Yale School of Medicine ”Queer Family Making in Medical Spaces: An Interdisciplinary Discussion” Thursday, May 12, 2022 Remote transcription services provided by:

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Queer Family Making in Medical Spaces: An Interdisciplinary Discussion Yale School of Medicine Thursday, May 12, 2022 Transcriber: HFS

Dr. Anna Reisman: Can you hear me?

Kyle: I can hear you.

Karen Kolb: I can hear you. I was hoping they'd be there.

Dr. Anna Reisman: Welcome, everybody to the final event in this year's Program for Humanities in Medicine Speaker Series. I'm the Director of the program.

I'll tell you about the idea for today's event, which came to me via email from a colleague from the History of Science and Medicine, Joanna Raiden [sp?], who introduced her student, a Yale College senior and premed student, who taught in a Queer Science seminar. She spoke so highly that she suggested that Alie, Dr. Ha, and I discuss a possible event. Here we are with gratitude to Alie for taking this on, for Nathan for mentoring, etc.

I'll do introductions.

[Audio cut out]

[Audio restored]

In the fall, Alie will be working at ERIC at Yale School of Medicine. Nathan Ha, MD, PhD is a resident in the school of Psychology. He earned his degree in [Audio cut out.]

[Audio restored]

Before I turn things over, I want to acknowledge our ASL interpreters and Holly Fox-Schauffner for their wonderful services at this event and all of our recent events.

This is the last event of this calendar year. I want to shout out to Karen Kolb, the administrator, manager, who does everything splendidly and makes everything work out well. Thank you, Karen.

I'll turn things over to Alie.

Alie Brussel Faria: Hello. Thank you so much for the kind introduction. Thank you for coming to this event. It's lovely to see everyone here. We'll begin by thanking the Program for the Humanities in Medicine and Dr. Anna Reisman for hosting and supporting this conversation.

This event came out of a final project I completed for a class titled Queer Science taught by Joanna Raiden and Velocci. For the project I wanted to interrogate what queer family making could mean and to think about how contemporary medicine could support this possibility. To consider this I ask: how might we imagine queer family making within medicalized spaces when these spaces are often heteronormative?

That is they privilege heterosexual and nuclear families as the normal and natural standard. As a queer and non-binary person who plans to pursue medical school, I am interested in this question both personally and academically.

Particularly, I hope to create my own queer family one day as well as to focus my life's work in queering medical spaces, in order to provide more equitable and relational care for people marginalized by gender and/or sexuality.

I'd like to help frame today's conversation, by asking: what do we mean by the terms: "queer," "family," and "queer family?"

In one sense, queer can be used as an umbrella term to refer to people who identify as lesbian, gay, bisexual, or transgender – as well as many other identities. Yet, political scientist, Cathy Cohen, has suggested that queer also has broader political meanings for those whose genders and sexualities are understood as not "normal moral or worthy of state support."

Queer can also be used as a verb to challenge dominant norms of sexuality (i.e. heterosexual, monogamous, white, wealthy, and reproductively focused), thus queer can be used to think about ways to create new possibilities for the existence and well-being of those on the margins of power.

Likewise, the idea of family has a complicated history, especially for those who identify as queer. Due to systemic homophobia and transphobia many queer folks experience rejection and abuse from their families of origin throughout their lives and particularly when they "come out."

Thus, it was and is still common for queer people to create "chosen families" or to seek out and generate new forms of kinship and affective communities to provide each other with material, financial, and emotional support. This practice follows alongside a long history of minoritized communities making spaces for extended kinship networks and non-biological care taking.

[No audio]

[Call disconnected at 5:12 PM]

[Reconnecting]

[Call connected at 5:13 PM EST]

If you feel comfortable going first, that's wonderful. Instead, I'm delighted to introduce Dr. Ross, Lori E. Ross uses she/her pronouns and is an Associate Professor and the PhD Program Director in the Division of Social and Behavioural Health Sciences at the Dalla Lana School of Public Health, University of Toronto.

Dr. Ross is an established interdisciplinary scholar in the field of sexual and gender minority or 2SLGBTQ+ health, with a particular focus on mental health as well as reproductive health and family building.

Her current program of research focuses predominantly on qualitative and mixed methods investigations of health determinants and experiences for diverse members of the 2SLGBTQ+ communities, as well as developing and evaluating interventions to address identified disparities.

Dr. Ross, could you talk a bit about your research and what you have learned about how LGBTQ2S+ peoples are assisted reproductive services in Ontario?

Lori E. Ross, PhD: Thank you for having me. I appreciate the opportunity to be part of this conversation. I want to start with a land acknowledgement. I'm speaking from Toronto, the traditional land of the Huron, and others. I'm grateful to live and work on this land.

[No audio]

[Audio fading in and out]

[Audio restored]

I think about queer family. I think forced and coerced sterilization have Indigenous women and current eventers like the potential overturning of Roe versus Wade. They're interconnected through a reproductive justice [Inaudible.]

[Call disconnected at 5:17 PM]

It has roots in Black feminist thought, critical race theory, etc. Neither addresses reproductive rights through a social justice lens. Reproductive justice brought alternate to the ways.

[Audio restored]

I'll focus on how I've been involved in using that research to influence legislative decisions related to reproductive rights for LGBTQ2S+ people.

I started working in this area almost 20 years ago now with a $1300 grant from a local community-based funding organization, the Community One Foundation. I mention this to acknowledge the critical role of community founders and organizations who knew this work was important before academic funders and institutions.

In 2003, I did focus groups, with just cis gender women, including women in the process of trying to conceive a child. A few described vivid experiences with fertility clinics, but most encountered significant homophobia and heterosexism, exacerbated for those living outside of Toronto. Some reported undergoing police checks and home studies before doctors agreed to inseminate them.

The other issue participants discussed was lack of parental recognition for non-birthing parents. At the time, the birth registration form had one slot for mother and one for father. If a person with a feminine gendered name filled in the father box, the registration would be rejected.

Instead, to have a legally recognized relationship with the child, non-birthing parents to go through second parent adoption, which is time consuming and a gap without a relationship with their child. It was expensive and dehumanizing to have parenting rights recognized.

Around that time, I was invited to contribute my first expert witness affidavit to arguing it discriminated based on sexual orientation. The key argument was when a heterosexual couple uses assisted reproduction, the father is named on the live birth certificate, and it wouldn't be questioned. If someone whose name is identified as feminine sounding, the application would be rejected.

To contribute that affidavit, I drew evidence from my research as the stresses and challenges associated with second parent adoption.

The Superior Court in 2006 ruled the act was invalid based on sexual orientation. The Deputy Registrar of Ontario was given 12 months to remedy it. Unfortunately, the remedy provided by the government was partial and only impacted those who conceived a [Inaudible] donor. They did the narrowest remedy based on the Supreme Court decision.

Because of that, there were still barriers to legal recognition for families with unknown donors, birthing parents who don't identify as mothers, etc.

I started the study Alie mention, a qualitative study of LGBT peoples experience. I use a different acronym now. At the time, we used the acronym LGBT, so I'll use that when discussing this project.

The study involved 66 people across the province and LGBT acronym. Some we learned was the same we learned from my prior studies like the pervasive heteronormativity, challenges for folks using a known donor, in particular. Because of our broader focus in this study, we heard from men using surrogacy regarding costs.

We heard about trans people's experiences with fertility building and how these services were difficult and sometimes impossible to access. We heard the clinic's base is set up with an ideal or imagined patient in mind who is a heterosexual couple dealing with infertility. Anyone who doesn't fit that model, because they're not heterosexual, are single, or aren't dealing with infertility, the further from that imagined norm, the greater the challenges became.

In 2016, I had another opportunity to leverage this research with some other work I'd done in the meantime with students and colleagues to try to address the limitations and remedies in response to the first challenge, the Vital Statistics Act.

This Challenge, Grand versus Ontario, aimed to protect legal parentage for known donors, the gender birth registration documentation, the mother-father issue, and other things.

I cited a lot of research from the first challenge and creating our family study to talk about heterosexist discrimination on parents and families.

I made many of the same arguments I made 10 years prior except this time, I provided more nuance in terms of intersections with race, gender, and class. That experience of writing the same affidavit twice 10 years in between highlighted for me how slow policy change it. It's decades behind research, which is decades behind humanity, knowledge, and community activism.

The outcome of that challenge was ultimately a favorable superior court decision that agreed that the law violated section 16 of the charter. This is a quote from the decision. It didn't provide equal protection of the law to all children without regard to parents' sexual orientation, use of assisted reproduction, family composition, etc.

The court conceded and introduced new legislation; the All Families are Equal Act. However, family law in Canada is legislated provincially and territorially. It's not federal legislation. The problem isn't solved.

We worked in Manitoba. Until 2020, their family law, Family Maintenance Act, was as hetero and cis normative as before the first challenge in 2006. We participated in another challenge using section 15 of the charter, now enabling same-sex parents in Manitoba to be recognized from birth. Legislative changes there are underway to resolve the birth registration forms.

There have been major improvements in terms of protections for LGBTQ families. Back to the reproductive justice framework, we still have a lot of work to do. It's important to move forward by leaving some behind. I'm talking about protections for normative families that penalize those who don't wish to conform to heteronormative or cis normative of what makes a proper family.

Also, patriarchal, euro-centric, and colonial forms. I'm happy to engage in conversation about how to continue to do that. Thank you.

I think we're over our technology issues. I'm excited to introduce Professor Clement.

Elizabeth Clement uses she/her pronouns, she received her PhD in History from the University of Pennsylvania and is currently an Associate Professor of History at the University of Utah.

Dr. Clement’s work focuses on preserving and disseminating materials about the AIDS epidemic in Utah which has resulted in an archival collection and an oral history project.

A documentary film based on her oral histories, Quiet Heroes, premiered at Sundance in 2018 and won an Emmy. Dr. Clement is currently drafting a monograph titled The Reckoning: AIDS in Conservative America.

Dr. Clement, could you share with us your research into how queer kinship networks evolved during the AIDS epidemic and connections to contemporary moments?

Elizabeth Alice Clement, PhD: Sure. I'll share my screen. I'm not great at this.

Can people stress Ethernet? Is it in presentation view or weird?

Alie Brussel Faria: It's not in presentation view yet.

Elizabeth Alice Clement, PhD: Slideshow! How's that?

Alie Brussel Faria: Perfect.

Elizabeth Alice Clement, PhD: That doesn't work for me. My notes aren't there. We have to do it this way. Sorry.

In my work in Utah, I argue that the AIDS epidemic transformed family. It made it obvious that all families included queer people. Through joint caregiving, AIDS made queer identities visible to straight people.

I'm sorry. I'm having trouble seeing my notes.

In the 1950s, a wave of sex crime panics characterized queer people as pedophiles and were positioned as dangers tinge family. They were combined with negative startups of queer people as only interested in sex and unable to form emotional bods or make families of their own.

Can you see this?

[On screen]

Hello?

[Laughing]

Alie Brussel Faria: Yes.

Elizabeth Alice Clement, PhD: You also see my notes? That's unhelpful.

Alie Brussel Faria: I don't think so. We don't see notes, just an image saying, ”Come out!”

Elizabeth Alice Clement, PhD: You don't see my notes here?

Alie Brussel Faria: No.

Elizabeth Alice Clement, PhD: Alright.

The gay rights movement began at Stonewall in 1969 and advocated that all queers come out of the closet. Coming out is an individual and community strategy of empowerment. Very few non-activist gay people did so in the 1970s. The risk to work, friendship, and family relationships were too great.

For example, in 1983, two years into the AIDS epidemic, Newsweek Magazine found only 23% of straight people knew a gay person. AIDS changed that in two ways. It drove people with AIDS out of the closet about their sexuality if that was the mode of transmission because AIDS is written on the body with KS and the disability. It pushed people out of the closet.

It made the stakes of staying in the closet, even for those who didn't have HIV more deadly than anyone imagined.

Act Up distilled this argument into the silence equals death graphic. My work shows that this forces queer and straight people to cross paths as they cared for the dying together in straight and queer homes. What follows is a discussion about queer family formation historically with evidence from Utah showing these practices of family happened around the country in liberal places like San Francisco and New York City and small, conservative places like Utah.

I concluded the discussion on how AIDS expanded notions of queer kinship, made that kinship of queer people, and began seeing gay people as family people.

Notions of queer family developed through the 20th century. For white queers, this began in bars. For Black and Latinx queers, it happened in the [Inaudible.] People began to socialize at home, creating networks that became family. White bars discriminated against people of color. I have a cartoon from the LA Gay Paper, where a white bull is telling the Black one they need to see two [Inaudible.] This is ubiquitous in the 20th century literature. Queer people of color have difficulty accessing commercial spaces, mainly white bars. They used the notion of family to describe what they were doing

From here on, I have oral history quotations showing photographs of the people. Ben Barr reported that folks he knew in the '70s in Salt Lake used gendered language of family referring to each other as mothers and sisters. Similarly, he recalled his older friend and called them ”the queen mother of Logan.” He said they all had these deliberate quasi-families.

An anthropologist argued that queer people defined family through love and choice, not blood and law.

There are also different definitions of family. Queers saw each other as kin. Previously, people didn't. Straight notions to family and marriage were so gendered that it was hard for them to imagine people of the same sex capable of being family. How could men perform wifely duties?

They were more likely to define family by the labor done in the homes. For queer people, it was doing physical and emotional work.

People saw queer families as distinct and often mutually exclusive, as in ” You can pick your friends, not family” queers didn't make these distinctions. They were comfortable with friendship to family.

These experiences play out in an oral history with the actor, Charles Frost, who described a speech made by a lover for an AIDS funeral in in '80s.

[Reading quote on screen]

Men performed work traditionally done by female kin. Carl progressed to sociability and friendship to underscore that gays and lesbians saw love on a spectrum with romantic love and family relationships. Queers expanded the notion of family because of rejection from kin. Your family kicks you out, so you recreate family bonds.

Nikki Boyer, a lesbian bartender who moved to Salt Lake City, explained that they were all family. Most had been disowned or had moved far from family and didn't have a lot of family.

I was supposed to show you a picture of her, Nikki Boyer.

In Utah and the United States, the spaces in which queer family formation expanded. For gay men, it increased tricking (casual sex).

Ben Barr explained: [Reading quote on screen]

Tricking accelerated the spread of HIV and created networks of friends who considered themselves family who cared for the ill and dying. tricking saved many gay men from dying alone.

AIDS transformed the scope of gay families and practices. Labor as a defining feature of family dramatically increased the number of queer people as they contemplated the deaths of loved ones and their own mortality.

[Reading quote on screen, Paula Gibbs]

For Gibbs and others, the physical and emotional work spurred this.

[Continues reading quote]

AIDS eventually opened the definition of queer kinship to complete strangers, volunteers who works as buddies in the families, queer and straight, where people with AIDS lived and died.

The name ”buddy” evokes friendship. The work these queer people did was kinship labor, unpaid physical and emotional work women in families usually performed like switching out IVs, exposing them to blood. In the 1980s, fear of contagion ran high. Buddies also did work that professionals refused to do.

When Ben Barr's first buddy, Sheldon, died, the morticians argued over who would touch his buddy.

[Reading caption on screen]

Buddies did important emotional labor of family, as well. Starley [sp?] described you might hug or hold them. Towards the end, you'd read to them or hold their hand because they didn't have the energy to do anything.

Gene Forest moved to Salt Lake City to help her friend die. She kicked off her shoes to lay with him.

AIDS dismantled stereotypes of queers as a danger to family. As my work demonstrates, straight people began seeing queer people as ”family people,” who explains how quickly straight people accepted gay marriage as a civil rights demand. Thank you.

I'll unshare my screen.

Alie Brussel Faria: Thank you so much. That was wonderful. We'll now move on to our last speaker, Dr. Ng.

Henry Ng uses he/they pronouns and they’re a physician, educator and advocate for LGBTQ health. Dr. Ng completed their BS and MD degrees at Michigan State University and received a Master’s in Public Health at Case Western Reserve University with an emphasis on Health Promotion/Disease Prevention for LGBTQ+ populations.

Dr. Ng attained the rank of Associate Professor at Case Western Reserve University School of Medicine and served as the Assistant Dean for Admissions at the school working on diversity and inclusion initiatives. Currently, Dr. Ng is a Director for Center for LGBTQ+ Health and Director of the Transgender Surgery and Medicine Program at the Cleveland Clinic Foundation.

Dr. Ng, would you be able to speak a bit about how you see notions of heteronormativity and nuclear families being promoted in clinical and medical educational spaces and what you envision as steps to combat this?

Harry Ng, MD: Greetings from Cleveland. I'm excited to be part of today's conversation. There's so much to unpack. I'm nodding my head so much with the previous two speakers about historical challenges with heteronormativity, how we frame caring, and interact with families, especially in the healthcare setting.

Historically, we found little opportunity to have representation and presence and acknowledgement in either imagery or available healthcare literature, advertising, and marketing for years. For years, it's been lacking much diversity for racial/ethnic individuals, as well as people with different abilities, folks who are LGBT, and they share their relationship status in a way that's norm visible.

This has not been helpful in how we prepare healthcare professionals for preparing careers in the fields. There have been studies in the last 20 years that looked at the amount of content provided, for example, in undergraduate education in medical school, around LGBT health. It increased to around 5 hours the last time the study was done. That's so little. There's so much to learn and so much we're ultimately responsible for in terms of providing care for minorities and their families and folks who love them.

When we do have educational content in curricula, unfortunately, it may be a form of stereotype or will be a limited scope. Content may include infectious disease, a study case of a gay man or transgender woman who happened to be African American and was diagnosed with HIV. Similar individuals aren't included in other case scenarios that focus on other diseases that affect all of us like heart disease, neurological conditions, like MS, etc.

Unfortunately, this hasn't changed much for many different healthcare students throughout the United States. Many schools still lack any content on LGBT+ care. Those that do may still have limited or stereotyped kinds of learning opportunities.

Students have been driving change in healthcare education for many years. The challenge is that student leadership will change. The sustainability of educational content and curricular change has to be assumed by schools of medicine, nursing, social work, and other health professional schools to ensure that the next waves of graduates can take care of our LGBT+ patients and those who care for and love them.

There are tools to help guide the learning, skills, and experiences that may be helpful. The American Association of Medical Colleges put together a community of experts in LGBT+ care in 2014. They developed a series of tools and videos that describe some educational objectives and opportunities that can be employed at medical schools, as well as other health professional schools, and training levels like residency and fellowship.

I'd love to see that we can advocate for these types of changes in clinical and educational spaces to better care for patients. I'm blessed to work where I work, where we work in a multi-disciplinary, inter-professional group with different team members with different skills and experiences, all putting our efforts together to create physical and emotional environments of safety. Patients can share with us who they are, their concerns, and for us to have space for their experiences and understanding that healthcare hasn't be helpful for them sometimes. They've even been traumatic through either micro or macro aggressions, as well as intersectional aggressions like classism, colorism, disability status, etc.

It's critical that part of our conversation where we're thinking about creating space -- every visit I have with patients is a potential one to address some aspect of LGBT+ care.

As I wrap up my answer, I'll share an example that reinforces why we need to hold space for this. A few months ago, I worked with a new patient I hadn't met before. I greet by saying, ”Hi. I'm Dr. Ng. Happy to meet you. How should I address you?” They gave their name. They were a man in their 60s or 70s. They pointed a question at me, ”when did you know?” I think it referred to my own experience of gender and sexuality. I thought in the past, I may have reacted more defensively. I could tell from the person's tone and body language that he was earnest and wanted to understand my experience.

I wanted to understand why. I didn't exactly answer the question. I did acknowledge that he had asked it from a place where I felt he had earnest desire to learn. I asked why it was important to him. He shared that his grandchild is exploring gender. He was struggling to understand how he could be a great grandfather to the child and understand what the person was going through and how to be supportive of them. He was hungry to learn about resources and opportunities to demonstrate that he'd still be there to love the person regardless of their identity and feelings.

It was a beautiful moment for me personally and professionally. It reinforces that every visit we have with patients in the clinical setting is an opportunity to address LGBT+ health. It may be obvious, subtle, or something unexpected, but the opportunity is always there.

I feel it's important to have the skills, knowledge, and tools with which to support patients when these come up. I'm glad I spoke with you today in this panel. I'm happy to share more in the coming moments. Thank you.

Nathan Ha, MD, PhD: Thank you so much, Dr. Ng. Thank you, speakers and panelists.

I wanted to encourage everybody on the webinar right now to share your questions in the Q&A or in the chat as they come up. I'll do my best to look at them and share with the group, as well.

Dr. Ng, I wanted to ask a follow-up question.

Harry Ng, MD: I'm back!

Nathan Ha, MD, PhD: [Laughing]

You mentioned one of your priorities is creating psychological safety for patients. Can you tell us more about how you do that in the clinic?

Harry Ng, MD: Sure. I appreciate that. It's good to talk about what psychological safety is, so we have a common, shared understanding and knowledge.

Psychological safety has been talked about in a number of different settings, including with teams in terms of coworkers, teachers and learners, and in clinical settings. The idea is that we can speak our minds or share information and not feel we'll be judged or dismissed or punished or facing some retaliation or rejection for speaking our truth.

When we work with patients, many of whom have had negative healthcare experiences, folks are reticent to share thoughts and feelings. Some folks. Others, less so. Sometimes they can be outspoken, and that's wonderful when people advocate for themselves. Not everyone is in that place.

One approach I encourage people to have is to, first, think about their own implicit biases about people in general and. The Harvard Project is a great tool to know where we are.

When we have a patient clinical encounter, it's important to hold space for people to tell us their stories and truths, just to hear them.

Over the years, I learned that people want to be heard. We don't have to agree or disagree with the message, but people do want to be heard. It's important that we're genuine in creating the space for that to happen.

Especially for LGBT people, use language that patients use for self-identification. I ask patients how they identify or want to be addressed. A lot of patients tell me their pronouns, especially if it's different than their legal name, which demonstrates respect and helps build rapport.

Some of you may have been taught that you can offer your own pronouns. You can. You can ask a patient what pronouns they use. Recognize that some people may find that intrusive. Give people the option to tell you how they like to be addressed. You can offer that as a follow-up after. That's helpful, too.

Have health literature and tools around you that are inclusive of LGBT people and their health concerns or needs that aren't just stereotyped around HIV.

Have a diversity of faces and people who are part of the community, part of the care team, if possible. If the care team extends to medical assistants, schedulers of appointments, etc.

All of that intentionality is really important. Many healthcare organizations are recognizing how important that is at the micro level. We never know where someone's coming from in terms of their lived experience with healthcare. It may have been great or terrible.

If I do an exam, I explain to patients, "I don't know what you've experience prior to this, but these are things I'd like to do next and why." The patients often say I'm a little wordy, but I explain things in a way other providers haven't in a similar way or that level of detail. They appreciate that and have greater understanding. With the understanding, we can have wonderful, shared decision making in their care.

Nathan Ha, MD, PhD: Amazing. Thank you so much.

The question of acknowledging harms that many LGBT people have experienced in the past is one thing that's come up throughout all the talks.

I want to reflect on things that came to mind that I can contribute to the conversation. After this, I'd love to have all the speakers return and turn cameras back on to engage in group discussion with each other and with Alie about today's theme.

Two things came up for me as underpinning a lot of the talks. The first is suffering that LGBT people have experienced historically, in the recent past, and in the present in clinical settings like misgendering, mis-pronouns, not having families recognize, or their suffering as being disregarded, as Dr. Clement discussed.

There seems to be the suffering experienced by many queer people that Dr. Ross shared in terms of encounters in settings where they're trying to seek medical help for assisted reproduction or where they're seeking recognition for families and relationships. These would be the state and the law.

These two themes of suffering and recognition lay out in the different ways we've talked about queer families today. Dr. Clement, you laid it out beautifully for us the ways in which the notions of family have diverse functions and how those functions have changed over time, especially during the AIDS epidemic. Those functions are like performing domestic labor, providing care for one another, mourning for each other, etc. What happens when people are going through the process of dying? Those are some of the main functions some families have. There's also the function of sexual reproduction that seems to have also been highlighted in the talks.

All those together link with Dr. Ross's talk. If we're going to reimagine what it would be like to have families, whether related by biology or not, the state and medical practice itself play a huge role in the recognition of those families.

When the state or medical practices deny, negate, or invalidate our unique ways of arranging our families and our own kinship networks, that creates a humungous harm to the communities.

I appreciate how Dr. Clement brought up the idea of reproductive justice and reproductive rights, this larger thing to signal that these issues are ones that not only affect LGBT communities but also Black, brown, Indigenous communities, poor communities, those of lower socioeconomic statuses, and various communities from disabled communities and individuals, etc.

I was thinking that one thing we might be circling around is the issue of representation. What does it mean for queer people to represent who they are to themselves? At what point does the need for representation to others within or without the community also become a significant form of intervention?

I think those might be potential things we could explore further.

By doing so, I was wondering if I could ask the panelists to return.

What is the role of representation that queer families have to ourselves and to others? How does that process of representation accommodate the diversity that exists within and between queer families as you've experienced or studied them historically or in your own practices?

Elizabeth Alice Clement, PhD: I can't turn my screen on. The host has it off. That's why it's not on.

Nathan Ha, MD, PhD: We can see you now! Hi!

I wanted to ask you all if you could share your thoughts on the diversity that exists with and between queer families as they've evolved historically or as you see them in your own clinical practices, studies, and research?

Harry Ng, MD: I'll kick things off with my experiences working with queer families. I'm trained as an internist and pediatrician. At this point, I'm working with mostly adolescents, mostly adults -- geriatrics, In fact. I focused mostly on health issues of LGBTQ youth and younger adults. I've seen generations of patients and their families. I've met queer and LGBT people who I've followed for a decade or more. I've seen their partners, parents, family of origin, and families of choice.

I've learned there's lots to talk about at every visit. Being LGBTQ is something to recognize and celebrate because it's a way to be known and heard in different places, including in healthcare.

When we're invisible, that can lead to bad health outcomes. We don't know about someone's health. If we don't know someone's trans and they have abdominal pain or a uterus, and that could be why they have pain -- they could be pregnant. We've failed.

Learning the stories, recognizing relationships -- this is an important way to bring communities of people that have more in common, especially in divisive times now. That's important to try to bring people together.

Lori E. Ross, PhD: I don't know if I have a lot to add on this question. My understanding of what makes a queer family has evolved over the time doing this work. It started with a very health sciences training. I thought of queer families as families, queer people, and their children. Through learning more about the history of queer communities and kinship, I expanded that and understood the notion of family more broadly in a way that enriches my work in this area in terms of leaving space for participants to define their families and not going into that conversation with assumptions that that will mean there are two parents or a primacy of biological kinship, those kinds of things.

Also, to speak to your comment about representation, I think it's also important to think about and talk about representation of queer families in popular culture, which is still pretty lacking. There's more now than 10-15 years ago, but the representations in popular culture around queer parenting are pretty limited in terms of who is represented and what sorts of families are represented.

That impacts how folks imagine, not just in our communities -- but how straight folks imagine queer folks to look. It's important to challenge those representations, as well.

Nathan Ha, MD, PhD: Thank you so much.

I'd love to hear more if you're willing to share your own evolution. You said when you started the project, you thought the notion of queer families referred to queer parents and their children. Eventually, that notion for you has expanded over time. You and Dr. Ng hinted that you allow people you encounter to teach you to expand that notion.

Could you both share with us about what that's looked like?

Lori E. Ross, PhD: Sure. I can speak to that.

I've learned a lot through my close partnerships with community organizers I've worked with, particularly Rachel Epstein, whose work I read and cited. Rachel has done an enormous amount of organizing in Toronto. She's the first person I approached when I wanted to do work in this area. She was generous with her time and knowledge.

In general, acknowledge how much expertise in communities. That's huge. I learned a lot from that.

I started when I was young. My own conceptions of family have evolved as I've gotten older and found my own family, as we all do. We form, unform, and reform families. There's an interconnection of learning I've done professionally and personally.

Nathan Ha, MD, PhD: Thank you. Did you all want to comment on this question, as well?

Harry Ng, MD: Sure. I go back to the notion that being a queer person or in the LGBT community is intersectional with other identities and communities.

Family isn't monolithic or unidimensional. It includes other ways to participate and be in other communities.

Over time, I've grown to think about how queer families may or may not have monogamy or may have polyamory, have multiple parents, etc. It could be fictive kin, biological, etc.

I think about how patients I meet are sometimes celebrated and are sometimes shunned. They keep aspects of their interests closeted still, aspects of their sexuality that still hold stigma. Those are things I'm sensitive to, like folks who are part of a BDSM or kink or leopard community. People with disabilities aren't necessarily thought of as part of queer communities. Of course, we are. Sometimes it's visible. Sometimes it's not. That representation, that vulnerability, is one of the questions I saw in the chat, which is really important, too.

Of course, cross-relations, interrelations, etc. of folks within and among groups in terms of people of color and majority groups -- all these facets create the beautiful tapestry of people in families and how we see them.

We haven't talked about adoption, fostering, etc. Those are part of these discussions we've broadly described. Then we think about different places where people and their families touch healthcare. The children are seeing family doctors and pediatricians. Families see gynecologists, specialists, etc. We all see aspects of the queer family in slightly different ways. Sometimes it's the patient. Sometimes it's the caregiver. That changes as we age.

To answer the question about addressing vulnerability comes with visibility. Patients and their families may feel vulnerable in seeking care, being present, or being visible, especially in the environment for non-binary and transgender youth seeking care in states that are creating laws and policies that make it difficult/impossible for providers to provide care or it constitutes child abuse.

This is beyond making families vulnerable. This is absolutely horrifying and is creating great harm, emotional, psychological, and otherwise, for families and communities.

These are things we have to be aware of. I tell people to vote with the pen and paper. Speak your mind. Make sure things you care about are things you address. Vote how your heart is. Please vote.

Nathan Ha, MD, PhD: Thank you so much.

To magnify the point of potential costs of visibility, I was wondering if Dr. Clement could share. In your study, there seemed to be a great cost to being visible and coming out. That might have caused some queer people to be reticent to do so at the beginning. You said, it made certain things more visible. Could you talk about those potential costs, historically, that you might have seen, as well as how you've seen your family change over time?

Elizabeth Alice Clement, PhD: For the second question, there's more room for talking about queer and family in the same sentence now, which wasn't true for most of the 20th century. I agree with both Dr. Ross and Ng about how we have to be broader in our understanding of family and not just expect that queer family means homonormative units, families with two parents and children. Most of us don't do that.

I'm a stepparent. That's queerer than the parenting I do than the parenting I do of my biological child with my wife. Stepparenting is crazy because it's a difficult, delicate set of relationships.

I'm a historian. I've been thinking about the intersections and difficulties to think through in terms of the law around queer family, how that does and doesn't overlap with our practices of queer family, what everybody's actually doing, and what medical people can do in those contexts.

I live in a state that didn't get gay marriage until Obergefell. We had to move to California to do a second parent adoption because it was banned in Utah. We need to think broadly about queer family and about the legal structures around families. Even if practitioners disagree with them, we have to understand that people are confronting those and are dealing with those.

We're often embedded in institutions that don't recognize other ways of doing family that aren't even associated with a typical notion of queer. I'm raising a grandchild because his parent can't care for him. The father isn't allowing us to do a guardianship. I have a consent to treat letter, but nobody with their portals will take that.

I have to get this kid care because they didn't have it for a long time. I have to tell the hostile father, ”You won't let us do a guardianship, so fill out this form so the kid you kicked out can get therapy.”

On one hand, it's great to say to let us be expansive. We can do that consciously in medical spaces, but pay attention to ways in which legal structures we disagree with still form the parameters of people's lives and what they can do. You saw that with HIV and AIDS. Hospitals wouldn't let partners or friends in. They'd insist on next of kin.

A lot of that stuff isn't . . .

[Frozen screen]

[Audio restored]

People running hospitals, particularly nuns and priests, had a particular mission or interpretation of their understanding of Jesus Christ's mission on Earth. They realized that they had to open up their understanding of family to care for people with AIDS. Everybody has to think through that in this caregiving space, which is that we do have laws. We can't forget that laws define families specifically. That limits what people can do medically.

I also think medical spaces can push against those laws and set up practices to allow queer families to be who they are. That won't allow me to make decisions for my grandchild because I don't have a guardianship. That's how it is. I don't think any medical system will let me do that as sympathetically as the healthcare providers are. They're usually very sympathetic.

Another thing to think about is we have to make people who come to healthcare settings as comfortable as possible and acknowledge their understandings of family and how they define family. At the same time, we have to negotiate with systems of health insurance, hospital, clinic policy, and how those interact with law, which varies by state or county in terms of what people can do.

Our local Catholic hospital was the AIDS hospital in Utah. Nobody else would take people with AIDS. Even though Catholics are hostile to homosexuality, they figured that stuff out pretty quickly and realized they couldn't close the AIDS word to lovers, friends, or drag queen you performed with. They became more expansive. They were also a small, private Catholic hospital run by nuns who could do what they wanted to do.

Another thing to think about is what are the systems? How do people with limited and real power in the systems support queer family?

Why do the forms say mother and father? There's nothing wrong with the word ”parent”? The forms I access at the university say mother and father. That's a bureaucratic decision. The law doesn't require that. That's my thought.

Nathan Ha, MD, PhD: Thank you.

You've hit on so many topics. One is one that many are interested in. I can see in the Q&A, which is the question of what legal interventions or policy interventions might be helpful for queer families? Each of you have a strong take, but I'd love to hear that.

Related to that is a question Amanda Lieberman asked. What do you see is the upcoming overturning of Roe versus Wade? How might that impact queer families?

Who would like to start? I know you all have lots of thoughts on this.

Dr. Ross? [Laughing]

Lori E. Ross, PhD: The policy environment in my community in context is a bit different. We have had recent [Inaudible.] Our legislation is progressive. We're still working in other provinces and territories.

There's still lots of work to be done. I'm lucky to live in a progressive context.

I'll let American panelists speak more to Roe versus Wade. I'll say I'm concerned about this. I'm trying not to think in too apocalyptic ways.

I see things as very interconnected. I think this is all part of the same concerning move towards a scary policing around all kinds of activity, whether in relation to gender, sexual orientation, and race and class.

It's very concerning. We should all be concerned and ready to use whatever tools we have available to advocate in relation to this.

Nathan Ha, MD, PhD: Thank you.

I want to ask a follow-up question. You mentioned that a court ruling seemed to have ruled that the rights of the child were being impeded on by the structure of the forms and lack of recognition of parents. Can you speak more to that? That might be something unique in an international context, how the rights of a child can have different national contexts, which underpin legal rights that are substantive to queer families.

Lori E. Ross, PhD: That might be particular to family law in Ontario. The piece of legislation where parent was defined by the Child and Family Law Act. That's why the decision in that focused around the children's rights, particularly.

It's interesting because the quote I read from the decision focused on the rights of the child, but also, the decision was made based on the violation of section 15, violation of freedom around sexual orientation. It's the child's right not be discriminated against based on the parents' sexual orientation. They're interconnected.

Elizabeth Alice Clement, PhD: That's true around Obergefell. It all came down to thinking of the children! Both sides used, ”think of the children!” in the discussion. The pro-gay marriage side asked why children were being deprived of basic rights or respectability because of their parents.

You asked about a policy issue around queer family. The biggest policy issue that would be helpful that I see, though not in this climate perhaps, is to decouple a lot of benefits from family. It doesn't matter who your family is if you have universal healthcare. Then, it doesn't mean you can or can't access services based on family relationships. This is set up in the new deal in the United States and continues through private and public insurance things. It puts the heteronormative family as the central family. Anyone who deviates is often not eligible for benefits. That's' where you get the wife gets her husband's social security benefits, which means she's put on his health insurance.

One of the best things we could do to end these disparities in healthcare for queer families is institute universal healthcare that attaches to the individual, not to a particular set of families relations. Why should it matter to my university that I'm married to my wife or not for her to get healthcare? That's ludicrous.

There are things we have to do universally that would solve a lot of these problems. I don't think the family should be the basis through which we get basic benefits, from the state or private employers.

If we solved that problem, we'd solve many and make it possible for queer people, unmarried people, and other people in relationships in different, complex ways, that work for them, but don't fit with the U.S. state and U.S. private corporations' model, which bases everything through the family, which is if you're married or not.

In the healthcare setting, I'd worry that gay marriage set us back in terms of seeing the diversity of queer family formations. Then queer people can marry, but not all queer relationships fit into marriage. Not everybody wants to marry. What will I do with this grandson, which isn't related to that? I worry. That's something medical providers can do a lot around, which is to ignore even some of the victories we've had. The fact that queer people can marry doesn't mean they all will, or that's how I should think about what my patients should or can do. Instead, let me look at people around my patients, or who my patients say are important to them. Go from there about what kinds of conversations we should have about family.

In terms of Roe versus Wade, we have a trigger law in Utah if Roe goes down. It's 6.5 hours to the nearest abortion clinic. You can go to Vegas or Colorado.

LGBT people who can become pregnant are at higher risk for becoming pregnant because they tend to not be good at using birth control or aren't thinking about it when having sex with people who can make them pregnant because it cuts across their identity categories.

Nathan Ha, MD, PhD: Thank you so much for answering that question so thoroughly and connecting all the dots for us.

Unfortunately, we're out of time today. Thank you for all your amazing contributions today. I want to turn back to Alie for final words for bringing us together. Thank you.

Alie Brussel Faria: I'm so grateful. Thank you so much for your time, your talks, and your responses to the questions. It's been really eye-opening and interesting.

As someone who is interested in the history of medicine and as being a provider, I've learned so much today. A huge round of applause for the amazing panelists virtually. Thank you so much. And a fan!

Nathan Ha, MD, PhD: Thank you for coming today. We appreciate it. I hope you have a good night.

[End of webinar]