

# A Case for the Demedicalization of Queer Bodies

Erik Eckhert

*University of California San Francisco / University of California Berkeley Joint Medical Program*

The medicalization of queer bodies in the clinic and the lab is inexorably linked to the history of LGBTQ politics. Increasingly, activists and scholars are recognizing that while the natural origins of queer sexualities carry a certain political weight, invoking the naturalness of being “born this way” fails to articulate a more substantive challenge to the effects of unexamined cis- and heteronormativity on our social institutions. With this in mind, it is crucial to understand the way these biases operate in scientific research and healthcare so their impact on what we know and how we care can be addressed. It what follows, it will be shown that the medicalization of queer bodies not only fails to diminish these deep-seated biases from sexuality research and clinical practice, but that it also impedes care providers from addressing the healthcare disparities facing queer patients today.

## INTRODUCTION AND DEFINITIONS

The queer rallying cries “I was born this way” and “I was born in the wrong body” are as much a nod to the past as they are a sign of the times. They signify the rise of queer public identities and the eruption of a multifaceted political consciousness over the last hundred years. Their power is derived not only from the personal experience of their speakers, but also from a legacy of medicalization of sex and sexual orientation – as well as the misplaced but politically expedient equation of naturalness with morality.

In this essay, “queer” is used as both as an umbrella term as well as a signifier of disruption of the normative lesbian, gay, bisexual and transgender (LGBT†) identity categories. “Medicalization” is the (often unconscious) process by which organisms, tangible objects, or social constructions are rendered into biomedical terms. By couching a thing in a medicalized framework, clinician-scientists are able to describe it using the language of biology, which usually has the effect of discursively producing it as a “natural,” ahistorical phenomenon. The dispassionate language used in the medicalization process also facilitates the affective detachment of the speaker (the biomedical expert) from the thing itself.

Historically, labs and clinics have (for better or worse) had a heavy hand in shaping queer bodies and the queer body politic. This legacy continues to impact both LGBT politics and clinicians’ capacity to care for queer people today. Moreover, the lab and the clinic each exert influence on each other’s medicalizing capacity. In what follows, the roots of the medicalization of queer bodies are sketched through a brief analysis of the two aforementioned rallying cries. This will contextualize a discussion of the variegated relationship between the medical establishment and queer communities, and will historically ground a call for greater attention to the cis- and heteronormative biases that undergird our healthcare system. Ultimately, the purpose of this piece is to provide a bit of sociohistorical context to physician-scientists (who typically approach problems from a more biomedical perspective) in an effort to foster new ways of thinking about what it means to care.

## ORIGIN(S) STORIES

In *The History of Sexuality Volume 1*, Michel Foucault describes the process by which “the homosexual” came to be understood in biological terms. Whereas the

\*To whom all correspondence should be addressed: Erik Eckhert, University of California, Berkeley School of Public Health, 50 University Hall #7360, Berkeley, CA 94720-7360, email: erik.eckhert@ucsf.edu.

†Abbreviations: ACT UP, AIDS Coalition to Unleash Power; LGBT, lesbian, gay, bisexual, transgender; MSM, men who have sex with men.

Keywords: heteronormativity, history of medicine, LGBT, medicalization, nature, pathologization, queer

ancient “sodomite” was a criminal tempted to commit crimes against society, the nineteenth-century homosexual became a personage, a past, a case history, and a childhood, in addition to being a type of life, a life form, and a morphology, with an indiscreet anatomy and possibly a mysterious physiology” [1]. With this rhetorical speciation came an explosion of theories on the biological origins of “the homosexual.” By naturalizing the species, the desires and actions of the homosexual became biological facts rather than moral failings. This represented a fundamental departure from a Judeo-Christian value system that located the sodomite’s sin in the unnaturalness of their actions. And because pathologization organizes sexual deviation under the heading of natural variation, legal retaliation against people acting in accordance with their biology was argued to be insensible [2].

Sexual deviants came to be cast as objects of pity – cursed with the wretched burden of a cruel biological fate. Pop cultural references by early homophile activists like Karl Ulrichs (who was in 1867 arguably the first “out” gay activist as well as the first to describe a sexual ecology that closely mirrors our contemporary categorization scheme for sexual orientation) and Radcliffe Hall (who wrote the infamous 1928 literary classic *The Well of Loneliness* starring an ill-fated lesbian aristocrat) to people who would today fall under the queer umbrella promoted this newfound naturalization. And from 1900 until his death in 1939, Havelock Ellis (among other researchers) pushed for more neutral language in the field. By changing the conversation about homosexuals from one of neurological degeneration to one of biological anomalies [3], this small discursive move shrunk even further any implications of moral failing or personal choice. Decades later, grassroots organizations would denounce moralizing homophobic claims by invoking this (non-pathological) biological framework. For example, Harry Hay’s Mattachine Society (founded in 1950) organized gay men on the premise of a right to live publically without fear, and subsequently queer organizations like AIDS Coalition to Unleash Power (ACT UP) (founded in 1987) would protest for the right to medical care in response to the AIDS epidemic. It is through this general series of events that biological arguments were taken up as political tools and that “I was born this way” came to function as shorthand for the justification of queer rights.

The choice of the word “queer” and not “homosexual” is intentional. This is because while “I was born this way” was discussed primarily in the context of Foucault’s “birth of the [implicitly male] homosexual,” it is important to note that (as trans theorist Jay Prosser has previously argued), the most impactful early conceptions of “homosexuality” (i.e. sexual inversion – see below) look a lot more like our contemporary conceptions of transgender subject positions [4]. Moreover, the contemporaneous existence of Karl Ulrichs’s more complex categorization scheme (which consisted of lesbians (*urningins*), gay men (*urnings*), male bisexuals (*uranodionings*), female bisex-

uals (*uranodioningins*), intersex folks (*zwitterns*), and others) with the model of sexual inversion supports the idea that early medicalization of non-heterosexuals did not explicitly apply to homosexual men. This, and the fact that “I was born this way” is today brandished by anyone under the proverbial rainbow, supports the fundamental idea that medicalization shaped a spectrum of queer identities.

In contrast, “I was born in the wrong body” remains a uniquely trans signifier. However, the “trans” subject has changed over time from sexual inversion to transsexual to transgender. The “invert,” as described in 1886 by Kraft-Ebing in *Psychopathia Sexualis*, was characterized by a metamorphosis from a prototypical (heterosexual) male subject to one interested in other men – to one who wanted to be penetrated by other men – to one whose physical sensations are like those of women – to one in a permanent state of “paranoia” who believed he was a woman. As the concept of homosexuality was refined to be primarily about same sex desire, so did the idea of transsexuality come to be understood primarily as a desire to embody the opposite sex. Of course, it is important to note that the performativity of gender draws on both sex and sexual orientation, and in practice, knowing where one of these terms ends and the other begins can be tricky. “Inversion” gets at this relatedness, but it does so in a rigidly heteronormative way, whereby to be “born in the wrong body” also necessarily means being attracted to the “wrong sex.” From this rigidity, the transsexual was born.

Early clinical standards for candidates for sex reassignment surgery drew on Harry Benjamin’s 1966 *The Transsexual Phenomenon*. Highlights include a patient’s disidentification with their genitals (including an omission of any sexual pleasure enjoyed while living as the opposite sex before surgery), their ability to behave like the opposite sex, their expression of homosexual desires prior to surgery (and thus their expression of heterosexual desires afterwards), and the absence of unmanaged psychological conditions that could disrupt a patient’s transition. Thus, the early bars for sex reassignment surgery were nothing less than the conditions that would hinder a complete transformation to the “opposite” sex with the “right” anatomy, the “right” behavior and the “right” desire. Only by embodying being “being born in the wrong body” could patients get access to surgery, so predictably this requirement was quickly learned and performed by patients [5]. After most of these stringent requirements for surgery were dropped, and even after “transsexual” was rejected by many trans activists for the less medicalized umbrella term “transgender,” the “I was born in the wrong body” discourse persisted because of the way it has shaped the trans identity category itself. In sum, it is important to note that while all queer bodies were shaped by medicalization, the historical relationship to medicalization is more complex for trans people than it is for LGB people. Specifically, trans people are unique among queer people in that their identities are (to a greater extent) the product of med-

icalization's erasure or silencing of their actual lived experiences – either through omission of their experiences altogether, or through enforcing conformation to the medical script used to restrict access to the hormonal and surgical tools that they desire.

Admittedly, the above vignettes are highly abbreviated and quick to smooth over the intricacies and inherent contradictions of these events. But they illustrate that a critical aspect of homosexual, bisexual and transgender identity positions congealed in response to their medicalization. This solidification was not a unidirectional process. Homophile activists like Radcliffe Hall and Karl Ulrichs borrowed from the medical literature to knit together the cultural materials that would foster communities, push back against punitive laws and question social mores. Meanwhile clinicians (sexologists, psychologists and physicians) like Richard von Krafft-Ebing and Havelock Ellis created a swarming expansion of case studies to nail down the origins of a variety of sexual groups, the similarities and differences between them, and the ways their biologies, behaviors and desires diverged from those of heterosexuals.

## QUEER IMPLICATIONS

As described above, the medicalization of sexual orientation and gender identity can be understood as the beginning of a new paradigm shift in sexual politics that signified the start of public movements for queer rights. But crucially, it also opened the doors for increased scientific scrutiny of sexual minorities. The attention is in part because of the way scientific research on sexuality is conducted: populations are observed for variations and subsequently researchers attempt to explore the origins of those variations from numerous biological perspectives using a variety of skillsets. The identification of sex, gender and sexual orientation as natural phenomena was a windfall for curious minds seeking to better describe and understand the world around them.

But while this focus is inexorably tied to historical advancements in queer rights, the heightened scrutiny strikes many in the queer community today as unsettling. It's not that the attention itself is disconcerting but that the attention is so often filtered through researchers' observations or preconceptions about the ontological status of a sexual outlier in relation to a population-level heteronorm. Despite the fact that the language used to characterize sexual variation is much more neutral than it was during the time of Kraft-Ebing, most of the contemporary scientific literature on sexual orientation still subtly (and often not so subtly) privileges cisgendered heterosexuality above 'the other' variations [6].

The remainder of this piece will focus on the rhetorical complexities inherent to modern research on sexual orientation, the clinical implications of a legacy of sexual medicalization, and why medico-scientific discourses are not capable of addressing the fundamental impediments

to justice for queer people. Ultimately, it will be shown that the medicalization of queer bodies not only fails to diminish these deep-seated cis- and heteronormative biases from sexuality research and clinical practice, but that it also impedes care providers from addressing the health-care disparities facing queer patients today.

## I. RESEARCH

For the sake of brevity, this section will focus primarily on basic science and translational scientific research, which are often neglected in discussions of heteronormative bias in sexuality research. While the more esoteric content of basic and translational research does function as an inherent barrier to researchers making sweeping social generalizations in their published work, it is often paradoxically more profoundly affected than is clinical research. This has to do with the fact that translational scientists use animal models to ask different (and arguably more fraught) questions than do clinical researchers. While observational studies of human subjects are used for estimating prevalence of L, G, B, or T populations, for probing any associations between sexual orientation and genetics and anatomy, and for better understanding the health needs of these populations, animal models are employed for their potential to get at the underlying mechanisms for sexual orientation.

As alluded to above, these models are troubled by a number of assumptions that significantly affect their validity. For one, most of the animal models for homo- or bisexuality are based on the idea of sexual inversion, which hasn't been the prevailing clinical theory for homosexual or bisexual orientation since the turn of the 20th century. For example, true to the inversion model, neurobiologists studying the *fru* gene in *Drosophila* present animals that have been "feminized," "defeminized," "masculinized," or "demasculinized by physical castration, hormonal castration or genetic alteration;" what researchers mean by these terms, including whether they are invoking binary scales in which masculinization implies defeminization, etc., is unfortunately highly variable between papers and usually left undefined altogether. In any case, these animals are then studied for changes in sexual behavior, which are interpreted as alterations to sexual orientation. Problematically, there is so little compelling modern evidence for this ubiquitous inversion assumption that many authors in LGBT Studies now argue that the deployment of inversion as an explanatory model for homosexuality is nothing more than a truly antiquated bias, harkening back to the idea of the effeminate gay man and the mannish lesbian [7]. But leaving that aside (and also ignoring the fact that discerning sexual orientation from dominance behaviors in animals is often difficult), in most of these studies it would be impossible to discern whether behavioral changes are simply a change in the behavioral output of sex-specific behaviors (e.g. a change in "femi-

nization”) or a change in sexual orientation itself (e.g. a change in “homosexuality”).

Much more disturbing is the almost universal assumption that queerness in general represents a defect in an otherwise functional heterosexual biological system. By employing castration and genetic knockout studies (for example, of genes that are purported to enable an animal to tell the difference between the sexes [6]) as mechanistic explanations for LGB sexual orientations, researchers relegate these sexual orientations to the realm of the pathological. Restated, this sort of experimental design inherently structures scientific data in such a way as to equate heterosexuality with functional status and queerness with dysfunction. These animal models wouldn’t be so disconcerting if they weren’t so ubiquitous, if queerness (which is often described as a functional disadvantage) was *ever* described as a functional advantage on an individual level, or if their creators didn’t justify their use based on breezy references to the evolutionary superiority of heterosexuality [8]. Clearly, medicalization in research is doing little to quell old biases about the pathology of homo- and bisexuality.

It is notable that while there is also no significant mechanistic evidence to support the use of the inversion model as an explanation for transgenderism, there was no early recognition (and relatively scant current recognition) in the basic and translational literature that it would be a better fit based on what is known about the lived experience of transgendered patients. In fact there is a conspicuous absence of basic or translational research on transgenderism at all. As a case in point, a cursory PubMed search as of the publication of this article for transgender animal models yields no *relevant* results.<sup>1</sup> This absence is likely fueled by the fact that models for intersexuality and homosexuality, by way of conflating trans with intersex with homosex, already make up much of the potential research field. Moreover, given the significant biases that pervade basic and translational research of LGB subjects, it is unclear whether the absence of theories about trans subjects is actually problematic. That said, the lack of trans research (both here and, until recently, in clinical studies) harkens back to a history of erasure for trans people. While the relatively recent glut of public health and clinical studies on transgendered patients is changing this, the lack of any contemporary biological theorization on the origins of transgenderism highlights this longstanding problem (which remains untouched and perhaps even exacerbated by the basic science’s medicalizing framework) for the transgender community.

The problems described above are all compounded by the fact that peer reviewers in basic science are not as attuned to subtle heteronormative and cisnormative biases than are those in clinical research. In defense of both the reviewers and the researchers, much of the problem here is that the bulk of these papers (and indeed the vast majority of the work in the lab) is devoted to elucidating a highly technical pathway or very complicated structure – the model is often just a product of trying to explain the researcher’s new findings. But the appropriateness of the explanatory model to the biological system is crucial because it significantly shapes the reader’s understanding of the natural phenomenon under study [9].

### *Queer Problems with Translating Medicalized Explanatory Models*

Clinical and social scientists often cite findings in basic science to lend credibility to their work; when successful, not only is such cross-disciplinary citation integrative, but it also has the apparent effect of grounding controversial or novel claims in something fundamental. Often, the overall explanatory framework (rather than the specific content) is what gets translated between disparate fields [9]. In this case, an uncritical translation of the basic scientific medicalizing framework (which is both unsubstantiated and pathologizing) to a clinical research setting is problematic because it supports the idea that there exists “objective” basic scientific evidence of the underlying pathological nature of queer subjects; this translation (likely compounding preexisting biases of some clinical researchers) is reflected in the clinical literature around the sexual practices of men who have sex with men (MSM), with some early researchers going so far as to create extended metaphors that liken MSM to blood sucking mosquitos [10], and others that can only understand these behaviors by projecting damaged psychological states onto their subjects [11]. As a case in point, David Halperin showcases the rhetoric surrounding gay men’s sexual risk taking, which inevitably labels them with internalized homophobia, survivor guilt, low self-esteem, sexual compulsiveness, or a lack of self-control. Of course, heterosexual men with “unsafe” sexual practices are not medicalized in such pathologizing terms using such broad strokes.

When practicing clinicians adopt these pathologizing frameworks, the results can be dangerous because they reinforce old biases that pose the patient’s queer sexual orientation as the real problem (rather than the heteronormative social structures that systematically disadvantage queer people), and thus distract from more

<sup>1</sup>The search criteria were: (transgender OR transsexual OR transexual), filtered by Species: other animals. Note that there were a total of 22 results for this search as of 2/2016. Of these, one used the word “transsexual” to mean that the animal under study was displaying sex-specific behaviors of the opposite sex, but these were only in reference to dominance behaviors (like mounting). Another only used “transsexual” interchangeably with “intersex” and “hermaphrodite” – and in any case, transgenderism was not the focus of their research question. A third was a now disproven psychoanalytic claim about transgenderism from the 1980s. The rest of the papers were entirely unrelated.

pressing questions of how best to close health disparities gaps for these populations. There are also implications for the interaction between the provider and the patient in the exam room. From the literature on stigma and substance abuse, it is understood that negative attitudes of healthcare providers towards their patients contribute to poor care for these patients [12]. Similarly, translations of the medicalized framework from research to practice solidify clinicians' negative attitudes towards queer patients with "evidence" (or even the notion that there is evidence) for the pathological nature of queer sexual orientations. Moreover, the dual medicalization processes (in research and in the clinic) feed off each other – one (based on popular and clinical preconceptions about queer people) invokes the image of an evolutionarily unfit, neurologically or hormonally malfunctioning organism by claiming to be working towards finding the source of the queer organism's pathology, and the other (based on popular preconceptions and scientific "knowledge" about queer sexual orientation) confirms the existence of that pathology by observing worse health outcomes in and reduced social standing of queer communities. All the while, both are missing the point that many of the problems queer people face, as well as the pathology "discovered" by researchers, lies not in their biology, but in the hetero- and cisnormative society in which they are immersed.

## II. CARE

If the medicalizing gaze of the nineteenth and twentieth centuries wrestled "the sodomite" from the persecutory legal apparatus, then modern medicalization attempts to normalize all previously "deviant" sexualities by declaring them to be natural variations of human instinct and behavior. But as the pervasive biases in the contemporary biological literature demonstrate, the problem with such a goal is that medicine and biology still assign value based on heterosexual reproductive capacity. It is thus unrealistic to expect that a medicalizing gaze, which seems in many respects to be incapable of questioning the insidiousness of heteronormativity, would be able to carry out deeper, more meaningful depathologization. As described above, this is made clear by the fact that many of the clinical questions posed about queer populations are still premised on the assumption that our health disparities stem from some underlying pathology.

That said, given that it is now 130 years after the publication of *Psychopathia Sexualis*, now seems as good a time as any to demedicalize – and not just depathologize – sexual orientation and gender identity. Demedicalization is not just a simple rhetorical act. It entails much more than inverting antiquated sentence structures to suit the new politically correct order of the day. It requires re-

searchers to deconstruct their motives for putting heterosexuality on the mantle. It recognizes that being "born different" is distinct from being born an "other" and thus puts the onus of explaining the reasons for the perpetuation of healthcare disparities separating straight and queer communities on our healthcare system rather than on queer patients. And it changes the conversation about queer people from one that debates their immorality vs. pitiable natural victimhood to one about an underserved population whose disparities are structurally produced by our society's transphobic and heteronormative social, legal and medical institutions. In short, it turns the microscope inwards. Rather than asking "What makes them different?" it requires the members of the medical community to ask "What should we be doing differently to better care for them?"

### *Opportunities for Improvement*

The medical establishment has certainly made progress towards providing better care for queer populations. Diagnostic pathologization used to shame queer patients to silence in and absence from the clinic. That changed for LGB patients in 1973 with removal of homosexuality from the DSM-II, and is starting to change for trans patients with the 2013 step towards depathologization of transgenderism in the DSM-5.<sup>2</sup> There has been progress in other areas as well. In the wake of the AIDS firestorm that decimated gay and bisexual male communities (and likely – though there is less research to support this – trans communities), activists, patients, health care workers, scientists and allies drew together to push for the development and proliferation of antiretroviral drugs, which enabled new possibilities and (for some) a sense of empowerment. Concurrently, trans populations witnessed the propagation of gender management clinics that enabled them to shape their bodies as they saw fit. And in response to a vacuum in the public health literature described above, there is now a rapidly growing body of research on the healthcare needs of and challenges facing trans populations. Each of these shifts represents a step towards improving healthcare access to and delivery for queer people.

Nevertheless, there continue to be wide healthcare disparities separating queer communities and straight ones. The LGBT community faces higher rates of substance abuse, psychiatric disorders, cancer, obesity among women, and legal and social ostracization [13]. Factors such as lower rates of insurance, higher rates of systematic harassment and discrimination, and a lack of cultural competency in the healthcare setting put queer patients at higher risks for adverse health outcomes [13]. Within the queer umbrella, these problems are felt most by trans, low SES, non-white and HIV-positive patients. With this in mind, and in an effort to write to the all too often silence

<sup>2</sup>Though as discussed below, there are still plenty of conditions in the clinic that discourage queer patients from showing up.

on trans issues, the remainder of this section will focus on trans patients.

It's known that perceived discrimination is inversely correlated with healthcare outcomes (especially mental health outcomes) [14]. Unfortunately, mistreatment and discrimination of trans people happens often in healthcare settings. A 2010 national survey by Lambda Legal found that 21 percent of trans patients reported experiencing verbal abuse in a healthcare setting, while 8 percent of trans patients experienced rough or physically abusive treatment [15]. Qualitative research on the experiences of trans women in San Francisco-based healthcare settings revealed that many healthcare providers and staff remain ignorant of trans healthcare needs, deny or withhold care to trans patients, refuse to use requested gender pronouns, and that some even intentionally humiliate patients because of their trans status [16].

The rampant mistreatment that trans people experience in healthcare leads to a number of avoidant coping mechanisms. From the aforementioned study, mistreatment in a medical setting discourages patients from disclosing transgender status to providers, from frequenting specific providers or clinics, or from attending clinics that are not specifically designated as trans clinics; often it causes trans patients to opt out of the healthcare system altogether [16]. This is consistent with larger studies of trans patients, including the California Health Interview Study, which found that 30 percent of transgender adults delayed or did not seek care compared to 17 percent of their heterosexual counterparts [13]. And this also fits into the larger picture the effect of minority stress on health [17]. For example, 25 percent of respondents in a 2010 survey of trans people by the National Center for Transgender Equality and the National Gay and Lesbian Task Force reported misusing drugs or alcohol as a coping strategy in response to everyday instances of discrimination, while 41 percent had attempted to commit suicide in their lifetime [18]. These statistics deeply underscore the importance of a new study by Olson et al., which found that (unlike previously observed rates of mental health disorders in transgendered children living in their natal gender) rates of childhood depression were no different (and rates of childhood anxiety were only slightly elevated) in transgender children who were allowed to live as the gender they desired when compared to cisgendered, age matched controls or cisgendered siblings [19]. Collectively, these studies show us that the entrenched cis- and heterosexism of our healthcare system and the society in which it operates is repellent and hazardous to trans patients. Olsen et al. is an excellent example of the fact that the way forward for improving queer health outcomes is to focus on creating a more fair and tolerant world.

### *The Clinical Limits of Medicalization and the Appeal of Demedicalization*

Preventing discrimination against queer groups in the clinic a tricky task. On one hand, as opinions of LGBT people in broader society are becoming more favorable, blatant homo- and transphobia are becoming less common. But in settings with the potential to be as intimate as they do to be marginalizing (like the clinic), the leisurely pace of social progress is just too sluggish. Recognizing this, many healthcare organizations have responded with a proliferation of LGBT sensitivity training programs for their employees. Whether it's delivered through a dreaded 30-minute digital interactive multiple choice test or the an in-person presentation or forum, each of these occasions represent an intentional institutional response to the appalling rates of discrimination that queer people endure in the clinic. While the evidence for success of these interventions is favorable (if weak) [20], the more pressing issue is the continued lack of formal education that physicians receive around LGB and especially trans healthcare. Patients recognize this systematic ignorance; indeed "lack of provider education" is an often-cited problem in surveys of LBG T populations. Fifty percent of respondents in the 2010 National Center for Transgender Equality survey described having to educate their physicians about trans healthcare [18]! Unfortunately, most medical training programs in the country aren't doing enough to address the problem [21-22]. This must change. We as healthcare providers have a responsibility to gain the cultural competency as well as the healthcare knowledge and skills to care for queer populations.

The lack of provider education reflects a larger failure on the part of physicians to uphold the fourth and most often forgotten pillar of medical ethics: justice. The phrase "medically underserved" is an institutional attempt to highlight the systematic injustice – the failure to fairly distribute resources – endured by the groups it's meant to describe. Fundamentally, injustice has been the problem all along for queer people and it's something that the medicalization of queer bodies cannot undo. Indeed, calls inciting physicians to political action against injustice are often met with a kind of lifeless stoicism that could only continue to be justified under the pretexts of medicalization itself. By reducing queerness to an objective biological (and often pathological) fact, medicalization strips away social context and produces it as an ahistorical quality. This makes it easier to forget that healthcare disparities suffered by queer populations are socially produced – at least in part by the healthcare system itself – and that their persistence is enabled by mass indifference. Medicalization thus renders out the ethical obligation on healthcare providers to rise to political action for their patients. Demedicalization is a call to action.

Lastly, demedicalization in the clinic has the potential to affect medicalization in research, ideally by influencing the types of questions asked, how they're asked, and

how studies are designed. If care providers are able to recognize the dual hazards of stigma (towards patients in the exam room) and paralyzing apathy (about addressing the larger systems that create healthcare inequalities for queer people) generated by clinical medicalization, they may also be more likely to recognize that the current scientific literature about queer people is replete with cis- and heteronormative biases that ultimately limit what we know (and indeed what we can know) about the LGBT populations under our care. This recognition could give care providers the occasion to support their colleagues in basic, translational, and clinical research (who already actively try to reduce the impact of bias on their work, and hopefully will be more likely to address these types of biases in the future) in asking questions that probe the origins and implications of sex and sexuality in non-normative ways, so as facilitate the creation of a more objective knowledge base about queer populations.

### III. THE POLITICAL LIMITS OF MEDICALIZATION AND THE EFFECTS OF DEMEDICALIZATION

As described previously, medicalization has historically been useful for advancing queer rights – from decriminalizing homosexual acts in public or private to pushing for queer parenting rights to expanding insurance coverage to include genital reconstruction surgery. But as larger society comes to terms with accepting queer people, queer relationships, and queer culture(s), rhetorical recourses to nature are looking increasingly antiquated. Given the negative effects of medicalization in the research and care settings, it seems prudent to ask whether continuing this practice is ultimately politically useful to queer communities today.

Even if the ‘natural origins’ research were structured using less blatantly heteronormative frameworks, such research only has the potential to get us stuck in a defensive loop. By allowing the conversation to continually be bogged down by defensive recourses to nature, divisions are only further entrenched between those who promote the image of the morally corrupt sodomite and those who defend that of the biologically ill-fated queer. All the while, this century-long back and forth misses the meat of the problem that is being addressed loudly and proudly by queers on the streets: ‘What’s it to you if I was born this way? *I am this way. Right now, I am this way. And I like it.*’ These blunt responses represent an abandonment of the age-old Nietzschean tactics of *ressentiment* (in which the powerless seize moral authority by invoking their lack of power in order to shame the powerful) [23]. Indeed, they are the product of years of deliberate and effective displays of righteous anger by ACT UP and other radical queer organizations.

Politically speaking, medicalization has always been a fragile and dangerous tactic. For one, the assumption

that naturalness connotes normalcy and goodness is just that – a convenient assumption that fails to articulate a sounder ethical claim. And, relying on medicalization presumes that medicine will not someday refute that naturalness with sound scientific evidence. More chilling still, if the naturalness of queerness was incontrovertibly scientifically confirmed, the development of biological tests or “cures” for queerness become possible [24]. Even a superficial awareness of contemporary anti-gay or anti-trans rhetoric (including the 44 new transphobic bills across 16 state legislatures in the first two months of 2016 alone) makes the possibility of such a discovery terrifying [25]. It also highlights the imperative to distance the ethico-legal framework for the advancement of queer rights from biological narratives.

### CONCLUSIONS AND OUTLOOK

While historically the medicalization of queer bodies was used to effect social change, it is becoming increasingly clear to queer activists and scholars that century-old political strategies emphasizing the natural origins of LGBTQ identities are neither assertive enough nor sustainable to queer political movements. This is in part due to the heteronormative biases that pervade much of the experimental design for studies attempting to uncover a mechanism for queer sexual orientations. But the deeper problem is that arguing for the implicit moral goodness of naturally given things entrenches the movement in old (usually unwinnable) arguments. Clinically speaking, the modern day medicalization of the queer body isn’t doing queer patients or the researchers studying them many favors. Yes, overt pathologization and erasure are fading into the past (though there remain many obstacles for trans folks in this respect), but the air of clinical detachment that comes with medicalizing an entire underserved population enables many care providers to continue to remain ignorant about how best to advocate for and provide care to LGB and especially trans patients today and in the future.

Some providers may counter that the weight of medicalization is too valuable a political and clinical tool for advancing queer rights to discard so readily. Others will insist that the role of the physician should not extend into political territory at all. To the first objection – of course the patient in the exam room must always come first. This essay does not argue for unrealistic revolutions of thought that ignore the practicalities of ensuring patient safety (e.g. emphasizing the naturalness of queer identities to the hostile parents of a queer child), insurance coverage (e.g. using the political weight afforded to clinicians to push for comprehensive access to body modification treatments for trans patients), clinic funds, or research dollars for LGBT populations. Instead, it calls for a change in the way physicians and scientists frame discussions of sexuality in an effort to better address the impact of our own biases on care, research and policy. To the second, it would be

good to remember that inaction is a political decision. Furthermore, the interaction between scientists, care providers and queer patients is firmly ensconced in our collective past medical history – from the days of the sexologists and homophile activists who pushed for decriminalization, to the collective actions of ACT UP and the physician pioneers of AIDS care who pushed for compassionate use – caring for queer people has been and will likely continue to be political. In any event, better educating ourselves about the marginal populations under our care, carefully examining our biases towards them, and pushing to close disparities gaps is nothing less than an ethical and professional imperative. Moreover, by reducing cis- and heteronormative biases in our research, demedicalization has the potential to fundamentally alter how queer populations and the origins of queer sexuality are studied, and in turn to deepen and complexify our understanding of these topics.

## REFERENCES

1. Foucault M. *The History of Sexuality: Volume 1: An Introduction*. New York: Vintage; 1990. p. 43.
2. Symonds JA. *A Problem in Modern Ethics: being an inquiry into the phenomenon of sexual inversion, addressed especially to medical psychologists and jurists*. London: [s.n.], 1896. p. 131-132.
3. Bristow J. Symonds's History, Ellis's Heredity: Sexual Inversion. In: Bland L, Doan L, editors. *Sexology in Culture*. Chicago: University of Chicago Press; 1998. p. 80.
4. Prosser J. Transsexuals and the Transsexologists: Inversion and the Emergence of Transsexual Subjectivity. In: Bland L, Doan L, editors. *Sexology in Culture*. Chicago: University of Chicago Press; 1998. p. 116-31.
5. Stone S. The Empire Strikes Back. *Camera Obscura*. 1992;10(29):151-76.
6. Eckhart E. *Homosexual Mutants! Reframing the Neurobiological Discourses Surrounding Sex and Sexual Orientation [dissertation]*. Berkeley: University of California, Berkeley; 2015.
7. Stein E. *The Mismeasure of Desire*. New York: Oxford University Press; 1999. p. 190-205.
8. Sedgwick E. *Epistemology of the Closet*. 2nd ed. Berkeley: University of California Press; 2008. p. 43.
9. Haraway DJ. *Crystals, Fabrics, and Fields*. 2nd ed. Berkeley: North Atlantic Books; 2004. p. 189.
10. Bersani L. *Is the Rectum a Grave and Other Essays*. Chicago: University of Chicago Press; 2010. p. 3.
11. Halperin DM. *What Do Gay Men Want? An Essay on Sex, Risk and Subjectivity*. Ann Arbor: University of Michigan Press; 2009. p. 12.
12. van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. [Stigma among health professionals towards patients with substance use disorders and its consequences for health-care delivery: systematic review]. *Tijdschr Psychiatr*. 2015;57(7):489-97.
13. Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. National Academies Press. Washington (DC): National Academies Press (US); 2011.
14. McLaughlin KA, Hatzenbuehler ML, Keyes KM. Responses to Discrimination and Psychiatric Disorders Among Black, Hispanic, Female, and Lesbian, Gay, and Bisexual Individuals. *Am J Public Health*. 2010;100(8):1477-84.
15. Tillery B, Somjen F, Hirshman R. *When Health Care Isn't Caring*. New York: Lambda Legal; 2010. p. 12-16.
16. Rorvig L. *Transgender Women in San Francisco: Understanding the Nature, Extent, and Meaning of Their Negative Health Care Experiences [dissertation]*. Berkeley: University of California, Berkeley; 2012. p. 35-40.
17. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav*. 1995;36(1):38-56.
18. Grant J, Mottet L, Tanis J, Harrison J, Herman J, Keisling M. *Injustice at Every Turn*. Washington DC: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011.
19. Olson KR, Durwood L, DeMeules M, McLaughlin KA. Mental Health of Transgender Children Who Are Supported in Their Identities. *Pediatrics*. 2016;137(3):1-8.
20. Horvat L, Horey D, Romios P, Kis-Rigo J. Cultural competence education for health professionals. *Cochrane Database Syst Rev*. 2014;5:CD009405.
21. White W, Brenman S, Paradis E, Goldsmith ES, Lunn MR, Obedin-Maliver J, Stewart L, Tran E, Wells M, Chamberlain LJ, Fetterman DM, Garcia G. Lesbian, Gay, Bisexual, and Transgender Patient Care: Medical Students' Preparedness and Comfort. *Teach Learn Med*. 2015;27(3):254-63.
22. Obedin-Maliver J, Goldsmith ES, Stewart L, White W, Tran E, Brenman S, Wells M, Fetterman DM, Garcia G, Lunn MR. Lesbian, gay, bisexual, and transgender-related content in undergraduate medical education. *JAMA*. 2011;306(9):971-7.
23. Brown W. Wounded Attachments. *Political Theory*. 1993;21:390-410.
24. Lancaster RN. *The Trouble with Nature*. 1st ed. Berkeley: University of California Press; 2003. p. 268-81.
25. Human Rights Campaign Foundation. *Anti-Transgender Legislation Spreads Nationwide, Bills Targeting Transgender Children Surge*. San Francisco: HRC; 2016.