing an anonymous note, leaving medical school, and so on. These kinds of responses could and should be studied in terms of students' own perception of their moral meaning, namely, what values are served by these choices.

There can be and probably should be another axis of analysis in looking at the ethical conflicts of LGBT students: long-term professional consequences. If students adopt protective strategies in medical school, do they imagine that these will limit their ability to enter fully into professional relationships with colleagues later on? Because of ethical conflicts, do they see the medical profession as hypocritical or worse? If students disclose themselves as lesbian or gay to other students or to faculty do they imagine that they will be able to have more trusting relationships with their patients than those LGBT professionals who do not?

Admittedly, the research that could get answers to these questions is somewhat difficult to articulate. Indeed, it might be that sagacious commentary by seasoned physicians who have been through ethical conflicts of this kind could be as incisive and instructive as any long-term survey research of a small cohort of subjects answering structured questions. Whatever methods might be useful, it is enough to point out the value of asking whether ethical conflicts in medical school affect core values and engagement in the moral life of the profession. I do not, certainly, assume that only these kinds of ethical conflict are worthy of study; they are however the only issues under consideration here. In any case, study in the area should try to get at whether and to what extent LGBT students faced forced ethical choices—choices that the students would prefer not to make—that ultimately work against an unconflicted personal moral integrity as well as against trusting relationships with patients and colleagues.

Another goal of such study should be to identify recommendations to reduce the ethical conflicts LGBT students face and to help students negotiate the conflicts that remain (even if those problems seem at present intractable to intervention). These recommendations might include, for example, initiatives to increase visibility of LGBT faculty, to institute student groups where there are none, to appoint formal liaison officers, to treat homophobic acts as violation of honor codes in schools having that option, mechanisms by which students can recommend modifications to educational materials, and so on. Certainly, this is an incomplete list of examples. Without asking them, there is no knowing what might help LGBT students.

CONCLUSIONS

By reason of its intensity, medical school can be the occasion of ethical conflicts, and students' responses to those conflicts can resonate for a lifetime. These conflicts can also shape the tenor of the profession as a whole. LGBT students face not only the ethical conflicts that pertain to their status as students, they also face conflicts unparalleled in the lives of other students, conflicts that bear on their sexual and gender identities. Students can face, for example, dilemmas about disclosing their sexual or gender identities in educational and professional settings. At this point it is an open question whether LGBT students are compromised in any significant way by these ethical conflicts or whether they are able to negotiate responses that do not compromise or vitiate their personal morality. Or, is it even possible that ethical conflicts forge a stronger personal morality than they might otherwise have had? For example, if students do choose to disclose their sexual/gender identity during a moment of conflict, do they see themselves as better persons and better situated to confront and reform the morality of the profession at large? Or, by contrast, if they choose not to disclose their sexual/gender identity during medical school, do they interpret this choice as a moral lapse or a necessary evil?

The foregoing discussion amounts to a plea to back up questions about the ethics of instruction with

research on the incidence and significance of ethical conflicts faced by LGBT students. I have not myself done this research. I have tried to prepare the way for it by describing what we do not know yet. Research in this area would be relevant not only insofar as it described the moral experiences of medical students but also as it opened a window on the values of the profession generally. It is not an idle question to try and learn whether there is anything about the ethical conflicts LGBT students face—or their responses to them—that works for or against the ethical values important to personal and professional integrity. Because this area of study is without much precedent, there are many ways in which it might go forward. It could certainly move in stages: first establishing a baseline of identified conflicts, students' responses to them, and students' perceptions of the impact of those conflicts on their personal and professional development. Beyond that, the research might try to characterize moral development according to various schemas that describe levels or stages of moral growth. However this research might go forward, it will work to improve not only the climate for patients but *for students* as well, and that would be no small accomplishment.

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