The wrong('s) place: discrimination against lesbians, gays, and bisexual women in medical education

O lugar (do) errado: discriminações contra lésbicas, gays e mulheres bissexuais no ensino médico

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Abstract

This article aims to analyze the experience of medical students who identify themselves as lesbians, gays, and bisexuals inside the professional health corporation of highest social prestige in contemporary Brazilian society, the Medicine. The categories found show that the undergraduate course has a hidden curriculum that operates in the logic of excesses, with a conservative, masculinist, and heteronormative medical model. People of the LGBTI+ community are made invisible, both in terms of curriculum and in social relations, in a process of excessive and constant surveillance of students to adapt to a model that privileges heterosexual men, whereas the rest are considered abject.

Keywords: Sexual Minorities; Sexual Diversity; Medicine; Higher Education

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DOI 10.1590/S0104-12902022180349en

Resumo

Este artigo objetiva analisar a experiência de estudantes de Medicina que se identificam como lésbicas, gays e bissexuais dentro da corporação profissional da saúde de maior prestígio social na sociedade brasileira contemporânea, a Medicina. As categorias encontradas apontam que o curso de graduação apresenta um currículo oculto que opera na lógica dos excessos, com um ideário médico conservador, masculinista e heteronormativo. Pessoas da comunidade LGBTI+ são invisibilizadas, tanto em termos curriculares como nas relações sociais, em um processo de vigilância excessiva e constante dos estudantes para a adequação a um modelo que privilegia o homem heterossexual, enquanto os demais são considerados abjetos.
Palavras-Chave: Minorias Sexuais; Diversidade Sexual; Medicina; Ensino Superior.

Introduction

Australian sociologist Raewynn Connell (2016) conceptualizes gender as a structure that organizes social practices in defined roles through the relationships that mark bodies and attitudes. She argues that "Social practices do not happen without bodies. (...) Gender is an issue specifically of social embodiment" (Connell, 2016, p. 17). In the same direction, gender relations belong to a group of contemporary discussions, both in terms of organization and social meanings, including in this scope sexual minorities formed by Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI+).

Despite excluding homosexuality as a category of disease in the late 1970s by the American Psychiatric Association, Speight (1995) argues that homosexuality is still understood as a condition of biological and psychological risks, especially in an underlying way, with teaching based on stereotypes about homosexuals as promiscuous people and the risk to public health.

Speight (1995) argues that homophobia is a health issue, explicitly denouncing inadequate, homophobic, and transphobic medical care by silencing and the lack of qualified listening. The historical context of the emergence of medical care for LGBTI+ people refers to the nineteenth century when the issue becomes important in medical knowledge with the incarceration of people in mental hospitals in search of medical interventions to cure the disease of homosexuality (Speight, 1995). The author also analyzes that physicians evaluate homosexuals more negatively than heterosexuals in situations of similar health/disease conditions, still tending to maintain a personal distance – non-objective attitudes, which create an impaired and incomplete doctor-patient relationship.

The lack of familiarity of physicians with the debate and with the health aspects of LGBTI+ people, as pointed out by Moretti-Pires (2017), directly impacts the quality of care provided in health services, with several possibilities of damage, namely: if, on the one hand, there is the invisibility of LGBTI+ people who are taken as heterosexual and, hence, are not considered in clinical and psychosocial singularities, fundamental to the integral view

of their health; on the other hand, there is the stigma and prejudice that correlate, simplistically, LGBTI+ people to the risks for Sexually Transmitted Infections (STIs), disregarding that there are other related health problems.

The marginalization of gender and sexual diversity themes in medical education are interconnected in the analysis of Cheng and Hsing-Chen (2015). Regarding gender, they analyze that, when they appear, they are restricted to the difference in risk factors, to certain health problems, signs, and symptoms between men and women, disregarding the socio-cultural complexity and the mechanisms of power-exclusion that perform the context of the emergence of these medical parameters. Knowledge of health and Medicine has an essentially "male-centered" epistemological basis, including the predominance of models for studying physiology only with male animals. Regarding sexual diversity, the authors exemplify the exclusion with phenomena such as the ridicule of LGBTI+ people in non-curricular practices among students. The division of labor between physicians, or the exclusion and pathologization of LGBTI+ people, is building the posture of future professionals, including the use of medical vocabulary at the service of misogyny, homophobia, machismo, sexism, and compulsory heterosexuality (Cheng; Hsing-Chen, 2015).

Lempp and Seale (2004) argue that in addition to the curriculum itself, medical students must "learn to survive" at the university through the learning of customs, rituals, and how social relations are structured, in a process that builds them not only as students but in their future professional practice when they graduate. Medical educators may not perceive the existence of implicit beliefs, values, and codes of behavior that exclude and marginalize issues of gender and sexual diversity (Gaufberg et al., 2010, p. 1709). With the silencing and even exclusion of the 'LGBTI+ issue' in Medicine, there is a need for the emergence of societies such as the *Gay and Lesbian Medical Association*[1] as a support for students and professionals who are not heterosexual, especially in relation to the isolation experienced within Medicine and the lack of training to address this specific audience.

Given the problem presented, the challenges and impacts in medical training, this article aims to analyze the experiences experienced by Lesbian, Gay, and Bisexual Women students in a Medicine course.

Research paths

The Focus Group technique (Morgan; Hoffman, 2018) was used with LGBTI+ students. To select the participants, the snowball technique was used, according to use in medical education studies that employ focus groups (Ghaljaie et al., 2017), with potential for investigations that analyze common experiences when constituting a recruitment strategy that is based on the participants' own networks of social relations. All participants attended at least the eighth semester (fourth year) at the time of the research, a phase that ends the cycle of theoretical disciplines of medical training. As there are peculiarities that refer to each of the expressions of gender and sexual orientation, the criterion of internal homogeneity of the two focus groups referred to gender: one with self-declared gay students and the other with self-declared lesbian or bisexual women students. There was no search for bisexual men in the present study. It is noted that the only transsexual student who was enrolled in the Medicine Course at the time did not want to participate in the study despite being among those contacted by the snowball. All the people who were part of the focus groups were white, cisgender, and none had their entry into the university through affirmative action policies. In the university in question, several collectives work on the themes of human rights and sexual minorities, but none of the participants was a member of these student movements.

1 Founded in 1981, the association assumed as its mission the activism in terms of continuing education, in guaranteeing equity in the health care of individuals and LGBT professionals.

Table – characteristics of the participants of the focus groups.

Identification	Sexual orientation	Gender Expression	Age	Semester (year)	Family income per capita
Gay Focus Group (GFG)	Gay	Male	22 years old	10th (5th year)	8 + MW
	Gay	Male	27 years old	10th (5th year)	Between 1 and 3 MW
	Gay	Male	32 years old	11th (6th year)	Between 6 and 8 MW
	Gay	Male	27 years old	10th (5th year)	8 + MW
	Gay	Male	25 years old	11th (6th year)	8 + MW
	Gay	Male	25 years old	11th (6th year)	Between 6 and 8 MW
Lesbian and Bisexual Women Focus Group (LBFG)	Lesbian	Female	23 years old	8th (4th year)	Between 6 and 8 MW
	Lesbian	Female	29 years old	9th (5th year)	8 + MW
	Lesbian	Female	22 years old	9th (5th year)	8 + MW
	Lesbian	Female	24 years old	9th (5th year)	Between 6 and 8 MW
	Bisexual	Female	23 years old	10th (5th year)	Between 6 and 8 MW
	Bisexual	Female	23 years old	8th (4th year)	8 + MW

Legend: MW – Minimum wages.

Before the focus groups, all participants were contacted by the researcher, who thoroughly explained the theme, the relevance, and the intentionality of the constitution of the Focus Groups in the computation of the research. They were informed about the treatment and analysis of the information, as well as the dissemination of the results, following the current protocols of the Legislation of research with human beings thoroughly[2], including the explanation phrase by phrase and signing of the Free and Informed Consent Form, in two copies. Each date and duration were also agreed upon.

After the initial explanations as detailed above, the moderator employed the following guiding question "I would like you to report how the issue of gender and sexual diversity are experienced and learned during the Medicine course". We chose to conduct the focus groups with unstructured questioning based on the Social Constructionist perspective of co-production of meanings (Spink, 2010). Without a structured script, this strategy allowed a more comprehensive dialogue and the production of a chain of ideas, concepts, and discussions, with less interference and direction from the researcher and greater protagonism of the members.

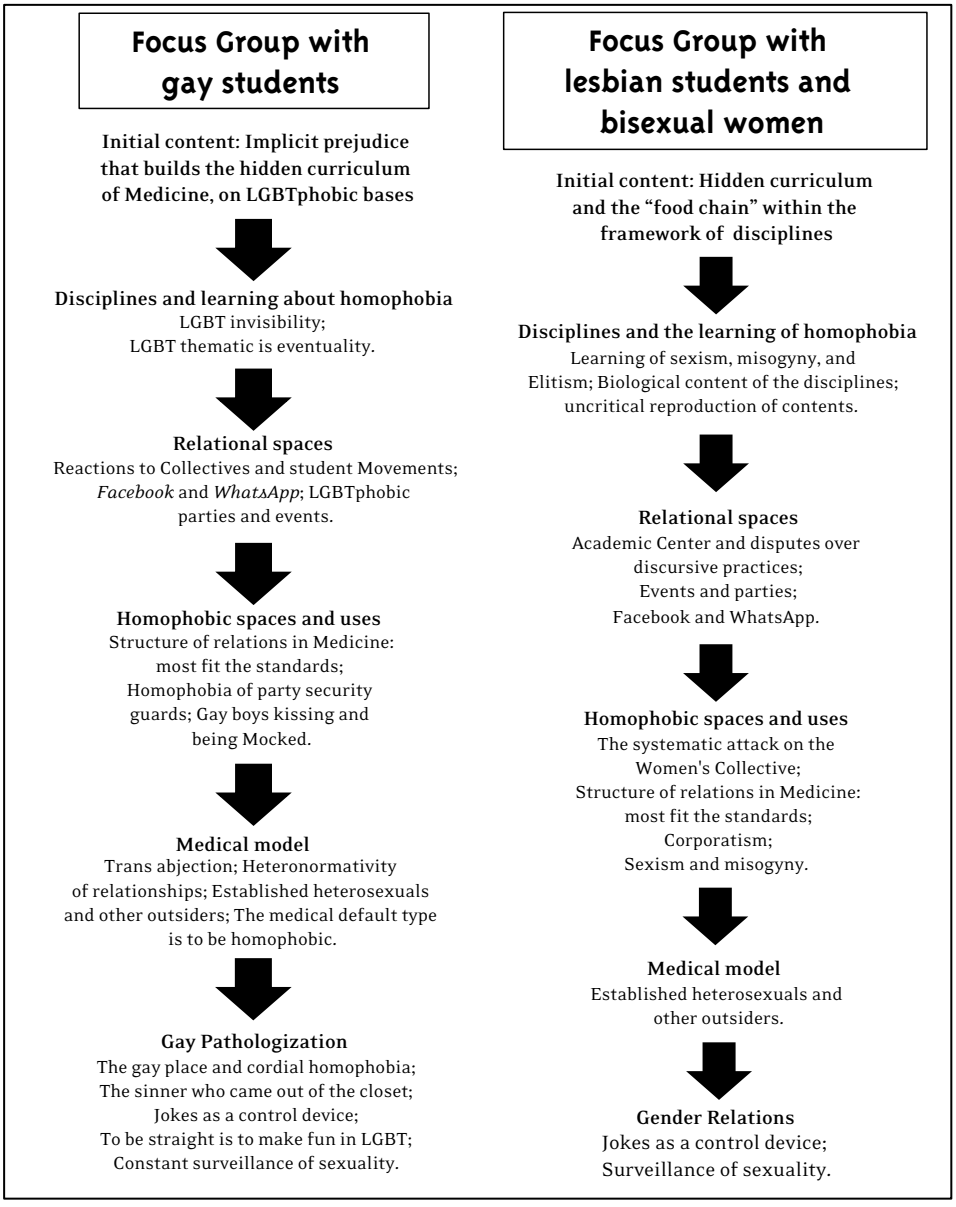
All dialogues were recorded with a visible digital recorder and an observer's written record. The two groups were held between January and February 2018, with a single meeting per group, with an average duration of 50 (fifty minutes). Thematic analysis was used in the construction of the categories, according to Maguire and Delahunt (2017). In this process, the discursive repertoires and meanings given by the participants were raised, as well as the explanations and internal contrasts of each group. Finally, the common results were grouped into broader categories until two major emerging themes were established: on the health of LGBTI+ people and students' experience in the Medicine Course.

Results and discussion

After categorizing the results, the flow of themes appearing in the results of the focus groups is summarized in the following figure, followed by the analysis.

2 The research project was approved by a Human Research Ethics Committee (CAAE 34999514.4.0000.0118).

Figure 1 – Sequence of themes that emerged from both focus groups



The place (of) wrong about who should be assisted – about the health of LGBTI+ people

Gender relations were referred to through a discursive repertoire of exclusions and unfeasibilities. There is a certain sense of "taking the wrong place" as LGBTI+ people suffer when they "*dare to try to be physicians*" (LBFG). The idea that LGBTI+ people dare to be physicians is, in itself, an outlining idea of social expectations about a certain pattern of who may or may not occupy this prestigious space, a context mediated by the reach of homophobia in contemporary society, according to Schilt and Westbrook (2009). The authors analyze that the heterosexual man is adopted as the maximum referent of gender relations, with the effect of distributions of social positions and possibilities of the existence of people who flee from this referent to the margins, especially from the heterosexual woman to LGBTI+ people.

This distribution is political and organizes the social fabric through normative assumptions that not only rank men and women but also reaffirm that only the two genders are possible as heterosexuals, as well as "(...) homosexuality is almost always conceived, in terms of the significant homophobic economy, both uncivilized and unnatural." (Butler, 2015, p. 229).

During the focus groups, the debate about the lack of information about the lives of LGBTI+ people in the medical curriculum emerged, restricting itself only to Sexually Transmitted Infections (STIs). At the same time, the participants justify this lack by the fact that professors "teach" how a physician should address the theme through naturalized prejudice:

> *"I saw several cases in which the patient was homosexual and could not explain the condition for STIs, but also did not close in any diagnosis. They keep insisting 'If it's homosexual, it must be sexual, it's something sexual, it's something sexual...'"* (GFG)
> *"When you see a heterosexual or a homosexual, you feel that you have a very different concern for the scope of things you think about."* (GFG).

The insistence that STIs would always be associated with the clinical conditions of homosexuals, as well as the different focus of the "scope", point to naturalization and essentialization of "normal" and "abnormal" health conditions and problems, as if sexual orientation were the origin and determinations of health. On the other hand, due to the lack of a transversal curriculum focus on sexual diversity, it is also possible that lack of knowledge leads professionals to appeal to the relationships established within the disciplines since LGBTI+ people are alluded to when talking about STIs.

Another scenario presented by Connell and Pearse (2015) is that the prominence of the gay movement after 1969, along with the emergence of Acquired Immunodeficiency Syndrome (AIDS) in the early 1980s, had the effect of a "(...) new set of relations between doctors and the State" (Connell; Pearse, 2015, p. 183), in which LGBTI+ people became one of the main targets of policies aimed at this pathology, given the focus that they constituted themselves as a "risk group". According to the authors, public policies and investments against AIDS aimed at gays and transvestites brought a content of hygiene linked to the image of promiscuity, impurity, and dirt, especially from a moral-religious discourse, to the point that many advocates of same-sex marriage would justify their position as a way to protect society from the spread of sexually transmitted diseases, including AIDS.

For Weeks (2016, p. 37), "many people, and not just the sensationalist press, presented AIDS as a necessary effect of sexual excess as if the limits of the body had been tested and had not passed the test of "sexual perversity". As Brito et al. (2001) pointed out, this is a social stigma since there is no risk group in itself but behaviors that increase the risk of infection by the virus. Nevertheless, in the social imagination, to be LGBTI+ is to have a propensity to acquire and transmit AIDS, even in the 21st century.

Although, at the time of the research, there is still a prohibition on blood donations by homosexuals, a perspective judged as unconstitutional by the Brazilian Supreme Court in 2020, the management, without due respect to the person and critical reflection on the situation by professors when explaining the situation to students points to the naturalization of exclusion, as in the following report

> *"the (gay) boy asked the professor 'Oh... what if she was homosexual? What would happen?' and the professor answered, 'What we do is follow the interview normally, collect the person's blood, but then we discard it'.* (LBFG).

That is: the professor recommends the patient undergoes the entire procedure, including the blood collection, which is simply discarded because she is an LGBTI+ person, in a teaching posture that, according to Cardinali (2016, p. 132) is based "(...) in outdated scientific conceptions that end up reinforcing negative stereotypes that relate homosexuality to 'promiscuity' and 'danger', acting in the perpetuation of stigmas".

The personal and moral(izing) background opinions take place in medical education, as expressed in the reports of the focus groups:

1) about a professor who brought studies to the students showing that "if the first pregnancy was a girl and the second was a boy, and then in the mother's womb there were female hormones, and then the son took it and became gay" (LBFG)*;*
2) that "in gynecology, they even talk about partners, but never talk about the question of whether the person is homo or not. The fact of having other partners is there theoretically, but the fact of another sexual orientation is not." (LBFG)*;*
3) "the reference is always talking about the gender of the straight couple. If the girl has such a disease, one has to treat her (male) partner. And if the man has such a disease, one has to treat his (female) partner". (GFG)*'.*

This position of naturalization of heterosexuality as a model, as well as the essentialization and biologization of explanations of sexuality and sexual diversity, is certainly related to what Judith Butler (2015a) points out about the reproduction of compulsory heterosexuality. The three reports presented refer to a certain unity of gender, which implies uniform regulatory practices, in which "(...) an excluding production apparatus operates, restricting the relative meanings of 'heterosexuality', 'homosexuality', and 'bisexuality', as well as the subversive places of their convergence and resignification." (Butler, 2015a, p. 67).

Another practice of LGBTI+ invisibilization in the medical curriculum is the lack of discussions about contraception between lesbians and transgender men, as well as the use of hormone therapy for transgender people in Primary Health Care:

"And when you are in a consultation, and the person reports that he is not heterosexual, most doctors are 'baffled', stand still, say something about it, but then divert until you forget and follow the normal path, the routine consultation" (LBFG).

The students reported a case in which a boy arrived at the Emergency Department of the University Hospital for being stabbed and "*it was his partner because of jealousy. And at no point did anyone consider bringing up the domestic violence case. I found out why the patient told me later.*" (GFG).

Other "unusual" cases refer to situations in which even the user's confidence in medical knowledge is questioned, such as:

"We are instructed to recommend condoms to all women. I have already seen it happen that the doctor gives the woman a lecture and she says, 'But I'm homo'". (LBFG) *or "When the patient reports that she is a lesbian, the general thing is for the doctor to be embarrassed, to go around, and circumvent because they have no idea what to do"* (GFG).

Even among professors, students do not know how to identify whether there are LGBTI+, operating stereotypes in the classifications between heterosexual and presumably non-heterosexual professors, such as:

"There is a professor who was a disappointment for the class. And he is a camp, but with a closed beard, the arm of this size (indicating something big), white, tall, and with muscles. His way of speaking and behaving is not what they would expect from his body" (GFG)*;*
"Some say there are some gay and lesbian professors. But it is kind of an urban legend. You know some servers at the University Hospital because they talk openly about it. (LBFG)*".*

The astonishment before an LGBTI+ patient, the invisibility of situations such as those of violence between homosexual intimate partners, the standardization of the use of protection against STIs based on heterosexual sexual relations, and the embarrassment of professionals when informed that the patient they attend is a homosexual person are elements of the focus groups that reinforce Britzman's (2016) considerations that school curricula - and we extrapolate to that of Medicine, depending on the results - are still today based on eugenics and social hygiene with a strong moral(izing) appeal and foundation, that by hiding certain possible contents and lives, as Butler (2015b) analyzes, reinforces not only compulsory heterosexuality but also pathologizes other ways of living sexuality. The author also points out that the restriction of classical content on gender and

sexuality to specificities and themes demonstrates the strength of hiding that operate in curricula that, in her analysis, talk about sex all the time, naturalizing and reinforcing roles.

These are, for example, institutionalized rules about the relationship established with patients, with their care, interprofessional and intraprofessional interaction, among other aspects, and that, in the author's words, "model" the student (Phillips, 2009). When - clinical or theoretical - professors decide to explain a certain aspect of the content and omit/hide/minimize another, they are modeling the pedagogical process. Bloom (1988) warns that aspects of the social dimension of the disease are not addressed in medical training.

Murakami et al. (2009) concluded that disciplines and curricular contents have little social importance compared to networking constitutions between physicians, especially concerning identity training of the profession. The relevance of this aspect was one of the students' justifications for accepting the persistence of the hierarchy in the relationship between professors and students, despite the verbal abuse and humiliation to which they are subjected, as the interviewees understood it as part of the process of becoming a doctor to adhere to these configurations of social relations. Besides the knowledge that physicians constitute as such, there is also the recognition of other physicians and their position in this network, which further puts LGBTI+ people at a disadvantage compared to heterosexuals, according to both focus groups.

It should be considered that, in addition to the specific aspects of the Medicine course, the issue of homosexuality and subversions of compulsory heteronormativity refer to broader social processes. As Butler (2015b) analyzes, the intelligibility of normal is associated with what is considered human, and there is no way to take as lost the lives that are not susceptible to mourning as they are not human. This is an epistemological problem since it refers "(...) to the frames by which we apprehend (...). They are politically saturated. They are in themselves operations of power. They do not unilaterally decide the conditions of appearance, but their objective is nevertheless to delimit the sphere of appearance as such." (Butler, 2015b, p. 14).

In these "frameworks" (Butler, 2015b), it is distinguished which are the lives that can be the object of social action from those that cannot, a panorama that seems correlated to how Medicine is built through provisions that operate heteronormativity as the only ontological possibility. In this sense, it is important to emphasize that "subjects are constituted through norms that, when repeated, produce and displace the terms through which subjects are recognized." (Butler, 2015b, p. 17).

Butler (2015b) warns that, in these issues, it is not only about understanding the contexts to include people, but rather, and in a previous way, understanding how "(...) existing norms give recognition in a differentiated way." (Butler, 2015b, p. 20), to the extent that they are schemes of intelligibility and that "(...) establish domains of the knowable" (Butler, 2015b, p. 21).

The place (of) wrong among those who learn to be a doctor

In the relationships between students, assuming to be homosexual is a reason for rejection, both of groups in class as well as the opportunity for extra-class coexistence, such as the report that a student who worked with other heterosexual men and, when assuming to be gay, was excluded from the groups "*They never presented a workshop with him again. When a person assumes themself as a homosexual they are automatically excluded*" (GFG). The exclusion of the theme and LGBTI+ people also happen by professors, for example, employing prejudiced jokes and comments on patients when they are only among the team, as in the following speeches: "*Professor G had a visit in the infirmary, a crowded room, a lot of students, residents. He said 'one has to donate blood for surgery. Ask the family to donate blood. Just don't ask any Gaucho or Faggot, right?*'" (GFG).

Teamwork is also a type of relationship that reinforces the exclusion and inadequacy of LGBTI+ people in the medical environment, as can be seen in the following comments:

"In the dermatology outpatient clinic, there was a lesbian patient, and nothing happened in the office, but at the time of leaving the staff met with another and started making some bizarre comments about the patient, like, harassing." (LBFG);
"There were some cases that in the care of people with inappropriate behavior such as heterosexuals, at the time of calling, you saw the professionals, so, especially in the Emergency, they look with a strange face". (GFG).

The tranquility with which playful and prejudiced expressions like these are mobilized in teaching-learning environments is emblematic of how there is a constant reinforcement of prejudice and discrimination against LGBTI+ people.

The reactions of LGBTI+phobia by the faculty, the staff, and even among students appear in the expressions as the environment "get heavy", "not being a routine thing, as if someone was feeling something strange". It is not explicit. It is implied. But violent, since there is no direct mention of the harm to LGBTI+ people, making them "*feel uncomfortable, as if they were bothering. As the professor does not speak directly, but is there making a joke."* (LBFG). This climate is built especially by professors in the classroom, when "*they make very homophobic jokes, thus assuming that the entire classroom is straight. Or not caring if there is someone there who has a different sexual orientation.*" (GFG), mobilizing a repertoire of discrimination both implicit and explicit, which certainly builds both the perception of the normal and the abnormal, as well as the posture that most of these future doctors will take as a model.

As in other movements that make the diversities in the training and daily life of medical students previously reported invisible, openly gay students experience experiences of erasure with the idea that "*it is okay that you are gay, but you have to be a gay boy, you cannot be a camp*" (GFG). Another stereotype mentioned refers to gay students "*knowing and should dance to specific songs at parties, choreographing them" (GFG).* As well as the construction of meaning that gays are *"very good friends because they are sincere, funny, help to choose clothes and make up the girls. If you are not that gay, you are no longer fit to be a friend*" (GFG).

At another end of the erasures is the reduction of homosexuals through a hypersexual approach to their lives, even when the context does not refer to the exercise of sexuality.

"We were walking in the middle of the university, and she turned around and asked if I taught her how to have anal sex... If you are gay, people think you are always prepared to stop and talk about sex" (GFG).

Another aspect of reducing the life of LGBTI+ people to the field of sexual practices, such as the clinical association of the health conditions of non-heterosexual patients with STIs, as previously analyzed.

The naturalization of these situations among the students themselves, and reflecting that it is a course whose professional practice is directly in contact with human diversity, is the questioning of the responsibility of professors, individually or in the Medicine course, in these expressions of discrimination and prejudice against LGBTI+ people. Junqueira (2009, p. 27) is emphatic: "The lack of solidarity by professionals, the institution, and the school community in the face of the most common scenes of moral harassment against LGBTI+ students can produce subsequent effects on aggressors and their accomplices". This is not just about strengthening heteronormativity. These are violent acts against non-heterosexuals, expressed by homophobic attitudes and behaviors, from the most declared to the most subtle, hidden. In this sense, it is the responsibility of the Medicine Course to perceive and review these distortions on gender and sexual diversity, especially due to their impact on the teaching and production of knowledge and practices.

Junqueira (2009) points to the production of a heterosexual, homophobic, and misogynistic universal subject in teaching, who employs "(...) an inexhaustible 'harmless' arsenal of (racist, misogynistic, and homophobic) jokes and pranks" (Junqueira, 2009, p. 27), and which will also be built on the containment of the expressions of intimacy, appreciation, and affection for other men, women, and LGBTI+.

In the context of the Medicine course in question, it is essential to emphasize that there are spaces and initiatives to resist this context. Due to a specific tradition of the university in question regarding research in the field of gender studies and sexual diversity, many medical students can participate in curricular and extracurricular activities on the subject. Especially in the course, there is an elective discipline created in 2019 that deals with these themes with a clinical focus by a movement conducted between the Academic Center, Course Coordination, and a research group led by a professor who works on these issues at the graduate level in collective health. The discipline has ample demand, with the need to expand the thirty vacancies offered every semester since its activity began. However, students' actions are the focus of tensions, discouraging resistance, as in the report of the focus groups that a feminist collective for gender discussions was built in 2015 and undone a few months later due to the great attack of both students and professors to the students who organized this initiative.

Therefore, an institutional climate is built that seems permanently risky to discussions on the subject, as well as to LGBTI+ people in terms of harm and violence, who must be perpetually attentive to what Junqueira (2009) denounces as "homophobic homosociability", correlated to other social spaces such as bars, soccer matches, armed forces, boarding schools, convents, seminars. The educational institution, in its curriculum, in its practices, and its relations between people, promotes means and opportunities "(...) to produce, reproduce, or feed mechanisms of discrimination and violence against female students, LGBTI+, as well as every individual whose gender expression, seems to disagree with what is considered conventional" (Junqueira, 2009, p. 22).

This whole process, with the curricular, extracurricular, and informal experiences, leads to growing sedimentation of perceptions, attitudes, and behaviors in the future doctors, with epistemic bases and practices based on stereotypical and stereotyping dispositions towards LGBTI+ people. We agree with Junqueira that it is a process of invisibility and silent exclusion that "(...) is configured as one of the most overwhelming forms of oppression. It is disturbing to note that someone who cannot exist, be seen, heard, known, recognized, considered, respected, or loved cannot be hated". (Junqueira, 2009, p. 30)

Representation and political existence imply a certain subject that is recognized as such, as pointed out by Butler (2015). Subjects are produced in the structures that form, define, and reproduce regulated subjects. Besides, language will be "(...) the imaginable domain of gender" (Butler, 2015, p. 31), so coercion will be exercised by naming people intelligible according to the norms as normal. Those who disagree with the norms as abject since "The construction of the "not-me" as the abject establishes the boundaries of the body which are also the first contours of the subject" (Butler, 2015, p. 230).

Butler (2015a, p. 229) states that "(...) homosexuality is almost always conceived within the homophobic signifying economy as both uncivilized and unnatural." In the context of gender relations within the Medicine course, it seems that the panorama is related to the idea that any hierarchy dispenses with at least two. Logic and analysis are norms of intelligibility for Butler (2015a), who conceptualizes identity as something that is ensured by concepts that stabilize sex, gender, and sexuality. What is incoherent and discontinuous is questionable. The author also adds that "(...) we must question the power relations that condition and limit dialogic possibilities" (Butler, 2015a, p. 40).

Phillips (2009) argues that the hidden curriculum is one of the deepest ways medical students learn to be professionals because they are implicit and undeclared/declarable elements involved in medical education. When analyzing that it is the reproduction of values and attitudes among students through a certain institutionalized structure in the University and by the organization of the educational program, it goes beyond the framework of the explicit curriculum, whether formal or informal.

For Koifman (1998), the combination of the explicit, disciplinary curriculum in the classroom with factors, experiences, and experiments of medical students, related/made possible by the university, produces the distance between prescribed medical education and official training, and what occurs socially in the construction of the profession and

the professional, which is more and more different from that prescribed, according to the author. One of the unforeseen perspectives in the curriculum is the apparatus of beliefs that operate the idea that the doctor is the "owner of the body that is being treated (...) because he considers himself the owner of knowledge and does not listen to the opinion of the owner of the body" (Koifman, 2001, p.53), a process whose justification and epistemological support starts from the biomedical model.

It should be noted that Sinclair (1997), when researching anthropological aspects of medical education, points out that students acquire theoretical knowledge but also participate in rituals and acquire a certain pattern of attitudes read as typically medical. The author noted that there are formal ways in which students are taught but also devotes time to backroom activities and unofficial socialization activities. It also points out that the acquisition of duties and privileges among group members is characteristic, with the disapproval of those who give up this status.

Also in this sense, Cutolo and Cesa (2003) warn that the aspects of training "beyond the disciplinary" in the Medicine course are reflected not only in an unforeseen training but especially contradictory to the ideals of health professionals in Brazil, stating that in addition to being biomedical, the medical training model reproduces a professional inadequate for social performance, and that meets the needs of Brazilian society.

Final considerations

The medical profession is particularly prominent in its social valuation and reflects the relationships of exclusion in this same society. The role of the physician in the face of people's health is unquestionable in contemporary society - as in other times. Constituted as an elite group and privileges, the physician is responsible for care and life. However, the meanings of these terms - especially concerning their operation - are diverse and constructed through bundles of relationships that are also supported by exclusions, here studied those directed at Lesbian, Gay, and Bisexual Women, both as students and LGBTI+ patients.

There is a permanent feeling of inadequacy on the LGBTI+ theme in the perception of students, with the reduction of the teaching approach to the experience of sexual diversity linked to STIs to promiscuities. At the same time, in many contexts, the silence of professors and lack of transversality in the discipline end up teaching how to make these aspects even more invisible.

Disciplining the bodies is to discipline sexuality, which will be questioned and transformed into discourse - or is already discourse itself -, with sex being the operative figure in the apparatus of sexuality. In which sex will also be hidden, something to be triggered by knowledge and powers, which will produce realities as subjects of practices, production of objects, and production of problems. The physician operates there. Students who enter the course have a certain accumulation of positions and recursion on the subject. Still, medical professionals - even Lesbians, Gays, and Bisexuals - are not technically trained to work professionally with LGBTI+ health.

In the social validity of heterosexuality as a norm, it would not be expected to be different precisely in the Medicine course, in which heterosexual people are more valued and, in a way, represented as the most successful and privileged.

This is not just a university health course. It is the most prestigious social course and sought-after course in college entrance examinations. To what extent, then, can the identity and expression of genders in Medicine be thought of as a marker/predictor/tracer of possible gender trajectories in these games of power relations of Society? What are the resistance spaces? To what extent also the disciplinarization of the human being, the fragmentation in disciplines sustains these (im)possibilities in the scope of Medicine and being a doctor?

It is essential to recommend both curricular changes and the construction of awareness-raising strategies in other spaces used by scholars for the difficulties experienced by LGBTI+ people and the relationships of these experiential contexts with medical interventions in front of health service users. In this sense, it indicates the need for studies that focus on the group of LGBTI+ students and heterosexual students to understand how to trace transformation paths. It is noteworthy that the

groups did not refer to personal experiences as LGB people but to cases of others. Likewise, it is essential to establish investigations with the professors of the Medicine course.

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Authors' contribution

Moretti-Pires and Grisotti jointly elaborated the project, data processing and analysis, as well as the final writing. Moretti-Pires conducted the focus groups and performed the transcription of the final products.

Received: 03/05/2022
Resubmitted: 04/16/2021; 03/05/2022
Approved: 03/11/2022