Re-Thinking Clinical Aesthetics: Lessons from a Queer Professor and Patient

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Let me begin this reflection by saying something about who I am: I am a philosopher and bioethicist who spends a great deal of time thinking about the ways patients from structurally marginalized groups experience health care systems, and the degree of safety they feel in healthcare spaces. I am also queer. Consequently, visits to healthcare spaces are at once concrete reflections of the things I spend my professional life researching, but are also deeply personal moments of vulnerability, and in the worst cases, anxiety, dread, or fear.

For many queer people, going to the doctor can be a significant source of anxiety (Petrow 2016). Tragically, this can cause many queer people to delay care, or to avoid care altogether (Mirza & Rooney 2018; Seelman et. al. 2017). Delays and avoidance of care can, of course, lead to health conditions going undiagnosed or untreated, which can, tragically, exacerbate the extant health disparities experienced by queer communities (Rubin 2015).

It is this set of concerns which motivates my research, which focuses on uncovering ways we might go about making healthcare spaces less anxiety-inducing and more genuinely inclusive and welcoming for structurally marginalized patients, including LGBTQ+ patients. More specifically, a great deal of my research focuses on *microaggressions* – seemingly subtle and often unintended messages that are sent to members of marginalized groups that signal disrespect, hostility, bias, or lack of belonging (Freeman & Stewart 2018).

In health care spaces, microaggressions often occur interpersonally. In such cases, the messages of disrespect, hostility, bias, or lack of belonging are sent either verbally, via words spoken, or behaviorally, through things like gestures and body language. When it comes to queer patients, this can include misgendering or mispronouning trans or non-binary patients, or asking questions that assume that patients are cisgender and heterosexual when they are not. There is much to be said about such interpersonal microaggressions, and the ways that health care providers (often without realizing it) convey harmful messages to queer patients through their speech or actions.

But here, I want to focus on a different way that microaggressions can manifest in clinical settings – as features of the built environment, or the aesthetics of the physical clinical space. With this type of microaggression, it is not that a particular health care professional is saying or doing something that sends harmful messages to their patients, but rather that features of the clinical space itself sends such messages.

Let me again draw from my personal experience. I recently visited a new clinic for the first time. A first visit at a new clinic can be somewhat uncomfortable as a queer person, anticipating that certain things about one's identity and intimate life will have to be addressed, and having no way of knowing how the person in the white coat will react in light of those disclosures – whether they will grimace without realizing it, or contort their body in discomfort, or recoil in disgust, or simply start to look at you differently. But this time was different. This time, I felt uncomfortable before there was a white coat in the room at all, indeed, before the clinical interaction had really started. And this discomfort was not the result of anyone's direct comments or actions, but rather of the examination room I found myself waiting in. Despite the fact that this was not an overtly religious health clinic – and nothing on its website indicated it as such – when I arrived in the examination room, I was met with an abundance of Christian imagery – framed copies of the "Christian Doctor's Prayer," and the "Christian Physician's Oath" among them. The latter had a list of beliefs, to which my new doctor had indicated their assent via their signature at the bottom of the document. From this signed, framed Oath, I could see that my new doctor was committed to practicing medicine in a way that

"depends on the Holy Ghost" and "glorifies God," and, most unsettlingly, which "respects the sanctity of life" and "rejects all interventions which either intentionally destroy or actively end the lives of the unborn, the infirm, or the terminally ill." Our value systems could not be more divergent, and moreover, I was left to question whether their expressed value system would allow them to see me, and accept me, and treat me -- *as I am.*

Let me be clear: I wholeheartedly believe that all people are entitled to endorse whatever religious beliefs they see fit within the domain of their personal lives. Moreover, I recognize that there are some who believe they have reconciled such belief systems with acceptance of, or at least tolerance for, LGBTQ+ people. I do not intend to deny either. But, what I do believe is that those tasked with providing care for all patients must realize the historical and ongoing ways in which these belief systems have been mobilized to justify serious harms to LGBTQ+ people and communities, ranging from the pathologizing of queerness as inherently sinful or unclean, to participation or complicity in deeply harmful conversion therapy abuses, to actively resisting marriage equality and the right for queer people to have and grow families via fostering and adoption, among other things that stand directly in the way of queer life, health, family, wellbeing, flourishing, equality, and justice.

In light of these histories, such imagery and such statements hung proudly on the examination room walls can send the message to queer patients that the person responsible for their care might not be equipped to see and treat them as an equal, to respect their identity or their family, or indeed, to see them as worthy of care at all. This can be incredibly triggering for queer patients. It can resurface past religious traumas, or experiences of people using religious beliefs to invalidate them and their identity and their experience. And can make it very difficult to trust or feel open communicating with whomever ends up walking in the room. It can shut down conversation before it begins. In my own case, upon looking around the space and seeing all of these visual cues, I immediately wanted to escape. I texted my partner asking whether I should leave and try to find a more explicitly queer-inclusive provider elsewhere, even if that meant delaying the care I was in need of and had already been waiting for. When the doctor walked in, I was nervous, and soft-spoken, and brief – all somewhat out of character for me. I felt uneasy answering questions about my sexual health and indicating that my partner was a woman. I felt so much more uneasy and anxious than I needed to, or than I normally would have.

Visual cues matter. They alert patients to things. They shape how comfortable patients feel in a space, and therefore how likely they will be to trust and be open with their provider.

And it isn't just the cues that are present, but also the cues that are absent. When I sat in that new examination room, it wasn't only the cues that were present that made me feel uneasy, perhaps unwelcome. It was also the total absence of anything reflective of me, or my experience, or my relationship. As I looked around,

there was nothing to indicate that this space, this practice, was also for people like me. There were pamphlets featuring heterosexual couples on them, interspersed with the various Christian images. But there was no queer representation or affirmation to be found – no indication of awareness that queer people and queer families and queer sex exist and deserve to be visible and recognized and accepted and treated as equal and valid.

As clinicians and bioethicists, interested in health justice, we must think critically about the look and feel of clinical spaces, and we must be more robustly cognizant of the messages that we send to patients, as well as those that we fail to send. Clinical spaces can have visual cues which cause harm – microaggressions built into the very clinical spaces we inhabit, often without noticing or thinking twice about. But, there is equal opportunity to re-imagine clinical spaces – to think carefully about the inclusion of meaningful microaffirmations – visual cues which can indicate openness, acceptance, and inclusion to marginalized patients.

Healthcare spaces should not be spaces of trauma for any patient. They must become the spaces of healing they purport to be. To do so, it is imperative that we pay careful attention to the messages and cues that are sent, and their impact on vulnerable patient groups. And we must seek to create spaces in which all patients see themselves meaningfully reflected, and in which they feel as if their needs have a fair chance of being met.

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