Expression, Oppression and Queer Bodies: A pilot study exploring the lived experiences of LGBTQ+ medical students in the UK.

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LGBTQ+ | heteronormativity | lived experience | intersectionality | identity | oppression | medical students | medical curriculum | stigma | healthcare inequalities | post-structuralism | materialism

Abbreviations
LGBTQIA+ - lesbian, gay, bisexual, transgender, intersex, queer/questioning, asexual and other sexuality, and gender identities
LGBTQ+ - lesbian, gay, bisexual, transgender, queer and other sexuality, and gender identities
GLBT – Gay, Lesbian, Bisexual and Transgender
LGBT - Lesbian, Gay, Bisexual and Transgender
FANI – free association narrative interview
FPDA – Feminist Poststructural Discourse Analysis
HIV/AIDS - human immunodeficiency virus/ acquired immune deficiency syndrome

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What this paper adds:

This paper explores the under-represented voices of LGBTQ+ medical students in the UK. Novel adaptation of the utilised methodologies significantly enhanced the dialogue with participants. The results suggest that medical curriculum is an act of LGBTQ+ violence, and that students have to navigate their queer identities within persistent academic heteronorms.

Abstract: This article details a qualitative study exploring the lived experiences of LGBTQ+ medical students in one university in the UK. Few studies exist, especially those that

directly include LGBTQ+ voices, that explore the lived experiences of LGBTQ+ medical students. Those that exist suggest that there are significant, ongoing problems with heteronormativity in medical schools and society and more could be done to appropriately support this student population during their medical studies. Therefore, in this study the author set about exploring the lived experiences of LGBTQ+ medical students using first-person narratives to capture their lives in their own words.

The author used an adapted qualitative methodology and method underpinned by philosophical concepts including post-structuralism and materialism to realise their study aims. Outcomes showed that fear and violence but also subversion of heteronorms, community formation and protection, and 'queer joy' were a significant part of the students' lived experiences. Interpretive understandings also illustrated perceptions of 'queer bodies' as other and/or normative and intersectional repression and oppression as an ongoing, significant experience for participants. Here the author understands queer bodies to be constantly redefined understandings of queer identity emerging from entangled relationships between gender and sexuality 'norms'.

In line with intersectionality and decolonisation literature the author argued that medical curriculum is an act of LGBTQ+ related, epistemic violence and highlighted the importance of intersectionality and intersectional transdisciplinarity in enacting change in this respect. Finally, it is argued, in line with participants' documented experiences that queerness and ''queer bodies' are both personal and community experiences/entities and awareness of this relationship is important for re-considering LGBTQ+ related stigma and healthcare inequality.

Introduction: There are few studies that explore the lived experiences of LGBTQ+ (lesbian, gay, bisexual, transgender, queer and other sexuality and gender identities) identifying medical students and clinicians, especially first-person accounts, and from researchers in the UK. The author argues that it is vital to better understand the lived experiences of LGBTQ+ medical students in order to appropriately support their educational needs and professional identity formation during medical school. They also argue that it is important to gather this information from the students themselves utilising first-person accounts to appropriately document their experiences in their words.

Much of the evidence that exists in the literature concerning the lived experiences of LGBTQ+ medical students and clinicians comes from the USA. Most studies use quantitative or mixed method approaches with very few adopting a narrative approach. What these studies show is that the lived experiences of LGBTQ+ medical students and clinicians is complex and often negative with harassment, bullying, depression and burn out a reality for many (Lapinski and Sexton, 2014; Lee *et al.,* 2014; Dimant *et al.,* 2019; Ko and Dorri, 2019; Samuels *et al*., 2021).

First-person, narrative accounts of the lived experiences of LGBTQ+ medical students and clinicians are infrequent and are mostly, from the USA. Those that exist reinforce the outcomes from mixed method and quantitative studies on the subject. As an example, Schuster (2012), in their speech at a GLBT event in the USA describes being 'closeted'; feeling unable to disclose their LGBTQ+ identity in medical school or postgraduate medical contexts. They also describe overhearing negative comments about LGBTQ+ people in hospitals and experiencing harassment as a consequence of their sexual orientation. Interestingly, they also discuss LGBTQ+ related medical curriculum as poor, commenting that, 'One week we learned about prostitution; another, about drug addicts. In between, we learned about homosexuals' (Schuster, 2012, p. 75).

Despite an extensive literature search using a number of search criteria in PubMed, ERIC, JSTOR, Web of Science, EMBASE, Cochrane Library, and MEDLINE, only a small number of studies were identified that explored the lived experiences of LGBTQ+ medical students or clinicians in the UK. The few that exist reinforce the themes already discussed including discrimination, harassment, heteronormativity, poor LGBTQ+ curriculum content, and concerns related to career progression (Kitzinger, 2005; Brill, 2015; Nicallen, 2016). Here the author defines heteronormativity as 'the idea that heterosexual attraction and relationships are the normal form of sexuality' (Barker, 2014. p. 858).

Another significant issue previously identified by the author (Bintley and Winning, 2020) is non-disclosure as well as heteronormativity and a lack of LGBTQ+ content in the undergraduate medical curriculum. Interestingly, the curriculum felt to participants in the aforementioned study as if it was 'real': a physical object with power over people and things. It was considered as a 'thing' that reinforced the norms discussed above through the language it contained and the people who used and interpreted its words and instructions (Bintley and Winning, 2020).

A solution to these issues identified in this previous research (Bintley and Winning, 2020) was to *re-examine* the complexity of LGBTQ+ identity and in so doing, re-appreciate the importance of difference in medical education and curriculum. In this way, re-appreciation makes real the possibility of moving towards meaningful inclusion of LGBTQ+ voices in curriculum and a re-consideration of how we engage with LGBTQ+ medical students to provide the best support possible for them to succeed.

One way it was proposed to re-examine the complexity of LGBTQ+ identity in this previous research, inspired by the work of Judith Baxter (2003), involved using the 'productive friction' of intersectionality and transdisciplinarity. Intersectionality is defined as, 'A way of understanding and analysing complexity in the world … the self can seldom be understood as shaped by one factor. They are shaped by many factors in diverse and mutually influencing ways'

(Collins and Blige, 2016, p. 2) and transdisciplinarity is described by its creator as 'between the disciplines, across the disciplines and beyond the disciplines' (Nicolescu, 2014, p. 187).

What combining intersectionality with transdisciplinarity makes possible is a re-assessment of the limitations of both approaches and a 'reconsider[ation of] difference as both a philosophical and practical issue' (Bintley and George, 2019, p.13). In this way, 'Intersectional Transdisciplinarity' (Bintley and George, 2019) has the propensity to challenge the perceived stability of norms and re-assess inequality across and beyond social systems. Intersectional Transdisciplinarity, therefore, forms the underpinning of this research and using this approach the author's aim was to better understand the lived experiences of LGBTQ+ medical students in the UK. This paper refers to the outcomes from a pilot study of participants attending a UK medical school referred to here as 'centre 1'.

Underpinning this research and providing the author with a 'lens' through which to consider the 'productive frictions' of the participants' experiences is post-structuralism and materialism. There are important ideas within these theoretical standpoints that need highlighting in the context of this study. Firstly, poststructuralism is a complex concept emerging from and challenging the unifying logic and absolute truth posited by structuralist theorists such as Descartes (1596-1650). Post-structuralism encourages the de-centring of the subject (Foucault; 1969), deconstruction of meaning (Cohen *et al*., 2011), and the utilisation of discourse and discourse analysis. Discourse here is understood as 'bodies of ideas that produce and regulate the world in their own terms, rendering some things commonplace and other things nonsensical' (Youdell, 2006, p. 36).

Post-structuralism also underpins theories about a person's gender and sexuality as not being 'fixed' entities; considering gender and sexuality as fixed truths, it is argued, perpetuates dominant, oppressive discourses and consequent discrimination (Butler, 1990). Secondly, materialism, defined as 'the view that the world is entirely composed of matter' (Blackburn, 2016) explores, amongst many other things, how 'things' (objects, bodies, places, spaces) interact (or intra-act) with each other and are entangled (Barad, 2007). These entanglements are complex, non-linear and ever-changing and this complexity allows for re-examination of difficult ideas from multiple perspectives. Furthermore, whereas post-structuralism generally leans towards the importance of how reality is *represented* (i.e., through language) some materialist thinkers would argue that this representational approach inappropriately splits and dichotomises language and materials and simplifies experience, perpetuating existing oppressive norms (Barad 2003; 2007; Brown *et al*., 2020).

By utilising both of these theoretical standpoints in the context of the 'productive friction' of intersectionality and transdisciplinarity, the author aims to

create new understandings about the lived experiences of LGBTQ+ medical students through re-alignment in relation to accepted norms. It is important at this point to identify the author's assumptions and standpoints going into the study. Supported by the theories above as well as queer theory, intersectionality and race theory, the author ascribes to the position that there is no absolute truth and discourse, and deconstruction of meaning is important in understanding the foundations underlying social structures. Furthermore, gender is not a fixed entity, meaning emerges from intra-actions between objects and subjects, and power is important in the material intra-actions between objects and subjects. Finally, in the context of this study entanglements of intra-actions, power, and discourse enable individuals to identify, name and subvert societal norms, which aim to suppress and oppress people.

Ethics: Ethics approval was sought via university ethics at the university under study and full approval was obtained.

Methods: In this study, qualitative data collection and methodological techniques were used to realise the study aims. All data was qualitative, and the author undertook walking narratives, unstructured interviews or written narratives (using Free-Association Narrative Interview (FANI) techniques. Based on the Freudian concept of free association, FANI (Holloway and Jefferson; 2000; Holloway and Jefferson, 2008) were developed to combat the power inequalities (argued from multiple perspectives including feminist perspectives (Oakley, 1981)) in 'traditional' style question and answer interviews (Holloway and Jefferson, 2008). FANI uses the participant's story as the starting point and conversational direction of travel. As Holloway and Jefferson (2008) describe it in their writing on the subject, "The interviewee is a story-teller rather than a respondent" (p. 302) their aim being to avoid the 'suppression' (Mishler, 1986) of participants' stories that is, arguably, found in traditional structured and semi-structured interviews due to power imbalances between participant and investigator.

Data Collection: The choice of data collection method was based on peer-reviewed examples from the literature that explored issues of identity and challenging subjects (Holloway and Jefferson, 2000; 2008; Roseneil, 2007; Garfield *et al*., 2010; Gordon; 2017). These examples used or commented on the importance of a two-part approach to FANI with a first interview/written narrative used to establish the overall experience that the participant is describing, and a second interview/written narrative exploring the specific discourses/ themes and so on, that come out of the first interview. Although in two parts (first and second interviews/written narratives), this forms part of a whole with the final analysis being based on the outcomes of both interviews/written narratives from any one participant.

To further facilitate discussion and reduce the influence of the author's power, the participants were given the

choice of when, where and how to document their narratives across the two interviews. This included written narratives, unstructured interviews or walking narratives at a time, date and location set by them.
Walking narratives were used because this ethnographic method is designed to enable discussion between author and participant that is purposeful, but which is also co-constructed and material (Moles, 2018). In this way, the very act of moving (Kusenbach, 2003, Law and Urry, 2003), discussing and exploring a particular material place and space together has the propensity to facilitate more meaningful conversation about potentially challenging concepts, memories and ideas (Soja, 1996, Anderson and Moles, 2008). However, due to participant choice there was a change to online format and therefore the walking narrative and FANI approaches were adapted to fit this format. The interviews remained unstructured, led by the participant and variable in length and content in order to fit with this approach and its emancipatory aims.

The interviews were recorded either orally (in the case of the two students who undertook walking narratives) or visually and orally (in the case of the nine students who met the author online) except for one participant who undertook a written narrative account. The author also took field notes throughout the interviews. The online interviews were transcribed by a computer system and the in-person interviews were transcribed by the author after the event. In each of these interviews the author compared field notes to the transcriptions to ensure alignment with ideas, concepts, and understandings.

Data Analysis: Successive rounds of data analysis occurred for the 24 interviews that were undertaken. This included 2 x12 interviewee interviews and included approximately 75,000 words. The interviews were undertaken using an immersive, qualitative approach based on Feminist Poststructural Discourse Analysis (FPDA) (Weedon, 1996, Baxter, 2003) that assessed and reassessed both the post structural discourses and (through adaptation of the FPDA approach) material processes involved in the data sets.

The author firstly identified separate post structural discourses and material relations. Following this, in line with the underpinning epistemology and methodology (including Intersectional Transdisciplinarity), the author identified the co-constitutive discourse and materials relations in the data sets with the aim being to create a productive friction that created new knowledge about the experiences of the participants.

To do this, an FPDA and materialist deductive analysis was undertaken for each participant, as well as an FPDA and materialist connotative analysis. The deductive and connotative analytic methods were taken directly from the ascribed FPDA analytic technique. Deductive analysis refers to commonalities, links, repetitions, and pre-occupations that emerge from data when viewed through a feminist, post-

structural lens. In this study this approach was also adapted for analysis through a materialist lens. Connotative analysis refers to the intersections, tensions, oppositions, and conflicts that emerge from data when applied to feminist, post-structural concepts, and theories and again in this study also applied to materialist concepts and approaches (Baxter, 2003).

Concepts of materiality as body, objects, space, and place were used as well as entanglement, intra-action and agential realism amongst others (Barad, 2003; 2007; Haraway, 1991; 2016; Latour 1987; 1996; 2007; Ringrose and Rawlings, 2015; Renolds and Ringrose, 2016). Entanglement here describes an interconnected state of being between all 'things' (objects) (Latour, 1987; Haraway, 1991; Barad, 2003; 2007). As explained by Brown *et al.* (2020, p. 219), 'separateness is not the original state of being'. In this way, all matter matters (Barad, 2003; 2007) in that through this connectedness 'matter' contributes to all actions, experiences, and movements through time. If we accept that all objects are connected in this way, we further need to consider that all objects intra-act (act with/in and between each other) (Barad, 2003; 2007) and objects emerge and have agency from these intra-actions (agential realism) (Barad, 2003; 2007).

Concepts of discourse as decentring the subject, power as an emancipator and oppressor, gender and sex as complex and socially constituted, and shifting norms were also used (Foucault, 1969; 1972; 1976; Butler, 1990; Hooks, 1994; Youdell, 2006; Cohen *et al*., 2011). In line with similar approaches (Hardy and Thomas, 2015) discourses were used as a framework for understanding and reassessing material processes so that their relations emerged through the action of analysis. It is important at this point to say that the author is not suggesting, as Hardy (2015) is not suggesting in their article on the subject, that post-structuralism and materialism are the same or interchangeable but more that they are inextricably linked and influenced by each other and to separate them is arguably artificial.

Results (Interpretive Understandings): Utilising adapted FPDA and FANI method/ologies to incorporate material concepts and approaches, the author interviewed 12 participants twice each in a university in the UK. All participants identified as LGBTQ+ and were medical students at Centre 1 (cntr 1). Nine of the twelve participants wanted to meet online for the interview, with two others meeting the author in person in a place of their choice, and one participant writing a written account. The four dominant, co-constituted discourse/matter relations are detailed below but included fear vs. 'fuck it', violence, queer expression and/or repression and intersectionality and queer bodies as other and/or normative. Here, queer bodies are 'defined' by the participants through discussion in the interviews and the following is therefore an emerging understanding of a concept as opposed to a definition per se, 'constantly redefined understandings of queer identity emerging from entangled relationships between gender and

sexuality norms'.

Fear vs. 'fuck it': The word 'fear' was discussed overtly 'people are feeling more justified in their … hatred' (Interview (Int) 9 centre (cntr) 1) and covertly, through entangled discussions of violence (actual and potential), HIV/AIDS, COVID-19 and queer expression. Predominantly, fear related to discussions about perception; being judged for being LGBTQ+ by peers, healthcare professionals and university staff, 'you don't know who's safe to be around' (Int 9 cntr 1). This repeatedly led to discussions about the consequences of such judgement that being, the potential for violence and the violation or disregard of queer bodies and spaces. In relation to violence, one participant commented, 'and some days … I just can't like … live like with this fear' (Int 6 cntr1).

As such, fear seeped into all other discourses and matter relations, it influenced many participants' behaviours and approaches, and was restrictive for participants. One participant noted in relation to observed discrimination of LGBTQ+ patients on placements: 'That's like they're talking about someone like me in a way that I don't like … ummm … and that happens quite a lot' (Int 12 cntr 1). Another participant explained that wearing rainbow lanyards or pronoun badges in hospitals or university enabled the possibility that people would 'make assumptions' about the participant and this made real the potential for 'transphobia and homophobia' (Int 9 cntr 1).

Another dominant feature of fear was its material form: a describable 'visceral, brutal' (Int 3 cntr1) entity with power of its own, which oppressed and depressed participants. The ability of fear to oppress in this way was in some examples physical, with some people feeling they needed to 'hide the flamboyant parts' (Int 5 cntr1) of themselves. The participants explained that this was exhausting and led to a *need* for many to turn away from fear in some way. This gave form to the concept of 'fuck it' (Int 7 cntr1); this being a need to be liberated from the oppressive fear, which affected their health, identity formation (both professional and personal) and relationships. One participant noted that, 'I deserve to be treated like I *should* be there' (Int 7 cntr 1).

This manifested through subversion of the causes of fear those being restrictive, homophobic norms such as medical school dress codes, prohibition of body art and certain hair colours and styles. Participants described shaving their hair, getting visible tattoos, and making and wearing clothing that subverted fashion norms such as 'granny core' (Int 7 cntr 1). They also wore visible symbols of queer identity such as non-binary pronoun badges and rainbow patterned shoes. Importantly, when exploring subversions of fear participants exclusively described things that they did to themselves (i.e., shaved their hair) as opposed to things they did to others/ changes they enacted institutionally.

In summary, fear was considered

material, powerful and malign in relation to LGBTQ+ identity and seeped into all other discourse/ matter relations. Fear influenced participants' behaviours and was perpetuated by perceived societal heteronorms. A predominant implication of fear was that it was exhausting for participants to maintain, and this opened up the possibility of turning away from fear. This manifested in subversion of these perceived societal heteronorms, often focussing on changes that were possible to self, place, and objects.

Violence: Directly related to fear and again with its own materiality, violence was a predominant conversation for many participants. Participants described the considerable implications of actual and potential violence and the fear that this created for their own safety and that of others. Many participants had experienced violence, and several had experienced recent violence that was directly related to their queer identity.

There was also a perpetual thread throughout the interviews/written account that participants felt 'lucky' (Int 1 cntr1) that they hadn't experienced particular types of violence such as hate crimes whilst simultaneously playing down other forms of violence that they had experienced. For participants, this dissonance between feeling grateful for not experiencing some forms of violence and minimising other forms of violence appeared to be driven by 'internalised homophobia' (Int 3 cntr1) and the associated perception of what some forms of violence might mean for them, i.e., outing them as queer. Furthermore, violence was seen as an accepted norm and inevitable amongst the LGBTQ+ community.

Another source of violence, and one which created conflicting, complicated reactions amongst participants was COVID-19. COVID-19 was ascribed materiality by participants, an entity with its own violent power. One participant explained, in relation to social gatherings that, 'there's a cost of that … like a risk of getting ill or getting someone else ill' (Int 8 cntr1). Violence in this respect related to the danger of contracting COVID-19, which as a material entity was perceived to have power over those infected. Violence also related to the implications of such power that being the potential to harm others, the power to isolate an already isolated community, and the potential for COVID-19 to be used by society, as HIV/AIDS was to isolate, persecute and subjugate the LGBTQ+ community.

Participants felt that COVID-19 also had a considerable impact on their education and social networks. One participant noted that, 'because of COVID I didn't really build up that big of a network' (Int 4 cntr1). In this way, COVID-19 violated participants freedom of movement and 'our little community' (Int 4 cntr1) that was important to their health and wellbeing. However, COVID-19, through isolation, gave many participants an opportunity to process their identities and for several participants was a time in which they re-examined their sexuality and gender identity. One participant explained that 'COVID was good in some ways … I was more confident finding and being me' (Int 9 cntr1). In this

way, COVID-19 created a private, protected space for some participants to re-examine their understanding of self and others.

Violence was also described in relation to HIV/AIDS. Several participants discussed HIV/AIDS as an ongoing LGBTQ+ crisis and like COVID-19, HIV/AIDS also appeared to be an enduring patient narrative with power of its own that was used to pathologise LGBTQ+ people. In this way, it was seen as an ongoing violation and stigmatisation of queer bodies, particularly in relation to the way it was taught in medical school. In relation to lectures, one participant noted that a lecturer presented the HIV/AIDS crisis in the 1980s and 90s as, 'primarily it was like blood transfusions and like secondarily it was like … you know, a human rights crisis' (Int 3 cntr1). Another participant noted in relation to tutorials that, 'the fact that MSM [men who have sex with men] it will be relevant information because they have like HIV' (Int 7 cntr1). Interestingly, HIV medicine was perceived to be (along with some other specialities including psychiatry and emergency medicine) a safe, queer-friendly working environment. One participant noted that, 'it is a bit stereotypical but I can see myself … picture myself in those that group … because I've met like queers in that speciality' (Int 6 cntr1).
In summary, violence was considered symbolic, and material and it had considerable power over participants. Violence, in many forms, was a reality for most participants, and the relationship that the participants had with violence depended on the type of violence and its perception by wider society. Furthermore, specific infections (COVID-19, HIV/AIDS) had emerged as having specific violent power in the way they violated and stigmatised queer identities.

Expression and/or repression and intersectionality: Queer expression and its repression were a significant preoccupation for participants. They described how their individual, complex, intersectional identities contributed to a *need* for queer expression but that it was not always possible. For example, 'not being British' (Int 2 cntr1, Int 4 cntr1) was important for many of the participants in relation to queer expression as the UK represented (for many but not all) liberation from 'conservative' (Int 2 cntr1) norms at home. However, this was twinned with a perception of societal othering because 'the UK is such a class society' (Int 7 cntr1) and UK cultural norms were perceived to favour queer repression rather than expression. For participants this was linked to a sense of being 'other'; they were an intersectional entanglement of 'not British', differently accented, as well as gendered (or misgendered), queer, intelligent and a future doctor. From these emerged complex feelings about power, worth, place and understanding of self, which the participants found destabilising.

The role of participants' race and sex in feeling 'other' was also discussed and was predominantly described in relation to racism and sexism (again both observed and personally experienced). This added to the layers of perceived

oppression, which compounded participants' hesitation to be open about their gender identity and sexuality to avoid further potential oppression and discrimination. In relation to identifying as female, one participant noted, 'being described as like the girl rather than … the queer one … there is something weirdly offensive about that … probably got to do with a level of internalised homophobia' (Int 3 cntr1). Participants less frequently discussed the impact of racism and sexism within their LGBTQ+ communities. Although there was some discussion about perceived, exclusionary activities (such as drag, discussed later) and some discussion related to racism within the LGBTQ+ medical community, this was never expanded on in any great detail. Instead, the focus for participants was the experiences of those in the community versus those outside of the community in the way they felt 'other' or were 'othered' by wider society.

Furthermore, the medical school was perceived to be a microcosm of UK 'class society' (Int 7 cntr1), which was described as 'elitist' (Int 10 cntr1) and one that promoted norms that discouraged queer expression. For some, medical school was seen as a repressive institution and leaving medical school (to start Foundation training) was seen as 'freedom' (Int 10 cntr1). This was further entangled with discussions of stigma in relation to intersectional parts of a participant's identity, including the compounding, othering effects of mental health issues and queer identity. One participant noted that the university was 'noisy and dirty' and 'isolating', and that this 'fed' their anxiety and depression.

Participants' perceptions of academia frequently led to discussions about the relationship between queer expression and professional identity in medical school. All participants considered that the perception of queer identity was that it was unprofessional in a medical context. This was in part due to the paucity (and when included, poor) incorporation of LGBTQ+ issues into medical curriculum. Furthermore, the perception that LGBTQ+ identity was unprofessional was compounded by LGBTQ+ related discrimination observed or experienced by students in clinical contexts and the 'compulsory heterosexuality' and 'respectability politics' (Int 7 cntr1) that surrounded these observed or experienced behaviours. Students described feeling 'powerless' to change observed discrimination, instead opting to withdraw their identity completely from the clinical environment, in some cases explaining that, 'it doesn't matter who ... I personally am' (Int 3 cntr 1).
Another participant commented that they had been told in teaching that, 'a successful consultation [is] when a patient leaves and can't tell anything about your identity' (Int 10 cntr1).
Despite these difficulties, participants described multiple ways in which they managed to express their queer identity. As well as the examples of queer expression discussed in the last section, drag, and drag culture was important in terms of queer expression for most participants. Drag was seen as a cultural norm for LGBTQ+ people at medical school and it formed a large part of the

social calendar for queer people. Drag also had its own materiality, which was surrounded by entangled intra-actions between community, buildings, curtains, sexuality, gender identity, faith, privilege, race, visibility, clothing and beauty standards, stages, alcohol, music, performance, weather, sweat, and attraction. This was particularly true for participants who had come to university in the UK from places in the world where being queer was illegal or frowned upon; drag was seen as a physical example of liberation and 'queer joy'. Even so, drag was also seen as an exclusionary activity by some as it formed such a significant part of the social calendar for LGBTQ+ people in the community, which they felt left little space for other queer activities and events.

In summary, queer expression, repression, and intersectionality formed a complex, entangled web of intra-actions that represented the normative discourses they emerged from. Repression of queer identity was compounded by layers of intersectional oppression, and this was perpetuated by medical school culture, medical curriculum, and societal expectations. Despite this oppression participants felt able to express their queer identities in a number of ways, which they found liberating and validating.

Queer Bodies as other and/or normative: Homo- and bisexuality was considered by participants to be a societal norm with few commenting that sexuality was considered other by most people. However, *expressions* of sexuality other than heterosexuality were considered other and as one participant described it, 'it is ok for you to be queer but only in a certain way – as long as you don't rub it in my face' (Int 10 cntr1). Trans and non-binary identities were considered by participants to be othered by society and this manifested through the healthcare inequalities and discrimination that trans and non-binary individuals experienced. One participant noted: 'There is somebody on the female ward … who had their pronouns on the little white board where it says your name and it said they/them and somebody dropped it off like the next day and the patient was still there … and all the doctors were referring to them as she. And it's just like, that's not even passive [discrimination]' (Int 1 cntr1).

This example is one of several in which participants observed or personally experienced clinical situations in which queer people were othered or, as here, queer bodies were denied or erased. Participants described these othering, denial, and erasure events as personal experiences but also as something which was experienced by the whole community because it was something many had experience of dealing with.

Although defined briefly elsewhere in this article, it is important to explore the definition of queer bodies further at this point. Definitions of 'queer body/ies' vary across and beyond disciplines, often including what it *doesn't* appear to do, i.e., 'produce intelligible gender' (Mitchell and Rogers, 2021) and often relies on actual physical bodies as the basis of the definition. Here the author refers to queer bodies as both bodily and not, as

representational and material; queer bodies as constantly redefined understandings of queer identity that are 'made along the way' (Gleeson, 2021), emerging from entangled understandings, rejections and subversions of gender and sexuality norms.

Erasure of queer bodies made participants feel 'maybe not as kind of seen … by the curriculum or the medical school' (Int 6 cntr1) and again led to discussions about the paucity of LGBTQ+ related content in medical curriculums. In particular, participants thought that LGBTQ+ related curriculum was designed for straight people. One participant noted, 'when the university tries to weave in LGBT teaching, I feel like often it's kind of aimed at non-LGBT students and when you're the queer student in the room you're like hello, I'm here' (Int 6 cntr1). This left participants often having to teach other students and academics about LGBTQ+ health issues, outing them in a public setting and making them feel inappropriately 'put on' to fill in the gaps that the curriculum didn't fill.

The perceived extent to which queer identity was seen as normative or otherwise also depended, the participants thought, on where queer identity was enacted by an individual. Queer spaces were seen as private, protected spaces where participants didn't have to do 'straight passing' (Int 10 cntr1) but which were separate from non-LGBTQ+ spaces and therefore societally non-normative. These spaces were physical (one participant took the author to one of these space as part of the walking narrative) and virtual. Physical spaces included queer cafes and venues, drag nights, and interestingly, home. Home was seen as an important queer space that needed to be protected and nurtured. Participants described being very careful about who comes into, stays, and lives in their home so as to maintain it as a safe, queer space.

Virtual, online queer spaces were important to participants as opportunities to express their identity and learn more about queer identity. These spaces included queer art classes, queer crafting spaces, discussion spaces and webinars and were all described as 'guarded' (Int 8 cntr1) from the real possibility of hate and hate speech that exists online.

Furthermore, the participants felt that university social societies had an uneasy relationship with queer identity. Some, such as sports societies, were perceived to be 'heteronormative spaces' (int 8 cntr1) with mixed reactions to queerness. Others, such the drama or LGBTQ+ societies, were seen as safe queer spaces where participants felt 'liberated' but also had a 'vibe' which was 'alcohol' orientated and 'very white middle class' (Int1 cntr1) and therefore had the potential to be excluding to some LGBTQ+ students.

A source of tension that emerged from the interviews/written account was the role of the author. The students knew the author as an LGBTQ+ advocate and queer person but their theoretical power

as an academic in a medical school in the UK and an author exploring this topic made them a queer body, which was both normative (as a part of the university system in a position of power) and non-normative (as a queer person and LGBTQ+ advocate). This made for a variety of discussions about their authenticity and loyalties with respect to furthering the cause of LGBTQ+ people in medicine and medical curriculum. One participant commented that, 'I've … always seen you as personally as like an advocate for people like me … but I was worried in saying, oh, I don't think I had any teaching'. With an awareness of the possibility of such a power dynamic occurring in this study, the author designed the study so that it encouraged participants to challenge them, and it was validating to see that students felt able to debate with the author throughout the interviews and written account.

Participants felt that queer doctors were a potential source of role models but that they were hard to find. One participant commented that 'more openly queer role models' (Int 12 cntr1) were needed for LGBTQ+ medical students to make them feel that they were seen and acknowledged. Furthermore, although some queer doctors were described as being visible in subtle ways in practice, which made them identifiable to other queer people but not necessarily the general public many were not visible to participants, with one participant commented that 'I've never met any non-binary doctors …so I don't know how people respond to them … and I guess there's a fear that I'm going to be found out for being non-binary' (Int 9 cntr1).

In summary, queer bodies were considered material and powerful and personal as well as a community entity shared by all LGBTQ+ people. The normative nature of queer bodies was complex with power shifting between the personal queer body, the community queer body and wider society. Place and space were important in this power shift as was the problematic relationship between queer role models, university and participant's experiences of personal and community discrimination.

Discussion: Aware that this is a single cohort in a single research centre, the author was cautious in transferring any experiences at any point. However, the outcomes reflect other interpretations and wider theoretical understandings of LGBTQ+ and othered people. Firstly, fear and violence are lived realities for many participants and these concepts are described as material with form and power. They are also inextricably entangled with each other and with many other material entities and post-structural discourses as wide ranging as the cost-of-living crisis, gender, social media, night-time, attraction, power, hospitals, home, compulsory heterosexuality, the colour pink, tattoos, rainbows lanyards, the word 'fuck', and the smell of a particular perfume.

To consider the implications of fear and violence in this context, the author first turns to Michel Foucault's post-structural perspective on violence, which he describes as 'a way of acting upon an acting subject …by virtue of their acting

or being capable to action' (Foucault, 2000, pp. 340-341). Foucault argues that when violence is exerted on an 'acting subject' (in this case an LGBTQ+ medical student) any power relation is lost between the person undertaking the violence and the person receiving the violence. This is because power is designed to bring about change (i.e., in behaviour) and in exerting violence a subject loses choice and therefore the relation of power between the two subjects is lost (Foucault, 2000). However, it could be argued that there is often choice even after violence (excludes tragic cases where one or other subject is killed) that the study participants' 'fuck it' attitudes is a choice from which emerges a regeneration of a power that is validating.

When talking about violence and fear, participants often referred to experiences and feelings that related to their LGBTQ+ identity. If then we accept interpretations of Butler and Wittig (Wittig, 1980; Butler, 1990; 2007; Karhu, 2020) that the act of separating sexes into binary notions (and associated expectations) of male and female is a form of discursive violence, Butler's (2011) proposition that bodies can have precarity forced on them violently (and therefore they are made more easily invisible) and Foucault's (2000) concept of violence as a schism in any one power relation it is understandable that participants would feel fearful as the potential for violation of their core identities is actual.

One situation in which participants discuss this binary separation is medical curriculum. Participants felt that curriculum was heteronormative, excluding of LGBTQ+ identities or when included, pathologizing of queer identities. Participants being told in tutorials that teaching cases including LGBTQ+ identities were 'trick questions' (Int 7 cntr1) and transgender healthcare being excluded from the curriculum altogether were common. The author argues that these approaches are continual acts of violence towards LGBTQ+ people, which have implications for individuals through loss of power and through creating an environment in which fear is predominant, the wider LGBTQ+ community through perpetuation of institutional heteronorms and pathologizing language and material practices, and medical education through the need to enact change to stop this violence.

Added to this was participants' observations that curriculum appeared to have materiality of its own with power, which reinforced heteronorms and hierarchies that oppressed and suppressed queer identities. In this way, from the entangled intra-actions between agentic objects (i.e., curriculum and LGBTQ+ medical students) emerges the material-discursive possibility (Barad, 2003; 2007) that curriculum can enact violence on/with LGBTQ+ people. In addition, this violence is enacted on LGBTQ+ people who are also people of colour or experiencing disability to name but a few of the entangled parts of an individual's identity that can experience this violence and induce fear in and of itself.

Although the author was unable to find specific examples in the literature of LGBTQ+ bodies discussed in relation to medical curriculum and violence in this way (that being medical students in the UK), other scholars have discussed the 'violence in medicine' (Shapiro, 2018; p. 2), particularly in relation to language, metaphor and structural inequalities and hierarchies (Shapiro, 2018). Others have discussed the need for but also the complexity and dangers of discussing queerness in a facile or tokenistic way in science and healthcare curriculum (Broadway, 2011; Finn, 2021). There is also an important body of literature exploring the violence and trauma for people of colour in curriculums across and beyond the academy based on white supremacist, middle class norms (Jones, 2020; Arday *et al*., 2021; Iyer, 2022) and the epistemic violence of knowledge and knowledge institutions in relation to colonisation (Nielson, 2020; Zaidi *et al*., 2021; Bruner, 2021). An important element that this evidence discusses is the need for curriculums to overtly incorporate a re-appreciation of the complexity and nuance of othered people and their identities (Jones, 2020; Finn, 2021). What this has the potential to do then is 'normalise queer [and other entangled parts of] identities … improving experiences for LGBTQIA+ patients and staff' (Finn, 2021, p. 28) and the author argues, students.

An important, established way of re-considering this complexity is intersectionality (Crenshaw, 1991; Collins, 2016). Intersectionality plays a significant, ongoing role in making visible oppression and discrimination. This was evident from the author's discussions with participants, and the associated oppression made participants less likely to be open and able to express themselves. The author has previously defined intersectionality in this article and has argued the importance of intersectional transdisciplinarity as a methodology for re-examining this complexity. An important aspect of intersectionality, discussed by the person who coined the term, Kimberle Crenshaw is that 'Sometimes, "It's complicated" is an excuse not to do anything' (Columbia Law School, 2017, no paged). What is important then is that any re-examination of the complexity of intersectionality in curriculum or elsewhere creates change that improves peoples' lives.

In line with transdisciplinary approaches, the author looks outside of academia to consider ways in which to do this meaningfully.

The New York City (NYC) LGBT Historic Sites Project (1994; 2015) is a multi-agency, intersectional 'scholarly initiative and educational resource' (NYC LGBT Historic Sites Project, 19942015) that, amongst many other things, maps queer places, spaces and people that have contributed significantly to American history in New York. In this way, the project is a material entity geographically documenting intersectional spaces, which celebrate difference. As such by grounding their exploration of difference and intersectionality in place and person the project encourages the reader/user to engage with the complexity of

peoples' lived experiences in a very personal way. For instance, as a person in/coming to NYC you are provided with an online, interactive map with locations pertinent to the people and places featured in the project and are encouraged (if you feel able) to directly engage with the spaces by visiting them. Sites span the whole city and incorporate queer voices that intra-act complexly with amongst others poverty and wealth, race and racism, access, and disability. By moving through these spaces then, the author argues, it is possible for an individual to engage physically and emotionally with the complex intra-actions that make up identity and difference.

What these approaches and initiatives illustrate is the need for medical curriculum to change in this respect and also ways in which this could be done. Utilising initiatives outside of academia could give students an everyday perspective on everyday issues, for those affected. Furthermore, having intersectionality as a thread throughout medical curriculum could enable more meaningful, honest conversations about, for instance, privilege and act as a regulatory mechanism for questioning and changing normative discourses as they are identified. This discussion of place and person opens up more general discussions about queer bodies, which have been defined previously in this article and explored in this study.

The queer bodies of the participants and the spaces they inhabit were perceived to have an uneasy, constantly shifting relationship with society and institutions, which the participants felt reflected the changing attitudes of UK society to othered people, bodies and objects. Queer bodies also appeared to shift and change in their intra-actions with other parts of peoples' identities such as race and sex. Furthermore, these queer bodies were considered by participants as a personal and simultaneously, a community object/relation shared by the entire queer community at medical school.

If we accept Butlerian concepts of gender as performative and not-fixed (Butler, 1990; 1995), Barad's concept of agential realism (Barad, 2003; 2007) and Haraway's concepts of tentacularity and embedding (Haraway, 1990; 2016) and, utilising the previously discussed definition of queer bodies in this context then the material-discursive possibility of personal queer bodies and simultaneously, community queer bodies become possible. This is because gender and sexuality are arguably constantly re-evaluated in society in line with the social constructions that they emerge from (Butler, 1995; Gleeson, 2021). Furthermore, these social constructions have a complicated, entangled relationship with an individual's experience of having/not having gender and sexuality from which emerges material entities with power relations (Barad, 2003; 2007) that shift depending on social norms, politics, and human/ non-human material relations (Haraway, 1990). Therefore, the queer body is both a social, material entity imbued with power and recognisable to and about queer communities and also a personal reality that is accepted or

denied depending on who/what has power.

By way of further explaining this idea, a recent example of this entangled social/ personal relationship, which echoes HIV/AIDS in the 80s and 90s and could be extrapolated to COVID-19, is monkeypox. Monkeypox is a virus spread through close contact, causes lesions and viral symptoms, and is usually self-limiting (UK Health Security Agency, 2018; 2022). A number of those affected in the UK have been from the LGBTQ+ community, especially gay and bisexual men (UK Government, 2022). However, this is not an exclusive association, with a number of different communities affected (UK Government, 2022) and the reporting on monkeypox has been criticised as enabling homophobic and racist stereotypes (UN AIDS, 2022). Furthermore, the UK Government have also been criticised for their 'inaction' in relation to their LGBTQ+ related health communication strategy for monkeypox (Terrance Higgins Trust, 2022). With this example in mind, the author argues that queer bodies and particularly those queer bodies who are people of colour in this example, are objectified as other and through this objectification and associated stigmatisation, denied.

The blood of those affected holds infection that defines a community; from any queer body infected with monkeypox emerges the concept that the whole queer community has the potential to be infected with monkeypox and therefore the queer body is both a personal experience in terms of the individual infected and a community experience through the community being stigmatised as being infected.
Again, what these approaches highlight is a need for medical curriculum and education reform in this respect. The author argues that in order to enact change, academia and society need to sit with and explore complexity more meaningfully with students and staff. We need to face our own biases, question the morality that underpins these biases and those that underpin our profession more widely. In so doing so, we open up the possibility of considering, at an undergraduate level, if the fabric of what we accept as true in medicine (beneficence, non-maleficence, autonomy and justice for instance) is emancipatory for all or in fact oppressive for those who are subjugated by normative discourses (Bonnie and Zelle, 2019).

This paper highlights the need for reform in the way medical education manages and teaches difference. With this in mind, the author is aware of the need to highlight important limitations of this study, which will affect its application to other medical education contexts. Firstly, that this is a single centre study with participants from, in the majority, a similar socio-economic background. Secondly, that this is a UK-only study and is constructed within the medical education frameworks particular to the UK.

Finally, despite multiple approaches aimed at mitigating it the author was a person known to all participants as a medical education professional and

queer person. This is a limitation in that it created a power dynamic in favour of the researcher and this may have affected the information that the participants were willing to share.

In summary, in considering what the outcomes of this study might mean for participants, other LGBTQ+ communities in the UK, and the medical education community, this discussion highlights three points. Firstly, that fear and violence, in many forms, are realities for participants, and the author argues this violence extends to medical curriculum. The medical education community needs to consider how this might be changed through honest discussion and engaging with difficulty. Secondly, that intersectionality and intersectional transdisciplinarity are important ways in which to reassess the complexity of LGBTQ+ identity but that any such reassessment has to have emancipatory aims for communities, including and beyond LGBTQ+ people, to be meaningful. Thirdly, participants felt that experiences and understandings of queerness and queer bodies are both personal to an individual and simultaneously inclusive of whole communities and societies.

Awareness of this last point is important in providing a lens through which to re-examine LGBTQ+ stigma and healthcare provision and encourages the profession to re-examine the foundational moral principles with which we practice. Finally, an important point to highlight from these interpretive understandings is the participants ability to turn away from these barriers and challenges and embrace 'queer joy'. Participants in this study felt able to subvert, love and flourish despite the difficulties they faced in and out of medical school.

Conclusion: This article details a qualitative study exploring the lived experiences of LGBTQ+ medical students in one university in the UK. This subject was explored because of the lack of first person, narrative accounts of this population in the UK, as well as the author's personal determination to highlight a perceived lack of curriculum content pertaining to LGBTQ+ issues in medicine and the importance of thinking intersectionally when considering queer issues in this way. Therefore, in this study the author set about exploring the lived experiences of LGBTQ+ medical students using first-person narrative to capture their lives in their own words.

The author used an adapted qualitative methodology and method (FPDA and FANI) underpinned by philosophical concepts, including post-structuralism and materialism, to realise their study aims. Outcomes showed that fear and violence but also subversion of heteronorms, community formation and protection, and 'queer joy' were a significant part of the students' lived experiences. Outcomes also illustrated that perceptions of 'queer bodies' were other and/or normative and intersectional repression and oppression was an ongoing, significant experience for participants.

In line with intersectionality and decolonisation literature, the author argued that medical curriculum is an act

of LGBTQ+ related violence and highlighted the importance of intersectionality and intersectional transdisciplinarity in understanding the complexity of difference and enacting change in this respect. Finally, it is argued, in line with participants' documented experiences, that queerness and ''queer bodies' are both personal and community experiences/ entities and awareness of this relationship is important for re-considering LGBTQ+ related stigma and intersectional healthcare inequality.

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