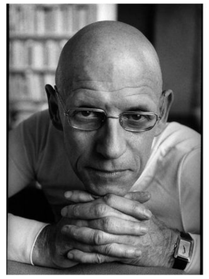
COLLEGE OF LIBERAL ARTS & SOCIAL SCIENCES
Department of Anthropology

LGBT+ Healthcare Access in Texas: An Intersectional Approach

Undergraduate Research Fellowship 2023, by Zachary Prater with Dr. Jara Carrington

THEORETICAL FRAMEWORK: THE CONTEXT OF WESTERN MEDICINE & THE "MEDICAL GAZE"



Michel Foucault

"The Care of the Self": Ideologies of Sexual Health and Individualism
Greek and Roman philosophies of sexual activity inform the ongoing idea that health is an individual responsibility (*cultivation of the self*). In turn, the healthcare system takes on an individualistic mindset where sexual health is seen as the patient's responsibility rather than the healthcare provider's and where health concerns related to sexuality are seen as consequences of failing to cultivate oneself (Foucault, 1986).

"Necropolitics/Necropower" as Institutional Modes of Oppression
Necropower is the power to place varying values on human life, determining who is worthy of life and death through systemic means. The healthcare system is a prime example of this, as it functions as a privilege in our society both in access and quality of care (Mbembe, 2019).

"Seeing and Knowing": The Medical Gaze as a Means to Discriminate
Medical professionals are encultured within the education/curriculum of their discipline to view patients as bodies in need of fixing rather than as holistic individuals (*the medical gaze*). This process often renders the specific needs of patients invisible, particularly vulnerable populations (Foucault, 1963).

METHODOLOGICAL APPROACH: CHALLENGING THE MEDICAL GAZE IN RESEARCH

"Witnessing and the Medical Gaze": A New Way of Seeing the Patient
The medical gaze becomes increasingly more difficult to employ when engaging with the same group of individuals over time. They become more than just bodies in need of fixing (*gazing*); instead, their humanity is rendered visible once more (*witnessing*). This allows for a more holistic and nuanced method of providing healthcare (Davenport, 2000).

"Mapping the Margins": Intersectionality as a Means to Witness
Intersectionality posits that axes of identity (sexuality, gender, race, etc.) intersect in ways that create unique lived experiences that are greater than the sum of their parts. This can help us to better understand patient needs both by allowing us to see them as intersectional beings and by being used as a method of data analysis (Crenshaw, 1991).

LGBT+ Healthcare Access Survey: Intersectionality and Qualitative Analysis
To demonstrate the pitfalls of over-homogenization while also acknowledging the importance of quantitative data, I chose to conduct a survey of LGBT+ patients in Texas regarding their healthcare experiences. Analyzing this quantitative data intersectionally showcases the validity of intersectional analysis in healthcare studies, but also the advantages of supporting future qualitative research with quantitative survey data.

Kimberlé Crenshaw

OUTCOMES & FUTURE RESEARCH

What We've Learned:

-What we commonly refer to as the "LGBT+ community" is a diverse collection of people with various unique positionalities. Sexuality and gender are not the only factors which impact their healthcare experiences, and attention must be paid to those factors outside of what makes them LGBT+. This makes intersectional analysis of this group's experiences in healthcare is not only useful, but inherently necessary if we wish to gain a holistic understanding of the spectrum of these experiences. This analysis is critical in both the qualitative aspects of the research, but also equally as relevant during in the quantitative aspects.

Continuing the Research:

-Continuing the survey data collection while marketing it through "LGBT+ friendly" healthcare providers and other organizations which serve those demographics that are under-represented in the survey data at this time.

-Begin collecting qualitative data via ethnographic interviewing with patients at various intersections of identity as well as healthcare providers in order to contextualize the quantitative survey data and to better understand the intricacies of the relationship between healthcare providers and their LGBT+ patients.

Final Goal:

-Create an LGBT+ cultural competency training module for healthcare providers in Texas that is rooted in the lived expertise of LGBT+ patients, the professional expertise of LGBT+ friendly healthcare providers, and mediated through the academic expertise of anthropology.

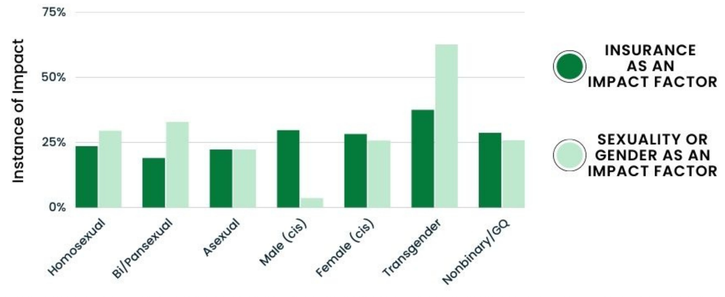
IMPACT FACTORS OF LGBT+ PATIENTS (HOMOGENOUS)

"Impact factors" are herein defined as factors that significantly impact the patient's experience in the healthcare setting. 114 instances of impact were collected from 59 survey respondents.

While this serves as a good starting point for understanding impact factors, viewing them in this homogenous context can result in inaccurate takeaways. For example, the graph shows that only 8.5% of the respondents reported race as in impact factor; while this is true, to suggest that race is not a significant impact factor based on this data would be incorrect. Similarly, insurance reported as significantly more impactful than sexuality or gender can be similarly misconstrued at face value. Intersectional analysis can help to contextualize this information in order to gain a more holistic understanding of what this data actually suggests.

INSURANCE AS AN IMPACT FACTOR (INTERSECTIONAL)

The homogenous data suggests that insurance coverage is more likely to be an impact factor than sexuality or gender. When viewed intersectionally:



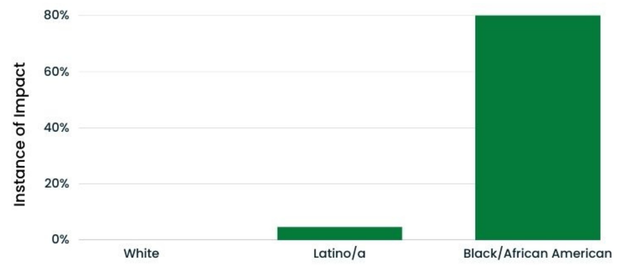
Several demographics still experience sexual/gender based oppressions more frequently than insurance coverage as an impact factor; however, the impacts of insurance coverage are still notable enough to justify special attention in further research. For example, is it the lack of insurance coverage or the quality of insurance coverage that is impactful? Are specific health needs being covered by insurance? What barriers to insurance coverage are LGBT+ patients experiencing?

59 INDIVIDUAL RESPONDENT BREAKDOWN BY...

SEXUALITY: 25 HOMOSEXUAL, 29 BI/PANSEXUAL, 6 ASEXUAL, 5 OTHER
GENDER: 14 MALE (CIS), 20 FEMALE (CIS), 6 TRANSGENDER, 18 NONBINARY/GENDERQUEER
RACE: 44 WHITE/CAUCASIAN, 23 LATINO/HISPANIC 5 BLACK/AFRICAN AMERICAN, 2 ASIAN

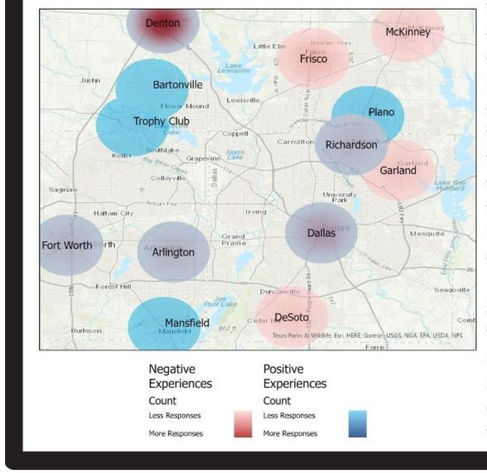
RACE AS AN IMPACT FACTOR (INTERSECTIONAL)

When we look at those who reported race as an impact factor intersectionally, we see that there are disparities between different relevant racial/ethnic categories:



What we see clearly here is rendered invisible without this intersectional approach. This helps us to achieve a more holistic understanding of the nature of this specific impact factor, which helps to guide the future direction of this research in order to address these disparities by highlighting the kinds of questions we should ask next. Why is race a more significant impact factor for Black/AA patients? Why is it lower for Latino/a patients than other areas? And how can we collect more data from other racial/ethnic populations so that they are equally represented in the research?

LGBT+ HEALTHCARE EXPERIENCES MAPPING: QUESTIONING THE RURAL/URBAN CULTURAL DIVIDE



There is a cultural assumption that LGBT+ patients are more likely to have positive healthcare experiences in urban/progressive areas than in rural/conservative areas. Survey participants were asked to provide examples of cities in Texas where they had positive and negative experiences, which was used to create this working map of the DFW area to analyze that assumption. Thus far, the data shows that the DFW area has a mixture of positive and negative reviews, and that cities where multiple experiences were reported tend to be mixed.

As more data is collected, we should be able to see if there is any validity to this assumption, to what extent it is true or false, and ultimately gain a more accurate understanding of the lines that these experiences fall along. Are they rural/urban, are they political, or are they mixed regardless of these factors?

ONGOING RESEARCH SURVEY LINK

SURVEY SPECIFICS, LIMITATIONS, & FULL CITATIONS