



# Tips for Beginning to Incorporate LGBTQ-Inclusive Content into Medical School Curricula

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Author: Allison Rhodes (MD/MPH candidate)

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## 1. Understand Key Terms Related to LGBTQ Identities and Health.

It is essential for clinicians to be informed about lesbian, gay, bisexual, transgender, and queer (LGBTQ) health because of the unique health disparities affecting LGBTQ populations, the prevalence of violence and victimization related to homophobia, biphobia, and transphobia, and the long history of anti-LGBTQ bias in health care.<sup>1,4,10,15</sup> It is therefore critical to understand sexual orientation, sexual behavior, gender identity, and gender expression.<sup>17,18</sup> Further, recognize that patients are the first experts on their bodies, and that clinicians must mirror the language that their patients use to describe themselves and their behaviors.<sup>4</sup> Clinicians should ask patients to describe what they mean if the patient uses language with which they are not familiar.<sup>10</sup>

## 2. Note the Prevalence of LGBTQ Individuals and Normalize LGBTQ Identities by Presenting LGBTQ Patients with Unrelated Health Conditions.

Researchers estimate that approximately 3.5% of United States adults identify as LGB and at least 0.3% of adults identify as transgender.<sup>1</sup> Even greater numbers of people engage in same-sex behavior or report attraction to members of the same sex.<sup>1</sup> LGBTQ individuals have multiple intersecting identities and should not have their experiences reduced to solely being labeled LGBTQ. LGBTQ health must be taught longitudinally and not be relegated solely to modules on psychiatry, sexuality, or HIV.<sup>4,8,15</sup> One way to incorporate LGBTQ health throughout courses is to modify the language of question stems to include LGBTQ patients and families. This can be done with a 'one-example' or 'one-case' approach, which involves including one LGBTQ patient per lecture.<sup>2</sup>

When incorporating LGBTQ patients into the curriculum, LGBTQ identity need not be critical to the disease entity or to the teaching point of the case. This will help to normalize LGBTQ individuals as typical patients. Examples of patients with intersecting identities:

- Lesbian woman with breast cancer
- Gender non-conforming patient seeking family planning counseling
- End of life scenario with black woman and her female partner
- Transgender man with pneumonia

## 3. Consistently Use Modifiers for All Populations, Not Just Minority Populations.

Adjective modifiers in case presentations help students to identify risk factors based on health disparities. However, often these modifiers are only used to identify minority populations. For example, race modifiers are often only used to identify non-white patients;<sup>6</sup> a question stem might begin "the patient is a 40-year-old man" or "the patient is a 40-year-old black man." Selectively using these modifiers implies that the norm is to be white, and that other races are abnormal, unusual, or should evoke a stereotyped image or health concern. Similarly, sexual orientation and gender identity are often only mentioned in the context of LGBTQ patients. For example, a question stem will read "the patient is a 20-year-old woman" or "the patient is a 20-year-old transgender woman." Educators should update case presentations and question stems to consistently use modifiers, including for frequently assumed identities (i.e. this is a 40-year-old white cisgender heterosexual man).

## 4. Do Not Make Assumptions Based Solely on Sexual Orientation, Gender Identity, or Gender Expression.

Gender identity and sexual orientation are distinct from how one expresses themselves and presents to the world.<sup>10</sup> Regardless of sexual orientation or gender identity, being perceived as having an LGBTQ identity often puts individuals at risk of harm.<sup>13,16</sup> As a result, LGBTQ individuals may not be 'out' in certain spaces, or may present in a way that does not align with their identities in order to preserve their safety. Teach students to avoid making assumptions, to ask their patients how they identify, and to ask inclusive questions, such as "tell me about your sexual partners," or "how would your sexual partners identify their gender?" or "tell me about your sexual activity. What body parts are involved and how?"<sup>1</sup> These questions address the behaviors that influence risk and are more inclusive of all patients, including LGBTQ individuals.

## 5. Trust LGBTQ Patients and Clinicians and Their Experiences.

Case questions featuring LGBTQ patients or providers should be intentionally worded to prevent discussions where students question the lived experience of the LGBTQ individual. Poorly constructed cases present the opportunity for questioning the decisions the LGBTQ individual has made about their gender identity or presentation, sexual orientation, or disclosure ("coming out"). Instead, discussions should emphasize the right of LGBTQ people to make decisions about their identities and should examine the impact of systemic barriers and victimization on access to

care. For example, instead of asking whether an LGBTQ provider is obligated to disclose their identity to patients, discuss the power dynamic of the physician and patient and the benefit of safety planning before disclosure.

## 6. Acknowledge the Lack of Clinical Research and Epidemiologic Data Where It Does Not Exist.

Wide gaps in research on the health of LGBTQ populations exist.<sup>7,9</sup> Many population-wide surveys do not include questions about LGBTQ identity or behavior, and formal epidemiologic studies on the incidence and prevalence of transgender and nonconforming identities have not been conducted.<sup>19</sup> Further, research often focuses on LGBTQ individuals presenting at the hospital or at specialist gender clinics, neglecting marginalized LGBTQ individuals who face significant barriers in access to care.<sup>11,19</sup> Finally, sexual identity and sexual attraction can be disparate and do not always dictate sexual behavior.<sup>11</sup> Rather than not mentioning health data on LGBTQ populations, clinician-educators should take the opportunity to acknowledge the lack of data and the barriers to researching LGBTQ populations.

## 7. Assess Personal Biases and Assumptions.

The most important thing a clinician can do is to honestly evaluate their own feelings and implicit biases about LGBTQ communities. Implicit anti-minority biases in physicians have been shown to lead to less positive perceptions of interactions with minority patients, lower referral rates for specialty care, undertreatment of pain, and lower rates of patient satisfaction.<sup>3</sup> Clinicians and educators, regardless of their sexual orientation or gender identity, should be aware of their explicit beliefs and implicit biases about LGBTQ individuals.<sup>5,14</sup> The Safer Spaces Project from the Sexual Assault Centre of Brant has also developed a Personal Assessment of Anti-LGBTQ Bias, which provides statements and questions for self-reflection.<sup>12</sup> Understanding personal biases can help clinicians to adjust their behavior and language so that they can provide optimal health education.<sup>19</sup>

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