Sexual and Gender Minority Health Curricula in Health Care Professional Schools

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Research article

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Abstract

Background Lesbian, gay, bisexual, transgender, queer, and intersex people—inclusively termed “sexual and gender minorities”—have unique health and health care needs that are not being met by most healthcare providers due to lack of training in health care professional schools. The purpose of this study was to examine implementation factors for advancing sexual and gender minority health professional student curricula in academic settings.

Methods: Semi-structured interviews, structured by the Consolidated Framework for Implementation Research, were conducted with sixteen curricular champions to identify factors relevant to curricular adoption, integration, and sustainment. Themes were coded using a hybrid of deductive and inductive approaches.

Results: Facilitators supporting implementation of sexual and gender minority health curricula included collaboration among multiple stakeholders, alignment of formal and hidden curricula, fostering an organizational culture that valued inclusion and diversity, engagement with external subject matter experts or faculty with content expertise, and thoughtful and inclusive planning.

Conclusion: This study contributes to health care professional education research as well as to implementation science. Facilitators that were identified in this study can be used to increase the adoption, integration, and sustainment of sexual and gender minority health curricula in diverse academic settings.

Introduction

Lesbian, gay, bisexual, transgender, queer, and intersex people—inclusively termed “sexual and gender minorities” (SGM)—have unique health care needs not being met by most health care providers.^{1–3} Lack of provider competence—including knowledge of and attitudes toward SGM, culturally-affirming behaviors, and clinical management strategies—have a direct impact on SGM patient experiences with health care, healthcare seeking behaviors, and health outcomes. The purpose of this study was to examine implementation factors that advanced SGM health curricular adoption, integration, and sustainment in academic settings.

Methods

A literature review was conducted to identify SGM curricular interventions published within the last five years. Authors from 21 studies were invited for interview. A total of 16 participants from the United States and the United Kingdom were interviewed from January to February 2019. Qualitative data were transcribed using Rev.com (San Francisco, CA) and coded using NVivo 12 software by QSR International. No incentives were provided. A hybrid deductive-inductive coding approach was used.

Credibility was established through expert review of research design, instrumentation, and results.⁴ Transferability of findings was demonstrated through thick description, memoing and transparency of data collection protocols, and review of findings by a subject matter expert.⁴ Member checking was conducted with all interviewees prior to reporting.⁴

Results

Deductive coding based on Consolidated Framework for Implementation Research (CFIR)⁵ was followed by inductive coding to categorize themes based on the following temporal phases: foundation, preparation, implementation, and looking ahead.

Foundation

Foundation refers to influencing factors that existed prior to the introduction of the SGM curricular intervention. Sociopolitical context, availability of external guidance, organizational culture, institutional commitment, and curriculum champions emerged as themes.

Sociopolitical context. Sociopolitical context refers to how national, state, or local politics influenced community response to curriculum changes and shaped expectations of students. Some institutions prepared for conservative political backlash while others did not: “You know, it is a disparaged population. So you have people who are against that population for whatever reason coming out against teaching related to that” (Participant 13). Administrator preparation for negative community responses did not necessarily correlate with actual backlash. Community responses did not impede curricula from moving forward, but raised decision-maker awareness of community dissent.

Greater community awareness at a national level was a facilitator for dialogue among students and faculty: “[There’s] a lot more recognition and awareness, you know...I think people’s awareness, of what these things are and what these things mean—you know, we obviously live in a society that continues to evolve” (Participant 5).

National dialogue influenced curriculum change over time: “[H]aving students that are out and vocal and transparent about who they are. And, just expect acceptance” (Participant 1). Over time, students expected greater sophistication in SGM content: “[A]s time has progressed, students...give me feedback and say, ‘Well, this isn’t really news to me.’...When we started off, people were saying, ‘Wow, this is so eye-opening.’ Or, ‘I don’t really wanna know about this,’ because it was uncomfortable for them, given their religious beliefs or other beliefs that they had.” (Participant 2).

External guidance. Information and guidance from credible sources was another factor that changed over time. Early champions in the 2000s and early 2010s indicated a lack of any real guidance from health care professional organizations, guideline bodies, or the research literature: “So when [we] ... looked for material... there was nothing, really...to find, because this was back in either 2011 or 2012” (Participant 4).

The most cited guidance, by far, was the AAMC's 2014 report, *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals who are LGBT, Gender Nonconforming, or Born with DSD: A resource for medical educators*⁶: "[T]hose are really our marching orders. I mean, we work from those competencies, that's how we diagrammed out a whole curriculum. What would go where, what the sub-competencies or learning objectives would be, what the assessments would be" (Participant 1). *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*,⁷ Fenway Institute online resources, the Lambda Legal report *When Health Care Isn't Caring*,⁸ and the Institute of Medicine report *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*⁹ were also cited as lending credibility to SGM curriculum adoption.

Organizational culture. Values, mission, and the "hidden curriculum" (i.e., the ways in which clinical practice and faculty behaviors reinforce or contradict what was taught in the classroom) emerged as key aspects of organizational culture. "[S]o much of med school learning is the hidden curriculum: How you model it, what words you use to describe certain patients, I mean that extends to so many things beyond sexual gender minority status. And it's really variable depending on sites, as well" (Participant 10). Alignment of the hidden and formal curricula was a cross-cutting facilitator for success.

Institutional commitment. Culture was closely linked to institutional commitment in the form of leadership support, staff support, and protected faculty time. In terms of leadership, one participant said: "[I]f he hesitated or hadn't given me the top cover to really kind of push on this and be very visible, then I don't know if we would have moved forward" (Participant 5). Staff support was noted as a major facilitator: "[T]his work would not have moved forward without having someone [who] is a passionate advocate and great at getting people together, and she's got this strange ability, like nobody can say no to her" (Participant 1). Protected faculty time to develop and implement SGM curricula was another example of support: "I got time carved out to work on this and then when I became dean... I carved out faculty time to work on curriculum" (Participant 7).

Institutional champions. Another foundational ingredient for success was empowered, motivated institutional champions. While participants described varying levels of institutional authority, all faculty champions felt empowered at some level to enact curricular change. Institutional champions noted a motivation to advance health equity and social justice:

[I]t doesn't matter what your personal belief system is related to transgender health or care. If you believe that people should be transgender or don't believe that they should be is irrelevant. Their human health is what's relevant. So we have people that can't access healthcare based on their provider bias. (Participant 13)

Motivation was due to personal experiences of discrimination, others' experiences, or a learning gap in their own education.

Preparation

The importance of thoughtful planning emerged as important for preparation. Themes that were cross-cutting from preparation through sustainability were use of data and collaboration.

Needs assessment. Needs assessment processes ranged from informal conversations with peers to formal survey-based assessments across departments: “[T]here’s no point in just starting something if... other people are like, ‘We already know this, but we really wanted to hear about’—So I just tried to ask around and to see what people knew about and what they didn’t know about. And kind of get it from that perspective” (Participant 4). Other approaches included feedback from community members and literature review to identify important SGM health considerations not being taught.

Strategic planning. From informal collaboration among peers to formal faculty retreats to align SGM content with the core curriculum, strategic planning was key. Creation or use of standing committees, steering committees, or task forces were inclusive approaches for planning curricula. Committees typically included faculty, but some also tapped community members: “We formed a community advisory committee...[a]bout eight community members...met monthly for about a year, and reviewed all the curriculum content and offered feedback. [I]t was, ya know, nothing about us, without us, kind of thing” (Participant 1).

Facilitators and barriers. During the planning phase, curriculum revision and time constraints were major contingencies. Curricular revision was seen as both opportunity and obstacle: “We were undergoing curriculum renewal anyway. So, it was a good time to take advantage of that opportunity and - to kind of focus changes into all the other changes that were happening anyway” (Participant 1). The same participant mentioned that ongoing change was part of the culture, which facilitated SGM curricular introduction: “Faculty are really not used to having anything be the same from one year to the next....So, it made making changes a little bit easier” (Participant 1). In contrast, curriculum revision was noted as a barrier by others: after an effort to add substantial SGM content to the curriculum, one interviewee reported that “a lot of that content and initial work was lost” when a subsequent revision shortened the traditional two-year preclinical education to thirteen months (Participant 5).

Like curriculum revision, time constraints were divergently perceived as a barrier or an opportunity. Fitting additional content into an already-packed curriculum was an obstacle: “[T]he other big challenge would actually be curriculum being very impacted” (Participant 7). Time constraints were perceived by others as an opportunity to be more intentional about how medicine is taught:

We need to do a better job of intentionality...to move away from this old model of, I just spew every piece of knowledge that I have versus, what do they really need to know, what can they look up later, what’s available in the database? You know, what’s going to give them the foundation to be successful and I see that an awful lot in kind of, our curriculum. That it’s too jam packed and the students are too stressed to even think about adding something else in. But...if we removed redundancies and were more intentional, there would be space for things that are important and quite frankly, I feel like a curriculum should be a living organism. (Participant 6)

In sum, participants emphasized the importance of assessing need and strategic planning—including planning for curriculum revision processes and time constraints.

Implementation

SGM curricula varied in depth, level of integration, and topics. A major theme that shaped curricular content was availability of expertise in the form of faculty or community experts. Experiential learning for students to work with SGM people emerged as a valuable addition to classroom content.

Variation in depth and integration. Interventions were diverse, ranging from nonacademic community member panels held during one class session to complete curriculum overhaul throughout four years of medical training. The level of integration varied widely from student-led projects to adoption of content by course directors to curricular leaders requiring students to demonstrate competencies for graduation. Level of integration had direct bearing on perceived impact and sustainability. Highly integrated approaches to curriculum revision delivered content strategically at relevant, teachable moments:

Like, if we're talking about hormonal medication...they're used to treat prostate cancer, they're used to treat breast cancer, they're used to prevent...conception, and they're used for multiple other purposes, and they're also used for gender affirming care in transgender patients...When we taught the sexual history, we just integrated more affirmative inclusive language...So we didn't have a, oh, and once you realize your patient's gay, you need to do these sort of things. It was more...Like...approaching the personhood, and then things would unfold a little bit more naturally. When we talk...psychiatric treatment...and counseling...teaching that conversion therapy is contraindicated [and] carries with it a higher risk of suicide. (Participant 1)

Student-led elective interventions were at risk of being perceived as a less important than core content: “I...had classmates feel like this was more cosmetic, elective stuff that I was teaching” (Participant 10).

Content expertise. The availability or lack of content expertise shaped what was included. Participants reported that SGM content was not taught, because colleagues did not were not confident: “They don't feel comfortable teaching it” (Participant 7). To address this gap, subject matter experts were brought in to build capacity: “[W]e hosted a one day faculty development event that brought in...national leaders in LGBT care...to develop all of our faculty that we felt would have a role in adapting our education...” (Participant 1). Community organizations representatives also directly taught students: “[H]onestly, because I was so new to this and, initially the very first time I had just done a Safe Zone training, it opened my eyes. And, I asked the Gay Alliance. Like, I kinda followed their lead about what should be incorporated” (Participant 2).

Interaction with SGM. Curricular approaches focused on or included exposure to SGM peoples’ lived experiences through personal interaction, question and answer community member panels, faculty

narrative, or documentary. Panels where students could ask questions of SGM community members were described as highly impactful to combat bias:

But when you see them actually engaging and talking to the students, that's where it was like, 'This is what students need.' They need to understand that these are individuals. To have that really open discussion with them. And it was remarkable. It was remarkable (Participant 15).

Avoiding stereotypes. A cross-cutting theme was the importance of avoiding stereotypes of SGM people in curricula. Participants noted the importance of including content that provided a fuller picture of SGM health than stereotypical cases of SGM with HIV and mental health problems: "I graduated in 2011...so somewhat recently. But my clinical and pre-clinical education was: "HIV happens more frequently to gay men. The end." (Participant 9). Intentionality in planning curricula was a way to avoid perpetuating stereotypes.

Across settings, identifying and/or developing content expertise, fostering student interactions with SGM people, and being intentional about avoiding stereotypes while also working to build an inclusive environment were perceived as important.

Sustainability

Sustainability depended on two primary factors: multi-level engagement and alignment of formal and hidden curricula. Use of data also emerged as helpful to demonstrate the importance of sustaining SGM health curricula.

Collaboration. Multi-level engagement was cited as critical in preparation and implementation for sustainability:

[A] lot of more senior physicians haven't had any training in this area...[I]nstead of just relying on one expert...we were able to show that non-experts could also teach this content if they had appropriate material. (Participant 12)

At institutions with one or few champions, content was vulnerable to faculty attrition: "My bigger question would be, what happens if [she] leaves? What happens, is there somebody who is going to step into that role if she goes?" (Participant 6). Limited faculty champions also meant limited student exposure: "So, my course is pretty much the only content, LGBTQ content that is in our curriculum to my knowledge." (Participant 2).

Alignment of hidden and formal curricula. Efforts to reinforce a culture of diversity, inclusion and social justice included direct and ongoing campus outreach to raise awareness among diverse stakeholders that SGM health was important; new clinical services for SGM patients—especially transgender patients; and environmental changes to make clinics more SGM affirming. Efforts to align hidden and formal

curricula included establishing a concierge service specific to SGM patients and developing a mentorship program to match incoming SGM medical students with “out” faculty.

At institution with longer-standing programs, expanded clinical rotations emerged as a way to reinforce classroom learning: “[T]hat’s the thing that really seals it is when...medical trainees have a chance to take care of real people” (Participant 7). These efforts reinforced the message that understanding SGM health care needs was important for students’ clinical practice.

Use of data. Evaluation data was important to demonstrate the need for curricular sustainment: “I think that student reflections and student feedback on how impactful that was, is the reason that we continued it. I mean other things came and went but that very consistently stayed in our, our syllabus because the student feedback was that it was really important” (Participant 6).

Looking Ahead

Interviewees were asked about facilitators to advance SGM health curricular integration going forward. Two themes emerged: the need for better evaluation tools and the need to incentivize inclusion of SGM curricula for sustainability.

Need for better evaluation tools. Universally, interviewees were unhappy with existing evaluation options in the literature: “[H]aving a tool of assessing how good the teaching is would be helpful... to see if people actually retain it for longer than half an hour after they go out of the session” (Participant 4). Some participants specifically mentioned future plans to improve evaluation within their own settings: “So, we’ve done the content integration, which is great, you know, we think that our students are learning, but we don’t have any milestones in this space that are baked into our assessment tools that allow us to really know, and have confidence, that our students are graduating with these competencies” (Participant 5).

Incentivizing SGM health in curricula. Interviewees suggested integrating SGM knowledge into graduation competencies, presenting SGM inclusion at competing institutions as market competition to administrators, and the need to access ready-made modules on SGM health as ways to incentivize SGM content inclusion in more schools.

Discussion

Findings from this study support past research that has shown the importance of collaboration in the implementation of new curricula¹⁰ and the impact of aligning formal and hidden curricula.¹¹⁻¹⁴ Collaboration through multi-level engagement of learners, faculty, and leadership bolstered curricular integration and sustainment of SGM curricula. Institutions that had organizational cultures that valued inclusion and diversity were more likely to have leaders that provided resources to SGM curricular champions and were more likely to build synergistic initiatives to align the formal and hidden curricula.

Content expertise was addressed in a variety of ways—either starting with faculty who felt like experts, building faculty capacity through guidance from external experts, or leveraging expertise from community organizations. Content expertise emerged as critical to SGM curricular success.¹⁵ A key to success was thoughtful planning to build faculty competence.

Limitations and Strengths

Qualitative findings are inherently subjective. Characteristics of the interviewee may produce social desirability bias through understatement or overstatement of institutional facilitators or barriers. Examination of both facilitators and barriers and assurance of anonymity intended to minimize these risks.

A major strength of this study is its use of implementation theory. This is the first known study to systematically examine contextual factors associated with SGM curricular implementation.

Conclusion

Few institutions have begun to incorporate curricular change to address the gap in medical, nursing, and pharmacy student learning about SGM health. Findings from this study provide unique insights and clear strategies to aid in the adoption, integration, and sustainment of SGM health curricula into diverse academic settings.

List Of Abbreviations

CFIR Consolidated Framework for Implementation Science

GW The George Washington University

LGBTQI Lesbian, gay, bisexual, transgender, queer and intersex

SGM Sexual and Gender Minority/Minorities

Declarations

Ethics approval and consent to participate

This study was determined to be exempt by the George Washington University IRB (#180842). Participants were provided with an information sheet describing the purpose of the study, what would be required as a participant, potential risks, and who to contact with questions. The information sheet indicated that willingness to participate would be implied if the person agreed to be interviewed. The IRB determination included documentation of this process of implied consent.

Consent for publication

The results reported in this article were originally reported as part of a mixed methods dissertation published in Health Sciences Research Commons available at https://hsrc.himmelfarb.gwu.edu/smhs_crl_dissertations/1/. The copyright was retained by the author who consents to publication in this journal under the open access option. Results were also reported in a poster entitled “Getting sexual and gender minority health ‘into the brick and mortar’: Results from a mixed methods implementation study” for the Academy Health 12th Annual Conference on the Science of Dissemination and Implementation in Arlington, VA on December 5, 2019.

Availability of data and materials

Blinded transcripts of interviews can be provided by contacting the corresponding author.

Competing interests

The author declares no competing interests

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Authors’ contribution

MPC conceptualized the study, collected and analyzed data, wrote the manuscript, and approved the final submission.

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References

1. Obedin-Maliver J, Goldsmith ES, Stewart L, et al. Lesbian, gay, bisexual, and transgender–related content in undergraduate medical education. *JAMA*. 2011;306(9):971–977. doi: 10.1001/jama.2011.1255
2. Dowshen N, Gilbert K, Feiler A, Lee S. Transgender health education impact on medical student knowledge, skills and attitudes. *J of Adolesc Health*. 2013;52(2):S35. doi: <https://doi.org/10.1016/j.jadohealth.2012.10.085>

3. McPhail D, Rountree-James M, Whetter I. Addressing gaps in physician knowledge regarding transgender health and healthcare through medical education. *Can Med Educ J*. 2016;7(2):e70-e78.
4. Lincoln YS, Guba, EG. *The Sage handbook of qualitative research*. Thousand Oaks, CA: Sage Publications, Ltd. 2005.
5. Damschroder L, Aron DC, Keith RE, et al. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implement Sci*. 2009;4(50). doi:10.1186/1748-5908-4-50
6. Hollenbach AD, Eckstrand KL, Dreger A, eds. *Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD: A Resource for Medical Educators*. Washington, DC: Association of American Medical Colleges, 2014. 280 p.
7. Institute of Medicine. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academies Press, 2011, 366 p. <https://doi.org/10.17226/13128>.
8. Makadon HJ, Mayer KH, Potter J, Goldhammer H. *The Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health, 2nd Philadelphia: American College of Physicians, 2015*.
9. Lambda Legal. *When Healthcare Isn't Caring: Lambda Legal's Survey on Discrimination Against LGBT People and People Living with HIV*. New York: Lambda Legal, 2010. Available at: www.lambdalegal.org/health-care-report
10. Solotke M, Sitkin, NA, Schwartz, ML, Encandela JA. Twelve tips for incorporating and teaching sexual and gender minority health in medical school curricula. *Med Teach*, 2019 Feb;41(2):141-46. <https://doi.org/10.1080/0142159X.2017.1407867>
11. Hafferty FW. Beyond curriculum reform: confronting medicine's hidden curriculum. *Acad Med*, 1998;73(4):403–407.
12. Maudsley RF. Role models and the learning environment: Essential elements in effective medical education. *Acad Med*. 2001;76(5):432–434. doi:10.1097/00001888-200105000-00011.
13. Fallin-Bennett K. Implicit bias against sexual minorities in medicine: cycles of professional influence and the role of the hidden curriculum. *Acad Med*. 2015;90(5):549-52. doi:10.1097/ACM.0000000000000662
14. Phelan SM, Burke SE, Hardeman RR, et al. Medical school factors associated with changes in implicit and explicit bias against gay and lesbian people among 3492 graduating medical students. *J Gen Intern Med*. 2017;32(11):1193-201. doi:10.1007/s11606-017-4127-6