

Pride and prejudice: LGBTQ+ communities and teaching hospitals in India

-Mukul Bhowmick and Sangeeta Rege³⁶

Medical and healthcare systems have historically vilified persons belonging to sexual and gender minorities, pathologizing all identities which do not conform to the cisgender-heterosexual (cishet) 'norm'. While many legislative strides were made in recognising LGBTQ+ rights in India- reading down of Section 377 by the Supreme Court in 2018, the Transgender Persons (Protection of Rights) Act in 2019- the medical discourse on such marginalised identities was not heeded to with equal vigour. The Indian healthcare and medical education system still continues denigrate sexual and gender minority identity as a 'risk factor' for HIV/AIDS, ignoring how such an identity creates vulnerabilities and impacts other health conditions. Back in 1996, the American Medical Association recommended that greater educational efforts be directed towards medical students and focus on healthcare needs of LGBTQ+ people in the United States. More than two decades later in 2021, Justice N Anand Venkatesh of the Madras High Court instructed the National Medical Commission (NMC) to rid medical

textbooks off its homophobic and transphobic content.^x

Thakurta emphasised how medical textbooks create biases and presumptions about non-normative gender and sexual identities in the minds of doctors that are difficult to unlearn despite continuous development in the field of gender-sexuality and availability of 'new knowledge'.^{xi} The language of medical textbooks in this regard is also problematic. Achuthan and Singh (2019) found that the manner in which gender and sexuality are positioned in medical texts produces notions of normativity and claims scientific objectivity in medicalising 'unnatural, pathological and deviant' sexual-gender identities in the garb of value neutral knowledge.^{xii} In August 2022, an expert committee recommended queer-inclusive changes in the Forensic Medicine and Psychiatry syllabi^{xiii}, in a language focusing on competencies as enshrined in the revised medical education curriculum introduced in 2019. Some examples of the recommended competencies are listed below:

FM 3.16: Describe and discuss histories of gender and sexuality-based identities and rights in India

PS 13.1: Demonstrate an understanding of difference between sex and gender, gender identity, sexual identity and orientation, and knowledge about basic tenets of LGBTQ+ affirmative counselling

³⁶ CEHAT

PS 13.4: Demonstrate in a simulated environment the ability to educate and counsel individuals or family members about intersex variations, sexual orientations and identities

PS 13.6: Enumerate criteria to diagnose gender dysphoria according to the latest psychiatric classifications (World Professional Association for Transgender Health- WPATH guidelines)

PS 13.7: Discuss situations where there is a role for mental health support in gender dysphoria like, discussing with family, deciding on hormonal treatments or gender affirmative therapies

PS 13.8: Demonstrate knowledge and ability to educate family members that unnecessary medical interventions on individuals with intersex variations are unethical

As laudable as these recommendations are, there is a need to critically examine existing educational and clinical practices in medical colleges to understand how such transformative changes can be operationalised in teaching hospitals. Narrain and Chandran (2016) in their book, dove deep into the phenomenon of healthcare discrimination faced by sexual and gender minorities through multiple examples of violence and violations and highlight the need for affirming support by medical systems.^{xiv} Efforts to integrate gender perspectives in medical education by the Centre for Enquiry into Health and Allied Themes (CEHAT) since 2015, including developing

teaching modules relating to gender-sexuality, training of trainers in this subject, and expanding this knowledge into clinical practice, gives unique insights into the current state of the medical establishment vis-à-vis LGBTQ+ communities.

Findings from our recently conducted situational analysis of practices in teaching hospitals of peripheral Maharashtra revealed that there is little to no interaction of medical educators with LGBTQ+ individuals. Interviews with psychiatrists highlight problematic protocols and attitudes in the rare instances they are consulted for gender certification by transgender individuals. An overwhelming sense of diagnostic authority, coupled with referrals made to cities located hundreds of kilometres away from the facility for psychological evaluation undermine the supportive role played by doctors in the process. One doctor even said that they are not aware of the standard guidelines to be followed in such 'cases', and reached out to their professional network of other psychiatrists should they face this 'problem'. This is not surprising, as testified by the many horrific experiences shared publicly by transgender individuals across India on online fora like transgenderindia(dot)com. Despite the policy and clinical frameworks outlined by Transgender Persons (Protection of Rights) Rules of 2020, NIMHANS Manual on Mental Healthcare of Transgender Persons in India and WPATH guidelines, there is a blatant lack of awareness among doctors about

these, which raises questions on their training capabilities of future doctors.

Similarly, through our experience of training educators, we know that, albeit seldom, educators spare a thought about intersex variations only when a child with 'ambiguous genitalia' is born. However, doctors are not trained in the ethics involved in managing these babies and their families. Firstly, the rarity of such 'cases' predisposes intersex babies to be a spectacle, for students, interns and other doctors in teaching hospitals, often compromising their right to privacy, confidentiality and dignity. Secondly, there is an overwhelming urgency to classify intersex babies into the gender binary, which is disconcerting. Premature medical assignment of sex to babies with intersex variations are known to cause many physical and psychosocial health problems in the future, as documented by psychologist John Money's John/Joan case at Johns Hopkins hospital^{xv}. Such negligent attitudes and practices, compounded by public policy failures like necessitating submission of a gender-binarized birth registration certificate to the registrar within 30 days of birth, is violative of intersex rights. Eliminating such practices, effective training of medical students in these matters and advocating for intersectoral policy changes is impossible without building perspectives of educator-providers in these issues.

Yet another concern which deserves attention is the abysmal deficiencies in doctors' soft skills related to interaction

with LGBTQ+ individuals. It is pivotal that doctors realise overlooking salient aspects of communication with LGBTQ+ individuals, especially transgenders, severely impacts an effective doctor-patient relationship. Institutionalising a protocol for enquiry about preferred pronouns, knowledge about deadnaming, along with a non-judgemental and empathetic attitude can help allay fears of an individual belonging to a community which suffered the brunt of medical dogmatism. Efforts in this direction are essential to put an end to LGBTQ+ communities' ordeal of hunting for queer-friendly spaces to access basic healthcare. Comprehensive management also includes acknowledging what medical institutions cannot manage and preparing a list of support groups and civil society organisations who can offer assistance—a glaringly absent practice in most medical colleges.

As for the recommended competencies themselves, it is crucial to underscore the need to educate students on other health needs of LGBTQ+ communities. This can begin with emphasising on topics like intersex variations (differences of sex development) in anatomy and physiology, community-based approaches to LGBTQ+ health in community medicine, unique sexual and reproductive health issues of LGBTQ+ in clinical specialties like gynaecology, medicine and surgery and principles of LGBTQ+ affirmative care in attitude-ethics and communication (AETCOM). However, revising medical curricula is

just a small step in bringing change to a 'culture' of medicine that still largely operates within a largely cis-het framework. Institutionalised discrimination in the context of sexual and gender minorities ranges from overt violence to lesser conspicuous violations of their rights stemming from a failure to recognize unique needs of LGBTQ+ communities. There must be a larger impetus in crushing biomedical dominance in medical education, addressing the asymmetrical power dynamics in healthcare provision and creating a medical education ecosystem which trains students on the social determinants of health. Only this can ensure we produce doctors, who go on to treat patients, run health programmes and draft health policies in a manner that is not only gender-responsive, but gender-transformative.

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