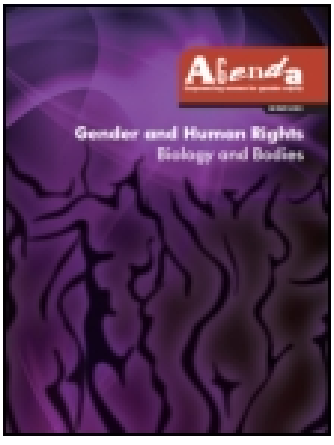

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Challenging medical knowledge at the source – attempting critical teaching in the health sciences

Alexandra Müller and Sarah Crawford-Browne

abstract

This *Briefing* examines the challenges in including feminist gender and sexuality pedagogies in the curricula of the health sciences at the University of Cape Town. Drawing from both personal experience and existing research, the *Briefing* argues that the positivist paradigm of orthodox health science has historically contributed to oppressions based on difference in race, gender, and sexuality. The *Briefing* traces our experiences in challenging the dominant paradigm of knowledge production around gender and sexuality in the health sciences. It highlights and contextualises our key challenges and contributes to an emerging conversation about the inclusion of social sciences content into the health sciences, including strategies to influence the health sciences paradigm from within.

keywords

Medical education, gender and sexuality pedagogies, health sciences, critical diversity theory, MBChB curriculum

Introduction: gender and sexuality in the health sciences

The health sciences hold great authority over the production of knowledge related to the body, sex and sexuality. The scientific evidence health sciences produce is often used to support powerful commonly held beliefs pertaining to race, gender, sex, sexuality and identity (White, 2008). This *Briefing* reflects on our endeavours to shift the production of knowledge and normativity for future health care workers toward a critical understanding of gender and sexuality. We seek to bridge the divide between the social and health sciences and challenge the current pedagogy on gender and sexuality. We have organised our *Briefing* around four main themes:

- The politics of transforming the medical curriculum, and strategies for a 'campaign' of feminist curriculum change;
- The challenges of creating a critical, feminist curriculum in an environment that is highly hierarchical, sexist and often homophobic;
- Difficulties and strategies of creating a framework for teaching critical thinking in a positivist curriculum that claims to produce 'neutral' knowledge;
- Strategies to incorporate social science and social justice teaching into the health sciences, in order to educate health professionals that are more than just 'medical technicians'.

Encouraged by Cribb and Bignold's (1999: 195) call for "more interpretive and reflexive research in medical schools and by medical

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pp. 25–34

school staff", we write using critical reflection, following feminist methodologies of interrogating our own space, identities, and positionalities. As such, we can only speak to our own experiences at the University of Cape Town (UCT) Health Sciences Faculty as white, middle-class, cisgender women, one of us identifying as queer, the other as heterosexual. We recognise that some of these experiences are uniquely rooted in our context, challenging the curriculum in a large and complex South African health sciences faculty; however, many of our challenges are inherent to the nature of a professional curriculum situated in the biomedical paradigm. We use the term 'biomedical' – of or relating to both biology and medicine – to describe the health sciences' knowledge about and engagement with bodies, body functions, and diseases. Biomedical discourse bases its authority on empirical evidence – 'objective' scientific facts – and constructs people's bodies as results of biological processes and determinations. It provides little to no opportunity to situate these bodies in their social context, and hence makes conversations around the social construction of identities very challenging.

Patients who do not fit a heteronormative identity experience health care as an unsafe space, largely because of the attitudes of health workers.

Before we discuss pedagogies, institutional culture, or identity formation in the health sciences, a brief overview of the discipline's contribution to systemic violences such as racism, sexism, and homophobia is important. This highlights not only the authority of scientific thought in informing public discourse, but also provides a vital insight into the political economy of biomedical knowledge production. Nineteenth century European anatomists popularised physical anthropology, and led the general Western movement towards a dogmatic pseudo-scientific racism (Curtin, 1964; Dubow, 1995). It claimed the superiority of the white 'race', and provided numerous theories of the intellectual inferiority of people of colour (for example the assertion that intelligence could be measured by skull size, which was 'naturally' bigger in white skulls). But medical science did not only provide the scientific justification for white supremacy and racial apartheid, it also actively facilitated its translation into social enforcement. In South Africa, public health legislation, framed as disease control and prevention, was used to justify segregated town planning and forced removals as early as 1910, decades before the apartheid Group Areas Act (Parnell, 1993). In Victorian England, the medical establishment confirmed and reinforced the belief that women were passive creatures, prone to hysteria, and unfit for a public role.[1] These arguments have sustained sexism until today. Since the early twentieth century, the health sciences provided pseudo-scientific explanations for same-sex desire and laid the foundations for psychiatric 'reparative theories' (Wilton, 2000). It is revealing that until 1992, the World Health Organisation (WHO) classified homosexuality as a mental illness, and that 'gender identity disorder' is still considered a pathology.

While there are progressive voices, it becomes clear that the health sciences traditionally regard bodies through a positivist lens that hardly allows for the recognition of socially constructed identities. Scholars, educators, and activists have posed a thorough critical interrogation of this stance, yet it remains mostly unchallenged within the discipline itself. It is crucial then to acknowledge that for many trained in the orthodox scientific paradigm, challenges of cross-disciplinary literacy make it difficult to access these debates. The limitation of a perspective that characterises strictly positivist medical training often cuts health care workers off from valuable sources of insight and understanding (Kneebone, 2002).

The examples of scientific-endorsed discrimination evidence the need for feminist scholars to be concerned with knowledge production in the health sciences. While the authority of scientific discourse in the public opinion often remains unchallenged, it is in people's direct encounters with the health system that this authority reveals its full power to define, essentialise, and exclude. The consequences of these authoritarian discourses for people whose identities do not fit the dominant paradigm are devastating. Patients who do not fit a heteronormative identity experience health care as an unsafe space, largely because of the attitudes of health workers (Brotman, 2002). Lesbian, gay, bisexual and transgender (LGBT) patients[2] perceive health workers' disdain, which alienates them from the medical

system and reduces their utilisation of screening modalities, risking higher morbidity and mortality from infections, cancers, and heart disease (O'Hanlan, 1997). A 2006 South African study highlights the consequences for LGBT people's health-seeking behaviour: in the Western Cape, 16% of LGBT people either delayed seeking health care for fear of homophobic treatment, or did not seek medical help at all (Rich, 2006). Their fear is often justified: recent studies from various South African contexts document how LGBT people are discriminated against, insulted, and sometimes even refused health care when accessing HIV services (Bateman, 2011; Lane, 2008).

In order for us to challenge the biological constructions of gender and sexuality, and the systemic violence it perpetrates, we need to re-create knowledge in the very discipline wherein it is produced – the health sciences. This involves enabling medical students to access social science discourse, a discourse described as "impenetrable" by a senior medical educator (Kneebone, 2002: 514). The societal context in which we attempt to achieve this is incredibly complex. Despite progressive legislation around sexual and reproductive health rights, protection from sexual and domestic violence, and comprehensive antidiscrimination laws, the realities are far from rosy. Massive inequalities and high levels of violence skew access to resources and the implementation of rights, and an increase in religious and 'cultural' conservatism restricts expressions and interpretations of gender and sexual identities (Bennett and Reddy, 2009). Our students need to negotiate their personal and professional identities in these realities, and the borders between the two are fluid.

Little is known about the pedagogies of sexuality in South African tertiary education institutions. The shortcoming of current research is that:

> "surveys have yet to investigate in any systematic way what happens in the 'learning spaces' of the university – in lecture theatres, tutorials, laboratories and seminar rooms" (UCT, 2005: 2).

Bennett and Reddy (2009) recently analysed existing curricula across disciplines as part of an international research project. In the health sciences, the dominant approach was biomedical and developmental, focused on reproduction and sometimes on risk or dysfunction with almost no space for an interrogation of the concepts of gender and sexuality through social constructionist theories or as a predictor of health. Furthermore, sexualities rarely feature in analyses of power relationships, health access, health systems management, or epidemiology. Consequently, the biomedical and pathological aspects of sexuality are isolated from its social and political meanings, people's sexuality is reduced to anatomical (ab)normalities and physiological (dys)functioning, and their sexual identities, desires and pleasures are rendered invisible.

In order for us to challenge the biological constructions of gender and sexuality, and the systemic violence it perpetrates, we need to re-create knowledge in the very discipline wherein it is produced – the health sciences.

It is in this context that we have begun our work on diversity in the health sciences. One of us researches sexualities in health care, and aims to challenge the current paradigm in order to reduce the discrimination that people with non-heteronormative identities face in the health system. The faculty is supportive of this work, and has provided funding for a postdoctoral fellowship. The other is involved in undergraduate teaching, and has been active in pursuing curriculum change to include critical diversity literacy for all medical students.

Context

The UCT Health Sciences Faculty was initiated in 1912 as the Faculty of Medicine and is the oldest medical school in southern Africa. It has about 1100 medical students across six years of study, who are trained at Groote Schuur Hospital, Red Cross Children's Hospital, and at a network of health facilities across Cape Town. The faculty recently gained recognition as the first African faculty to be placed in the top 50 health sciences faculties world-wide.[3]

Over the past two decades, the faculty has critically examined its own past and sought to advance transformation. It acknowledges that:

> "although there were significant attempts by staff, students and the institution to resist apartheid injustices, UCT was not

> immune to the racist, sexist, and other discriminatory practices and values that typified society under apartheid."[4]

The Faculty Charter, born of the recognition of the faculty's responsibility to social justice, highlights the commitment to the principles of non-discrimination, equity, and participation. Progressive scholars within the faculty have played an integral part in the collection and submission of testimonials from the health sector to the Truth and Reconciliation Commission (TRC)[5]. The faculty's Transformation Office monitors racial and gender equity among students and staff, and has led various initiatives to address racism and (to a lesser extent) sexism on the health science campus. The faculty has a progressive sexual harassment policy, and hosts three research units on gender, health, law, and rights[6], which contribute to ground-breaking feminist scholarship on violence, sexual and reproductive health, and health rights. It is worth noting that these units either exclusively or mostly raise their own funds to cover staff, research, and publication expenses.

Despite these efforts, students and staff in the health sciences experience racism, sexism, and homophobia. A study commissioned by the Dean (Erasmus and De Wet, 2003) illustrated the challenges of black students who navigate predominantly white spaces. Among other findings, it highlighted that more than half of the participating students felt 'uneasy' around students of another race. A student's report (Rose, 1995) alarmingly underlines that most UCT medical students do not perceive sexist or homophobic acts as such – that they are largely lacking the analytic tools to recognise and deconstruct sexism and homophobia.

What this evidence suggests is that despite the 'top down' transformation efforts by the faculty, racism, sexism and homophobia prevail in the institutional culture of the health sciences. Steyn and van Zyl (2001: 9) defined institutional culture as:

> "the prevailing ethos – the deep-rooted sets of norms, assumptions and values that predominate and pervade most of the environment on a day to day basis."

As Bennett and Reddy (2009: 47) have noted:

> "Theories on the history and culture of higher education institutions suggest the overwhelmingly patriarchal nature of institutional norms within African (and indeed, global) higher education systems. These norms include curricular approaches to the body, identities, sexualities and the relevance of such concepts to diverse disciplines."

Hames (2012: 66) concludes that "South African learning and teaching environments remain some of the most conservative and untransformed spaces in the country", and that "all universities remain essentially heteronormative" (2012: 68).

The current MBChB Curriculum

The MBChB (Bachelor of Medicine, Bachelor of Surgery) is an undergraduate degree from which students graduate into an internship and community service and finally register with the South African Health Professions Council to practice as doctors in the public and private sectors. Acknowledging the social and historical dimensions of health care in South Africa, the curriculum uses a primary health care approach to teach the values of quality care, health equity and social justice[7]. The principles of primary health care, a human rights-based approach and patient-centred practice, form the foundation of teaching in the first year and are developed in the following years, alongside basic sciences such as anatomy and physics. In the first three years of the six-year degree, students learn the basic sciences of medicine through a problem-based learning approach. This is followed by three years of clinical learning, organised into blocks for each clinical discipline.

In the current curriculum, neither gender nor sexuality teaching follows a systematic approach or defined pedagogical framework. The faculty has acknowledged the need to re-structure its teaching on gender and sexuality, to extend the transformation process beyond race and gender. It based its need for revision on primary health care principles, which explicitly seek to consider the impact of social contexts and dynamics on people's health and to 'treat the whole person', as opposed to the more traditional approach of 'treating the disease'. Resultantly the faculty established a working group for curriculum reform in 2011. The working group supported an initiative to evaluate the extent of gender

and sexuality teaching in the faculty, led by one of us. As a first step towards creating a comprehensive curriculum, we reviewed the existing curriculum and demonstrated that topics of LGBT health were neglected in current teaching. We found that the current medical curriculum does not prepare students to take sexual histories from non-heterosexual people, or offer safer-sex counselling to them. Nor does it address the impact of homophobia, heteronormativity and social exclusion on the health of LGBT people, let alone challenge student-doctors on their own attitudes towards homosexuality (Müller, 2013). There are individual pockets of educators committed to teaching issues of gender and sexuality in their social context, but this is negligible against the overall invisibility of these topics, inadvertently reproducing exclusion through an uncontested hidden curriculum.

The concept of the 'hidden curriculum' operating alongside the formal curriculum describes the structural, environment, interpersonal, experiential, and cultural influences that inadvertently shape students' attitudes and behaviours (Aultman, 2005). The institutional culture forms a central influence, as does the choice of content for formal teaching. The highly experiential nature of medical education relies heavily on lengthy apprenticeship alongside multiple role models to facilitate both practical learning experience and enculturation, often exposing students to informal and unintended teaching within under-resourced contexts (Du Preez, Pickworth and Van Rooyen, 2007).

Opportunities

Bennett and Reddy (2009: 55) assert that:

> "at multiple points, health sciences courses hold enormous potential for thinking through a critical analysis of gendered relations, and a sophisticated understanding of sexualities. [Thus]..the intellectual and practical expertise introduced through health sciences hold great potential for excellent gender and sexualities education, despite the current positivist and bio-medical orientation of the curriculum."

We concur with this assessment, and have started to rethink our pedagogical strategies. If we are to un-do the powerful forces of patriarchy and heterosexism (alongside all other –isms), intersectionality offers a valuable approach to critical reflection. It recognises, analyses and challenges sexism and homophobia, and other interacting axes of oppression such as racism, ableism and classism (Tsouroufi, Rees, Monrouxe and Sundaram, 2011), with the potential to engage both the formal and hidden curricula. We have a social responsibility to teach our students a critical intelligence for furthering progressive sexual rights and feminist approaches – not only to equip them to provide adequate, respectful, and well-informed care to their future patients, but also to sustain and develop these approaches for generations to come. Questions of gender and sexualities thus become a matter of "social and political literacy" (Bennett and Reddy, 2009: 55). The same way that "pedagogies of sexualities must prioritise the destabilisation of heteronormativity, as a precondition of their integrity" (Bennett, 2006: 68), pedagogies of gender must challenge patriarchy. In considering gender and sexuality beyond their biology, we follow Hames' (2012: 71) analysis that while:

> "gynaecology is the specialisation on the female reproduction system, knowledge of gynaecology is simultaneously knowledge of the way political and cultural meanings about women's bodies come into the medical arena."

Our students need to recognise these meanings and understand their inherent complexity, to prepare for active citizenship in a complex and changing world in which political and cultural power, together with socially constructed identities, affect people's health-seeking behaviour and access to care.

Challenges

With these pedagogical aims in mind, we set out to reflect on the challenges we have encountered in attempting to incorporate feminist, anti-oppressive teaching into our health science curricula. Not surprisingly, our challenges are manifold. In this section, we present an overview, grouped into six main categories.

Curriculum challenges

The MBChB curriculum consists of only mandatory courses, which aim to educate competent, independent health care workers to be well versed and knowledgeable in a wide range of clinical areas. As a result, the curriculum is packed - and any new addition is perceived as coming at the expense of an existing teaching unit. Under these circumstances, immediate, 'life-saving' knowledge, for example how to diagnose a heart attack, is often prioritised over 'soft skills'. As Risberg and colleagues (2011: 620) have described in Sweden, it is often assumed that gender-related attitudes are "self-evident and would emerge naturally" when students are taught at the bedside. Hence, courses that are rated worthwhile are those within the traditional canon of biomedicine – clinical skills, 'hard' clinical sciences, and esteemed disciplines such as surgery. As a consequence of rigorous positivist, sciences-based training "most doctors believe their practice to be essentially scientific", however:

> "medical decisions are seldom based on science alone, but rely instead on a complex amalgam of factual knowledge, personal experience, anecdote and empathy, played out against a background of professionalism and underpinned by a sense of care and compassion" (Kneebone, 2002: 515).

The current curriculum hardly offers students a wider range of epistemological positions through which they can make sense of the complex social and political contexts in which they learn and practice their science.

The large size of our classes and the impersonalised nature of health sciences learning pose extraordinary pedagogical challenges for us and make reflective group discussions and other small group methodologies almost impossible. Our curriculum usually does not accommodate preparatory reading, which leaves limited opportunities to get to grips with new concepts and modes of analysis, or find academic 'role models' that students can identify with, and seek guidance from. A recent report from the faculty recognises the pressures on space and group size and suggests that these will be addressed in future years (CHED, 2011).

However, there exist valuable assessment tools for medical curricula, and we need to encourage their use throughout the curriculum. Objective Structured Clinical Examinations, or OSCE, evaluate a student's communication skills, interaction skills, as well as knowledge. These could be used to assess skills in engaging with patients' identities that have been taught within an integrated curriculum.

Student engagement

When students question why our subjects are important, it may well be to prioritise learning areas in a competitive and packed medical degree. However, many of our students come from privileged backgrounds, and struggle to process the realities of patients in public health facilities with high burdens of disease and often various levels of poverty. A common reaction to being confronted with one's own privilege, and other people's disadvantage, is resorting to 'othering', which we experience in our students in varying degrees.

Some of our students have also been crucial allies in our attempts to introduce critical gender and sexuality teaching. A few years ago, an initiative by the student representative council (SRC) lobbied the faculty to introduce more LGBT health topics into the curriculum. The campaign was initiated by two fifth year students, who realised that they did not possess enough knowledge to advise a gay man they saw in one of their clinical electives. Supported by one of us, they managed to pass a resolution for better curriculum coverage of LGBT health topics in the SRC, which subsequently laid the foundation of the faculty's initiative to restructure its teaching of gender and sexuality. This example proves that students can be powerful allies in advancing a feminist curriculum.

Faculty resistance

Within the faculty, there is insufficient knowledge of the concepts, social meanings, and health impacts of gender and sexuality. At one of the curriculum working group meetings, it was suggested that sexuality, and, more specifically LGBT health, be taught in the gynaecology module where it "naturally belonged". The assumption here is clear: sexuality equals reproduction, the responsibility for which is still placed squarely on women even though LGBT identities include men, transcend the gender binary, and LGBT

health concerns exceed having children. The creation of teaching space for LGBT health hosted by the Department of Obstetrics and Gynaecology is to be applauded, with appreciation that the initiators of the workshop enthusiastically motivated for the need. Yet within a crowded health science curriculum, the complexity of social science discourse is frequently essentialised to the most basic ideas leading to discussions of universal truths about LGBT health, as opposed to deconstructing heteronormativity and patriarchy. Thus well-intentioned colleagues elide the complex discourses of social construction, stereotype, difference and experiences of marginalisation into a human rights framework that does not grapple with the core questions of identity formation, gender roles, and knowledge construction itself.

Lack of teaching materials

One of our main challenges is the lack of teaching materials or methodological approaches that speak to an African health care setting. We struggle to find material that situates gender and sexuality in the health sciences, and draws on a paradigm of 'critical diversity' (Steyn, 2010), or 'liberatory pedagogy' (hooks, 1994) rather than positivist approaches. Furthermore, these materials are produced in the canon of western academic knowledge, and as such are often counter-productive to our attempts at providing feminist teaching that is rooted in alternative epistemologies and paradigms. As Prah (2011) recounts from her experience in Ghana, teaching sexuality in African contexts is often challenging because of cultural taboos surrounding the topic. Bennett (2006) and Hames (2012) argue that much of the teaching, training and the designing of workshop material on sexuality is undertaken within the non-governmental organisation (NGO) sector. We believe this may reduce the integration of the knowledge with broader clinical practice and may reduce the status of the material.

The current health system

The MBChB curriculum prepares students to work in the South African public health system. Yet the challenges in the system are manifold, with the quadruple burden of disease, including the current HIV and TB epidemics, placing our under-resourced and understaffed health facilities under great duress. In these circumstances, our attempts to teach inclusive history taking, recognising social context and identity, are perceived as an impediment to an efficient, streamlined patient interaction. Under the pressure to see as many patients in as little time as possible, students revert to simplistic, stereotyping algorithms and focus solely on the disease.

within a crowded health science curriculum, the complexity of social science discourse is frequently essentialised to the most basic ideas

Furthermore, we need to recognise that our current health system is structurally abusive. It is hard on health care workers, without much support and often without adequate financial compensation. It is even harsher to the patients who use it, who have to compete to gain access to the limited resources and services it can offer. Abuses of power by frustrated health care workers are frequent and often target people with non-conforming identities. Our students can play crucial roles by either condoning and perpetuating abuse, or by taking a principled stand against it. Our responsibility as feminist health care educators is to provide the tools to challenge these systems. The "social and political literacy" that Bennett and Reddy (2009: 55) advocate helps us frame this responsibility, and extend our students' understanding of patient rights' abuses to violations based on gender and sexuality.

Our own identities

As Bennett (2006: 78) has pointed out, "the intersection of pedagogic processes with sexualities raise dilemmas which are simultaneously 'personal' and 'professional', demanding ethical and intellectual interrogation". She notes that the identity of the teacher can be a powerful 'tool' in the process of teaching. Because we teach from a position of introspection where we deconstruct identities and social structures, our teaching is inherently personal. Yet this is difficult within a positivist curriculum with large classes and small slices of time. We are made acutely aware of how personal experience and lived realities are not awarded the same value as strictly scientific evidence. Throughout our conversations rose a striking theme of shared intellectual loneliness linked to

the complexity of interdisciplinary engagement at the nexus of health and social science.

Strategies to address these challenges

Beyond providing a space of solidarity, our conversations have helped us think through and shape our longer-term strategies, and identify allies and resistances. We gratefully recognise the feminist activists, advocates and scholars who share and support our endeavour, within the faculty and beyond. While it is vital to use the concepts of intersectionality within South African health sciences to assist students to engage with the complexity of people's identities and experiences, Risberg, Johansson and Hamberg (2011: 613) remind us that the challenges are not unique through their conclusions that in Sweden "faculty measures are needed to counteract prejudice and to upgrade the time allocation, merits and status of gender implementation work." In the following section, we briefly outline some of our recent efforts, in the hope that the underlying approaches and strategies can be useful for other feminist scholars teaching in the health sciences.

Create faculty awareness

To ensure that the health of LGBT people is not compromised by our future health professionals it is essential that our students are taught core content regarding specific health risks and needs, but also that their skills, attitudes, consciences and awareness are appropriately shaped. This requires that we gradually challenge the faculty to take up the complex demands of critical diversity literacy within both the institutional culture and the curriculum. Recognising that a sustainable approach requires educated, well-informed educators, we have begun to introduce pedagogical approaches of critical diversity literacy (Steyn, 2010) into departmental journal clubs, interdepartmental seminars of continuing education and research symposia, framing the issues within existing priorities and accepted principles, such as the primary health care approach.

Find allies and experts

It is important for us to acknowledge that the fields of gender and sexuality are vast and specialised – and that we are not experts either. As 'generalists' and junior academics trying to 'diversify' the curriculum, we rely on experts from other disciplines and fields – for example, we are fortunate to have Jane Bennett as a guest lecturer in the undergraduate module on sexualities, and are inviting civil society organisations to share their knowledge and expertise as guest experts. By partnering with civil society organisations, we aim to bridge the divide to ensure that we don't 'teach about' people, but 'with people'. This also allows us to bring personal narratives into our classroom, but it is crucial that these teaching units are firmly anchored in a theoretical framework, acknowledged as part of a comprehensive curriculum and integrated with other elements of clinical teaching (Nobelius, 2011). Like Nobelius (2011), we recognise that senior academics and particularly senior men, are vital in advocating for change.

Create evidence

Disbelief is a common reaction to our assertion that non-heteronormative identities experience marginalisation and discrimination in health sciences and health care ("But our students are trained so well. Surely, that can't really be a problem …"). Therefore, one of us leads a research project that documents the experiences of LGBT people in the health system, aimed at providing the evidence needed to substantiate our claims. Within this project, a postgraduate student investigates medical students' knowledge of and attitudes towards sexual and gender identities that transgress the heteronormative paradigm. Both these projects are investigated through an access angle – a strategic framework well established in health sciences, that translates aspects of normativity, (in)visibility, and oppression into evidence (Nobelius, 2011).

Seek opportunities to mainstream gender and sexuality content

Drawing on such research projects, it is possible to identify tipping points within the core curriculum where students may be taught inclusive approaches, thereby actively addressing the hidden curriculum. This may involve suggestions regarding the teaching of history taking, sexual health promotion and family structures, or simply disrupting heteronormativity in case studies by including a

same-sex partner with whom the students should discuss the patients' health.

Challenge the scientific paradigm

We need to challenge the assumption that scientific orthodox knowledge is objective and apolitical. Sometimes, as within other contexts, we are accused of teaching 'too politically', or 'too passionately' (Nobelius, 2011). This suggests that we need to engage in ongoing, personal conversations with our colleagues and deconstruct the assumptions and ideologies that inform their view, recognising that these ideologies undermine, stress and impoverish all in society. The focus on creating inclusive health care for all may reduce the anticipated threat or blame of those who have been privileged (Nobelius, 2011).

Conclusion

We agree with Hames (2012: 73):

> "that the law, political science, government studies as well as the faculties of medical and health sciences amongst others should have curricula which teach beyond the traditional frameworks about sex, sexism and sexualities."

This is a crucial time to discuss the pedagogies of sexuality and gender in the health sciences, and we hope that our contribution will help to facilitate conversations, discussions and debates. Changing the structures of knowledge production not only challenges dominant discourses around gender and sexuality, but at best will improve the health care system itself. By educating diversity-affirming health workers, the system may finally provide adequate care for people whose bodies or identities transgress the dominant paradigm of gender and sexuality.

Notes

1. See, 'Victorian women and menstruation' by E Showalter and E Showalter, 'Stereotypes of femininity in a theory of sexual evolution', by J Conway, and 'Innocent *femina sensualis* in unconscious conflict' by PT Cominos in Vicinus (1972) *Suffer and Be Still. Women in the Victorian Age*.
2. We acknowledge that sexual orientation and gender identity are fluid, and encompass more than the LGBT acronym. However, the current research evidence that we cite only focuses on LGBT identities – in itself an indicator of the rigid, positivist categories created in the health sciences.
3. The prestigious ranking by Times Higher Education assesses teaching institutions by five performance indicators, among them teaching, research and citations. A high rank improves an institution's reputation, and, by consequence, creates an influx of students, funding, and faculty.
4. UCT Health Sciences Faculty, Faculty Charter, http://www.health.uct.ac.za/about/charter
5. For example, see the book *An Ambulance of the Wrong Colour* (Baldwin-Ragaven, London and de Gruchy, 1999), which examines the complicity of health professionals, and the failure of the health system to address the human rights violations under apartheid.
6. These are the Women's Health Research Unit, the Gender Health and Justice Research Unit, and the Health and Human Rights Programme.
7. These values are outlined on the website of the UCT health sciences faculty, available at http://www.health.uct.ac.za/about/mission.

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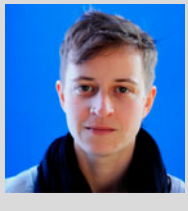

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