A Queer Perspective on Challenging Hetero- and Cisnormativity in Pharmacy Education in the United Kingdom

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Abstract

UK pharmacy education, like many other professions of healthcare, is grounded in stong heteronormative and cisnormative paradigms that value the queer identities and experiences. This paper looks at critically how such normative structures are inscribed in curricula, which are enacted through pedagogies and institutional governance, making UK pharmacy education a quiet formidable adversary to queer inclusion. Using queer theory, intersectionality, and testimonies from pharmacies students and professionals, the study shows that there is the invisibilization of queer health needs, lack of representational equity and perpetuation of gender binaries in both classroom content and clinical training. The research implies pharmacy education tends to emphasize neutrality and objectivity (and hence, silences conversations about sexual and gender diversity), thereby further institutionalizing differences in health care delivery to LGBTQ+ populations. The paper advocates for the rapid disassembling of the normative pedagogical paradigms and calls for integrating queer-affirmative frameworks that celebrate diversity, encourage critical reflexivity and enable future pharmacists to stand up for care that is inclusive and equitable. Doing this, UK pharmacy education can become a transformative space in which queer lives, bodies, and the health narratives that are built from them are not just recognized but actively affirmed.

Keywords: ***Pharmacy education, heteronormativity, cisnormativity, queer theory, LGBTQ+ healthcare, UK higher education, intersectionality, inclusive curriculum, professional training, health equity.***

1. Introduction

In current practice, there is an increasing understanding that pure clinical knowledge is inadequate to prepare practitioners to provide care to ever more diverse populations of patients. Yet even coming in the aftermath of this understanding, there are significantly few curriculum in the United Kingdom that still function within rigid expectations elevating heterosexual and cisgender identities to the default.In pharmacy education the implications of this silencing are not academic; they resonate into the clinical practice, sustaining inequity for LGBTQIA+ individuals in healthcare systems.

Institutional erasure of queer lives and experiences in UK undergraduate pharmacy education is discussed in this paper. Despite equal amounts of references in policy documents and accreditation standards, the translation into practical pedagogical practice has been inconsistent, fragmented, and sometimes even performative. Representation of LGBTQIA+ individuals in the situation is often tokenitic in nature, focused only on narrow biomedical discourses regarding HIV/Growth hormone therapy rather than being integrated as part of a larger vision of person-centred care. Students therefore graduate unable to interact perspectively, informedly, and kindly with queer communities, even though they are supposed to work with these populations in professional settings(1).

We argue that the state of pharmacy education today serves to reproduce societal heteronormativity and cisnormativity. This complicity is not a function of a direct prejudice; rather it comes to us from epistemological structures specifying whose knowledge counts, whose bodies are viable, and whose stories are told. Consecutive curricula that depict patients as cisgender and heterosexual maintain narrow notions of identity, health, and normality, while leaving out anyone who fails to conform. The erasure is very personal for queer students: their identities are themselves erased in the very places they are learning to care about others.

Institutional silencing does not only prevail in pharmacy. Medical and allied health education has struggled for some time with how best to integrate social and cultural aspects of training in the clinical setting. But, in contrast to race, disability, or religion that move into institutions seeking a slice of attention, gendered identity and sexuality are sites of neglect or resistance. Research indicates that even when LGBTQIA+ issues are covered, they are typically viewed as anomalies, pathologies, or “sensitive topics” that “need” to be specially addressed. Such framing supports a deficit model that makes queer people problematic when they are quite normal members of the society that have

needs that are on equal footing with those of the rest of the citizens(2).

The current study views the phenomena through constructivist lens, based on queer theory and pedagogy, to understand the influence of hetero- and cisnormative ideologies on pharmacy education. Queer pedagogy is not just about inclusion of LGBTQIA+ topics; it is calling for a major rerethinking of what is taught, how it is taught, and to whom it is accountable. This strategy requires the dismantling of binaries, instead of championing them and the negation of "neutrality," as well as the admission that even education is always political. By doing so, queer pedagogy rejects the normalization of identities that dominate and makes the lived experiences of the marginalized the center of focus in the traditional curricula.

Our inquiry starts with a national survey of course leads and students on 29 UK MPharm programs on how the representation, perception and enactment of LGBTQIA+ topics are. We explore not just the formal curriculum (the aspirations of what might be taught) but also the hidden one (what may be inferred), discovering insistent contradictions between policy rhetoric and pedagogical practice. By qualitatively analysing students' testimonies and teachers' insights, we shed the light on structural and cultural levers that restricts visibility of LGBTQIA+ identities and disrupts inclusive practices.

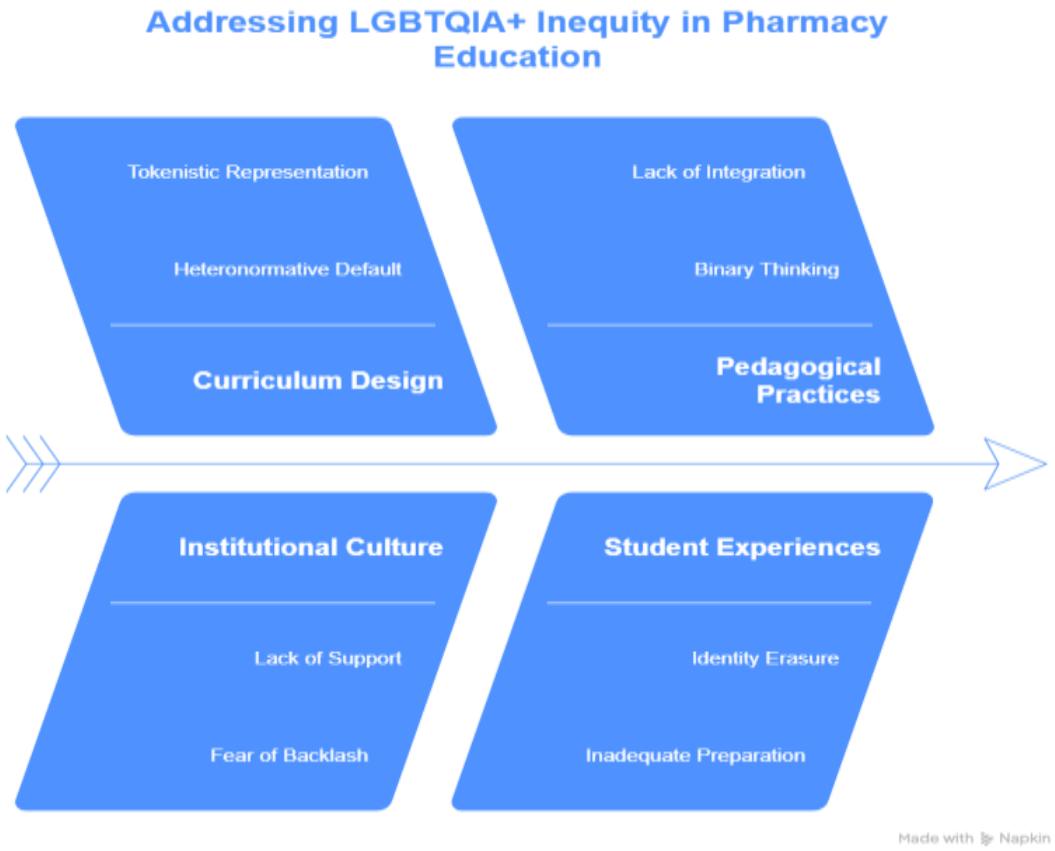

FIGURE 1 Addressing LGBTQIA+ Inequity in Pharmacy Education

What you see is a picture of an educational system split between movement and stagnation. Some institutions, however, show promising attempts, such as including inclusive language, collaborative work with the LGBTQIA+ organizations, or the embedding of queer health scenarios to the assessments, but these are not widespread. Many educators state lack of time, fear of negative cultural backlash, or just lack of support from the institution as barriers to the more meaningful inclusion(3). At the same time students say that they felt ill equipped to care for queer patients; frustrated with curricula that institutionalize binary thinking; alienated in the absence of representations like themselves in case studies, lectures, and simulations.

Finally, this paper does not only evaluate pharmacy education for its omissions. It provides a theory-driven

transformational roadmap based on data and lived experience. We argue that a queer-informed curriculum is not a bonus; but rather a required intervention to confront structural inequities and ensure real inclusion of care. By expanding the "voices" that comprise dominant paradigms, and by countering the entrenched norms with which they are charged, it can become a place of liberation, justice, and healing, rather than performative allyship.

2. Blueprints of Erasure: How Pharmacy Curricula Normalize Gender and Sexual Conformity

To interrogate the task of hetero- and cisnormativity and in what ways they are structurally embodied in UK pharmacy education, it is essential to look beyond anecdotal assumptions and to work with the empirical data from educators and learners themselves. What we find is not a curriculum aligned with overt stridency against queer identities, but a curriculum developed using omissions, silences, and passive compliance to dominant cultural logics. This gives the curriculum a false impression of "neutrality," in that it is ideologically charged.

Among the 29 programs surveyed in the United Kingdom for the 29 MPharm programs, the design of the curriculum is overwhelmingly normative in its gender and sexual expectations. When educators were asked what their teaching contained regarding the LGBTQIA+ content, most indicated they were covered minimally to non at all, with those who had coverage outside of the HIV/AIDS as biomedically focused. In a similar vein, student answers shone a very big gap as to how such issues (gender diversity; transgender health, etcetera), were handled. For the majority, the lack of the LGBTQIA+ representation was so shallow that the participants only learned about it after filling in the study survey.

This silence carries more than oversight. It is organized in terms of accreditation frameworks, assessment priorities and a historical perspective on professionalism where neutrality is associated with objectivity. Therapeutic training practically all the other professional training system has always been proud of its clinical detachment, rational knowledge, and evidence-based practice. Nevertheless, such ideals may inadvertently create grounds in which sociocultural problems become regarded as "soft," "irrelevant," or "too political". Consequently, such topics are attached to elective slots or placed in special modules which are rarely incorporated in the overall curriculum(4).

Several justifications were given by educators for these curricular gaps. The most common barrier reported was "lack of time", which suggests that core pharmacological knowledge must have priority over identity-based education. Others alluded to "lack of institutional support", "uncertainty on how to teach the topic" or, "cultural and religious sensitivities" with particular students, most especially, those from international backgrounds where such non-heteronormative identities are criminalized. Such concerns are concerning in that they embody an unsettling tension between inclusivity and perceived risk whereby the assurance of the comfort of the many trumps the guarantee of equity for all learners.

Consider the following educator commentary:

"We have a great number of students from countries where homosexuality is not a legal issue. Incorporating LGBTQI+ content may provoke controversy or even a possible legal problem for them".

"We avoid these topics unless they pop up in clinical relevance, such as HIV. Otherwise, it is better not to go there."

Such statements are indicative of a larger scheme in which such queer content is policed through the guise of "sensitivity" and perpetuates its status as marginalized. Famously, however, no similar constraint seems to be extended to heterosexual narratives, who dominate consultation skills training, clinical situations and – bizarrely – case simulators. Role-playing exercises habitually default to cis-heterosexual family bodies–men talking about their wives, women in relation to their husbands–thus making invisibly cis-heterosexuality the default norm.

The exclusion is also methodological. Often, curriculum planners fail to recognize the importance of intersectional representation in case-based learning and thus reproduce health knowledge as race-, gender-, and sexuality-blind. For instance, when it comes to clinical cases, students do not find clinical examples of trans patients or queer relationships in reproductive, cancer screening and chronic health management. LGBTQIA+ lives are only relevant in the terms of "specialist issues" (HIV prevention, hormone therapy etc.) – queer identities are 'reduced' to risk categories/medical abnormalities.

From a pedagogical point of view, this produces an education system that socializes students to "otherize" LGBTQIA+ patients. When non-conforming identities are policed as exceptions, rather than as part of the full continuum of care, students learn to internalize clinical gaze that pathologizes or exoticizes difference. Quite

frankly, more than 70% of the student respondents affirmed that they had been trained for nothing on same sex history taking, no guidance on gender neutral language and no exposure to discussions of gender identity outside of binary story structures.

These patterns are an instance of curricular gaslighting, by which students are subtly taught to believe that only specific patients matter, or that some identities are unsuitable for professional discourse. As one student observed:

"All is learned from a highly binary gendered perspective Nothing on respective comparison between sex and gender, no mention of intersex people. It's like we don't exist."

Other people illustrated that LGBTQIA+ health issues were regularly approached as "optional," which disadvantaged their status as key issues of clinical competence. This approach could not be more diametrically opposed to the philosophy constructed by the General Pharmaceutical Council (GPhC) so that inclusive or patient-centred care may form the very foundation of pharmacy education. Nonetheless, until the LGBTQIA+ subjects are incorporated as necessity rather than optional content, these standards are aspirational, not actionable.

Curricula are insufficient for queering course materials if they are self-contained and lack the critical language to make manifest the structures that create and reproduce exclusion. For instance, history-taking scenarios should have varied relationships while the pharmacological contents should be responsive to the interaction of gender-affirming treatments with standard prescriptions. The communication skills modules should equip students to deal respectfully with patients at all points on the sexual and gender scale, and evaluation should reflect readiness for such interactions(5).

The aim is not just representative equity, but also epistemic justice, which involves an education, understanding, and practice that reckons the value of LGBTQIA+ lives and equips practitioners to respond to them with knowledge, respect and empathy.

For that purpose, this paper calls on pharmacy programs to reexamine their blueprints not only what has been put in, but what systematically has been omitted. In our subsequent section, we discuss how even good curricula tend to perpetuate the problem of invisibility and intolerance via the 'hidden curriculum' – a powerful ideological tool that conditions student attitudes to issues of race, diversity, and gender.

3.Methods

To interrogate in a useful way how hetero- and cisnormativity structure the design, delivery and experience of pharmacy education in the United Kingdom we utilized a full mixed methods approach based in a constructivist paradigm. Our methodology was not just empirical, but also philosophical, which was based on the critical commitments of the queer pedagogy. This theoretical lens denies the false neutrality of mainstream educational discourse and focuses on the curricular choices' political implications, especially in professional health education, where systemic erasures are realized as real-world inequalities. Therefore, our methods were constructed so as to make visible both the structural forms of curricular exclusion and the embodied realities of such curricular navigation as learners and educators in these hegemonic spaces.

The study was a national cross sectional study with two core populations: academic staff holding responsibility for designing and controlling undergraduate pharmacy programs, as well as students studying these programs. These two groups were selected based on their central position in the production and reception of the curriculum – course leaders as architects and gatekeepers of what is taught and assessed and students as those who ingest, interpret and embody by internalizing formal and hidden curricula. In collecting data from both ends of the pedagogical spectrum, our goal was to create a multidimensional image of the positioning of LGBTQIA+ identities in pharmacy education both texted (in content and policy) and socially (in lived academic cultures) (6).

Data collection involved two unique online surveys designed for each of the stakeholder groups. The surveys were conducted using Qualtrics® – a secure survey platform accessible by most people – between June and December of 2021. Course leaders of all 29 GPhC accreditated MPHarms in the UK were targeted via institutional emails directly, listed on official university websites. To recruit students, a decentralized approach which involved outreach by pharmacy departments, student unions, LGBTQIA+ networks, professional associations (British Pharmaceutical Students' Association and Pharmacists' Defence Association) and social media venues such as Twitter was employed. This recruitment strategy was intended to increase reach in particular, among students who might feel alienated or ignored in the conventional academic context. In total, there were 19 full responses from course leads

and 458 from students from 25 universities in the student cohort.

Each of the surveys was developed with a mix of closed and open-ended questions. These were based on validated instruments used in previous LGBTQIA + curriculum review of studies on medical education, specifically the tools developed by Obedin-Maliver et al. (2011) and Tollemache et al. (2019). However, in light of the contextual dependency of pharmacy education and the diversity of pedagogical regimes in MPharm where the tools were implemented, we adapted the language, scope and structure of these tools with care. In the educator survey, the 24-item survey asked questions regarding hours spent 'in' the content of LGBTQIA+, perceived barriers, and perceived readiness for 'in' diversity. Other inquiries questioned the received role of institutional policy and accreditation standards in contouring curricular choices. At the same time, the student survey included 32 items, covering both content recall and attitudinal questions and nine items probing their lived experience of normativity, allyship, and marginalization in their academic programs.

Quantitative data from the two surveys were analyzed using descriptive statistics on IBM SPSS Statistics v25. Frequencies, means and cross-tabulations were used to determine whether LGBTQIA+ content exists, is missing, or varies across core thematic domains (sexual health, gender identity, communication skills, mental health, and transitions of care). Where appropriate, comparative analyses were made between course leader responses and aggregated student responses in order to observe congruity or dissonance in perceived curriculum content and values. These statistical results had a dual purpose; not only to provide a wide base of inclusion/exclusion trends, but also to help guide thematic coding for open-ended responses based on a highlighted set of misalignments.

Qualitative data, drawn from the free-text portions of the surveys, was explored via a thematic analysis that responded to Braun and Clarke's six-phase framework, but deformulated using an epistemic lens that originates with queer inquiry. Coding initially anchored on deductive categories drawn from queer theory and curriculum studies, for example, "heteronormative default," "queer erasure," "pathologization," and "tokenism". From there, these categories were then further developed and refined inductively so that new themes that arose from the data itself could be included, such as "educator fear of offense," "cultural relativism as a barrier," "disempowered allyship" and finally "student-led resistance". Each data set was coded separately by the two authors who then had a reflexive dialogue in order to calibrate interpretations, challenge unconscious assumptions and deepen theoretical understandings. This collaborative analysis was crucial for producing critical rigor especially in consideration of the politicalized matter of the topic and the varied positionalities of the participants(7).

It should be noted however that although the surveys were mainly instruments for data collection, they were also instruments of provocation and reflection. Some of the student respondents reported that the completing of the questionnaire was for them a first time of critical thinking of the (in) visibility of queer identities of their learning, suggesting that even the act of participating in the study was of transformative potential. We read this as the reflective effect of latent disciplining of a curriculum not only in structuring the world of what is known, but limiting the world of the knowable. This pedagogical silence, in itself, was one of our most important discoveries and our practice was developed to recognize those silences as data in and of themselves.

Ethical permission was obtained from the University of Manchester Research Ethics Committee (Project ID: 11543). All participants gave electronic informed consent. Participation was strictly voluntary, where all names details were anonymized as a protection measure. According to GDPR and academic best practice, all data were stored securely and are available for audit or further analysis on formal demand.

In designing this methodology, we did not only "want to study" queer erasure, but wanted to oppose it. By providing space for the marginalized voices, contextualizing structural barriers and theorizing the material implications of curricular design, this study locates itself within a growing corpus of critical education research that treats method as praxis. Our goal, however, was not to test a hypothesis, but to shed light upon an architecture of exclusion – and, in doing so, to ask health educators to deconstruct and reconstruct hermeneutics of their pedagogical frameworks towards equity and justice.

4.Results

These findings from this national study provide a tragic portrayal of curricular normativity and institutional inertia in UK pharmacy education. Based on the responses of 19 course leaders and 458 pharmacy students from 25 centres,

our data present a painfully entrenched routine of erasure, wherein therapeutic colours of the LGBTQIA+ rainbow are systematically excluded, anodyne dabbled, or confined to a biomedical corner. The curriculum as delivered and taken seriously, no matter how hard one tries to see it as objective or classy, is dominance cisgender heteronormative, at best. This phantasm of neutrality is some of the strongest stuff from the "phantom syllabus"—the unarticulated and unchallenged norms that govern who is visible, what is teachable, and whose realities are credible within the pharmacist professional formation.

According to the quantitative data derived from the educator and student surveys, it is represented in least quantities in majority of subject areas, especially modules beyond HIV/AIDS or sexually transmitted infections. In those traditional areas of societal discourse, representation is thin and is also pathologized. As an example only 26.3% of educators indicated that their programs had specific LGBTQIA+ teaching inputs and only 5.3 % identified their coverage as "very good". Many rated their curriculum as "poor" or "very poor" vis-a-vis inclusivity in relation to LGBTQIA+. These rulings were repeated, and in some cases increased, by student participants, 70% of whom reported that their programs did not provide even introductory exposure to the health needs of LGBTQIA+ people. Almost 80% had no formal training in this area and 74.3% reported absence of any training in obtaining same sex/gender diverse sexual histories.

What is especially disappointing though, is when not only is there a lack of such content to begin with, but also its absence is soarticulately explained. Repeated by course leaders were structural barriers including a lack of time in an already packed curriculum, the absence of stated requirements in accreditation standards, and the fear of "cultural sensitivities", especially among international students. Many educators referenced student demographics from homophobic countries as the basis for refusing to include LGBTQIA+ themes. In doing so, these educators were successful in maintaining a model of curriculum design that favors the quo over social justice thus allowing for discriminatory ideologies to shape teaching content through passive acquiescence. This dynamism sustains the spectre of the phantom syllabus: the strategy of being silent, invisibility as institution(8).

Theme	Quantitative Findings	Qualitative Insights (Examples from Participant Narratives)
Curricular Inclusion	Only **26.3%** of educators report any dedicated LGBTQIA+ sessions	"The only mention of LGBTQ+ people was during a brief HIV lecture."
Educator Perceptions	**5.3%** rated LGBTQIA+ coverage as "very good"; majority rated it "poor" or "very poor"	"We avoid these topics due to cultural sensitivities and limited time."
Student Experiences	**70%** of students reported *no exposure* to LGBTQIA+ health training	"We never learned how to ask about same-sex relationships in patient history."
Communication Training	**74.3%** of students lacked training on inclusive sexual history taking	"All patient scenarios assume heterosexual couples—it's never discussed otherwise."
Language and Identity Representation	**80%** had no training on gender-neutral or affirming language	"I've never heard 'they/them' used in any of our OSCE practice sessions."
Hidden Curriculum	High levels of silence and erasure in clinical scenarios and assessments	"We only ever simulate straight patients. It's like we don't exist in healthcare."
Barriers Identified by Educators	Time constraints, lack of guidance, fear of controversy, student background	"Our international students may find queer topics offensive, so we leave it out."
Signs of Progress	**89.5%** of educators said they are *planning* to increase LGBTQIA+ content	"We've begun consulting with queer patient advocates to revamp our materials."

Theme	Quantitative Findings	Qualitative Insights (Examples from Participant Narratives)
Student Desire for Change	**71.3%** believe curriculum reform is needed to align with GPhC standards	"Inclusive education isn't extra—it's essential for being a competent pharmacist."
Instances of Discrimination	Student reports of passive exclusion and unchallenged queerphobia	"Staff joked about pronouns; no one corrected them. It felt humiliating."

TABLE 1 Summary of Key Findings from National Survey on LGBTQIA+ Inclusion in UK Pharmacy Education

The data also indicate a severe dissonance between espoused, enacted and experienced curricula. Whereas a few educators claimed to be making low-level moves toward inclusion, claiming isolated workshops or guests, nearly all the students characterized the initiatives as tokenistic, inconsistent or absent. Some indicated that the only reference to LGBTQIA+ people anywhere in their entire program was in relation to HIV prevention, or substance misuse. This constraint both makes LGBTQIA+ people into categories of peril, and removes opportunities for students to become acquainted with the complexities of queer lives. Largely, case-based learning and simulations training, critical to due pharmacy training were reported as largely heteronormative: Patients were assumed to be straight and cisgender; consultation scenarios assumed nuclear family structures; and relationship contexts were handled in husband-wife dyads (Cptr 365).

Student narratives also came up with remarkable examples of how exclusion is internalized. Numerous voices spoke of being alienated from a curriculum that never recognized their identities, acknowledged their realties, or trained them to speak on behalf of patients like themselves. Several LGBTQIA+ students discussed the discrepancy between what they have actually experienced and the assumptions assumed in their education. One of them wrote, "Everything is taught from a very binary, gendered perspective. It's like we don't exist." Another added; "All our OSCEs [clinical exams] are needlessly gendered. It's always a man speaking about his wife, or a woman about her husband. Why can't I just be me in these situations? Why? Such comments demonstrate the emotional cost of curricular erasure, not only to knowledge-practices, but also to learner-identity, confidence and feeling of belonging.

In addition, beyond silence, the hidden curriculum ran deep. Several student answers noted clear instances of queerphobia among peers and faculty, which were not questioned in class classrooms or even within professional settings. One student wrote, there's a lot of tolerance at arm's length – people pretending to be accepting but keeping their distance. It doesn't feel safe." Another replied, "I've heard staff make jokes about pronouns or roll their eyes when gender identity is brought up. That stuff sticks with you." From these experiences it follows therefore, that the phantom syllabus is not only what is omitted but also what is allowed by passivity. The lack of explicit institutional messaging or strong training in LGBTQIA+ inclusion has set the stage for a vacuum space where implicit biases and harmful attitudes are able to propagate uncompelled(9).

In spite of these worrying trends, however, the data also indicated that there are indications of resistance and hope. Some of the students stated what they wanted was a more inclusive type of education, not merely to serve LGBTQIA+ patients better, but to challenge the constrictions of the current professional paradigm. These students thought of inclusion as a clinical competence, an ethical responsibility and a human empathy. Their recommendations consisted of putting LGBTQIA+ health needs across the curriculum, using scenarios which involve queer families, identifying trans-specific drug implications, and faculty receiving cultural competency training. Hearteningly, 71.3% of students said that it is necessary to reform the curriculum to satisfy new GPhC requirements, implying a willingness for change even though institution leadership is behind the times.

The educators also displayed pockets of progressive practice. Others have claimed collaboration with the LGBTQIA+ for guest lectures as well as the integration of unconscious bias training as well as the use of actors from queer communities in clinical simulations. Nevertheless, such initiatives were usually disconnected and the initiative was spear-headed by a small band of committed individuals. In the absence of institutional support, mandates in the curriculum, or integrated strategies, such inclusion remains ad hoc and open to burnout or blowback. Most pertinently, 89.5% of educator respondents indicated that they were planning to increase the amount of LGBTQIA+ representation in forthcoming years, largely in response to revised accreditation criteria. This implies

that policy change can be a key lever of structural reform, but only if accompanied by pedagogical courage and organizational accountability(10).

To sum up, the findings of this research reinforce that the current arrangements of UK pharmacy education operate more as a passive adversary than an active partner to LGBTQIA+ people. The curriculum whether explicit or tacit is premised on normative assumptions that ensure that queer identities are non-existent or peripheral or problematic. While some students and educators are fighting back against such restrictions, their protest is generally silenced in a larger culture of compliance, caution, and silence. Such silences until they are broken will continue to form not only what is taught but who feels seen, heard, and valued in the making of tomorrow's pharmacists through such silences.

5.Conclusion and Future work

The conclusions of this study provide insights into the lapidary and entrenched nature of hetero- and cisnormativity into UK pharmacy training. This research indicates a strong chasm between the espoused (claimed) curriculum, the enacted (delivered) and the experienced (sensed) curriculum. The study nonetheless reveals how LGBTQI+ issues are marginalized, often as episodic mentions in separated contexts; consider HIV/AIDS or transgender hormone therapy. This compartmentalisation relegates the LGBTQI+ health into components that fail to amalgamate it across the curriculum and leave the graduating population unresponsive for equitable inclusive care for all patients.

The invisibility and marginalisation of the LGBTQI+ individuals in pharmacy education are not accidents or coincidences but seemingly inevitable but the outcome of systemic and structural biases that continue to uphold the heteronormative and cisnormative ideologies. This research provides insight to show how this curriculum, as currently structured, maintains binary and normative assumptions about gender and sexuality and hence perpetuates a culture of 'othering'. This provides spaces for queer students and workers and patients to feel alienated or medicalised identities instead of acknowledged as whole beings with various needs and lived experience. The repeated association of health problems facing the "LGBTQI+" community and their mental health solely to pathology further enhances the stigma around the issues but fails to acknowledge other related issues such as mental health rights, the right to reproduce and healthy relationships.

One of the most important findings from this work is the manner in which pharmacy educators go or avoid the inclusion of LGBTQI+ subjects. Much depends upon the willingness of external agencies or a narrow group of highly motivated people, usually of lived queer experience, to plug these gaps in their teaching. Semicompliant, this may speak to good will in some measure, but it also points to a systemic abdication of responsibility from the larger academic community. Inclusivity must not be borne alone by LGBTQI+ educators and allies. Rather, it requires an active, across-the-board willingness to deconstruct normative structures and live queer competence across the entire spectrum of health professions education.

The model used for inclusion of LGBTQI+ in this research, Ward–Gale model, is deliverable and may serve as an invaluable backbone for adaptation by institutions to make their curricula more inclusive. This model stimulates instructors to discover what language, queer role models' visibility, and inclusive content in all health-related subjects exist. The implementation of this model can lead institutions to depart from tokenistic acts towards a truer, systemic embedding of LGBTQI+ health concerns. Such an approach is essential not only for learning to take care of the needs of the LGBTQI+ patients but also for developing a culture of respect, empathy, and equity among future generations of pharmacists.

The research also brings a scary gap in regulatory controls to the fore. Although the General Pharmaceutical Council (GPhC) prescribes standards of inclusive education, there is still vagueness regarding the extent to which these standards are implemented in really meaningful curricular change. The lack of specific benchmarks for the development of LGBTQI+ subject areas in pharmacy education allows for the diversity of approaches to be generated and provides a climate in which it is possible to view inclusivity as optional, rather than an integral component. We look forward to strengthening regulatory requirements and creating accountability for the inclusivity commitments of institutions as necessary next steps to increasing LGBTI + health equity.

Of limitations of the present study include the fact that some respondents might not have known that there is LGBTQI + material in their learning materials, which may have distorted the findings of the study. In addition the study may have drawn participants that had a stake in the LGBTQI+ issues which might affect the representativeness of the data. However, limited as it may be, the study offers a strong setting from which to explore

issues of hetero- and cisnormativity in health professions education and a conceptual framework for educators to critically view their curricula.

The implications of this work are not just for pharmacy education. All medical and health professions reflect the covertness of hetero- and cisnormativity. To do this calls for a basic shift in pedagogical philosophy—a turn towards a queer pedagogy that overturns norms and values inclusivity at every level of learning. This is not just recalibrating curricular content, but also remolding the institutional cultures to become really inclusive of multiple sexual orientations and gender Other worlds.

Finally, this research highlights the urgent need for a sustained and systematic work to end hetero- and cisnormativity within pharmacy education. It appeals to educators, curriculum developers, and instituting mechanisms to use a critical queer perspective and consider inclusiveness as a central principle rather than as a tangential consideration. How educators can consciously and reflectively begin to dig up hidden biases, subvert normative discourses and create a learning culture that will actually prepare future pharmacists to be compassionate and competent in providing care to all patients regardless of their gender identity or sexual orientation is a question that they face. Through commitment to continuous critical reflection and curriculum change, pharmacy education can turn from a passive onlooker (or even opponent) into an active ally in the quest for the equity of the LGBTQI+ health.

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Conflicts of interest

The authors have no conflicts of interest to declare

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