

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



Learn

Serve

Lead



This report was produced by the AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development, which helps the academic medicine community advance the health care of individuals who are LGBT, gender nonconforming, or born with a difference of sex development.

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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

First Edition, 2014

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List of Abbreviations

AAMC:	Association of American Medical Colleges
AASECT:	American Association of Sexual Educators, Counselors, and Therapists
ABIM:	American Board of Internal Medicine
ABMS:	American Board of Medical Specialties
ACGME:	Accreditation Council for Graduate Medical Education
AMA:	American Medical Association
AMSA:	American Medical Student Association
CE:	Continuing Education
CEX:	Clinical Evaluation Exercise
CEU:	Continuing Education Unit
CIR:	Curricular Inventory and Reports
CME:	Continuing Medical Education
CBME:	Competency-Based Medical Education
CPI:	Campus Pride Index
DSD:	Differences of Sex Development
DSM:	Diagnostic and Statistical Manual of Mental Disorders
EBM:	Evidence-Based Medicine
EPA:	Entrustable Professional Activities
FtM:	Female to Male
GB:	Gay and Bisexual
GLMA:	Gay and Lesbian Medical Association
GME:	Graduate Medical Education
GQ:	Graduation Questionnaire
GSA:	Group on Student Affairs
HBIGDA:	Harry Benjamin International Gender Dysphoria Association
HEI:	Healthcare Equality Index
HRC:	The Human Rights Campaign
ICM:	Introduction to Clinical Medicine
LB:	Lesbian and Bisexual
LCME:	Liaison Committee on Medical Education
LGB:	Lesbian, Gay, and Bisexual
LGBT:	Lesbian, Gay, Bisexual, and Transgender
LGBTI:	Lesbian, Gay, Bisexual, Transgender, and Intersex
LGBTQ:	Lesbian, Gay, Bisexual, Transgender, and Queer
LGBTQI:	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
MERG:	Medical Education Research Group
MSLS:	Medical Student Life Survey
MSM:	Men who have Sex with Men
MtF:	Male to Female
PBL:	Problem-Based Learning
PBLI:	Problem-Based Learning Initiative
PPM:	Professionalism and the Practice of Medicine
QIKAT:	Quality Improvement Knowledge Assessment Tool

OSCE: Objective Structured Clinical Exam

OSR: Organization of Student Representatives

RIME: Reporter, Interpreter, Master, and Educator

SAGE: Services and Advocacy for GLBT Elders

SAMHSA: Substance Abuse and Mental Health Services Administration

SSSS: Society for the Scientific Study of Sexuality

STI: Sexually Transmitted Infection

TACCT: Tools for Assessing Cultural Competency Training

UME: Undergraduate Medical Education

WPATH: World Professional Association for Transgender Health

WSW: Women who have Sex with Women



Foreword

Diversity in academic medicine today faces both exciting momentum and important challenges. A growing appreciation for diversity and inclusion as drivers of excellence is coupled with the charge of building and sustaining the capacity to positively affect health care for all. In addition, significant legal and societal advances have resulted in encouraging improvements in the health and well-being of lesbian, gay and bisexual (LGB) members of the population. Still, disparities persist both in the delivery of quality health care and in the health outcomes experienced by people in these populations. Transgender individuals and people born with differences of sex development (DSD) face even greater difficulties in obtaining compassionate, evidence-based, and patient-centered care.

In response to these disparities, the Association of American Medical Colleges (AAMC) convened a multidisciplinary team of experts to form the AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development. Together, the AAMC and the committee have spearheaded the development of appropriate educational resources for undergraduate medical education in addressing the health needs of people who are or may be LGBT, gender nonconforming and/or born with DSD. After more than two years of work by some of the most respected voices in the relevant disciplines, you are now reading the result: *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*. The committee's work represents one of many steps being taken by the AAMC to assist our member institutions in providing outstanding training to our nation's health care workforce and exemplary levels of care to diverse patient populations.

We believe this groundbreaking publication represents a significant advance towards ensuring that all people receive quality, equitable health care. Our goal is ambitious: to have this publication serve as a primary resource for the medical education community to use in determining whether trainees can provide clinically sound, culturally competent care to these patient populations. Our goal can be so ambitious because this publication is targeted, specific and, most of all, flexible and easily adapted to each institution's unique needs. The first of its kind, this publication provides support for medical school administrators, faculty, and students in learning about populations who are or may be LGBT, gender nonconforming and/or born with DSD, evaluating cultural climate, and facilitating the implementation and assessment of new curricula to address these important issues. Thank you for reading this publication; we look forward to continuing this valuable work in the years to come.

A handwritten signature in blue ink, appearing to read "Marc A. Nivet".

Marc A. Nivet, Ed.D., M.B.A.
Chief Diversity Officer, Association of American Medical Colleges



Preface

Understanding health disparities requires acknowledging that a greater burden of suffering exists for certain populations. Long-standing ethical and humanitarian foundations of medicine compel physicians and other health care providers to alleviate suffering in individuals and to advocate for social justice as a means to eliminate the structural sources of those disparities. Further, recent advances in health equity and diversity research have led medical schools and teaching hospitals to shift their education and training strategies to better serve diverse patient populations. Medical education, for example, is actively engaged in identifying the competencies necessary for future physicians to care for all patient populations, as is discussed in this publication.

Great strides have been taken nationally and globally to promote equality over the past several decades. Acts of violence against LGBT people are now recognized as hate crimes; federal employers can no longer deny jobs to LGBT individuals; and increasingly, states are recognizing same-sex marriage and adoption in support of LGBT couples and families. Despite these advances, people who identify as lesbian, gay, bisexual, transgender (LGBT) and/or gender nonconforming continue to experience health disparities. Individuals born with differences of sex development (DSD) have received little national attention, yet they too are burdened by distinct disparities. The challenges faced by individuals who are or may be LGBT, gender nonconforming, and/or born with DSD in accessing and receiving quality, personalized care commands the attention of all professions that are dedicated to human health.

The AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development first convened in 2012 and is proud to introduce *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*. This publication offers evidence- and best practices-based recommendations for curricular and climate change with the aim of creating a welcoming and inclusive educational infrastructure within health care that is responsive to the needs of people who are or may be LGBT, gender nonconforming, and/or born with DSD, whether those individuals are patients, trainees, faculty, and/or administrators. Inherent in this aim is the challenge to redefine health to affirm identity and sexuality as important components of personhood. These include not only sexual orientation and gender identity/expression, but also how these constructs interact with other aspects of identity and culture across the lifespan. The intersections of these identities create the spectrum of diversity among people who are or may be LGBT, gender nonconforming, and/or born with DSD-, and contribute to each individual's unique health needs.

As demonstrated by larger societal changes, now is the right time for a transformation in medical education. We believe this publication will equip health care-related educational institutions to make substantial strides paralleling the national movement toward equality for all people.

The members of the AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development look forward to supporting learners, educators, and institutions as they embark on this journey. Further, we invite the academic medicine community to join us in advancing curricular change to improve health care delivery, as outlined in **Chapter 7, Using AAMC's MedEdPORTAL to Advance Curricular Change**.

With best regards,

A handwritten signature in blue ink, appearing to read "Kristen L. Eckstrand". The signature is fluid and cursive, with the first name "Kristen" being more legible than the last name "Eckstrand".

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We are also grateful to Emily Paulsen, Darcy Lewis, and Elizabeth Gardner for their excellent editorial contributions to this publication, and for their hard and diligent work on an accelerated timeline. We also appreciate the efforts of Nikita Zeyfman, whose design talents transformed the text of our publication into the book you are reading today.

We would also like to thank the following health care providers and advocates for allowing themselves to be featured on the cover of this publication as well as participating in our upcoming faculty development video series on LGBT and DSD health care: lore dickey, Jamie Feldman, Jennifer "Jae" Goines, Leon "Lee" Jones, David Malebranche, Melanie Davis, Siddarth "Sid" Puri, and Barbara Warren. We are grateful to all of these people as well as to all who supported the work of individual committee members and the work of the committee as a whole.

Finally, the committee would like to extend a special thanks to the Josiah Macy Jr. Foundation for recognizing that academic medicine has a critical need for this resource and funding our work in collaboration with the AAMC.

Executive Summary

Great strides have been taken nationally and globally to advance the needs of people who are LGBT, gender nonconforming, and/or born with differences in sex development (DSD); however, these populations still face disparities in accessing and receiving health care. As demonstrated by larger societal changes, now is the right time for change. Addressing the unique health needs and health disparities of these populations necessitates action in all realms of the health care system, especially medical education.

The Association of American Medical Colleges (AAMC) convened the Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development in 2012 to develop a set of competencies for undergraduate medical education and to provide a framework for implementing and assessing these resources. Committee members represent multiple disciplines, including nursing, medicine, psychology, and the basic sciences; and multiple levels of training, from student to established clinical or research faculty. Combined, they have decades of experience supporting and advocating for the best patient care for individuals who are LGBT, gender nonconforming, and/or born with DSD. The members of this committee further bring to the table their own experiences as patients, many having faced the same disparities addressed in this publication.

With this foundation of multifaceted expertise, this publication serves to:

1. Provide education about the health needs of individuals who are LGBT, gender nonconforming, and/or born with DSD, and the role of academic medicine and the health care system in supporting these populations.
2. Support medical schools by discussing how to integrate this content into medical education, with a focus on the role of institutional climates.
3. Provide a framework to facilitate the assessment of learners, curricula, and institutions.
4. Highlight national resources and curricular innovations within academic medicine.

For this publication to succeed at these ambitious goals, the reader must understand the terminology used throughout and why the committee chose specific terms. The acronym “LGBT” is an umbrella term encompassing people who identify their sexual orientation as lesbian, gay, bisexual, and/or who identify their gender identity as transgender. While these may appear to be discrete categories, sexual orientation and gender identity exist along a continuum that has the potential to change over time. The diversity of terms used to describe the sexual orientations and gender identities along this continuum are as diverse as the members of these communities. So too are the terms people may use to describe their own sexual orientations and gender identities across the lifespan.

Differences of sex development also represent a diverse array of clinical entities that require differing levels of clinical care. While individuals born with DSD may identify as LGBT and/or gender nonconforming, many will identify as heterosexual and cisgender. This publication strives

to be sensitive to the diversity that can arise for each individual patient when considering sex, sexual orientation, sexual identity, sexual behavior, gender, gender identity, and gender expression. Indeed, sexual orientation and gender identity may not always align with a person's sex, sexual history, sexual practices, and sexual orientation, gender identity, and gender expression evolve over time.

While the terms “LGBT,” “gender nonconforming,” and “born with DSD” are adopted here, it is crucial that health care providers respect patients' self-identities and use their preferred terminology. Individuals who are or may be LGBT, gender nonconforming, and/or born with differences in sex development (DSD) are unique, complex, and each person deserves respect and comprehensive, sensitive health care.

This publication's utility is not limited to medical education, nor do readers require expertise in the health of individuals who are LGBT, gender nonconforming, and/or born with DSD. This publication is for anyone who wants to become more familiar with medical education and desires to use medical school curricula and climate to address the health disparities and health care issues faced by these populations. Chapters progress sequentially, each building on the content of the previous chapter to add additional layers of detail and understanding:

Chapter 1: Laying the Foundation for Inclusion and Equality introduces the language for inclusion and the health disparities faced by individuals who are LGBT, gender nonconforming, and/or born with DSD.

Chapter 2: The Role of Medical Education and Health Care Professionals in Eliminating Health Disparities discusses growing awareness of and changing attitudes towards the unique health care needs of these populations, and focuses on competency-based medical education as a tool for addressing disparities.

Chapter 3: Professional Competency Objectives to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD lays out recommended learning competencies for undergraduate medical students across eight domains of competence.

Chapter 4: Integrating Competencies into Medical School Curricula to Improve Health Care For People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD discusses the role that trainees, faculty, administrators, and institutional climate play in ensuring integration of the competencies into medical school curricula, and delineates specific examples of how competencies can be integrated using a variety of curricular modalities.

Chapter 5: Clinical Scenarios and Discussion Points for Experiential Learning provides clinical teaching cases and questions for learning that can be adapted to medical school curricula.

Chapter 6: How to Assess Learners and Evaluate the Impact of Curricular and Climate Initiatives discusses how curricula and programs are evaluated, how competency attainment can be assessed in learners, and how institutions can evaluate themselves to support an inclusive climate.

[Chapter 7: Using AAMC's MedEdPORTAL® to Advance Curricular Change](#) introduces MedEdPORTAL as a venue for accessing and sharing curricular materials to enhance teaching about individuals who are or may be LGBT, gender nonconforming, and/or born with DSD.

[Chapter 8: Future Directions](#) highlights next steps for the integration, evaluation, and expansion of the material presented in this publication.

The Key Points for Each of These Chapters are:

Chapter 1

Laying the Foundation for Inclusion and Equality

Individuals who are LGBT, gender nonconforming, and/or born with DSD often experience challenges when interacting with the health care system.

These challenges may translate into disparities in the quality of care received and, subsequently, into health disparities.

Historically, disparities for LGBT and gender nonconforming persons arose from egregious discrimination, including the open pathologization of homosexual behavior.

Change began when larger social and political movements of the 1800s and 1900s slowly began to change societal perceptions of LGBT identities as “healthy.” Eventually, this led to homosexuality being fully de-classified as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders*.

Significant structural, interpersonal, and individual stigma concerning homosexuality persists; efforts to “treat” homosexuality through so-called “reparative therapies” continue in some areas, even though most professional organizations recognize them as harmful to patients.

Individuals born with DSD have historically also suffered from a health care system that has reinforced cultural stigmas around sex and gender atypicality; this stigma has resulted in children diagnosed with DSD being subjected to highly invasive and even damaging medical and surgical interventions in an attempt to ensure sex and gender normalization.

Despite progress, disparities persist. These populations:

- Experience inadequate or inappropriate care ranging from unconscious bias to overtly discriminatory acts.
- Suffer from disparities in mental and behavioral health, physical health, and are more susceptible to risk-taking behaviors.
- The demand for medical education to train physicians to care for these populations is growing at a faster pace than materials can be developed to fulfill this demand.

Medical education can serve to:

- Increase health care professionals' awareness and knowledge of health risk and potential resiliency of LGBT and gender nonconforming individuals, and individuals born with DSD.
- Train students to provide high-quality, patient-centered care to people who are or may be LGBT, gender nonconforming, and/or born with DSD.
- Inspire students to be advocates for the health of individuals who are or may be LGBT, gender nonconforming, and/or born with DSD.
- Significant strides have been made in medical education, often as a result of hard work on the part of students and community health center workers.
- National medical organizations are listening to this need and are advocating for improvements in medical curricula to address the needs of individuals who are or may be LGBT, gender nonconforming, and/or born with DSD.

Chapter 2

The Role of Medical Education and Health Care Professionals in Eliminating Health Disparities

- LGBT individuals experience high rates of trauma—including discrimination, victimization, and violence—often beginning in childhood and persisting into old age.
- Understanding these experiences and their impact on the patient-provider relationship is of the utmost importance for all health care providers in order to provide comprehensive, sensitive, and optimal health care.

- Providers must understand an individual's reactions to trauma, how their responses may facilitate positive or negative health outcomes, and the key role health care providers can play in fostering resilience among patients.
- Even in the most optimal care environment, being a patient and/or having to cope with illness involve a level of exposure and vulnerability that most people find traumatic to some degree. This feeling is exacerbated among individuals who have experienced multiple, cumulative prior traumas.
- Patients responding to trauma may appear to providers as disengaged, unfriendly, defensive, and/or demanding, which can lead providers to respond reactively. A self-perpetuating pattern is thus set into play whereby a patient who is LGBT, gender nonconforming, or born with DSD avoids receiving care to avoid feelings of fear and discrimination. This, in turn, leads to the development of additional risk behaviors and adverse health outcomes.
- Providers can break this cycle by promoting resilience to foster positive health outcomes.
- Health professions' training programs are increasingly focused on assessing clinical competencies that demonstrate a learner's readiness for unsupervised practice; competency-based medical education (CBME) delineates what physicians must do to care for all patients using observable combinations of knowledge, skills, and attitudes across eight domains of competence.
- CBME can serve as an educational framework for addressing health disparities.

Chapter 3

Professional Competency Objectives to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD

The Reference List of General Physician Competencies was adopted and expanded Professional Competency Objectives to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD, which appear in Chapter 3.

These competencies are built within eight existing competency domains:

1. Patient Care
2. Knowledge for Practice
3. Practice-Based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems-Based Practice
7. Interprofessional Collaboration
8. Personal and Professional Development

Chapter 4

Integrating Competencies into Medical School Curricula to Improve Health Care For People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD

The scope of these competencies is broad, allowing latitude for individuals or institutions to examine their specific situations to determine how best to incorporate and evaluate the competencies.

Successful integration requires an inclusive climate, including:

- Broad institutional engagement
- Inclusive nondiscriminatory policies and practices
- Valuing and celebrating diversity
- Community outreach and engagement
- Technological infrastructure to support commitment to diversity

Trainees, faculty members, or administrators can each serve as champions at their institutions to support competency integration.

Trainees can:

- Support the development of curricular innovations
- Take on a research project with a defined, narrow scope to contribute to national and local data collection about curricular needs and assessment
- Advocate for inclusive curricula and climate

Faculty can:

- Identify barriers to competency inclusion
- Implement strategies for competency inclusion
- Identify strategies for influencing the curriculum outside of the classroom setting
- Mentor students in curricular improvement projects

Administrators can:

- Value cultural competency and diversity
- Ensure an inclusive culture and climate
- Support partnerships within the institution and community organizations
- Support champions

Competencies can be integrated across learning modalities, including didactic instruction, case-based and active learning, and in clinical rotations.

Each competency can be taught in a variety of ways with different clinical scenarios; diversity of topics and of learning modalities is important for effective training.

Any champion, regardless of training level, must be supported by professional and productive collaborations addressing curricular changes suited to their unique environments and, given the slow pace of change, the work of champions and any meaningful change must be positively recognized and prioritized to promote its sustainability.

Chapter 5

Clinical Scenarios and Discussion Points for Experiential Learning

Clinical scenarios provide an excellent opportunity for experiential learning.

Discussion points appropriate to student learning needs should accompany scenarios to facilitate exploration of ways to improve care for different populations.

This chapter consists of eight clinical scenarios with discussion points across a wide range of topics and clinical experiences:

1. Gender Nonconformity in a Prepubertal Child
2. Gender Dysphoria in an Adolescent
3. Iatrogenic Trauma in a Man Born with DSD
4. Possible DSD and Gender Dysphoria in an Adolescent
5. A Child with Two Lesbian Mothers and Two Gay Fathers
6. HIV Risk Behaviors in an Adult Man
7. A Straight Man Who Has Sex With Men and Women
8. A Transgender Man with a Pelvic Mass

Chapter 6

How to Assess Learners and Evaluate the Impact of Curricular and Climate Initiatives

Evaluation of the effectiveness of a curriculum is as important as the curriculum itself and should be designed as the program is being developed.

Several theoretical models are available for the evaluation of curricula/programs, learners, and institutions.

Curricular and program evaluation begins with curricular planning and preparation, before moving to teaching, data collection, reflection, analysis, and revision. Evaluation models can help guide assessment and the outcomes of interest.

Cost, perceived impact, and conformity with program objectives or goals all influence the evaluation process.

Assessment of learners demonstrates the effectiveness of curricula, and should have the following goals:

- To provide direction and motivation for continuous improvement and lifelong learning.
- To protect the public by upholding high professional standards and screening out learners who are incompetent or who need remediation.
- To provide a basis for selecting applicants for advanced training and positions of leadership, including the evaluation of attitudes, knowledge, skills, and competencies of learners.

Learner assessments should:

- Begin with the end goals in mind before delineating specific learning objectives, training methods, and assessment tools
- Use assessment methods chosen to evaluate learning gains congruent with learning objectives, type of instructional activity, and level of the learner
- Include a variety of assessment methods, including direct observation and incorporating the patient's voice.

Each school or training program should decide at what level (pre-clinical, clinical, residency, etc.) their students or residents should achieve mastery of specific learning objectives.

Institutional climate should be evaluated across five major categories:

1. Efforts to educate
2. Protections against mistreatment
3. Promotion of equality
4. Leadership and commitment
5. Welcoming patient care environment

Institutional diversity and inclusion can support students' ability to care for patients who are or may be LGBT, gender nonconforming, and/or born with DSD.

Chapter 7

Using AAMC's MedEdPORTAL® to Advance Curricular Change

MedEdPORTAL®, a free, online service provided by AAMC, is a powerful resource for sharing knowledge, publishing peer-reviewed health education tools and, ultimately, transforming health education.

MedEdPORTAL® provides health educators opportunities to access and publish educational materials that prepare tomorrow's physicians to provide better care to their patients, including individuals who are or may be LGBT, gender nonconforming, and/or born with DSD.

MedEdPORTAL is divided into three services:

1. *Publications*
2. *iCollaborative*
3. *CE Directory*

Publications peer reviews and publishes educational modules that represent various methodologies. These include standardized patient cases, team-based learning activities, faculty development sessions, assessment tools, and many others. All materials are fully classroom tested; authors earn a scholarly citation.

iCollaborative provides a platform for the easy sharing of materials across the health education community. AAMC encourages faculty, students, and administrators to submit their innovative ideas and materials for inclusion in this helpful resource.

CE Directory offers a listing of online continuing education activities developed by faculty or staff at a noncommercial health institution. These CE programs are officially certified by an accrediting body and may be completed in their entirety through the online learning format. Activity postings in the CE Directory include information about credit awarded and costs as well as direct links to the website of the institution hosting the online course.

Chapter 8

Future Directions

Adopting strategies outlined in this publication will accelerate more formal curricular and climate transformation to quickly improve care for patients who are or may be LGBT, gender nonconforming, and/or born with DSD.

This publication has application beyond physician education. Other health care disciplines, including but not limited to nursing, dentistry, physician assistants, psychology, and social work, are also key to providing comprehensive and sensitive health care to patients who are or may be LGBT, gender nonconforming, and/or born with DSD. Each of these disciplines has their own core learning competencies that students must master, and many of these competencies are similar to the competencies that form the core of this publication. The Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development believes that the principles, ideas, concepts, and roadmaps laid out in this publication can be easily adapted to serve the needs of champions leading change efforts in any health care profession.

The committee hopes that this publication will serve as a useful guide for much-needed change within and across all health care professions. By designing, implementing, and evaluating curricular inclusion efforts and effecting changes in institutional climate, together we can transform the education of tomorrow's health care providers. Through the effective teaching of health care trainees to be attentive and sensitive to the unique needs of each patient, we can further improve health care delivery and outcomes for patients who are or may be LGBT, gender nonconforming, and/or born with DSD.

Chapter 1

Laying the Foundation for Inclusion and Equality

Chapter Editor: Andrew D. Hollenbach, Ph.D.

Introduction and Publication Goals

Authors: Andrew D. Hollenbach, Ph.D.; Kristen L. Eckstrand, Ph.D.

Significant legal and societal advances have resulted in overall improvements in the health and well-being of the lesbian, gay, and bisexual (LGB) populations. Nevertheless, many patients who may be LGB still face substantial disparities in treatment within health care systems. Individuals who are born with differences of sex development (DSD) and transgender individuals often face even greater difficulties obtaining compassionate, evidence-based, patient-centered care. To eliminate these disparities, we must teach future health care providers early in their careers how to address the specific health care needs of people who may be LGBT (lesbian, gay, bisexual, and transgender), gender nonconforming, and/or born with DSD. As part of this education, medical institutions need to promote a climate that supports, values, and includes people in these populations.

In order to address these concerns, the Association of American Medical Colleges (AAMC) convened the Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development in 2012 to help develop appropriate educational resources for undergraduate and graduate medical education and to provide a framework for implementing and assessing these resources. This publication is a direct result of that AAMC initiative. To our knowledge, there has been no standardized set of competencies for medical education to address the health of individuals who are or may be LGBT, gender nonconforming, and/or born with DSD. Therefore, even the most progressive institutions have lacked a guide or template to direct curricular change specific to these populations. This publication was developed to fill that gap and is based on solid educational and assessment practices and theories. It is also designed to assist institutional champions in implementing curricular and climate change in medical educational institutions or programs.

Specifically, this publication has a three-fold purpose:

1. To educate the reader about people who may be LGBT, gender nonconforming, and/or born with DSD and about the role of academic medicine in supporting these populations.
2. To instruct medical schools on the importance of evaluating their cultural climates and on how to implement curricular changes and assess the effectiveness of curricula as they relate to people who may be LGBT, gender nonconforming, and/or born with DSD.
3. To provide a framework to facilitate the assessment of new curricula.

Educate:

While making it convenient to identify subgroups of society facing similar types of discrimination, the acronyms LGBT, LGBTI (“I” for intersex), or LGBTQI (“Q” for genderqueer, questioning, or gender nonconforming) create the perception that these groups are homogeneous and that individuals under these umbrella acronyms have parallel or even identical health care needs and concerns. In fact, the individuals within these populations are far from homogeneous. As a population, gay men have very different health care needs from lesbian women, just as the health care needs of people who are bisexual differ from those of gay men and lesbian women. Further, transgender individuals (including male-to-female [MtF] or female-to-male [FtM] people) face distinctly different health care and societal issues than people whose gender identity aligns with their natal sex (cisgender). People who today identify as “intersex” may or may not be affected by DSD, while some people born with DSD carry special health risks (including iatrogenic harm) that others do not. Thus, the populations represented by each individual letter in these acronyms are complex and heterogeneous, especially when we consider differences in age, race, ethnicity, religion, culture, socioeconomic class, and geographic location. This publication is meant to serve as an educational resource that can provide a preliminary framework for meeting the health care needs of these diverse populations. (See “Equitable Care Begins with Appropriate Terminology” later in this chapter for more details.)

Instruct:

Many times curricular and educational changes are not initiated and implemented by a single group within an institution; administrators, faculty, and students may work individually or in groups to initiate these changes and to assist in implementation. Further, each medical school has its own unique institutional climate: a school in the South may have a very different cultural “feel” from a school on the West coast, and a school in an urban area may have an environment different from one located in a rural setting. Schools also differ in their approaches to education, varying the proportions of didactic learning, active learning, and competency-based learning to suit their resources and institutional philosophies. Taking all these issues into consideration, each institution must tailor the methods used to implement curricular change to its own individual needs. This publication provides direction on how to assess institutional climate, implement curricular change using a variety of educational modalities, and evaluate the curriculum and learners.

Provide framework:

Many times, the perceived hesitancy of institutions to implement educational material concerning patients who may be LGBT, gender nonconforming, and/or born with DSD does not stem from disinterest or reluctance. Instead, schools may simply not know what evidence-based information is available for teaching or how to effectively and sensitively incorporate these topics into a curriculum. Alternatively, institutional leaders may mistakenly believe that the teaching of these topics requires specialized knowledge or large curricular restructuring. This document provides a framework to lead individual schools toward a relatively simple pedagogical undergraduate and

graduate medical education framework for health issues that apply to people who may be LGBT, gender nonconforming, and/or born with DSD.

We have structured this publication to provide a logical flow. In the following section, we provide a discussion and explanation of terms that will be used throughout this publication. The publication continues with an overview and history of the disparities faced by patients who are or may be LGBT, gender nonconforming, and/or born with DSD, a discussion of the barriers that exist to curricular reform, a discussion of trauma and resiliency in the affected populations, and an overview of competency-based medical education.

We then provide educational competency objectives for all stages of medical education as they relate to individuals who are LGBT, gender nonconforming, and/or born with DSD. Next is a discussion of how to integrate these competencies into the curriculum, including information on how institutional climate can influence this integration, how different groups (i.e., administrators, faculty, and/or students) can initiate curricular change, and how educational modalities direct the manner and nature of implementation.

This chapter is followed by representative educational case studies, with illustrative clinical scenarios and suggested topics for discussion. The next chapter examines how to evaluate the effectiveness of the curriculum, how to assess how well learners have assimilated the information, and how to determine whether this new curriculum affects the institutional climate. Chapter 7 describes AAMC's MedEdPORTAL® and how students, faculty, and administrators can use this resource to advance curricular change at their own institutions and beyond. The publication concludes with a look at possible next steps in the quest for equality and inclusion in medical education as well as health care for patients.

The appendices contain a wealth of information, including a partial list of institutions and schools that are actively addressing health care concerns of patients who are or may be LGBT, gender nonconforming, and/or born with DSD in their curricula with links to their programs, suggestions for additional reading, and a list of resources for more in-depth information.

This publication is targeted at a wide range of readers, from first-year students to teaching faculty and administrators, and their familiarity with educational theory and curricular reform will vary. We provide sufficient explanation to introduce key concepts to trainees and aspiring medical educators, along with more in-depth discussions for experienced professionals to use in implementing and evaluating new curricula.

Although this publication was written for a medical education audience, its use may extend beyond medical education. Comprehensive and sensitive care is often best delivered by interprofessional teams, consisting of individuals with varying expertise and roles in patient care. Members of these interprofessional teams—including but not limited to nurses, dentists, physician assistants, psychologists, social workers, and allied health professionals—must master their own core learning competencies in order to become effective and mature health care professionals. Many of these competencies are similar, or even identical, to the competencies that form the core of this publication. Further, institutional climate, curricular assessment, and administrative support and

dedication are important elements at any institution involved in educating tomorrow's health care professionals. The principles and concepts laid out in this publication can be easily adapted to any branch of the health care professions.

The committee hopes that this publication will serve as the foundation and guide to initiate much-needed change across the health care professions. By being attentive and sensitive to each person's individual needs, we can improve health care delivery and outcomes, not only for those who may be LGBT, gender nonconforming, or born with DSD, but for any population facing health care disparities as a result of implicit or explicit prejudice.

We on the committee also encourage readers to think of this publication as a tool for bridging the gap between patients and health care providers, especially given that these are complex patient populations who have had historical reasons to distrust medical environments and members of the medical community. Health care professionals must learn to listen to patients' unique voices and address their concerns, in order to sensitively and productively impact quality of care for all individuals. Institutions must modify their competencies and educational processes in the development of curricular change to incorporate concerns voiced by the patients.

When addressing curricular and institutional climate change, we urge all readers to keep in mind that even incremental change is important. Smaller changes frequently become the impetus for larger ones that affect a whole institution, and the actions of a person at one institution may spark someone else to initiate a similar process at another institution. The dissemination and documentation of these changes can lead to true, sustainable health system change.

In fact, these individuals are the champions who initiate and create positive change. If you are—or aspire to be—one of these champions, remember that patience, drive, and persistence are needed. Even in the most welcoming environments, change can be frustratingly slow. But the twin goals of health care inclusion and equality of access will make all your efforts worthwhile.

Equitable Care Begins with Appropriate Terminology

Author: Alice Dreger, Ph.D.

A group project like this publication—dealing with several heterogeneous populations—necessarily involves many conversations about terminology. Our committee wants to share with readers the background from our long and interesting conversations about terminology, specifically to explain the logic behind the words, acronyms, and phrases we have elected to use when referring to the patients whom we hope will ultimately benefit from this publication. We chose these terms in the interest of encouraging widespread respect for all patients who may currently, or at some point in their lives, identify as LGBT, gender nonconforming, and/or born with differences in sex development (DSD), but we emphasize to all readers—patients, health care practitioners, or educators—that an individual’s preferred terminology should be elicited and treated respectfully, even if it differs from or conflicts with the terminology we have selected for this text.

Because the acronym “LGBT”—an umbrella term encompassing people who are lesbian, gay, bisexual, and transgender—mixes up populations whose self-identities are based on sexual orientation (LGB) and individual gender histories (T), we have tried within this publication to be careful not to simply use “LGBT” when we are, in fact, not talking about all of those populations. As a consequence, readers will notice we sometimes write only about “LGB” or “LG.” We considered also addressing other identity categories—e.g., “queer,” “questioning,” “genderqueer”—but found it impossible to include every possible identity category that exists in the sex/sexuality/gender spectrum without creating an overly complex document that would ultimately mask the focus of this work. Therefore, within this publication, we refer to LGBT people as a kind of shorthand while encouraging medical professionals to elicit from all patients critical information about identity and life history. (We refer readers unfamiliar with terms like “questioning” and “genderqueer” to **Appendix A: Glossary of Terms**.)

This publication aims to improve medical education and ultimately patient care around four axes of human experience:

1. Sexual orientation
2. Gender identity
3. Gender expression
4. Biological sex development

Understanding the definitions of these terms and the differences among them helps form a foundation for providing respectful and sensitive care for all patients.

In terms of sexual orientation, something sexologists generally recognize as referring to core erotic arousal, we typically talk about the categories of lesbian, gay, bisexual (LGB), and straight. Current recommended terminology uses “homosexual” and “heterosexual” only as adjectives for behaviors, not as nouns to signal identity. A person’s sexual history, sexual behaviors, and/or sexual feelings may not match his or her public sexual orientation identity. For example, a man who identifies as straight may sometimes have sex with other men, while a woman who identifies as a lesbian may have male sex partners at some point in her life. Medical professionals and public health researchers should therefore recognize that sexual orientation self-labels, while very important, are not the same as sexual histories, sexual practices, and sexual feelings.

Because sexual orientation may not always align with a person’s sexual history, practice, or identity, and because children and youth are in stages of very active (and often unpredictable) identity formation, we have tried to consistently speak in this document of “patients who may be LGB.” We believe such language helps readers remember that, in fact, any patient who presents to a clinic may have a sexual orientation, sexual history, or sexual identity label that a clinician might otherwise not expect. In other words, keeping in mind that any patient “may be” LGB helps clinicians remember the importance of eliciting information about sexuality when providing comprehensive care to all patients.

Within this document we often use the linguistic construction “patients who may be” also to keep the whole person within focus. This “person-first” language, following language used by the disability-rights movement, encourages readers to remember that no one is only his or her sexual orientation, gender history, etc. While a patient may, for example, identify as bisexual, that label does not tell you all you need to know about that person, especially if you are a provider of health care services.

In terms of gender identity, we generally speak of people as “cisgender” (accepting the gender category of boy/man or girl/woman given to a person at birth) or “transgender” (identifying as belonging to a gender category different than that assigned at birth). Because a patient may appear to be cisgender but actually be transgender, because people who are transgender vary in how they wish to be identified, and because being gender nonconforming is not at all the same as being transgender, in this document we have again used the language of “patients who may be transgender.” This person-first language should remind us that the “T label” (or lack thereof) is not all that defines a person, and should remind us of the importance of eliciting gender self-identities and gender histories from all patients seeking care.

In terms of biological sex development, while most people are born with male-typical or female-typical anatomy and physiology, perhaps as many as 1 in 100 people are born with some atypical feature in their sex chromosomes, gonadal development, or anatomical sex.¹ These atypical features can range from subtle variations, such as when a boy is born with uncomplicated subcoronal hypospadias (in which the urinary meatus forms in an atypical location), to more significant atypicality, as when a girl is born with androgen insensitivity syndrome (XY chromosomes

but complete insensitivity to androgens, so female-typical external genital development). Until relatively recently, various forms of sex atypicality fell under terms based on the root “hermaphroditism.” Recognizing that such terminology is outdated and can be stigmatizing, the medical establishment abandoned this in 2006 in favor of “disorders of sex development” (DSD), meaning “congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical.”²

This shift amounted to “a profound and rapid change in terminology...without parallel in recent medical practice,”³ presumably because clinicians were ready as a group to abandon the older stigmatizing terms for people born with atypical forms of sex anatomy. However, the term “disorders of sex development” has also been controversial. Some prefer terms like “intersex” or “variations of sex anatomy” because they reasonably believe that the word “disorder” may entail stigma and cause physicians to insist on unnecessary, risky, and sometimes harmful “normalization” procedures like cosmetic genital surgeries. Clinicians, meanwhile, generally prefer “disorder” over “difference” or “variation” out of the reasonable concern that speaking of sex atypicality as if it always involves merely benign variation may lead parents, patients, or medical professionals to ignore the serious health risks that attend some forms of DSD. (Some of these conditions, like gonadal dysgenesis, or their etiologies, including congenital adrenal hyperplasia, entail elevated risk of morbidity and mortality, although others, like simple idiopathic clitoromegaly, do not.)

Further confounding the terminology for sex anomalies is that while some adults with these conditions apply to themselves an identity label like “intersex,” others do not wish to be so defined by their biological histories. (Biology should not in itself determine social identity in a progressive society.) Add to this the recognition that some people (particularly transgender adults) who identify as “intersex” were not born with identifiable DSD, and we have a seriously challenging situation when it comes to terminology describing the less common forms of sex development.

When discussing patients born with something other than typical male or typical female biology, our group has elected to speak of “patients born with DSD” and to spell out the term as “differences of sex development.” As we have noted, the first “D” in “DSD” commonly stands for “disorder” within the medical literature, but based on conversations with specialist clinicians, we think that terminology may soon change. The term “differences of sex development” avoids equating biology with identity, and replaces a word that offends and worries some with one that is more neutral.

We again encourage all readers to understand that sexual orientation, gender identity, and sex development are not synonymous. As a consequence, knowing a patient has a DSD tells you absolutely nothing about his or her identity in terms of sexual orientation or gender. Indeed, because “DSD” is an umbrella term for dozens of distinct conditions, saying a patient was born with DSD also tells you nothing specific about her or his sex development, other than that it was somehow atypical. (For educational materials on DSD, including clinical guidelines and a handbook for families, we recommend the website of Accord Alliance.)

To summarize, we encourage medical professionals to:

1. Elicit from individual patients important information about sexual history, sexual practices, gender history, biological/medical history with regard to sex, etc., including the patient's preferred terminology for each of these items.
2. Respect patients' self-identities while not allowing those self-identities to stand in for good history taking.
3. Distinguish among sexual orientation, gender identity, sex development, and sexual practices.

We hope this publication will assist in these endeavors, and especially when teaching the next generation of clinicians to care for patients with diverse forms of sex, gender identity, and sexuality.

History of Health Disparities Among Individuals Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD

Authors: Kristen L. Eckstrand, Ph.D.; Andrés F. Sciolla, M.D.

Individuals who may be lesbian, gay, bisexual, and/or transgender (LGBT) and their families often experience challenges when interacting with the health care system: challenges that all too often translate into disparities in the quality of health care received.⁴ These disparities derive from systems that perpetuate structural stigma and providers who enact stigma attached to particular gender identities, sexual orientations, and sexual practices. The result is often poor, inadequate, or discriminatory care.

LGBT individuals are twice as likely as others to lack health insurance. When coverage is obtained, insurance plans often do not include marital or family benefits for same-sex partners⁵ or do not cover medical care to support gender transition (also referred to as gender-affirming therapies).⁶ This disparity in insurance coverage has decreased with the implementation of the Affordable Care Act: the uninsured rates of LGBT adults dropped from 24.2 to 17.6 percent after the first annual enrollment period.⁷ However, even insured LGBT individuals may not have coverage for certain population-specific beneficial medical treatments, such as screening with high-resolution anoscopy, or gender-affirming therapies.

History: Moving Toward Health Care Equity

Historically, disparities against LGBT individuals arose from egregious discrimination by the health care system and individual practitioners, including the explicit pathologizing of homosexual behavior.^{8,9} So-called “reparative therapies” assume “that some people who have had homosexual fantasies, behaviors, or identified themselves as homosexual, can become comfortably and fulfillingly heterosexual with psychotherapeutic treatment.”¹¹ Criticism led to homosexuality no longer being classified as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders*, but efforts to “treat” homosexuality persist even today¹⁰ (For an influential review of the empirical evidence supporting reparative therapy and a later recantation of that review, see the references to Spitzer 2003 and Spitzer 2012 in **Appendix C: Suggested Reading**.) On empirical and ethical grounds, major professional organizations, including but not limited to the American Psychiatric Association,¹⁴ the American Psychological Association,¹⁵ The American Academy of Child and

Adolescent Psychiatry,¹⁶ and the Society for Adolescent Health and Medicine¹⁷ have denounced reparative therapy (also known as “conversion” or “reorientation” therapy) as potentially harmful and have recommended that their members refrain from practicing it.

This change in health care’s perception of LGBT identities has come as the result of a long history of social and political movements advocating for LGBT rights. During the “free love” movement of the 1800s, German physician Magnus Hirschfeld began to challenge the belief that sexual acts between same-sex individuals were immoral. In 1897, he founded the Scientific Humanitarian Committee, considered the world’s first LGBT rights organization (although it only addressed male homosexuality), to fight for decriminalization of male same-sex sexual acts.^{18,19} The first medical textbook on homosexuality, *Sexual Inversion*, was published that same year by coauthors Havelock Ellis and John Addington Symonds. In this book, “inversion” referred to men who presented effeminately and had sex with men, and the term thus conflated sexual orientation with gender identity/expression. Nevertheless, the authors still argued that same-sex relationships between men were not pathological.²⁰

These efforts in Europe led to similar movements in the United States. Henry Gerber founded the foundation of the Society for Human Rights in 1924, the first American LGBT rights organization.²¹ While this organization lasted less than a year due to the arrest of its leadership, its establishment inspired other organizations, such as the Mattachine Society and the Daughters of Bilitis, whose efforts progressed into the modern LGBT rights movement. Alongside the social movements of the 1960s, the LGBT rights movement emerged as a powerful force following the 1969 police raid of Stonewall Inn in New York City, with the formation of the Gay Liberation Front (GLF) and Gay Activists Alliance (GAA).²¹

Medical progress advanced more rapidly in Europe during this time, with endocrinologists and surgeons pioneering the fields of cross-sex hormone therapy and what would eventually be called gender-affirming surgeries. In 1952, Christine Jorgensen became the first person to undergo gender-affirmation surgery, performed in Sweden. Twenty years later, Sweden became the first country to legally allow gender-affirming surgeries and to provide free cross-sex hormone therapy to transgender individuals.

At the same time, the influence of lesbian feminism began to rise. Dissatisfied with the GLF’s focus on men and the women’s liberation movement’s desire to distance itself from same-gender-loving women, lesbian feminists advocated for the end of gender identity oppression and rejected the notion of defining women’s sexuality only in relation to men (so-called compulsory heterosexuality²²). Working alongside the women’s liberation movement, lesbian feminists pushed to improve women’s access to health care and for increased autonomy within the health care system.

In the 1980s, the AIDS crisis led to severe discrimination and stigmatization of gay men and men perceived as gay. Fears of the “gay plague,” for which there was initially no effective treatment, compounded already existing homophobia in the health care system and resulted in profoundly unethical care in many medical settings. In some cases, health care providers shunned and even condemned patients who were infected through sexual activity, since many Americans

believed AIDS to be God's punishment for sinful behavior. Patients and their allies responded with unprecedented community organizing, political activism and even civil disobedience to demand both fair treatment by the health care system and direct involvement in public health policymaking and research.²³

Likewise, individuals and families who are affected by DSD²⁴ have also historically suffered at the hands of a medical system that has reinforced cultural stigmas around sex and gender atypicality.²⁵ Since the mid-twentieth century, children diagnosed with DSD have been subject to highly invasive and sometimes damaging interventions, including genital cosmetic surgeries, gonadectomies, and hormonal treatments, in an attempt to ensure sex and gender normalization.²⁶ Honest disclosure around DSD medical histories did not become the universal norm until very recently,²⁷ and even today, while many children's hospitals have designated interdisciplinary DSD teams, many scientifically unsupported elective interventions persist.²⁸ Further, DSD-affected families still have limited access to professional mental health support²⁹ in spite of the stress that often arises for individuals with DSD diagnoses and for their families.^{30,31} Expert care for adults born with DSD remains elusive in many locations, despite elevated health risks associated with specific types of DSD or their treatments (e.g., reproductive cancers and severe osteoporosis).

Patients who are or may be LGBT, gender nonconforming, and/or born with DSD can experience inadequate care in a variety of ways, stemming from unconscious provider bias or overt discrimination. For example, a provider may exhibit suboptimal knowledge of, and/or discomfort with, essential care, risk factor assessment, chronic disease management, and provision of mental health services.³² Some providers may outright refuse to care for individuals from these populations.³³⁻³⁶ Even in the absence of overt discrimination, research shows that providers often simply don't ask about sexual orientation³⁷ or fail to provide standard patient-centered care³⁸ to all patients.

Structurally and interpersonally enacted stigmas (see **Figure 1: Stigma: A Multilevel Construct**) may lead patients who are LGBT, gender nonconforming, and/or born with DSD to perceive discrimination. Because of this perception, patients may feel compelled to delay or avoid seeking care.

FIGURE 1.1: STIGMA: A MULTILEVEL CONSTRUCT



Level 1 comprises individual-level stigma experiences, including disclosing or concealing a stigma-related aspect of a person (e.g., a male-appearing medical student tells a classmate that he was born female), and felt or internalized stigma (e.g., internalized homophobia).

Level 2 comprises stigma-related experiences at the interpersonal level, which refer to micro-level interactions that occur between the stigmatized and nonstigmatized (e.g., a group of medical students and residents conduct repeated physical exams on a DSD-affected individual).

Level 3 comprises structural stigma, which is defined as “societal level conditions, cultural norms, and institutional policies and practices that constrain the opportunities, resources, or well-being of the stigmatized.”

Source: Hatzenbuehler ML, Link BG. Introduction to the special issue on structural stigma and health. *Soc. Sci. Med.* Feb 2014; 103:106. Doi: 10.1015/j.socscimed.2013.12.017).

Overview of Health Disparities Among LGBT Individuals

LGBT health disparities are hypothesized to stem, in part, from broad societal stigmas that devalue minority sexual orientations and gender identities.³⁹ According to Meyer's minority stress model,⁴⁰ LGBT individuals internalize enacted social stigma, accept the stigma and so learn to anticipate experiencing more of the same. Interactions among enacted, internalized, and anticipated stigma eventually result in disparities in physical and mental health and disparities in health risk behaviors.³⁵ (See **Table 1.1 for a summary of health disparities.**) These disparities may be amplified by feedback loops of discrimination that occur based on age, race/ethnicity, socioeconomic status, and other demographic factors.

TABLE 1.1: OVERVIEW OF HEALTH DISPARITIES AFFECTING LGBT INDIVIDUALS

Risk Behavior Disparities	
Smoking prevalence is higher among the LGBT population than among the population as a whole.	Lee JG, Blosnich JR, Melvin CL. Up in smoke: vanishing evidence of tobacco disparities in the Institute of Medicine's report on sexual and gender minority health. <i>Am J Public Health</i>. Nov 2012;102(11):2041-2043.
LGBT youth are more likely than straight youth to report histories of initiation into misuse of prescription opioids and tranquilizers.	Kecojevic A, Wong CF, Schrage SM, et al. Initiation into prescription drug misuse: differences between lesbian, gay, bisexual, transgender (LGBT) and heterosexual high-risk young adults in Los Angeles and New York. <i>Addict Behav</i>. Nov 2012;37(11):1289-1293.
Compared with their straight counterparts, young gay men are more likely to report inconsistent condom use, multiple partners within the past 30 days, and a history of illicit drug use.	Rhodes SD, McCoy T, Hergenrather KC, Omlil MR, Durant RH. Exploring the health behavior disparities of gay men in the United States: comparing gay male university students to their heterosexual peers. <i>J LGBT Health Res</i>. 2007;3(1):15-23.
Compared with their white peers, lesbian and bisexual girls who identify as "mixed" race/ethnicity have more than four times the odds of reporting both unprotected vaginal sex with a male and sex with multiple male partners.	Thoma BC, Huebner DM, Rullo JE. Unseen risks: HIV-related risk behaviors among ethnically diverse sexual minority adolescent females. <i>AIDS Educ Prev</i>. Dec 2013;25(6):535-541.
One-third of LGB youth engage in hazardous weight control behaviors, such as fasting more than 24 hours, using diet pills, or vomiting/using laxatives.	Hadland SE, Austin SB, Goodenow CS, Calzo JP. Weight misperception and unhealthy weight control behaviors among sexual minorities in the general adolescent population. <i>J Adolesc Health</i>. Mar 2014;54(3):296-303.

Families affected by DSD have reported experiencing stigma in medical clinics even while, paradoxically, the historically invasive medical treatment of DSD has been motivated by an interest in reducing stigma for these families (by attempting to conceal sex atypicality).⁴¹ Overt discussions of attributed shame and how it relates to DSD and its clinical management are new and still infrequent in the medical literature.⁴² In the U.S., referrals to professional mental health providers still occur mostly at moments of crisis rather than as an integrated part of regular care, in spite of the recognition that DSD carries an increased risk of psychosocial stress.⁴³ While the pediatric approach to DSD has tended to be medically and surgically invasive and sometimes a cause of significant iatrogenic harm,⁴⁴ affected adults often have a difficult time finding nonpediatric physicians and surgeons who have any previous experience of—let alone are experts in—their

Risk Behavior Disparities

- As compared with their non-LGBT counterparts, LGBT youth are significantly less likely to engage in moderate/vigorous physical activity or to participate in team sports.

Calzo JP, Roberts AL, Corliss HL, Blood EA, Kroshus E, Austin SB. Physical activity disparities in heterosexual and sexual minority youth ages 12-22 years old: roles of childhood gender nonconformity and athletic self-esteem. *Ann Behav Med*. Feb 2014;47(1):17-27.

Mental and Behavioral Health Disparities

- GB adult men and LGB youth have a significantly increased risk for depression, anxiety, suicide attempts and substance use disorders.
- GB men have a 2 to 4 times increased risk of suicide ideation compared with straight men, when measured in 12-month intervals and lifetime prevalence.
- LGB youth are more likely than straight youth to be suicidal, and much more likely to make serious attempts at suicide. While LGB youth are twice as likely to have suicidal ideation as straight youth, they are four times as likely to make suicide attempts requiring medical attention.
- LGB individuals have twice the risk of lifetime exposure to traumatic experiences compared with straight people.

Lewis NM. Mental health in sexual minorities: recent indicators, trends, and their relationships to place in North America and Europe. *Health Place*. Dec 2009;15(4):1029-1045.

King M, Semlyen J, Tai SS, et al. A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*. 2008;8:70.

Marshal MP, Dietz LJ, Friedman MS, et al. Suicidality and depression disparities between sexual minority and heterosexual youth: -a meta-analytic review. *J Adolesc Health*. Aug 2011;49(2):115-123.

Roberts AL, Austin SB, Corliss HL, Vander Morris AK, Koenen KC. Pervasive trauma exposure among US sexual orientation minority adults and risk of posttraumatic stress disorder. *Am J Public Health*. Dec 2010;100(12):2433-2441.

Physical Health Disparities

- LB women have twice the risk of obesity compared with straight women.
- LGB adults have 1.5 times the risk of asthma compared with straight adults.
- LGB adults have more than twice the risk for cardiovascular disease compared with their straight counterparts.
- Bisexual individuals have twice the risk of smoking as straight individuals.

Conron KJ, Mimiaga MJ, Landers SJ. A population-based study of sexual orientation identity and gender differences in adult health. *Am J Public Health*. Oct 2010;100(10):1953-1960.

- Young GB men show on average significant elevations in biomarkers of cardiovascular disease compared with straight men.

Hatzenbuehler ML, McLaughlin KA, Slopen N. Sexual orientation disparities in cardiovascular biomarkers among young adults. *Am J Prev Med*. Jun 2013;44(6):612-621.

- LGB people on average become disabled at a significantly younger age than straight people.
- Lesbian women have twice the risk of becoming disabled as straight women
- Bisexual men and women have almost three times the risk of becoming disabled as straight men and women.

Fredriksen-Goldsen KI, Kim HJ, Barkan SE. Disability among lesbian, gay, and bisexual adults: disparities in prevalence and risk. *Am J Public Health*. Jan 2012;102(1):e16-21.

- Gay men and transgender women (MtF) are at elevated risk for HIV/AIDS and other STIs.
- Transgender individuals are more likely than cisgender individuals to be uninsured and to postpone medical care due to lack of insurance and experiences with discrimination. The risk of postponing medical care is highest for transgender men (FtM).
- One in five transgender individuals has been denied care by a physician. Transgender individuals of color are even more likely to report denial of care.

Institute of Medicine (U.S.). Committee on Lesbian Gay Bisexual and Transgender Health Issues and Research Gaps and Opportunities. The health of lesbian, gay, bisexual, and transgender people : building a foundation for better understanding. Washington, DC: National Academies Press; 2011.

- Gay men are at greater risk for anal cancer than straight men.

Darwich L, Videla S, Canadas MP, et al. Distribution of human papillomavirus genotypes in anal cytological and histological specimens from HIV-infected men who have sex with men and men who have sex with women. *Dis Colon Rectum*. Sep 2013;56(9):1043-1052.

Physical Health Disparities

- LGBT people suffer from higher lifetime risk of violent victimization and maltreatment than straight, cisgender individuals.

Friedman MS, Marshal MP, Guadamuz TE, et al. A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *Am J Public Health*. Aug 2011;101(8):1481-1494.

Herek GM. Hate crimes and stigma-related experiences among sexual minority adults in the United States: prevalence estimates from a national probability sample. *J Interpers Violence*. Jan 2009;24(1):54-74.

McLaughlin KA, Hatzenbuehler ML, Xuan Z, Conron KJ. Disproportionate exposure to early-life adversity and sexual orientation disparities in psychiatric morbidity. *Child Abuse Negl*. Sep 2012;36(9):645-655.

Bazargan M, Galvan F. Perceived discrimination and depression among low-income Latina male-to-female transgender women. *BMC Public Health*. 2012;12:663.

conditions. Consequently, individuals born with DSD and their families have to navigate between far too much and far too little health care. The recent shift towards evidence-based management of pediatric DSD by dedicated interdisciplinary teams represents an effort to change this pattern,²⁹ but this approach is still in its early stages and largely neglects adult care.

The medical profession has progressed significantly toward recognizing the difference between behaviors, body types, and feelings that are relatively less common and those that are pathological. In so doing, it has progressed toward better care for individuals who are or may be LGBT, gender nonconforming, and/or born with DSD. There is still substantial work to be done in this area, and medical education is the logical place to focus significant effort.

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Chapter 2

The Role of Medical Education and Health Care Professionals in Eliminating Health Disparities

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Using Medical Education to Address Disparities

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Reducing health disparities that harm individuals who are or may be LGBT, gender nonconforming, and/or born with DSD calls for a comprehensive approach.

Medical education can serve to:

1. Increase health care professionals' awareness and knowledge of health risk and potential resiliency of people who may be LGBT, gender nonconforming, and/or born with DSD.
2. Train students to provide high-quality, patient-centered care to patients who are LGBT, gender nonconforming, and/or born with DSD.
3. Inspire students to be advocates for the health of these populations.

Medical educational initiatives to address the health of LGBT individuals began in community-based clinics in the late 1960s and early 1970s. Fear of bias and discrimination in private practices drove many LGBT patients to seek care in clinics that served all people, regardless of background or payment method. With little formal training or research to inform them about health concerns in the LGBT populations, clinicians in these settings learned how to care for LGBT patients directly from patients themselves or from other clinicians with experience in these populations. Several events, including the establishment of patient advocacy organizations, increased the visibility of LGBT patients in society and brought attention to the unique needs and disparities these patients faced in health care. It was not until the 1970s that the movement for better care for LGBT patients gained enough momentum to be essentially self-sustaining.

The following timeline, while not comprehensive, helps to map the progress that has occurred:

1948

Alfred Kinsey publishes the "Kinsey Scale" of sexual behavior in *Sexual Behavior in the Human Male*¹ (followed in 1953 with *Sexual Behavior in the Human Female*²), culturally influential work in which his research team reports, for the first time, statistics about homosexual activity in the American population at large.

1952

Dr. Harry Benjamin's first transgender patient, Christine Jorgensen, is the subject of a front-page story of the *New York Daily News* as the first American to receive "sex change" surgery.

1972

The Boston Women's Health Book Collective is incorporated and creates the book *Our Bodies, Ourselves*, which speaks openly and frankly about sexual orientation, sexual health, sexual practices, and gender-based discrimination.

**1973
1978**

The American Psychiatric Association removes homosexuality from its Diagnostic and Statistical Manual of Mental Disorders but adds the new category of ego-dystonic homosexuality (subsequently removed in 1986).

Fritz Klein, M.D. publishes *The Bisexual Opinion*.³

1979

The Harry Benjamin International Gender Dysphoria Association (HBIGDA) is established. The name is later changed to the World Professional Association for Transgender Health (WPATH).

1980

The first set of "Harry Benjamin Standards" is published, establishing guidelines for health professionals to help transgender people improve their overall health and psychological well-being.

**1981
1982**

The organization eventually known as the Gay and Lesbian Medical Association (GLMA) is founded. The name is later changed to GLMA: Health Professionals Advancing LGBT Equality.

The Gay Men's Health Crisis is formed as a response to the AIDS crisis.

1987

The AIDS Coalition to Unleash Power (ACT UP) is formed to push governmental officials to respond to the AIDS crisis.

1993

The Intersex Society of North America (ISNA) is founded to advocate for patients who are born with anatomies that do not fit standard definitions of male or female.

1999

The Institute of Medicine releases its report, *Lesbian Health: Current Assessment and Directions for the Future*.⁴

**2001
2002**

GLMA publishes *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health*, describing a 10-year plan for improving the health and health care of LGBT individuals.

The first national LGBTI Health Summit is held in Boulder, Colorado.⁵

2005

The Consortium on the Management of DSD publishes the first stakeholder consensus as a set of two handbooks: clinical guidelines and a parent's handbook.

2006

The pediatric endocrinology “Chicago Consensus” for management of DSD emerges, calling for honest disclosure of medical histories for patients born with DSD, team care for families, and provision of mental health services.

2007

The Human Rights Campaign Foundation establishes the Healthcare Equality Index, a resource that promotes health care organizations’ commitment to the care of LGBT individuals.

The Fenway Institute releases *The Fenway Guide to LGBT Health*, the first medical book solely dedicated to the unique health care needs of LGBT individuals.

AAMC publishes the Joint AAMC-GSA and AAMC-OSR Recommendations calling for medical students to be educated regarding LGBT health care issues.

2010

The U.S. Department of Health and Human Services releases *Healthy People 2020’s* goals for LGBT Health.⁶

2011

The Institute of Medicine releases its foundational report, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding, on the existing research and research gaps on the LGBT community*; The Joint Commission releases its report, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender Community*.

2012

The American Psychiatric Association removes Gender Identity Disorder from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).

2013

The United Nations Special Rapporteur on Torture calls for an end to “reparative therapies” as well as an end to medical approaches that harm children born with DSD.

The events and milestones listed above were complemented by many other efforts, including publications in the peer-reviewed literature that documented the need for improved medical education surrounding the health of LGBT people. In 1991, for example, Wallick et al. surveyed all U.S. medical schools to assess the number of curriculum hours devoted to the topic of homosexuality, and reported a national average of 3 hours and 26 minutes across four years of undergraduate medical education per institution, most frequently presented in didactic lectures.⁷ Seven years later, Tesar et al. reported an average of 2.5 hours for all four years of undergraduate medical education dedicated to the topic of homosexuality, with half of all schools’ curricula containing no content whatsoever.⁸ In 2006, another study showed that medical knowledge of LGBT health and frequency of exposure to sexual history taking from LGBT patients were positively associated with the amount of clinical exposure to those populations,⁹ demonstrating

that the number of hours in the curriculum may not be the only or even the best indicator of medical trainees' self-perceived ability to provide care for patients who are or may be LGBT.

Canadian medical educators also began promoting the need for improved LGB content in curricula in the 1990s^{10,11} and, in 1996, Robinson and Cohen published the first model for medical curricula on LGB health care issues.¹² This model outlined the importance of learning climates and multimodal learning styles to improving medical students' knowledge, attitudes, and skills in providing care to LGB patients. Specifically, Robinson and Cohen emphasized that the learning environment must be supportive and that learning styles must include didactic instruction and clinically oriented patient encounters to ensure the training of health care professionals who can provide comprehensive and sensitive care for LGB patients.

By 2010, studies were being conducted and published that sought to identify barriers to the implementation of LGBT-related curricula. For example, Tamas et al. (2010) surveyed medical school faculty on the barriers to including LGBT content in medical curricula, finding that the time spent in teaching LGBT content was shown to be inversely related to barriers perceived by faculty.¹³ Concomitantly, personal and institutional experiences with discreet educational interventions^{14,15} and integrated curricula¹⁶ pertaining to LGBT health began to be published. The most recent information regarding the status of LGBT-related medical curricula and associated curricular development practices in the U.S. and Canada was provided by the 2011 report of Obedin-Maliver and colleagues from the Stanford LGBT Medical Education Research Group.¹⁷ Between May 2009 and March 2010, the authors surveyed deans of medical education (or equivalent) at 176 allopathic and osteopathic medical schools and found that the median reported time dedicated to teaching LGBT-related content in the entire curriculum was 5 hours. One-third of schools reported 0 hours during clinical years, and 43.9 percent of institutions rated their curricular LGBT content as only "fair."

Community health care centers and academic medical centers contributed to the push for increased education of health care providers. For example:

- The Fenway Institute founded The National LGBT Health Education Center, which "provides educational programs, resources, and consultation to health care organizations with the goal of optimizing quality, cost-effective health care for lesbian, gay, bisexual, and transgender (LGBT) people."
- Howard Brown Health Center developed the Nursing HEAL Elders (HEALE) curriculum teaching cultural competency in caring for older LGBT individuals.
- The Mazzoni Center established its Professional Development Program offering nine separate "interactive and culturally appropriate trainings and support for staff at direct service agencies and medical organizations."
- The University of California, San Francisco (UCSF) created the Center for LGBT Health & Equity, the first LGBT-dedicated program in a health education or health care setting.

(For other educational efforts, please see **Appendix B, Medical School Programs and Related Resources.**)

Reflecting the field's growth, in 2003 the GLMA: Healthcare Professionals Advancing LGBT Equality (previously known as the Gay and Lesbian Medical Association) formed its education subcommittee. This led to the increase in education-focused content at the GLMA annual meeting and a venue for idea sharing among those committed to the cause.

The founding and success of professional organizations that promote the health of individuals who are LGBT, gender nonconforming, and/or born with DSD has had a powerful impact on medical education. In the last two decades, organizations like GLMA: Health Professionals Advancing LGBT Equality have not only offered formal opportunities for practitioners to share best practices, but have also allowed students and teachers to discuss the importance of LGBT and DSD health education. An unpublished archival review of GLMA conference proceedings by Kristen L. Eckstrand reveals that the inclusion of LGBT and intersex curricular content in medical education first appeared in that group's annual meeting in 2000, with a session on communicating about sexuality.

Subsequent presentations at GLMA and other medical education conferences over the past fifteen years have focused on several themes across medical education: understanding sexuality and LGBT health as important components of cultural competence; strategies for content integration; novel and effective teaching methods; training milestones across health curricula; the role of culture and climate in education; and advocacy strategies for learners. Notably, this burgeoning content has been generated from academic institutions spread across North America, and from students and faculty alike.

Indeed, the push for increasing LGBT content in medical education has truly been one of advocacy. Until the foundation of the UCSF Center for LGBT Health & Equity in 1998, no academic medical center had full-time staff positions dedicated to advancing LGBT health and education, and it took another 14 years for Vanderbilt University Medical Center and Mount Sinai Health System to follow suit.

Due to the lack of dedicated funding, resources, and institutional oversight, much of the early information developed for these programs was conceptual, highlighting the need for specific evidence-based educational interventions to improve students' knowledge, skills, and attitudes in caring for LGBT individuals. In 2007, the AAMC responded to this need with the Joint AAMC-GSA and AAMC-OSR Recommendations that medical school curricula ensure that students master the knowledge, skills, and attitudes necessary to provide excellent, comprehensive care for LGBT patients.¹⁸ In addition, in 2010 UCSF convened its National Summit on LGBT Issues in Medical Education, attended by faculty from more than 60 U.S. medical schools. Other professional organizations not directly focused on the health of individuals who are LGBT have supported improved teaching and training in these areas. (For examples, see reproduced position statements from the AMA and the AAMC; for further policy statements from other health care societies, please see GLMA's Health Profession Association LGBT Policy & Position Statements.¹⁹)

Position Statements

American Medical Association, as resolved in 2005:

H-295.878 Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education Our AMA:

1. Supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age.
2. Supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities.
3. Encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education.
4. Encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients.

Source: American Medical Association Policies on LGBT Issues.

<http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glbtc-advisory-committee/ama-policy-regarding-sexual-orientation.page>

The Executive Committee of the Association of American Medical Colleges (now referred to as the AAMC Board of Directors) resolved in 2007 to approve the following recommendations from the Group on Student Affairs (GSA) and Organization of Student Representatives (OSR):

1. Institutions recognize the professional obligations of:
 - Their physician faculty and graduates to treat each patient with dignity and respect, regardless of the patient's sexual orientation or gender identity.
 - Their faculty members to prepare students to respond effectively, compassionately, and professionally to the needs of all types of patients for excellent, comprehensive health care, regardless of patients' sexual orientation or gender identity.
2. Medical school curricula ensure that students master the knowledge, skills, and attitudes necessary to provide excellent, comprehensive care for GLBT patients. Specifically, these curricula should include:
 - Training in communication skills with patients and colleagues regarding issues of sexual orientation and gender identity.

- Visible faculty members and administrators who model behaviors reflecting respect and appreciation for each student, regardless of the student's sexual orientation or gender identity.
 - Faculty development programs for faculty members and residents regarding GLBT issues.
 - Comprehensive content addressing the specific health care needs of GLBT patients.
3. The AAMC consider initiating a Medical School Objectives Project (MSOP) effort designed to reach general consensus within the medical education community regarding the essential knowledge, skills, and attitudes that graduating medical students should possess in the area of human sexuality, including sexual orientation and gender identity, sufficient to prepare them to provide excellent, comprehensive health care to GLBT patients.
 4. Student Affairs deans and other responsible institutional officials ensure a safe learning environment for all students, regardless of their sexual orientation or gender identity. A safe learning environment includes:
 - Ensuring that all students are aware of institutional non-discrimination policies.
 - An institutional culture that promotes and respects diversity in the learning community.
 - Mechanisms for students to report any instances of discrimination or mistreatment without recrimination.
 - Clear policies and procedures to be followed when discrimination or mistreatment are reported.
 5. Admissions deans and admission committees be made aware that bias and prejudice concerning sexual orientation and gender identity are important issues in the learning environment for medical students. Admission materials and programs should educate applicants and prospective students about the learning community that they will be joining and about the institution's commitment to a safe, welcoming, and respectful environment for all persons.

Source: Darrell G. Kirch, M.D. and the AAMC Board of Directors. Institutional Programs and Educational Activities to Address the Needs of Gay, Lesbian, Bisexual, and Transgender (GLBT) Students and Patients. AAMC Presidential Memorandum 07-07; March 2007.

Medical schools have tackled the challenge of including curricular content attending to the medical needs of the LGBT population in a variety of ways, but mostly through three strategies:

1. Full curriculum revision with comprehensive integration of LGBT health concerns
2. Addition of a required curricular session on these issues
3. Provision of extracurricular elective material

Full curriculum revision, while ideal, can be difficult to evaluate. The most recent national curriculum survey reported that 11 U.S. and Canadian medical schools each train students in 16 different LGBT health areas with a maximum of 32 combined preclinical and clinical hours dedicated to teaching LGBT health.¹⁷ However, no formal evaluation of the efficacy of these curricula is available.

Other studies have focused on evaluating LGBT-focused subsets of the curricula, as they have been required for all students in particular institutions. For example, Kelley et al. (2008) examined the effectiveness of a two-hour educational initiative combining didactic teaching and small-group instruction for second-year medical students. The results showed short-term improvement in knowledge about access to health care and about LGBT relationships, increased willingness to treat patients with gender identity issues, and enhanced awareness that sexual identity and practices are clinically relevant.¹⁶ Among third- and fourth-year medical students at another institution, Sanchez et al. (2006) demonstrated that “medical students with greater clinical exposure to LGBT patients reported more frequent sexual history-taking with LGBT patients, had more positive attitude scores, and possessed higher knowledge scores than students with little or no clinical exposure.”⁹ Sullivan et al. (2013) showed that students who received a two-hour interactive didactic and small-group teaching session on LGBT health several months prior were more likely to interact comfortably and provide appropriate preventive health counseling during a required standardized patient encounter with a lesbian patient,²⁰ thus demonstrating the effectiveness of the intervention.²¹ Extracurricular electives have also proven effective at educating future physicians. However, there is likely selection bias for these electives by the students, and the presence of such electives in the curriculum should not replace a required medical curriculum for all students.

Challenges and Advancements to Education Reform

As cited above, there is much preliminary evidence that medical curricula addressing LGBT health are successful in supporting students’ acquisition of useful knowledge, positive attitudes, and compassionate and productive behaviors in caring for LGBT patients. However, academic medical institutions still struggle when considering how to include health issues relevant to patients who are or may be LGBT, gender nonconforming, and/or born with DSD into existing curricula. The barriers to content inclusion are many and include:

- Lack of curricular material that has been demonstrated to be effective
- Absence of faculty willing and able to teach relevant content
- General lack of instructional time
- Teachers’ perceptions that these issues may not be relevant to their specific courses
- Lack of professional development/continuing education for teachers on this topic
- Lack of LGBT- and DSD-related content on national examinations by accreditation bodies.^{13,17}

Additionally, poor clinical practice behaviors among attending physicians may reinforce the sense that sexual education does not matter to medicine. The majority of physicians do not regularly discuss sexual orientation, sexual attraction, or gender identity while taking a patient's sexual history.²² Teachers, therefore, do not model for their medical trainees the skills and attitudes relevant to the provision of high-quality, compassionate care for patients who are LGBT, gender nonconforming, and/or born with DSD. Their failure to deal with their patients' sexual orientations, gender identities, and sex development histories echoes the now-defunct U.S. military policy of "Don't Ask, Don't Tell."²³

Even if an institution maintains an ideal curriculum, attention also must be paid to learning environments. (See **Chapter 4, Integrating Competencies into Medical School Curricula to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD** and **Chapter 6, How to Assess Learners and Evaluate the Impact of Curricular and Climate Initiatives.**) For LGBT students and faculty, the cultural climate in academic medicine shows room for improvement. Several surveys have shown that some faculty would rank LGBT applicants to medical schools and residencies lower than non-LGBT applicants, or even refuse them admission.^{24,25} Predictably, discrimination does not stop after matriculation: 62 percent of a small sample of medical students (n=185) across 92 American medical institutions reported exposure to anti-gay comments,²⁶ suggesting that climates of bias and discrimination continue to exist. These negative climates persist into postgraduate training²⁷ and practice. For example, in a survey of LGBT physicians, Eliason et al. (2011) reported that 22 percent had been socially ostracized, 65 percent had heard derogatory comments about LGBT individuals, and 34 percent had witnessed discriminatory care of an LGBT patient.²⁸ This climate both perpetuates the existing bias and discrimination in health care and promotes a negative clinical learning environment for students still trying to understand LGBT-related health issues. Encouragingly, several institutions have formalized integrated programs that address institutional culture in addition to curriculum. (Please see **Appendix B, Medical School Programs and Related Resources.**)

The existence of LGBT population-level health disparities as well as reported disparities in quality of care of individual patients who are LGBT, gender nonconforming, and/or born with DSD should engage the medical profession's ethical imperatives, which remind doctors of their 'special obligations' to improve quality of care and patient safety, and reduce health care disparities.²⁹ These ethical imperatives are congruent with—and can be strengthened by—values of social justice, cultural humility, and humanism in medicine. Despite the ascendancy of biomedicine, or perhaps because of it, these values are continually promoted in education,^{30,31} research,³² theoretical critique,^{33,34} community activism,³⁵ and public policy,³⁶ as well as patient care.^{37,38} After centuries of lack of knowledge about, prejudice against, and stigmatization of individuals who may have been LGBT, gender nonconforming, and/or born with DSD, developments in the last few decades portend a sea change in the quality of medical care such individuals can receive. Jointly, the principles of professionalism and the aspirations of social justice compel medical educators to work creatively and collaboratively in educational reform to eliminate health disparities between those who conform to expectations of gender identity, sexual orientation, and sexual biology and those who don't.

Trauma and Resilience in the Lives of Individuals Who Are LGBT, Gender Nonconforming, and Born with DSD: Implications for Clinical Care and Health Outcomes

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“I know that the only way that I got to where I am now is through youth empowerment programs and they were specifically gay... what you gain from doing youth empowerment programs, from doing drop-in centers, from going to those spaces is so far-reaching. Like 7, 8, 10 years down the line you’re still going to remember the day you walked in there... that the world seemed a little bit better.” Anonymous study participant³⁹

Evidence demonstrates serious disparities in exposure to traumatic experiences between individuals who identify as LGBT (or who report same-sex sexual behaviors, even if they identify as straight) and their cisgender, exclusively heterosexual peers.⁴⁰⁻⁴² Understanding these experiences and their impact on the patient-provider relationship is of the utmost importance for all health care providers in order to provide comprehensive, sensitive, and optimal health care. These traumatic experiences may be perpetrated by strangers, friends, co-workers, intimate partners, and even family members, and can come in the form of emotional, verbal, physical and/or sexual abuse. Referred to here collectively as trauma, these events can occur across the lifespan and can begin as early as childhood⁴³ (see **Table 2.1: Trauma and Resilience Factors Across the Lifespan in LGBT Individuals**

Violence based on sexual orientation and gender identity was only federally categorized as a hate crime beginning in 2009 with the passage of the Matthew Shepard Act, so older adults identifying as LGBT have lived a significant period of their lives during a time when violence and discrimination against LGBT individuals was considered less than socially reprehensible and, in some cases, even socially acceptable. And, although there have not been systemic surveys of the experience of trauma among individuals born with DSD, anecdotal reports suggest a substantially increased risk of familial, social, and iatrogenic trauma for individuals whose sex anatomies are identified as something other than standard male or standard female. Some, for example, have been harmed through repetitive medical display,^{44,45} which they experienced as violating. Others have suffered from attributed shame^{46,47} within the clinical setting. Still others have suffered physical trauma as a result of undergoing “normalizing” surgeries.⁴⁸

In addition to trauma, LGBT individuals are the target of stigma at societal, interpersonal and intra-individual levels (for a more extensive discussion and description of a model, see **Chapter 1, Laying the Foundation for Inclusion and Equality**), and consequently experience an increased burden of stigma-related events and subtle acts of discrimination (microaggressions). One study reported that 20 percent of LGB adult respondents have experienced a person or property crime based on their sexual orientation, about half have experienced verbal harassment, and more than 1 in 10 have experienced employment or housing discrimination.⁴⁹ Another study reported an increased frequency of poor appetite, eating problems, and/or headaches among college students who hear the popular (and to some, perhaps, innocuous) phrase ‘that’s so gay’.⁵⁰

TABLE 2.1: TRAUMA AND RESILIENCE FACTORS ACROSS THE LIFESPAN IN LGBT INDIVIDUALS

Life Stage	Trauma Type	Prevalence or Odds Ratio (OR)	Resilience Factors
Childhood / Adolescence	Emotional	82% of LGBT youth report verbal harassment while at school¹ - More likely to miss school because of fear compared with heterosexual youth (OR = 2.4)²	- Family acceptance³ - Family connectedness^{4,5} - Adult caring⁵ - School safety⁵
	Physical	38% of LGBT adolescents report physical assault while at school¹ 29.7% of youth with same-sex sexual contact report physical dating violence (versus 21.1% same-sex only and 14.3 opposite-sex only)⁶ 39.9% of bisexual females, 50.2% of bisexual males, 43.3% of gay males, and 44.4% of lesbian females have experienced childhood physical abuse (OR 1.2 compared to heterosexual youth)²	
	Sexual	21% of gay males, 24% of bisexual males, 32% of lesbian females, and 40% of bisexual females have experienced sexual abuse (OR = 3.8)²	
Adult	Emotional	56% of transgender individuals report verbal harassment⁷	- Social support from friends⁸ - Social support from family⁸ - Legally recognized marriage⁹ - Positive LGBT identity¹⁰ - Self-acceptance¹¹ - Internal locus of control¹²
	Physical	38% of gay men report hate crimes against their person or property⁹ 11-13% of LB women report hate crimes against their person or property⁹ 19% of transgender individuals report physical violence⁷	
	Sexual	46% of bisexual women have been raped in their lifetime¹³ 47% of bisexual men have experienced lifetime sexual violence¹³ 50% of transgender respondents reported assault or rape by a partner¹⁴	

Life Stage	Trauma Type	Prevalence or Odds Ratio (OR)	Resilience Factors
Older Adult	Emotional	63-65% of older LGBT individuals report lifetime physical violence^{15,16} 65% of transgender individuals have experienced >1 instance of emotional or psychological abuse in their lifetime¹⁷	- Social support^{18,19} - Self-reliance¹⁸
	Physical	40% of older LGBT individuals report lifetime physical violence¹⁵	
	Sexual	58% of older transgender individuals report experiencing at least one instance of forcible sex in their lifetime²⁰	

Sources:

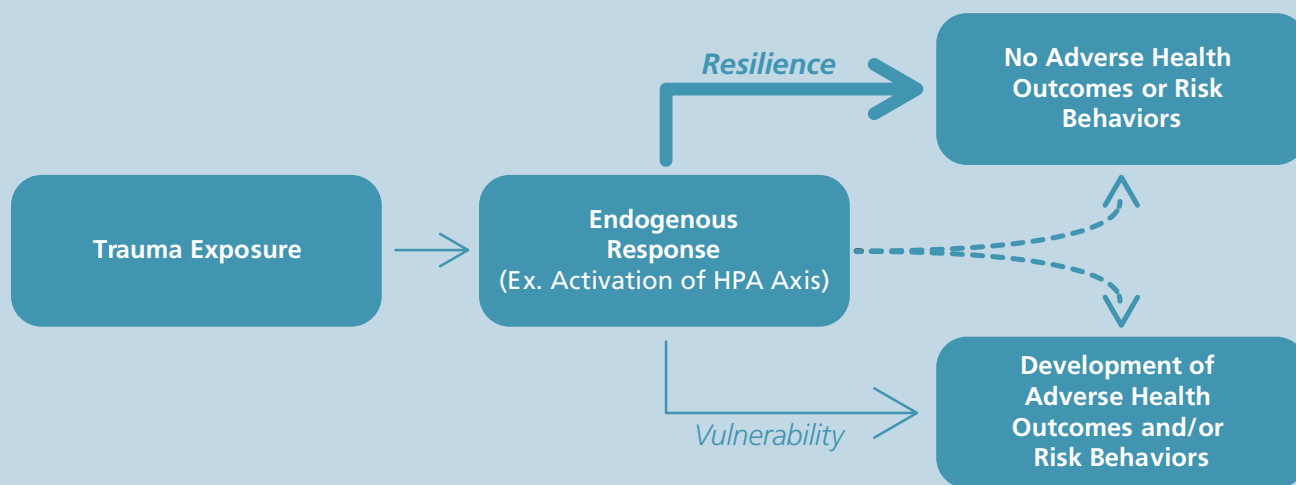
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In order for physicians to provide high-quality medical care, they must understand individuals' reactions to trauma, how physicians' responses may facilitate positive or negative health outcomes, and the key role they and other health care providers can play in fostering resilience (see **Figure 2.1: Response to Trauma**). At a very basic level, the experience of trauma triggers a physiologic stress response, such as activation of the hypothalamic-pituitary-adrenal (HPA) axis and related brain circuits, which leads to emotional and/or behavioral responses.^{51,59} These responses, which may or not be conscious, may help the patient adapt in the short term, since they aim to minimize the impact of the stressor or threat.

For example, the Adverse Childhood Experiences Study investigators have emphasized that early behavioral adaptations (e.g., smoking, aggressive behavior, etc.) are actually “solutions” to adversities experienced during childhood; however, these adaptations may become “problems” to others in the context of health care (or education or law-enforcement), especially later in life when related behaviors manifest as negative health consequences.⁵² The extent to which an individual's responses to trauma are ultimately adaptive or potentially harmful depends on many biological, psychological, and social factors. Individuals who have a lower level of education, identify as a racial/ethnic minority, have a history of prior trauma or a family history of depression or anxiety, and/or have experience a lack of family support, are more likely to develop risk behaviors and/or adverse health outcomes as a result of trauma.⁵³⁻⁵⁸

FIGURE 2.1: RESPONSE TO TRAUMA



Trauma exposure can trigger an internal, adaptive, physiologic response.

In the context of a variety of negative biological, psychological, and social factors, these responses can lead to the development of adverse health outcomes and/or risk behaviors. Factors promoting resilience facilitate the ability to adapt to adversity and recover from trauma.

Source: Adapted from Klaassens ER et al. Bouncing back—trauma and the HPA-axis in healthy adults. *European Journal of Psychotraumatology*. Supplement 1, 2010, 1: 5844 - DOI: 10.3402/ejpt.v1i0.5844

Scant research exists on risk behaviors and health consequences associated with trauma in individuals identifying as LGBT.⁵⁰ This is an important gap, given that both childhood and adult trauma exposures in the general population have been linked to decreased quality of life and psychosocial functioning, psychiatric and medical morbidity, and premature mortality.^{60,61} Moreover, the convergence of epigenetic,⁶² genetic and environmental interactions,⁶³ neuroendocrine,⁶⁴ immune⁶⁵ and neuroimaging⁶⁶ research demonstrates that childhood trauma is causally related to poor health in adulthood.

Given the staggering prevalence rates of traumatic experiences among LGBT individuals, future research should extend this literature to the risk behaviors and health outcomes documented in LGBT populations (see **Table 2.1, Trauma and Resilience Factors Across the Lifespan in LGBT Individuals**). The impact of traumatic stress on the health of LGBT individuals has not been studied as thoroughly as in other minority populations: research inspired by Meyer's minority stress model^{67,68} and its subsequent elaborations^{69,70} on the physical⁷¹ and mental health⁷² outcomes resulting from stigma-related experiences is far more extensive.⁷³⁻⁷⁵

The health care environment can contribute to the experience of trauma in LGBT populations: 11 percent of lesbian, gay, and bisexual (LGB) adults and 21 percent of transgender adults report experiences of verbal discrimination, and 4 percent of LGB and 8 percent of transgender adults report that providers were "physically rough or abusive".⁷⁶ Even in an optimal care environment, being a patient and/or having to cope with illness involves a level of exposure and vulnerability that most people find traumatic to some degree. This is especially the case for patients who are LGBT, gender nonconforming, and/or born with DSD, who are quite likely to have experienced multiple and cumulative prior traumas.

For these individuals, an experience such as sitting in a waiting room with unfamiliar people, "coming out" to a new provider, or undergoing a chest, genital, or anorectal exam can trigger a fear response or the re-experiencing of trauma. The fear response may promote a physiological reaction, with subsequent emotional and/or behavioral cascading reactions similar to the responses that arose after earlier trauma(s).⁷⁷⁻⁸⁰

Uncensored expression of these reactions may lead providers to perceive incorrectly that the patient is disengaged, unfriendly, defensive, and/or demanding. These misinterpretations can subsequently lead to reactive responses from providers that may in turn be perceived by the patient as uncaring or even hostile. A self-perpetuating pattern is thus put into play in which a patient who is LGBT, gender nonconforming, and/or born with DSD avoids seeking care to avoid feelings of fear and discrimination, which in turn leads to the development of additional risk behaviors and adverse health outcomes.

Despite these measurable negative effects of adversity and marginalization on the health of LGBT individuals, other research shows that the majority of these individuals are as healthy as their heterosexual and cisgender peers. Research on traumatic stress reveals that only a minority of individuals exposed to traumatic events develop post-traumatic stress disorder.⁸¹ This observation has led to a new field of study focusing on resilience and so-called post-traumatic growth.⁸² Resilience, an individual's ability to adapt to adversity and recover from trauma, is determined by

biological, psychological, and social factors,⁸³⁻⁸⁵ and can be promoted or hindered by interactions within the health care system. Advocates of resilience promotion emphasize several different types of structural and interpersonal interventions, including:

- Creating a health care system that is overtly welcoming and accepting.
- Fostering a bond between health care professionals and patients to counteract the ‘us’ versus ‘them’ mindset.
- Promoting an internal locus of control that encourages the belief that patients are in control of their lives.⁸⁶
- Focusing on individual psychological characteristics (e.g., self-acceptance,⁸⁷ spiritual coping⁸⁸).
- A brief reading list to aid practitioners in understanding resilience promotion across the lifespan is provided in **Appendix C, Suggested Additional Reading**.

To achieve competence in providing sensitive and comprehensive care to diverse individuals, it is not enough for physicians to understand the causes of health disparities affecting patients who are or may be LGBT, gender nonconforming, and/or born with DSD, or for them to avoid engaging in microaggressions, discriminatory remarks, or problematic assumptions. It is imperative that health care providers learn how to promote resilience in the lives and families of individuals who are members of these groups so as to mitigate the effects of real and perceived trauma on risk behaviors and adverse health outcomes.

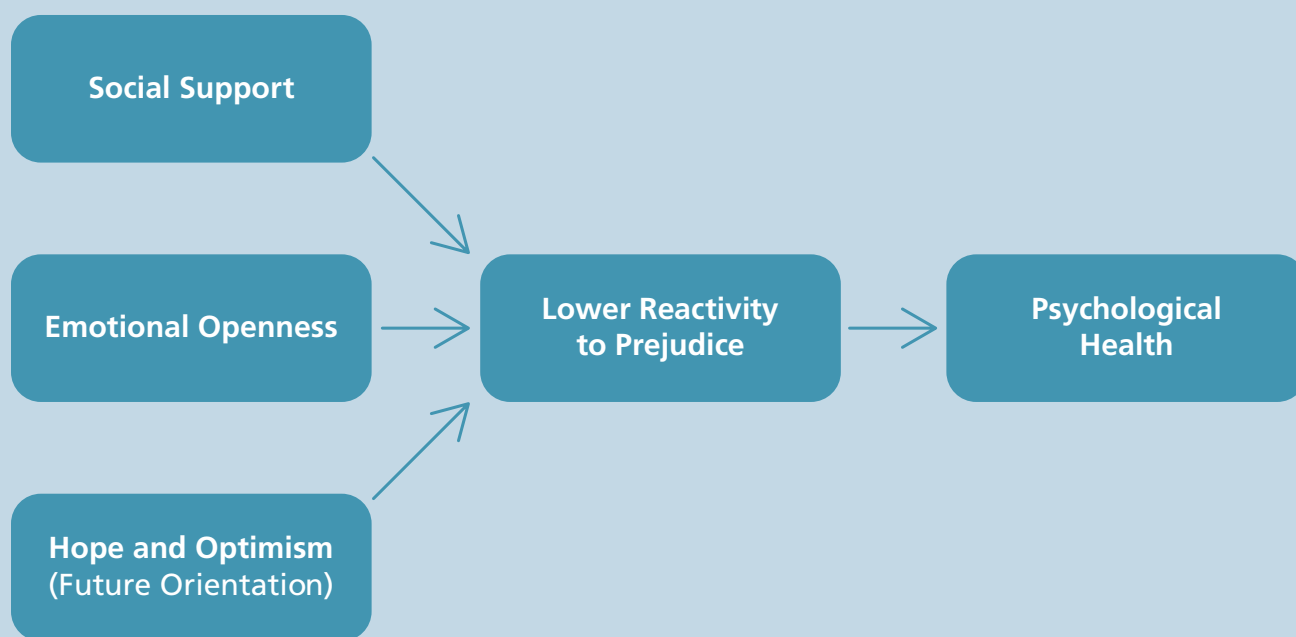
Many of these risk behaviors are modifiable, and health care professionals can play a key role in facilitating the development of crucial psychosocial support and interpersonal as well as intra-personal engagement (see **Table 2.1: Trauma and Resilience Factors Across the Lifespan in LGBT Individuals**). For example, health care professionals working with LGBT youth can facilitate resiliency by supporting the development of a positive LGBT identity and helping to plan “coming out” discussions, as well as working with families of LGBT youth to create a supportive and accepting environment. Health care professionals can also refer families to local PFLAG-National support groups to provide mentoring opportunities.

Health care professionals working with older LGBT adults can facilitate resiliency by supporting caregiver networks and focusing on maintaining patient autonomy and self-reliance.⁸⁹ Similarly, they can consider research showing the mitigating effect of peer social support on psychological distress of transgender patients when they encourage their patients to seek out social support.⁹⁰ Health care professionals working with individuals or parents coping with a DSD diagnosis can provide access to dedicated mental health specialists^{90,91} and refer patients and their families to support groups who will provide genuinely empathetic care.

The encouragement that physicians can provide in the development of a positive LGBT identity and community belonging may be particularly beneficial to individuals who identify as racial/ethnic minorities, who often grapple with the intersecting stigmas associated with low income in addition

to LGBT and ethnic minority status.^{92,93} For example, rates of nondisclosure of sexual orientation to health care providers are highest among bisexual men and women of color and bisexual men born outside the U.S.⁹⁴ Research, however, has shown that LGBT racial/ethnic minority individuals benefit equally from exploring the historical discrimination and contributions of their minority group and building a personal meaning out of shared adversity.^{95,96}

FIGURE 2.2: PROMOTING RESILIENCE AMONG LGBT INDIVIDUALS



Source: Kwon P. Resilience in lesbian, gay, and bisexual individuals.
Pers Soc Psychol Rev. November, 2013; 17(4): 371-383

Summarizing this literature, Kwon concludes that “[LGBT] individuals thrive when they have supportive social networks, accept their emotions and process them with insight, and view the future with hope and optimism” (see **Figure 2.2: Promoting Resilience Among LGBT Individuals**).⁹⁷ Given the important role that physicians can play in helping patients reduce risk behaviors and decrease adverse health outcomes, the competencies proposed in **Chapter 3, Professional Competency Objectives to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD**, are written with an emphasis on learners acquiring the knowledge, skills, and attitudes to promote the development of resilience among patients in these populations.

Competency-Based Medical Education: A Framework for Overcoming Health Disparities

Author: Andrés F. Sciolla, M.D.

“The challenge is to measure the impact of training in terms of improved patient care, and to assess the extent to which a physician is a self-directed, reflective thinker.” M. Brownell Anderson, M.Ed., former senior director for educational affairs at AAMC⁹⁸

In today’s multicultural world, where the pace of both social change and medical discoveries can border on overwhelming, a growing number of medical educators have come to believe that a new, more flexible model of medical education is needed. Tomorrow’s physicians need to know how to access the best possible scientific knowledge in clinical practice; in order to achieve that, they need to do more than to engage in rote memorization while in medical school. As physicians, they need to be able to stay up to date with clinical skills, and they need to be able to adapt to whatever tomorrow’s ever-changing clinical environment will ask of them.

Many medical educators believe that competency-based medical education (CBME) is the answer to this need. This curricular concept focuses on teaching the skills physicians need, rather than solely imparting a static, prefabricated collection of knowledge. A medical school or residency program using CBME defines a set of skills or competencies based on societal and patient needs, such as medical knowledge, patient care, or communication approaches, and then develops ways to help trainees ultimately achieve competency through a range of courses and settings.

Given society’s increasing acceptance of people who are or may be LGBT, gender nonconforming, and/or born with DSD, and the fact that these populations can be seen in any health care setting at any stage of the human life cycle, this committee wishes to provide a brief overview of CBME and how this curricular model is particularly well-suited to meet the needs of these patient populations. The committee also urges the reader to weigh the relative advantages of CBME compared to the older, more traditional model of academic medical education, particularly when serving patient populations whose needs have been overlooked and whose access to competent medical practitioners has too often been limited at best.

The move to CBME has been a long time coming, and can be understood to have ultimately evolved from the landmark Flexner Report of 1910,⁹⁹ which had as its goal the development of a new medical educational system that would ensure production of truly competent physicians. The Flexner Report specifically embraced the academic model of medical education while recommending the closure of for-profit proprietary medical schools in America.¹⁰⁰ This academic model featured full-time faculty and emphasized the importance to medicine of the constant advancement of knowledge and of scientific discovery. Although a steady stream of detractors (most prominently William Osler) argued for greater educational emphasis on direct patient care, the Flexnerian approach dominated medical education and helped elevate the medical profession to a level of high esteem by the mid-twentieth century.

That esteem has eroded since, partly because of some physicians' egregious and highly publicized ethical lapses and partly because of the widespread perception that money interests have had undue influence on patient care. At the same time, increased demand for public accountability and responsibility among medical professionals has further changed the way society views physicians. It is no coincidence that this demand has paralleled the establishment of CBME for all physicians,¹⁰¹ in which the curriculum and assessments focus on students' ability to demonstrate skills essential to practice. In most medical schools, Flexnerian curricular approaches (which focus on time-based exposure to disciplines) have become secondary or are being dropped altogether.¹⁰² It is now widely held that CBME is necessary to fulfill medicine's societal contract.¹⁰³

According to Epstein and Hundert, competency is "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served."¹⁰⁴ This holistic definition, which does not rely solely on observable, easily measureable skills, takes into account that professional knowledge is situational and derives in part from the context where this knowledge is acquired. In other words, much of this working knowledge is tacit,^{105,106} i.e., knowledge that we know implicitly or infer from others but normally do not or cannot explain easily.¹⁰⁴ This definition also encompasses cognitive and emotional self-awareness, two important principles that enable competent physicians to manage ambiguous problems, tolerate uncertainty, and make reasonable decisions with only limited information.¹⁰⁵

As intuitively attractive as this approach may be, there are challenges in implementing and assessing a competency-based approach to medical education. First, there is no evidence base for the relationship between "reflection in daily practice" and meaningful changes in actual clinical care or improvement in patient outcomes.¹⁰⁶ In addition, because of the subjective component of Epstein and Hundert's definition, competence cannot be assessed solely by licensing bodies or superiors. Patients and peers also have a role in assessing the intangible components of competence, such as professionalism and trust.¹⁰⁴ An even greater challenge is trying to assess competence-related habits of mind, which, for example, allow the practitioner to be attentive, curious, self-aware, and willing to recognize and correct errors. Despite these challenges, medical schools in the United States are being joined by other professions internationally in following a competency-based approach to education and training.

The essential elements of CBME include a functional analysis of occupational roles (e.g., breaking down work roles into small, discrete tasks), a translation of tasks and competencies into improved outcomes, and an assessment of trainees' progress in achieving these outcomes.¹⁰⁷ These elements guide a stepwise approach to curricular design that has been widely adopted:

Step 1: Competency identification

Step 2: Determination of competency components and performance levels
(e.g., beginning, intermediate, and advanced)

Step 3: Competency evaluation

Step 4: Overall assessment of the process¹⁰¹

Thus, the goal of CBME should be to facilitate the development of physicians to the point at which they demonstrate mastery of abilities required for optimal practice in each competency domain.

CBME has also benefited from the application of several educational theories and guiding principles. These include:

- Adult learning theory: adult learners are able to learn optimally from material that is most relevant to their personal goals.
- Self-directed learning: individuals initiate and evaluate the degree to which they have achieved their own learning goals.
- Self-efficacy: one's belief in one's ability to succeed in specific situations.¹⁰⁸

The rate at which a student masters a competency may vary by competency domain and context. For example, learning to deliver bad news effectively will take longer than learning breast cancer stages, and a student's competence in counseling middle class, educated diabetes patients may not translate well to a resource-limited clinic with underserved patients. Consequently, an individual will demonstrate a greater or lesser ability to master a competency depending on the skill being assessed and the context within which it was learned.¹⁰³

Contemporary conceptions of CBME envision professional competence as an ever-changing, contextual construct as opposed to envisioning a "competent physician" as someone who, once certified to practice independently, remains "competent" forever.¹⁰³ Competence can deepen or regress depending, in part, on how favorable or adverse the learning environment is for the particular knowledge, skills, or attitudes comprising that competence. This notion of the term "competent" aligns with the concept of competencies placed in the context of clinicians' chosen field, a concept now termed "entrustable professional activities" (EPAs). Authors ten Cate and Young define EPAs as "tasks or responsibilities to be entrusted to a trainee once sufficient specific competence is reached to allow for unsupervised practice."¹⁰⁹ The goal is for trainees to practice without supervision and then, ultimately, to supervise others. EPAs have been advanced as a bridge

in the gap between the theory of competency-based education, with its “deconstructed” approach to assessing individual competencies, and clinical practice, which requires the application and integration of multiple competencies in situated and fluid contexts.¹¹⁰

To help establish appropriate pedagogical expectations for undergraduate medical education and postgraduate medical education, ten Cate and Scheele distinguish between competencies and EPAs.¹¹⁰ Competencies require specific definitions that correspond to detailed learning objectives, and their assessment often requires multiple observations by multiple evaluators in artificial or simulated situations such as using standardized patients. In contrast, EPAs allow supervisors to observe trainees in the course of their clinical work to decide whether they can independently perform critical professional activities. In this way, supervisors are able to infer multiple competencies without directly assessing them. In the latest development of CBME, EPAs are not to be viewed as an alternative to competencies but as “a means to translate competencies into clinical practice.”¹¹¹

Whereas competencies describe in relatively generalized terms how a physician should act, EPAs describe specific professional tasks—tasks which “usually require multiple competencies [carried out] in an integrative, holistic” way. Other contemporary developments in the field include the terms “dyscompetence,” to refer to the skill level of physicians who have a relative deficiency in one or more domains of competence, such as communication abilities, and “incompetent” to refer to an individual not yet having achieved a specified stage of training or practice in a specified setting.¹⁰³

The challenges that accompany the competency-based paradigm shift cannot be overemphasized. These challenges include:

1. Developing assessment tools that are matched to specific competencies
2. Providing an evaluation process that reflects real-world scenarios and consists of a “portfolio” of assessment tools
3. Ensuring faculty and learner buy-in to the new educational philosophy
4. Ensuring that strong administrative support buttresses the creation of faculty development programs¹⁰¹

In addition to these challenges, several shortcomings of CBME have been summarized by Talbot¹¹² and Frank and colleagues.¹⁰³ These deficiencies include reductive approaches like creating highly detailed checklists of skills, which can promote students’ perception that the achievement of milestones, not achievement of independent competent practice, is the ultimate pursuit in medicine. Excessive utilitarianism like eliminating curricular content and experiences that are not directly relevant to a training program’s outcomes is another potential failing of CBME.¹⁰³

Ultimately, as noted by Hodges,¹¹³ outcomes-based medical education faces a particular challenge in that clinicians do not work in a void; most positive health care outcomes are a result of professional teamwork and do not depend solely on the competence level of an individual practitioner. Hodges’

point, along with the challenges faced by the current CBME system described above, are the subject of *Educating Physicians: A Call for Reform of Medical School and Residency*,¹¹⁴ funded by the Carnegie Foundation and often called the “second Flexner Report.” Recent proposals to address these challenges include:

- Renewed emphasis on interprofessional education and practice¹¹⁵
- Inter-institutional collaborations to develop massive open online courses (MOOCs) for didactic content
- Small discussion groups to leverage this online content in a “flipped-classroom” model
- Digital badges for credentialing EPAs across the continuum of learning¹¹⁶

This history and background on competency-based medical education provides context to enhance the reader’s appreciation of the competencies developed by this committee (see **Chapter 3, Professional Competency Objectives to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD**). We offer these competencies fully realizing the following strengths and limitations of CBME as outlined in this section, especially including that:

Individually defined competency domains pose unique challenges to institutional culture and make stakeholder buy-in a challenge.

Curricular design can be difficult because training duration depends on an individual learner’s time to achieve competency.

Competence needs to be assessed with multiple tools and perspectives (e.g., through the use of simulated patients), which can strain an institution’s resources.

Further, competency lists necessarily represent an artificial parsing of behaviors that are actually integrated in patient-specific, real-life situations. Finally, these lists define the performance of individual students, although patient outcomes depend on teamwork and systems of care. Well-integrated, patient-centered teamwork is critical whenever stigmatization is prevalent or there are glaring gaps in knowledge or evidence-based practices. We discuss how the successful deployment of the proposed competencies relies on the learning environment and institutional culture in **Chapter 4, Integrating Competencies into Medical School Curricula to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD**.

Despite these limitations, we believe these competencies represent a step forward in a process that we hope will be followed by the formulation of educational milestones and EPAs (see **Chapter 6, How to Assess Learners and Evaluate the Impact of Curricular and Climate Initiatives**). Ultimately, this process should culminate in the reduction of health disparities and improved health care outcomes for people who are or may be LGBT, gender nonconforming, and/or born with DSD.

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Chapter 3

Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD

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Professional Competencies to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born With DSD

Authors: AAMC Advisory Committee on Sexual Orientation,
Gender Identity, and Sex Development

Recent literature has documented a gap in health care for patients who are or may be gay, lesbian, bisexual, transgender (LGBT), genderqueer, gender nonconforming, or born with differences of sex development (DSD).¹ These groups, referred to collectively below as “the populations described” or “these populations,” face health disparities caused by decreased access to needed care, bias and discrimination both in society and in the health care setting, lack of provider knowledge and/or comfort in providing care; absent or suboptimal risk factor assessment, and medical management that is not grounded in the current best evidence. These disparities can lead to preventable harms. (For more about the historical background on health disparities among these populations, see **Chapter 1, Laying the Foundation for Inclusion and Equality.**)

In the August 2013 issue of *Academic Medicine*, Englander et al. reviewed more than 150 competency lists for health care professionals and presented the Reference List of General Physician Competencies. This list consists of 58 professional competencies in eight domains that define the intended outcomes for a graduating medical student.² The Reference List has its foundation in the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties’ (ABMS) Outcome Project.²

In order to develop competencies specifically to address the needs of the populations described in this publication, the committee started with the 20 most applicable of the Reference List’s competencies from within Englander’s eight domains. From there, committee members created a total of 30 competencies to address the specific needs of these populations. For each domain, we chose at least one and as many as six competencies. (To see the Liaison Committee on Medical Education (LCME) Standards that are related to these competencies, refer to **Table 4.2: LCME Standards**, in **Chapter 4, Integrating Competencies into Medical School Curricula to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD.**)

The competencies presented here aim generally to improve medical education around the biological, psychological, and social determinants of sex development, sexual behavior, sexual health, sexual function, sexual orientation, sexual identity, gender identity, gender discordance, gender dysphoria, gender role and expression, heterosexism, homophobia, and transphobia. (See the section on terminology in **Chapter 1, Laying the Foundation for Inclusion and Equality**, for the reasoning behind our choice of terms and **Appendix A, Glossary of Terms**, for their definitions.)

Although the committee developed these competency objectives to increase equality of care for people who may be LGBT, gender nonconforming, and/or born with DSD, these objectives are actually essential to providing safe, effective, patient-centered care to all patients. As such, their teaching and assessment may occur through a wide variety of learning experiences and may also be relatively easily integrated into existing curricula. (For suggestions about how to integrate these competencies within existing or emerging curricula, see **Table 4.3: Integrating the Competency Objectives into Educational Curricular Modalities** in **Chapter 4.**)

These 30 competencies are designed for use in undergraduate medical education. However, because these competencies and their respective objectives are based on the Reference List of General Physician Competencies and thus the combined ACGME/ABMS framework, they are designed to be easily adapted for use in graduate and continuing medical education.

Notes: The AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development based these 30 competencies on an adaptation of AAMC's Tool for Assessing Cultural Competence Training (TACCT)³ developed by the University of California San Francisco Chancellor's GLBT Issues Advisory Sub-Committee on Curriculum.⁴

In the competencies described below, the italicized text is excerpted verbatim from Englander et al.'s Reference List of General Physician Competencies (and may not adhere to the style and terminology used elsewhere in this publication). The numbered text that follows each competency is the work of this committee.

Competency Domain: Patient Care

Gather essential and accurate information about patients and their conditions through history taking, physical examination, and the use of laboratory data, imaging, and other tests by:

1. Sensitive and effectively eliciting relevant information about sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from all patients in a developmentally appropriate manner.
2. Performing a complete and accurate physical exam with sensitivity to issues specific to the individuals described above at stages across the lifespan. This includes knowing when particulars of the exam are essential and when they may be unnecessarily traumatizing (as may be the case, for example, with repeated genital exams by multiple providers).

Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment by:

3. Describing the special health care needs and available options for quality care for transgender patients and for patients born with DSD (e.g., specialist counseling, pubertal suppression, elective and nonelective hormone therapies, elective and nonelective surgeries, etc.).

Counsel and educate patients and their families to empower them to participate in their care and enable shared decision-making by:

4. Assessing unique needs and tailoring the physical exam and counseling and treatment recommendations to any of the individuals described above, taking into account any special needs, impairments, or disabilities.
5. Recognizing the unique health risks and challenges often encountered by the individuals described above, as well as their resources, and tailoring health messages and counseling efforts to boost resilience and reduce high-risk behaviors.

Provide health care services to patients, families, and communities aimed at preventing health problems or maintaining health by:

6. Providing effective primary care and anticipatory guidance by utilizing screening tests, preventive interventions, and health care maintenance for the populations described above (e.g., screening all individuals for inter-partner violence and abuse; assessing suicide risk in all youth who are gender nonconforming and/or identify as gay, lesbian, bisexual and/or transgender; and conducting screenings for transgender patients as appropriate to each patient's anatomical, physiological, and behavioral histories).

Competency Domain: Knowledge for Practice

Apply established and emerging biophysical scientific principles fundamental to health care for patients and populations by:

1. Defining and describing the differences among: sex and gender; gender expression and gender identity; gender discordance, gender nonconformity, and gender dysphoria; and sexual orientation, sexual identity, and sexual behavior.
2. Understanding typical (male and female) sex development and knowing the main etiologies of atypical sex development.
3. Understanding and explaining how stages of physical and identity development across the lifespan affect the above-described populations and how health care needs and clinical practice are affected by these processes.

Apply principles of social-behavioral sciences to the provision of patient care, including assessment of the impact of psychosocial and cultural influences on health, disease, care seeking, care compliance, and barriers to and attitudes toward care by:

4. Understanding and describing historical, political, institutional, and sociocultural factors that may underlie health care disparities experienced by the populations described above.

Demonstrate an investigatory and analytic approach to clinical situations by:

5. Recognizing the gaps in scientific knowledge (e.g., efficacy of various interventions for DSD in childhood; efficacy of various interventions for gender dysphoria in childhood) and identifying various harmful practices (e.g., historical practice of using “reparative” therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for patients in the populations described above.

Competency Domain: Practice-Based Learning and Improvement

Identify strengths, deficiencies, and limits in one’s knowledge and expertise by:

1. Critically recognizing, assessing, and developing strategies to mitigate the inherent power imbalance between physician and patient or between physician and parent/guardian, and recognizing how this imbalance may negatively affect the clinical encounter and health care outcomes for the individuals described above.
2. Demonstrating the ability to elicit feedback from the individuals described above about their experience in health care systems and with practitioners, and identifying opportunities to incorporate this feedback as a means to improve care (e.g., modification of intake forms, providing access to single-stall, gender-neutral bathrooms, etc.).

Locate, appraise, and assimilate evidence from scientific studies related to patients’ health problems by:

3. Identifying important clinical questions as they emerge in the context of caring for the individuals described above, and using technology to find evidence from scientific studies in the literature and/or existing clinical guidelines to inform clinical decision making and improve health outcomes.

Competency Domain: Interpersonal and Communication Skills

Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds by:

1. Developing rapport with all individuals (patient, families, and/or members of the health care team) regardless of others’ gender identities, gender expressions, body types, sexual identities, or sexual orientations, to promote respectful and affirming interpersonal exchanges, including by staying current with evolving terminology.
2. Recognizing and respecting the sensitivity of certain clinical information pertaining to the care of the patient populations described above, and involving the patient (or the guardian of a pediatric patient) in the decision of when and how to communicate such information to others.

Demonstrate insight and understanding about emotions and human responses to emotions that allow one to develop and manage interpersonal interactions by:

3. Understanding that implicit (i.e., automatic or unconscious) bias and assumptions about sexuality, gender, and sex anatomy may adversely affect verbal, nonverbal, and/or written communication strategies involved in patient care, and engaging in effective corrective self-reflection processes to mitigate those effects.
4. Identifying communication patterns in the health care setting that may adversely affect care of the described populations, and learning to effectively address those situations in order to protect patients from the harmful effects of implicit bias or acts of discrimination.

Competency Domain: Professionalism

Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation by:

1. Recognizing and sensitively addressing all patients' and families' healing traditions and beliefs, including health-related beliefs, and understanding how these might shape reactions to diverse forms of sexuality, sexual behavior, sexual orientation, gender identity, gender expression, and sex development.

Demonstrate respect for patient privacy and autonomy by:

2. Recognizing the unique aspects of confidentiality regarding gender, sex, and sexuality issues, especially for the patients described above, across the developmental spectrum, and by employing appropriate consent and assent practices.

Demonstrate accountability to patients, society, and the profession by:

3. Accepting shared responsibility for eliminating disparities, overt bias (e.g., discrimination), and developing policies and procedures that respect all patients' rights to self-determination.
4. Understanding and addressing the special challenges faced by health professionals who identify with one or more of the populations described above in order to advance a health care environment that promotes the use of policies that eliminate disparities (e.g., employee nondiscrimination policies, comprehensive domestic partner benefits, etc.).

Competency Domain: Systems-Based Practice

Advocate for quality patient care and optimal patient care systems by:

1. Explaining and demonstrating how to navigate the special legal and policy issues (e.g., insurance limitations, lack of partner benefits, visitation and nondiscrimination policies, discrimination against children of same-sex parents, school bullying policies) encountered by the populations described above.

Coordinate patient care within the health care system relevant to one's clinical specialty by:

2. Identifying and appropriately using special resources available to support the health of the individuals described above (e.g., targeted smoking cessation programs, substance abuse treatment, and psychological support).
3. Identifying and partnering with community resources that provide support to the individuals described above (e.g., treatment centers, care providers, community activists, support groups, legal advocates) to help eliminate bias from health care and address community needs.

Participate in identifying system errors and implementing potential systems solutions by:

4. Explaining how homophobia, transphobia, heterosexism, and sexism affect health care inequalities, costs, and outcomes.
5. Describing strategies that can be used to enact reform within existing health care institutions to improve care to the populations described above, such as forming an LGBT support network, revising outdated nondiscrimination and employee benefits policies, developing dedicated care teams to work with patients who were born with DSD, etc.

Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care by:

6. Demonstrating the ability to perform an appropriate risk/benefit analysis for interventions where evidence-based practice is lacking, such as when assisting families with children born with some forms of DSD, families with prepubertal gender nonconforming children, or families with pubertal gender nonconforming adolescents.

Competency Domain: Interprofessional Collaboration

Work with other health professionals to establish and maintain a climate of mutual respect, dignity, diversity, ethical integrity, and trust by:

Valuing the importance of interprofessional communication and collaboration in providing culturally competent, patient-centered care to the individuals described above and participating effectively as a member of an interdisciplinary health care team.

Competency Domain: Personal and Professional Development

Practice flexibility and maturity in adjusting to change with the capacity to alter one's behavior by:

Critically recognizing, assessing, and developing strategies to mitigate one's own implicit (i.e., automatic or unconscious) biases in providing care to the individuals described above and recognizing the contribution of bias to increased iatrogenic risk and health disparities.

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Chapter 4

Integrating Competencies into Medical School Curricula to Improve Health Care for Individuals Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD

Chapter Editor: Carey Roth Bayer, Ed.D., R.N., C.S.E.

As prior chapters have outlined, there is clearly a need for comprehensive medical education curricula that address the needs of patients who are or may be lesbian, gay, bisexual, transgender (LGBT), gender nonconforming and/or born with differences of sex development (DSD). These individuals face well-documented structural, financial, personal, and cultural barriers when interacting with the health care system,^{1,2} and these barriers have led to harmful health disparities.³ Medical education can play an important role in reducing these disparities.

Sporadic progress has been made in recent years toward inclusion of curricular content that specifically addresses the health care needs of individuals who are or may be LGBT, gender nonconforming and/or born with DSD (See **Chapter 1, Laying the Foundation for Inclusion and Equality, for more about the history of health disparities in these populations.**) With the development of the Professional Competency Objectives to Improve Health Care for People Who Are or May be LGBT, Gender Nonconforming or Born with DSD (please see Chapter 3), we have offered a learning framework in which to train medical students to care for people who may be LGBT, gender nonconforming, and/or born with DSD.

While the competencies we present in this publication provide a list of the knowledge, skills, and attitudes necessary for a physician to be ready to provide comprehensive and sensitive care for these populations, three major challenges remain:

1. Integrating these competencies into medical curricula.
2. Delineating the role of institutional culture/climate as it applies to the care and inclusion of individuals who are or may be LGBT and/or born with DSD.
3. Assessing these competencies in individual learners and institutions.

This chapter addresses the first and second challenges, while the third challenge is addressed in **Chapter 6, How to Assess Learners and Evaluate the Impact of Curricular and Climate Initiatives.** We will turn now to addressing how faculty, students, residents, and administrative staff in academic medicine can support integration of these recommended competencies into undergraduate medical curricula and how this integration can occur regardless of institutions' or individual instructors' preferred educational modalities.

Role of Institutional Climate

Authors: Carey Roth Bayer, Ed.D., R.N., C.S.E.

Kristen L. Eckstrand, Ph.D.

Medical students do not learn in a vacuum. They learn within systems, i.e., medical schools and health care institutions. Their development into knowledgeable and sensitive providers may be helped or hindered by the climates of the systems in which they are educated. Institutions that do not specifically prohibit discrimination based on sexual orientation and gender identity not only fail to support their employees and/or students, but also compromise the quality of care for patients who are or may be LGBT, gender nonconforming, and/or born with DSD.⁴

The institutional climate at medical schools can have a strikingly negative impact on LGBT students and may ultimately compromise the ability to develop competencies that promote equitable, quality care for patients who may be LGBT, gender nonconforming and/or born with DSD. In a 2005-2006 survey conducted by the Association of American Medical Colleges (AAMC), 15 percent of medical student respondents were aware of mistreatment of LGBT students.⁵ Almost 10 years later, the 2013 AAMC survey showed that, compared with straight students, LGB medical students report increased social isolation and stress, decreased social support, and poorer emotional climate.⁶ This discrimination, bias, and discomfort discourages the open instruction and discussion of health issues relevant to individuals who are or may be LGBT, gender nonconforming, and/or born with DSD. The first step toward more equitable care for all people is for academic systems to promote a culture—infrastructure as well as processes—that recognize and support students, employees, and patients who are or may be LGBT, gender nonconforming, and/or born with DSD. **Table 4.1, Opportunities to Promote an Inclusive Institutional Climate**, provides examples of opportunities for promoting an inclusive institutional climate.

While institutional change can start with the actions of any member of the educational community—including support staff, teaching assistants, and others—in the next sections, we focus on three groups most closely involved in the curricular integration of competencies: faculty, students and residents, and administrators.

TABLE 4.1: OPPORTUNITIES TO PROMOTE AN INCLUSIVE INSTITUTIONAL CLIMATE

Opportunity	Example
Broad institutional engagement	• Employment of LGBT-identified providers • Designation of diversity officers, student and faculty groups, and individual leaders who identify as LGBT • Formation of groups that promote LGBT student and employee wellness • Requirement of continuing education in LGBT issues for employees, especially leaders • Inclusion of a dedicated LGBT program with full-time staffing and/or an advisory committee • Funding for activities designed to promote LGBT health, such as community health fairs, continuing education sessions, film screenings, etc. • Use of internal listserv for communication about LGBT health concerns
Inclusive, nondiscriminatory policies & practices	• Inclusive nondiscrimination and visitation policies for patients and employees • Statement of commitment to LGBT diversity and inclusiveness in workplace, classroom, and health care settings • LGBT inclusion and equality embedded in strategic plans, mission statements, and philosophy • Designing new student and employee orientations to affirm inclusion of LGBT people • Identification of and steps to address instances of discrimination in the health care environment
Value LGBT diversity and cultures within institution	• Recognizing LGBT events such as Pride months, Transgender Day of Remembrance, National Coming Out Days, etc. • Recruitment of LGBT-identified students, faculty, and staff • Developing an “out list” of students, staff, and faculty who openly identify as LGBT and who are willing to speak publicly on issues and serve as mentors to students and employees
Outreach and engagement in wider community	• Participation in community health education and partnerships that address health issues of individuals who may be LGBT, gender nonconforming, and/or born with DSD • Visible presence of institutional representatives and/or leadership at academic events to learn and present on advances in the health of individuals who may be LGBT, gender nonconforming and/or born with DSD • Participation in events held in and for the LGBT community • Hosting educational events with speakers who are “out” as having been born with DSD
Technology that reflects commitment to diversity	• Development of culturally sensitive methods for collecting data on sexual orientation and gender identity on all forms (intake, electronic health records, educational, employment, etc.) • Actual collection of sexual orientation and gender identity information on all documents (paper as well as electronic) • LGBT visibility on institutional website/electronic communication

Integration by Target Population: Faculty

Author: Carey Roth Bayer, Ed.D., R.N., C.S.E.

Given their involvement in implementing the curriculum in classrooms and clinical settings, faculty members necessarily play a large part in curricular change. Faculty members are in a prime position to fulfill the following tasks:

Identify barriers to competency inclusion.

Implement strategies for competency inclusion.

Identify strategies for influencing the curriculum outside the classroom setting.

Identifying Barriers

Before attempting curricular change, faculty should attempt to identify potential barriers that may hinder implementation. Faculty members may want explore the following questions: How do I influence the curriculum (content and process)? What level of approval is needed for curricular change? With whom do I need to meet in order to add to or change curricular content (i.e., course directors, administrators, individual faculty, curriculum committee members, etc.)? Who will teach the new content? How will I assess student mastery of the new content? Is my institutional climate supportive of the curricular change?

Common barriers that faculty may encounter include:

- Low levels of readiness for curricular change
- Institutional traditions that inhibit innovation
- Reluctance to dedicate curricular time to the health of individuals who are or may be LGBT, gender nonconforming, and/or born with DSD
- Insufficient instructional time to accommodate recommended changes
- Lack of expertise and/or professional development opportunities about the topic among existing faculty

- Reluctance to teach the content
- Perception that data do not support the need for curricular change
- Absence of assessment methods to evaluate the effectiveness of the change
- Perception that this content is of less value since it is not included on national board examinations
- Skepticism and fear⁷⁻¹³

In order to achieve effective curricular changes, administrators must acknowledge the challenges inherent in an educational climate where faculty members must balance multiple roles in the academic and clinical environments. Therefore, allowing for adequate planning time and training is essential for success.

Implementing Strategies for Competency Inclusion

A variety of strategies exist for faculty to implement curricular change to address issues important to the health of individuals who may be LGBT, gender nonconforming and/or born with DSD. First, it is essential for faculty who teach this content to assess their ability to create a supportive learning environment for this content. The Center of Excellence for Sexual Health at Morehouse School of Medicine has outlined strategies by which faculty can examine their own values, attitudes, beliefs, and biases related to teaching sexuality.¹⁴ This process is important for faculty because students learn more readily in an understanding and accepting environment than they do in an environment that denies or condemns minority populations.¹⁵ Many of the ideas included in **Table 4.1: Opportunities to Promote an Inclusive Institutional Climate** to promote an inclusive institutional environment also apply in the classroom and clinical learning environments. Faculty champions and faculty willing to create supportive learning environments free of discrimination can therefore make a significant difference in the successful inclusion of curricular content relevant to individuals who are or may be LGBT, gender nonconforming, and/or born with DSD.

Several relatively easy methods exist for faculty to add content to medical curricula to boost education around issues of sexual orientation, gender identity, and sex development. Faculty can:

- Integrate enlightening cases into current lectures, clerkships, simulation experiences, journal clubs, grand rounds, and other presentation formats (for examples of cases, see **Chapter 5, Clinical Scenarios and Discussion Points for Experiential Learning**, as well as AAMC's **MedEdPORTAL**).^{14, 16-17}
- Evaluate student knowledge by including content about individuals who may be LGBT, gender nonconforming, and/or born with DSD into exam questions, evaluation scenarios, and patient scenarios.

- Review and modify existing educational sessions on health disparities, cultural competence, and diversity training.^{11,18-19}
- Implement elective courses and clinical rotations that focus on health issues of individuals who are or may be LGBT, gender nonconforming, and/or born with DSD.²⁰
- Make the case for the necessity of change by communicating effectively to students, enlisting support from those in leadership positions, and highlighting the innovation, equity, and financial benefits of delivering safe, effective and equitable care to all regardless of sexual orientation or gender identity.⁹

*(See the discussion of multimodal curricular integration of professional competency objectives later in this chapter for detailed examples of how to incorporate LGBT-related content, and also see **Appendix B, Medical School Programs and Related Resources.**)*

Influencing the Curriculum Outside of the Classroom Environment

Institutional, organizational, clinical, and classroom environments all affect students' likelihood of educational success. Yet, there are many additional ways outside of the classic classroom environment that faculty can help introduce students to content relevant to the health of individuals who are or may be LGBT, gender nonconforming, and/or born with DSD. (See **Table 4.1: Opportunities to Promote an Inclusive Institutional Climate.**) These include:

- Serving on leadership committees that have a direct potential for effecting curricular change (e.g., curriculum committees, equity and diversity committees, clinical practice committees, etc.).
- Reviewing institutional policies and curricula to minimize the potential for a problematic "hidden curriculum," (i.e., unwritten and unspoken values, lessons, and perspectives communicated to students through institutional culture) to take root at that institution²¹.
- Becoming a faculty advisor and champion for student groups (e.g., Gay-Straight Alliance groups, LGBT interest groups, etc.)
- Participating in mentorship programs to help LGBT students explore career options.
- Hosting institutional and community events on sexual orientation, gender identity, and DSD.
- Serving as a guest lecturer or small group facilitator to discuss health concerns of LGBT individuals and those born with DSD.
- Presenting, publishing, and keeping administrators aware of faculty successes in effecting curricular change.

Integration by Target Population: Students and Residents

Author: Kristen L. Eckstrand, Ph.D.

Despite students' crucial role in evaluating, enhancing, and modernizing health care delivery, they are often left out of quality improvement processes such as the implementation of curricular change. Historically, there have been barriers to the involvement of students and residents in integrating curricular content that relates to LGBT and DSD health, as discussed in **Chapter 1, Laying the Foundation for Inclusion and Equality**. Today these learners have the potential to act as agents of change and to initiate and lead successful institutional change processes aimed at improving the health of patients who are or may be LGBT, gender nonconforming, and/or born with DSD. Like faculty champions, student champions can now play a large role in influencing curricular change.

Several student-led projects have been nationally recognized for their excellence in promoting LGBT health curricula in a variety of ways.²³ The following programs have been presented at the AAMC Annual Meeting. (See also **Appendix B, Medical School Programs and Related Resources**, for a more extensive listing.)

Stanford Lesbian, Gay, Bisexual, & Transgender Medical Education Research Group (LGBT MERG)

Stanford LGBT MERG was founded in 2007 by medical students to address the lack of research into effective medical education on issues of LGBT health. The students sought to uncover and communicate new knowledge by conducting innovative research related to LGBT education, influencing health and educational policies to recognize this unique population, and advocating for LGBT patients and providers. Their work led to the publication of the most recent national curriculum content review, which found that even when basic LGBT concepts are covered, many medical schools do not require any clinical training in LGBT health.¹¹ Importantly, this student-led research project supported LGBT curriculum integration by evaluating strategies proposed by medical school deans to support enhanced LGBT content in medical education curricula. The group found that the most successful strategies were integrating material on LGBT health and health disparities into the curriculum, identifying qualified faculty to teach the curriculum, and ensuring curricular time for covering the content. This study helped create a base of evidence from which academic medical centers can initiate their own curricular reform.

Vanderbilt University School of Medicine

Curriculum change at Vanderbilt began in 2008 when medical students saw room for improvement in the quantity and quality of teaching of LGBT health in the existing curriculum. A group of students developed a report for the faculty and administration that summarized present medical standards and supported national data documenting medical students' and residents' lack of knowledge and skills to address LGBT health concerns. Further, it referenced initiatives developed at other institutions to provide evidence education reform, and who worked with students to revise courses to include the core aspects of LGBT health. These revisions were subsequently made mandatory for all medical students. LGBT health education at Vanderbilt now employs a combination of didactic teaching, small group work, patient panels, and standardized patient cases. These innovative efforts were successful in promoting students' knowledge and enhancing their ability to care for LGBT populations, leading to the publication of the first LGBT-focused curriculum intervention in AAMC's MedEdPORTAL.¹⁶⁻¹⁷

University of Washington QMed

University of Washington medical students founded QMed, a group committed to addressing the health inequalities that harm LGBT communities. QMed developed an elective medical course focused specifically on LGBT health and the health disparities that occur among patients with nonconforming sexual orientations or gender identities. This course uses the expertise and experiences of physicians, patients, activists, and other providers who are LGBT or who work actively with LGBT individuals in order to help medical students become better primary care providers for LGBT patients. The QMed approach includes an in-depth and comprehensive elective course that explores the nuances of LGBT-focused health care with students who are specifically dedicated to LGBT health promotion.²⁶

Each of these programs highlights the kinds of opportunities that may exist for students who want to influence curricular change, including:

- Contributing to national and local data collection about curricular needs and assessment
- Promoting content integration of core LGBT health-related issues throughout an established medical curriculum
- Developing an in-depth elective course in LGBT health care delivery

The committee does not know of other, similar student-led projects regarding DSD, but such efforts could potentially take the same kinds of approaches. (See the sidebar, Recommendations for Students and/or Faculty Developing Curricular Projects.)

Even without actual curriculum reform, students can support education related to the health concerns of patients who are or may be LGBT, gender nonconforming, and/or born with DSD through other mechanisms. They can form groups to focus on improving knowledge among health

professionals or to encourage discussions of gender identity and sexual orientation with their patients. These groups can individually, or in conjunction with other local organizations, promote student-sponsored lectures to fill curricular gaps in student education. Students can also get involved with committees that have the authority to enact institutional change (e.g., curriculum committee, admissions committee) in order to help guide specific institutional improvements. Finally, students can provide feedback to lecturers, clerkships, and schools on strengths and opportunities for improvement related to educational content on health issues in the target populations.

The individual and institutional benefits to fostering student-initiated improvement projects are potentially enormous. For students, these experiences provide opportunities to develop professional and leadership skills, project management proficiency, and expertise in a field of interest.²⁷ Specific improvements related to health care delivery can also enhance their knowledge of the health care system and prepare them to be leaders in a health care environment that is inclusive of people who are LGBT, gender nonconforming, and/or born with DSD.²⁸ For institutions, investing in student leadership yields improvements in multiple aspects of health care delivery and builds an institution's reputation for supporting individuals who identify as LGBT, gender nonconforming, and/or born with DSD.

Recommendations for Students and/or Faculty Developing Curricular Projects

Author: Kristen L. Eckstrand, Ph.D.

Recommendations for Students:

Students should focus on three areas to establish a successful project: project selection, team assembly, and data collection.

Project Selection

While passion and motivation to enact change should drive project selection, students must resist the temptation to overreach in scope and should select feasible projects with defined objectives. Consider resources and funding, including possible grants, awards, and school funding when defining project aims and framing them in a national and local context. For example:

- Mapping gaps in undergraduate medical education curricula at an individual institution
- Performing a needs assessment at an individual institution to determine areas for improving institutional inclusivity
- Developing a community-based program for creating awareness of LGBT health concerns

Team Assembly

Finding motivated team members and faculty mentors to assist with project leadership can be challenging, particularly in large institutions. Students should actively seek out the best possible mentors, understanding that not every faculty member has the time or ability to champion a project. Early efforts should focus on finding individuals with a vested interest in the project who are willing to drive the change forward. These individuals may be faculty, administrators, other student leaders, or even well-placed support staff (e.g., diversity office staff). The most important elements in team assembly are diversity in membership and individuals' willingness to work toward a shared goal. An interdisciplinary team typically fosters an organizational culture of collegiality and productivity.

Data Collection

Finally, students must collect process and outcome measurements to assess and demonstrate ongoing project efficacy. Aim to accomplish at least one element of a project early to demonstrate project feasibility and secure buy-in from key individuals. Carefully consider timing of publicly presenting the data to effectively recruit and motivate future leaders toward continued project success.

Recommendations for Faculty

The faculty member initially approached by a student may not necessarily be the ideal mentor for that student, although the person may be a powerful ally in helping the student find the ideal mentor. Faculty should understand that approaching a person of authority with a novel idea is intimidating for students, and discouragement by faculty upon first connection may be all-too-sufficient to stifle students' energy and ideas. Faculty members should work with students to discuss their level of commitment and motivation for the project, assist them in developing the idea into a tangible project proposal, and help connect students to those who can assist with project implementation.

Effective mentorship by faculty requires investment in both the student and his or her project plus participation as an active team member. Thus, both the student and potential faculty mentor should consider the mentor's interests, expertise, and limitations. Prior to project initiation, mentors must assess the balance between a student's passion and motivation with her or his capacity to take on a rigorous project. Mentors can assess students' interest, preparation, and dedication by looking at the strength and professionalism of the initial proposal.

Understanding that students are often naïve to institutional hierarchies and the climate of health care, mentors can help students frame their ideas within those contexts. Additionally, mentors should help to identify institutional stakeholders who may be able to move the change forward.

Recognizing the potential positive impact of student-initiated change within health care, institutions should provide support for their successes. While this support can include funding for

training, assistance in implementing new programming, or salary support for mentors, supporting student-initiated projects can be as simple as continually highlighting the institutional value of student-initiated projects. High visibility of student-initiated projects across the institution further provides opportunities to recruit team members to promote sustainability.

Enhancing Effective Student-Faculty Collaboration

While student-initiated change projects are conceived, designed, and led by medical students, their success is dependent on effective student-faculty collaboration. Students play a key role in driving the project forward with their fresh ideas, energy and perspectives, while faculty can provide context to align programmatic interventions with institutional goals and provide guidance through institutional hierarchy and help navigating past the inevitable red tape.

At routine intervals, students and faculty should together critically evaluate project strengths, weaknesses, objectives, and limitations to optimize project success and to avoid allowing potential problems to go unaddressed. Meetings between student and faculty leaders also enhance shared project ownership so that all individuals feel meaningfully involved in the change process.

Administrators and institutions can create a climate to promote student-faculty collaboration. Protected teaching time and providing salary compensation for mentoring enables faculty to balance their workloads to include good mentorship. By offering continuing education and professional development specific to mentorship, institutions can foster an environment for effective mentoring.

Source: Eckstrand KL, Albin M, Pilarski P, Lomis KD. Working in concert: fostering student-led programmatic improvements. Joint Southern/Northeast Regional Meeting of the Association of American Medical College's Group on Student Affairs/Organization of Student Representatives/Diversity Affairs Officers/Southeastern Association of Advisors for the Health Professions. Nashville, TN. April 2011.

Integration by Target Population: Administrators

Author: Carey Roth Bayer, Ed.D., R.N., C.S.E.

Though administrators may not be directly involved with teaching in the classroom or the clinical setting, they may have the power and means to bring about systematic change across an institution. Like faculty champions and student champions, administrator champions can be key for influencing curricular and institutional change. This section discusses the role of institutional vision in cultural competency and diversity as well as specific strategies for influencing the curriculum and institutional climate at the administrative level.

Valuing Cultural Competency and Diversity

“Cultural competency” and “diversity” are terms that resonate with most administrators and institutional leaders, particularly in medical education, where value is placed on training a culturally competent workforce equipped to care for diverse patient populations. Yet definitions of these terms vary widely regarding issues of sexual orientation, gender identity, and DSD. In the past several years, the growth of policies pertaining to the health of individuals who are or may be LGBT, gender nonconforming and/or born with DSD has increased the visibility of these communities and highlighted the importance of addressing their health needs.^{3,4,29-32} In addition, the Liaison Committee on Medical Education (LCME) mandates that “medical education programs must have policies and practices to achieve appropriate diversity among its students, faculty, staff, and other members of its academic community, and must engage in ongoing, systematic, and focused efforts to attract and retain students, faculty, staff, and others from demographically diverse backgrounds.”³³ Arguably, the increased visibility, governmental recognition, policy changes, and educational mandates are playing a role in influencing administrators and leaders to make conscious efforts to value all people in more visible ways.³⁴⁻³⁶

Table 4.2: LCME Standards, includes examples of LCME standards and elements that may directly apply when implementing the content in this publication.

TABLE 4.2: LCME STANDARDS

Current LCME Standard*	Current LCME Element*	Former LCME Standard**
Standard 3 Academic and Learning Environments	3.2 Community of Scholars/Research Opportunities	IS-13, IS-14
	3.3 Diversity/Pipeline Programs and Partnerships	IS-16, MS-8
	3.4 Anti-Discrimination Policy	MS-31
	3.5 Learning Environment/Professionalism	MS-31A
Standard 7 Curricular Content	7.6 Cultural Competence/Health Care Disparities/Personal Bias	ED-21, ED-22
	7.7 Medical Ethics	ED-23
	7.8 Communication Skills	ED-19

Sources:* Functions and structure of a medical school: Standards for accreditation of medical education programs leading to the MD degree. Updated March 2014. Liaison Committee on Medical Education website. <http://www.lcme.org/publications/2015-16-functions-and-structure-with-appendix.pdf> Accessed August 26, 2014.

** Functions and structure of a medical school: Standards for accreditation of medical education programs leading to the M.D. degree. Updated June 2013. Liaison Committee on Medical Education website. <http://www.lcme.org/publications/functions2013june.pdf> Accessed March 15, 2014.

Strategies for Influencing the Curriculum and Institutional Climate

Numerous guides exist for creating welcoming, inclusive institutional environments.^{2, 22, 37-41} **Table 4.1: Opportunities to Promote an Inclusive Institutional Climate**, summarizes specific examples of promoting an inclusive educational and health environment, many of which involve efforts by administrators. Administrators can improve the institutional climate and influence the medical curriculum by:

- Ensuring that inclusive language is present in nondiscrimination, equal opportunity employment, and admissions policies
- Evaluating health plans and institutional policies to ensure equal coverage for all people regardless of sexual orientation or gender identity
- Supporting equality and diversity committees and student committees addressing concerns of LGBT people
- Supporting partnerships with inclusive community organizations and events
- Being a role model for workplace equality

Administrators should not underestimate the role of straight allies to the LGB communities. Straight allies can be instrumental in helping to end institutional oppression and discrimination.⁴²⁻⁴³ They can also help shift the framing of inclusion to be seen as a matter of professional responsibility for the entire health care community.⁴⁴

Integration Using Various Educational Modalities

Author: Brian Hurley, M.D., M.B.A.

Institutions vary significantly regarding their preferred educational modalities. Integrating professional competency objectives into a specific institution's curriculum to improve health care for people who are or may be LGBT, gender nonconforming, and/ or born with DSD requires a rudimentary understanding of specific educational modalities and how each promotes student learning. Institutions may use these educational modalities at various times during the medical education process (i.e., M1, M2, M3, M4, and/or residency). The process of expanding curricular content need not be overwhelming, yet may require an institution to develop a task force composed of individuals who are familiar with the curriculum's modalities and possible ways to integrate the competency objectives described in **Chapter 3, Professional Competency Objectives to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD**.

Trends in Medical School Curricular Changes

Since the 1910 Flexner Report,^{45,46} medical education has been traditionally organized into two years of preclinical training followed by two years of clinical rotations. For most of the twentieth century, medical students' preclinical on-campus time was spent in didactic lectures, with some time spent in laboratories for anatomy, pathology, microbiology, or other hands-on coursework. Since the 1960s, colleges of medicine have increasingly transitioned toward less lecture-based learning and more problem-based learning (PBL)^{47,48} with PBL typically conducted in small groups.^{49,50}

The 1990s to 2000s saw the addition of new education modalities, including discussion groups, standardized patients (actors who are trained to simulate real patients in order for students to learn and practice clinical skills), clinical contact during the first two years of medical school, site-based activities in the community, and computer-based learning.⁵¹

Electronic technologies are now widely used in undergraduate medical education settings. Medical colleges deliver a great deal of learning material, such as syllabi, class notes, and other required readings; histology slides; and clinical case write-ups via digital platforms. Active learning methods (nondidactic modalities with an interactive component)⁵² have been used with increasing prevalence in undergraduate medical education. In addition, many didactic lectures are available

through video streaming, and students often communicate with teachers through electronic means (e.g., email and online course organizational programs). Within the context of didactic lectures, there is an increasing use of audience response technology to increase interactivity. Simulation technologies have been widely adopted, and many medical colleges have built simulation centers.⁵³ Some medical colleges use simulation or virtual technologies in place of the anatomy laboratories that were previously universal throughout American medical schools.⁵⁴

The AAMC and associated organizations have led the charge for competency-based, learner-centered medical education.^{55, 56} As a result of these and similar efforts, medical schools increasingly employ self-directed learning methods with interdisciplinary teams that focus on integrative learning. Some models “flip the classroom,” focusing class time on the application of didactic content, rather than its presentation, though skills practice and engaging with colleagues in group formats. Proponents argue that these models leverage digital technology, enrich teacher-learner interactions, and facilitate deeper learning.⁵⁷ Some medical schools employ longitudinal educational methods, in which a cohort of students remains together throughout their medical education or students follow a particular clinical case or family over time.⁵⁸

Clinical education in undergraduate medical education is traditionally centered in the third and fourth years and organized into short (3-12 week) rotations, usually in tertiary, urban teaching hospitals.⁵⁹ These rotations have typically been organized through historically defined specialty areas including internal medicine, obstetrics/gynecology, surgery, psychiatry, family medicine, and pediatrics. Some colleges have recently changed this format in favor of longitudinal integrated clerkships that span approximately 40 weeks.⁶⁰ Additionally, many colleges of medicine are increasing learner time in outpatient clinical settings in recognition of the fact that most practicing physicians have outpatient practices.^{61, 62}

Because of this diverse and evolving context, there has been an increasing call for medical schools to “standardize learning outcomes, individualize the learning process, integrate clinical experience with formal learning, inculcate habits of inquiry and improvement, and foster the formation of professional identity.”⁶³ In competency-based education, which is focused on learner outcomes, medical schools may organize training into variable lengths of time without the fixed interval format characteristic of twentieth century medical education.^{64, 65} Many medical schools already abbreviate preclinical training, with students beginning clinical rotations within the first 18 months of medical school.

Regardless of which educational modalities any given institution employs, many opportunities exist to integrate LGBT content into the curriculum.

Didactic Instruction

Didactic instruction in medical education is traditionally lecturer-led, with material presented in a linear, logical, and highly structured manner in front of a relatively large group of learners. In this mode, a lecturer delivers prepared material on a predefined topic. Since the 1990s, colleges of medicine have attached learning objectives to specific lectures, defining the key expected outcomes from specific lectures.⁶⁶ Lecturers commonly assign reading for medical students to complete prior to the lecture, and they use lecture time to both review key material and answer questions students have about reading materials. In learning theory, this model of instruction is usually focused on imparting knowledge (e.g., discrete testable facts as contrasted with the performance of specific skills).⁶⁷ As self-directed learning has been increasingly emphasized, some colleges of medicine have made lecture attendance optional, under the assumption that learners will acquire equivalent knowledge through reading or other means.

The lecture is often a default choice for incorporating a wide range of material into the curriculum, including basic concepts in pharmacology, microbiology, physiology, biochemistry, genetics, and cellular biology. Many colleges of medicine began by introducing diversity or cultural competency content into their curriculum via the lecture format; therefore, the content has been more knowledge-based than skill-based (i.e., learning about the importance of cultural competency vs. practicing cultural competency skills). Similarly, many medical schools offer lectures on topics that include medical ethics, sociocultural factors affecting health, and quality improvement topics.

As technology in medical education has evolved, didactic instruction has been increasingly delivered electronically through prerecorded or live video formats.⁵⁴ Small-group didactics are organized in an abbreviated and increasingly interactive fashion as compared to large group lectures. When in-person didactics occur in large group formats, schools use audience response systems to quickly assess learner acquisition of knowledge. There are also medical colleges that, as previously discussed, now use a flipped-classroom lecture model in which material traditionally taught in lecture is assigned as reading or in pre-recorded video format. In this approach, educators use class time to facilitate interactive large-group discussions on material reviewed by students prior to the discussion, in lieu of the typical lecture.⁶⁸

Case-Based Learning

A growing number of medical schools deliver educational content in case-based or problem-based learning formats in which students are placed into small group discussion sections.⁶⁹ Content is organized into clinically realistic cases associated with a set of assigned questions designed to teach underlying physiologic mechanisms, differential diagnosis, diagnostic workup, and treatment.⁷⁰ Answering these questions requires learners to apply their knowledge of various academic disciplines (e.g., pharmacology or microbiology) in a manner that integrates learning in clinically meaningful ways.

In these formats, colleges of medicine will cluster cases into blocks based on organ systems⁷¹ or based on a longitudinal study of medical concepts organized by increasing complexity such as the Johns Hopkins University School of Medicine's Genes to Society curriculum.⁷² Information relevant to a particular organ system will incorporate cases specific to that system. For a pulmonary curriculum block, students may focus on cases that include cystic fibrosis, asthma, and pneumonia to draw upon the student's knowledge of genetics, the inflammatory cascade, and infectious disease.

Small groups are also used to teach physical exam skills, either in conjunction with standardized patients⁷³ or with first- or second-year medical students meeting real patients on clinical services.⁷⁴ Some universities have used small group formats to teach professionalism,⁷⁵ ethics,⁷⁶ cultural competency,⁷⁷ and sociocultural concepts.⁷⁸ In general, colleges of medicine have tried to shorten the amount of didactic time dedicated to teaching concepts and increase the amount of time students spend in small groups discussing and applying concepts.

As students are asked to do more than repeat knowledge, they draw on higher learning skills, such as application, analysis, and synthesis.⁴⁷ Such educational modalities help students retain and better apply key concepts; this has been referred to as the "stickiness" of lessons.⁵⁶ There has been a great deal of research on the effectiveness of case-based learning, with some authors extolling its superiority to other formats,^{79,80} and others suggesting that it is no better than traditional learning formats.^{48, 81, 82}

Clinical Rotations

Most colleges of medicine maintain a clinical curriculum in which students rotate through various clinical services.⁶¹ The core rotations are typically based upon the clinical sites associated with the medical school, and as such usually include tertiary care settings with hospitalized patients. Core clinical rotations usually include internal medicine, surgery, obstetrics-gynecology, pediatrics, and psychiatry with many schools also requiring rotations through neurology and family medicine services. In addition to a school's set of required clerkships, medical students are offered elective time to set up rotations in clinical settings of their choice.

Clinical rotations usually employ a model in which students are attached to a clinical team or preceptor. In hospitals, students are involved with clinical rounds in which they are exposed to and meet with their team's patients. In ambulatory clinics, students are typically asked to interact with visiting outpatients alongside or prior to their preceptor. In either instance, students are assigned patients, are asked to conduct histories and physicals, present cases to their preceptor (usually a resident or attending physician), and document their findings and clinical reasoning.⁸³ The case presentation is typically an opportunity for immediate feedback about strengths and areas needing improvement.⁸⁴ Documentation is also reviewed and co-signed by students' supervisors.

Clinical rotations may involve large didactic sessions or small group discussion sections aimed at amplifying clinical concepts. Many rotations invite medical students to prepare an academic presentation, based either on a clinically relevant topic or a particular case, and to present this information to the clinical team. Additionally, many departments in academic medical centers have grand rounds presentations in which a particular topic relevant to the department is reviewed in a large-group setting for an audience of medical students, residents, fellows, and attending physicians.⁸⁵

Some medical schools have organized their clinical training into longitudinal clerkships that emphasize continuity of contact between trainees and patients, instead of employing the traditional relatively short-term rotation structure.⁸⁶⁻⁸⁸ Advocates of this approach believe the continuity of contact with patients, faculty, and peers, as well as improved appreciation for the social context of patient care, leads to more patient-centered attitudes and less erosion of students' idealism and empathy.

It is well documented that medical education decreases medical students' empathy toward patients, and some authors suggest this decrease results from a negative, or "hidden" curriculum within clinical training, producing learner distress that ultimately hardens the student to patients' needs.⁸⁹⁻⁹¹ The hidden curriculum in medical education has been described as an undercurrent of norms, values, and regulations within the process of training that the students are implicitly expected to assume and embrace in order to function effectively in a professional role.⁹² These undercurrents can encompass both undesirable cultural attitudes as well as positive and affirming attributes. Clinical supervisors have significant variability in their demonstration of empathic and patient-centered care; this variability, in turn, has a significant impact on students' experiences.⁹³ Empathy declines when students witness practices incongruent with the patient-centered, culturally competent, and professionalism-focused concepts introduced earlier in medical education. Clinical teaching that does not reflect the principles or information presented preclinically often creates dissonance for students expecting to put preclinical education into practice.⁹⁴

Multimodal Curricular Integration of Professional Competency Objectives to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD

Author: Scott Leibowitz, M.D.

Overview

The professional competency objectives proposed in **Chapter 3, Professional Competency Objectives to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD**, are organized according to domains of patient care that are used to assess postgraduate competency when working across disciplines. These competencies can be applied to the various models of skill acquisition used in medical schools. When expanding a curriculum, a common concern of educators is the amount of time required to include new material. The purpose of this section and **Table 4.3: Integrating the Competency Objectives into Educational Curricular Modalities**, is to help educators appreciate and recognize that issues related to sex development, sexual orientation, and gender identity/expression can be integrated into existing curricula in many ways.

Didactic Instruction

Didactic instruction can be used to enhance competence by changing knowledge and attitudes; however, skill acquisition usually requires reinforcement during a different modality, such as a clinical rotation. For example, during a seminar that explains how to perform a physical exam, an instructor may teach that patients from some populations (e.g., transgender or born with DSD) may require extra sensitivity when a physician examines their bodies. This type of competency in knowledge should be reinforced through skill acquisition during a clinical rotation.

Case-Based Learning

Curricula that use case-based learning may already have well-developed clinical cases that are fully integrated into the preclinical education years. However, where case-based learning is being developed or revised, institutions may look to the clinical cases that we have created to assist in incorporating the competencies into the curriculum. (See **Chapter 5: Clinical Scenarios and Discussion Points for Experiential Learning**.)

For pre-existing cases, classroom use of hypothetical questions (as outlined in the accompanying table or listed as discussion points with our clinical scenarios) can illustrate important concepts.

Incorporating these hypothetical constructs into pre-existing cases can be a solution for institutions that may already have well-established clinical cases without having to revamp an established curriculum. For example, in a pre-existing case that has students encounter a heterosexual couple trying to adopt a child due to infertility, students might be instructed to research answers to the following hypothetical questions:

- What would you do if the parents were a same-sex couple?
- Would the policies around adoption be the same or different for the two couples?
- What issues might the same-sex couple encounter that are different from the opposite-sex couple?
- What issues might be the same for both couples?

Using Scenario 2: Gender Dysphoria in an Adolescent, the following illustration provides an example of how our clinical scenarios can be used to elicit discussions about the populations discussed in this publication. By including the discussion points included in the clinical scenarios within a module on adolescent development, puberty, and/or primary care, educators may use Scenario 2: Gender Dysphoria in an Adolescent in its entirety, or they may select salient components of the case to elicit certain discussion points.

Jaime is a 14-year-old adolescent who was born with anatomy consistent with the male sex whom you have been treating since he was a young child. You ask one of the clinical assistants to take his vital signs during a well-child visit. She reads your chart, including some background information and learns that, as a child, Jaime “always liked ‘girl things’ and felt like a girl inside, but did not think that it was possible to do anything because “all people with a penis must be a boy.” He was a rather happy and smart child, formed peer relationships easily, played with boys and girls equally, and flexibly adapted to whatever activity was available.

At this point, one could introduce the discussion topic: “Describe the difference between sex and gender, gender identity and gender role, gender nonconformity and transgender (gender dysphoria).” Clarifying the terminology helps illustrate the following:

1. A patient’s anatomy may not always be congruent with the gender with which they identify (sex versus gender);
2. One’s internal experience of who they are may not necessarily be congruent with one’s behavioral expression of gender (gender identity and gender role); and
3. Gender expression inconsistent with one’s anatomy does not necessarily indicate an individual’s experience of affective distress from that discrepancy (gender nonconformity versus gender dysphoria).

The next component of the clinical scenario introduces aspects of sexuality and provides psychosocial context:

Two years ago (around the age of 12), at a routine visit, Jaime's mother asked if you could provide a referral for a therapist. She felt that Jaime started to become sadder for "no apparent reason" and the grades in school started to slip. You sent them to a colleague who works well with depressed adolescents. Several months later, the therapist communicated to you, sounding alarmed, that Jaime mentioned in a session that he thought he was having crushes on other boys, and questioned the counselor whether he might be gay.

From the scenario, questions remain that might lead a provider to further explore the potential relationship among slipping grades, attractions to other boys, or stage of physical development. The scenario offers the following discussion points:

- "Explain how to obtain a sexual behavior, sexual identity, and gender identity history in an adolescent using open-ended questions that lack presumptions."
- "Describe how the assessment and treatment needs of youth presenting with gender and/or sexuality issues may be impacted by aspects of identity and physical development in adolescence."

A provider or medical student might describe how to obtain a history using open-ended questions that do not make the assumption that an individual's sexual attractions and/or behaviors correlate with a specific identity or sexual orientation. Additionally, interviewing adolescents who are in the midst of exploring the meaning of sexuality, comprehending the role that their gender plays in sexual behaviors they might engage in, and understanding how that affects their concept of the difference between who they are and with whom they feel most comfortable sexually, involves an approach that normalizes variants in human behavior from societal expectations.

It is important for the provider or medical student to recognize that the scenario involves any of a number of situations, including:

1. An adolescent who is comfortable with his anatomy and same-sex attractions yet is simply not achieving in school.
2. An adolescent who may be a gender nonconforming gay and is experiencing attractions to other boys but has not quite self-identified as such.
3. An adolescent who may be experiencing distress from his changing body and starting to experience gender dysphoria (while having attractions to males).
4. An adolescent who may simply be somewhere in the middle of the gender spectrum and not quite clear how that translates to sexual identity.

A competent interviewer should ask the type of questions that differentiates among these experiences, affirms the individuals where they are within their development and awareness, and

allows for the potential to further explore the issues in a future visit. Understanding this would be the goal of these discussion points.

The scenario also brings up the issue of pronouns, which can be a sensitive topic for adolescents and others who may be gender nonconforming.

“He asks you to use female pronouns, and lets you know he (she) prefers to be called Martine, the name of a character from a movie he (she) likes.”

Fostering a healthy doctor-patient relationship with individuals who identify as another gender, prefer a different name from their legally assigned name, and/or prefer that one use the pronouns of a different gender involves logistical considerations of which a competent physician should be aware. This raises the relevant discussion point: “Describe logistical interventions in practice that could be used to enhance comfort in patient interactions between medical office staff and families when a gender nonconforming and/or transgender adolescent presents for care.”

Facilitating a discussion among students to identify the aspects of care where specific interventions may be necessary might include exploration of context-dependent pronoun use and systems-based changes to ensure affirming interactions (e.g. support staff education, electronic medical record changes, provision of a gender-neutral bathroom in the clinical setting).

On physical exam, Jaime (Martine) is at Tanner Stage III and becomes tearful when you examine his (her) genital area. Jaime (Martine) says that he (she) is afraid of getting taller and developing a lot of body hair, and then proclaims, “I just wish I didn’t have to feel this way.” You are unsure how to respond. You are also asked to “keep this a secret” from Jaime (Martine’s) parents. Martine asks you many questions about “blocking puberty” and “hormones” and whether or not it will be possible to start them without her parents’ consent.

At this point in the clinical scenario, medical students may be asked the following discussion point: “Explain the different medical treatment interventions that exist for transgender adolescents and specify when they are indicated.” An educator may consider having students do the necessary research to identify standards of care (e.g., World Professional Association of Transgender Health), evidence-based studies, or clinical practice guidelines that exist to identify various medical treatment interventions (e.g., pubertal suppression in some younger adolescents, cross-sex hormone therapies in some older adolescents) and when those treatments are indicated.

Confidentiality issues are also important to consider and raise the additional discussion point: “Discuss aspects of confidentiality, informed consent and assent policies that need to be considered when working with adolescents presenting with diverse sexual orientations, gender identities, and/or gender expressions.”

Educators can promote student discussion about maintaining confidentiality with regard to sexuality and gender issues, helping them learn that breaking confidentiality with patients should occur only in the context of an acute assessment where a harmful outcome (danger to the patient or others) is suspected. Even if issues of gender and sexuality are key components to an acute risk assessment (e.g., a patient is suicidal because he or she does not accept his or her sexuality

or gender identity), these specific issues need not be addressed with parents/guardians or others should the patient wish otherwise. Understanding a state's specific legal policy on consent and assent practices would be important.

Any of our clinical scenarios in **Chapter 5: Clinical Scenarios and Discussion Points for Experiential Learning** can lead to education and discussion on the specific health disparities faced by these populations, interprofessional collaboration considerations, and assessment of factors that enhance resiliency. Whether the suggested clinical scenarios are integrated into specific curricula or the discussion points are applied to pre-existing curricula, the case-based format offers an appropriate method for teaching these issues in an undergraduate medical education setting.

Clinical Rotations

The geographical location of a clinical rotation could affect the odds that a student will be exposed to a patient who identifies as LGBT, gender nonconforming and/or born with DSD.³ Even within urban medical centers, ensuring that every student is exposed to such diversity may be challenging, if not impossible.

Several caveats exist regarding incorporating the competencies into clinical rotations. First, some students may be more interested than others in being exposed to patients with variant identities, histories, and behaviors. Therefore, it is the role of a clerkship coordinator to ensure that case assignments are distributed evenly to minimize self-selection and to maximize equal exposure of students to all presenting patient populations. Second, given variable demographics, it is possible that individuals who are or may be LGBT, gender nonconforming, and/or born with DSD might rarely present (or be comfortable being identified) in the clinical education setting.

As a result, one could reasonably envision a scenario where a disproportionately large number of medical students might want to gain exposure to these issues from a small number of patients. Protecting the individual patients' right to respectful and confidential medical care should remain the priority. Alternative strategies should be employed to expose students to these issues so they can develop competency while protecting patients from overexposure. Such strategies might include the use of case discussions, videos, and case reports, which prevent patients from feeling "on display."

TABLE 4.3

Integrating the Competency Objectives into Educational Curricular Modalities

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How to Use the Table:

Table 4.3 offers suggestions by which schools can integrate education aimed at specific competencies according to individual teaching modalities. The 30 professional competency objectives introduced in **Chapter 3, Professional Competency Objectives to Improve Health Care for People Who Are or May Be LGBT, Gender Nonconforming, and/or Born with DSD**, are here revisited and listed in the middle column. They are organized by competency domain, which is indicated in the left column. (Within these competency objectives, the “populations and/or individuals described above” refer to the populations described in the introduction to the Professional Competency Objectives described in Chapter 3.)

Below each professional competency objective in the second column are examples of how this particular objective might be addressed in health care. Some of these examples are general; others are more specific.

The right column includes suggestions for how to integrate the teaching and learning of these points into various parts of the curricula using various instructional modalities. While there are many different formats and pedagogies used for medical education, we have selected didactic instruction, case-based learning, and clinical rotation as three main types of instruction as examples, recognizing that individual curricula may employ the use of many other educational modalities.

Educators can use these suggestions as a guide to determine the best method by which the recommended competency objectives can be integrated within their individual curricula as well as how the objectives can be applied to active learning methods (any nondidactic modality that has an interactive component). The clinical scenarios and associated teaching objectives in this chapter illustrate real-life situations relevant to specific competencies and offer another excellent way to introduce these topics into the curriculum.

Achieving competency in the areas described within the table does not necessarily require direct experience with patients from the full spectrum of sex, sexual orientation, and gender identity/

expression, just as students are not required to treat persons of every ethnicity, culture, and race before being considered culturally competent. In fact, educational approaches that enhance group learning—such as case discussions and rounds or self-guided learning through modules—should specifically address the learning needs of students who may not have direct clinical exposure to these patients, as this may represent the majority of students. Both the National LGBT Health Education Center and The Fenway Institute offer such modules that can be integrated into medical school curricula. (See **Appendix B, Medical School Programs and Related Resources**, for additional specific examples of existing programs.)

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Patient Care	1. Sensitively and effectively eliciting relevant information about sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from all patients in a developmentally appropriate manner. - Avoiding assumptions based on sex anatomy. If a patient has atypical sex anatomy, such as genitalia with signs of surgical scars, do not assume the patient is transgender. Sensitively elicit the medical history. - Approaching the clinical interview of a self-identified transgender person with open-ended questions that do not presume the individual wants or needs every aspect of gender reassignment. - Approaching self-identified gay, lesbian, bisexual, and straight patients with open-ended questions that do not presume they are engaging in specific types of sexual behaviors with a certain number of partners. - Approaching patients born with DSD without presuming they are struggling with issues around sexuality or gender identity.	Didactic: - Include a discussion during a lecture on history taking. Case-Based Learning: - Encourage students to use language that is open-ended and to avoid assumptions about current or future identity or particular biological history when conducting standardized patient interactions and/or case-based learning opportunities Clinical Rotation: - Ensure students demonstrate how to obtain a sexual history by using open-ended questions when encountering all patients where these issues may be relevant.

TABLE 4.3 CONTINUED

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Patient Care	2. Performing a complete and accurate physical exam with sensitivity to issues specific to the individuals described above at stages across the lifespan. This includes knowing when particular aspects of the exam are essential and when they may be unnecessarily traumatizing. • Being aware that repeat genital exams by multiple providers can be traumatizing, especially for patients who have histories of DSD or gender dysphoria. • Approaching all patients with the awareness that gender expression does not necessarily indicate anatomy and responding without judgment when expression and anatomy do not match. • Using a speculum that is appropriately sized for a patient's anatomy without judgment or comment. 3. Describing the special health care needs and available options for quality care for transgender patients and patients born with DSD. • Understanding surgical and hormonal options available for gender dysphoric individuals, including pubertal suppression (in youth) and/or cross-sex treatment; knowing when to refer to a specialist in pediatric, adolescent, or adult gender care. • Understanding the difference between elective and nonelective indications for specific surgical procedures for transgender individuals (e.g., considering a tracheal shave or a vaginoplasty as nonelective procedures for a gender dysphoric natal male). • Understanding that medical consensus calls for referral to specialist DSD teams when a newborn, infant, child, or adolescent is identified as possibly having DSD.	Didactic: • Include a discussion during a lecture on performing physical exams. Case-Based Learning: • In any standardized patient where a genital or breast exam is required, discuss common assumptions and the potential sensitivities required when approaching the patient. Clinical Rotation: • Address these issues when genital or breast examinations are performed during the clinical rotation and instruct students that certain patient populations may require extra sensitivity during this aspect of medical care. Didactic: • Discuss hormone treatments during an endocrine organ system unit. • Introduce sexual reassignment procedures in a human anatomy or reproductive health unit. Case-Based Learning: • Ask students to explore and discuss scenarios when nonelective surgeries are indicated in these populations using a standardized patient or case-based learning opportunity that raises issues around elective surgeries. • Raise these issues during a standardized patient or case that specifically includes a transgender individual. • Consider hypothetically raising these issues during cases where endocrine or surgical consultation is necessary. Clinical Rotation: • Discuss all types of surgical procedures (and their indications) for patients who are transgender and patients born with DSD during a surgery rotation.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Patient Care	4. Assessing unique needs and tailoring the physical exam and counseling and treatment recommendations to any of the individuals described above, taking into account any special needs, impairments, or disabilities. • Recognizing how misperceptions about adolescents and adults with significant impairments might impact history-taking and approaching the sexual history with the same open-ended questions as you would with other patients. • Recognizing the potential challenges faced by patients with minority sexual orientation, gender history, and/or DSD history who also has special needs, impairments, or disabilities that affect their sexual lives. Sensitively asking these patients what you can do to better understand his or her situation in terms of sexual health needs.	Didactic: • Include relevant LGBT and DSD-related content during a session on the needs of special populations. Case-Based Learning: • Ask hypothetical questions during a standardized patient or a case-based learning experience that includes someone who is impaired or has special needs. Elicit discussion about how the needs of those patients may or may not change if they were LGBT or had a history of DSD. Clinical Rotation: • Ensure that sexual history and sexual health needs are assessed and addressed as appropriate when students encounter patients who may have special needs, impairments, or disabilities.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Patient Care	1. Recognizing the unique health risks and challenges often encountered by the individuals described above, as well as their resources, and tailoring health messages and counseling efforts to boost resilience and reduce high-risk behaviors. • Providing positive sexual health messages for patients who are or may be LGBT in order to convey acceptance of primarily nonharmful sexual behaviors, while addressing specific aspects of those behaviors that could lead to unhealthy outcomes such as STIs or substance abuse. • Recognizing the attributes of an individual that confer resiliency, such as their ability to positively cope with victimizing situations or the presence of strong family/peer/community supports. • Mentally preparing prior to taking a sexual history in which a patient may describe less common forms of sexual attraction, sexual behavior, sexual relationships, etc., to prevent inappropriate expressions to the patient of disgust, alarm, or undue fascination. • Helping patients understand the difference between what society may consider sexually “normal” and what is healthy by screening appropriately for medical risk and discussing risk and prevention strategies with patients. • Helping patients who feel isolated by their sexual orientation, gender history, and/or DSD history and locating peer support groups that promote resiliency.	Didactic: • Address high-risk sexual behaviors during lectures on infectious disease. • Address health risks in these populations during lectures on sexual and reproductive health. • Discuss factors that confer positive health outcomes for these populations during lectures on sexual and reproductive health. Case-Based Learning: • Raise awareness of possible high-risk behaviors in LGBT populations during another case where high-risk behaviors (such as substance abuse or sexual activity leading to sexually transmitted infections) are addressed. Spur group discussion with a hypothetical question, such as “Are there any populations who are disproportionately affected by these diseases?” • Introduce ways to assess and tailor positive health messages about sexual health for LGBT populations during a case that raises issues of pregnancy and contraception. Clinical Rotation: • Ensure that sexual history taking is included in primary care, adolescent, or internal medicine rotations. • Discuss how to obtain the information by asking questions that both promote positive sexual health and self-image and also assess behaviors that may lead to disease states and poor outcomes • Address sexual health in discussions of counseling or treatment planning during a community clinic or OB/ GYN rotations. Ensure that these encounters are aimed at preventing potential negative outcomes and are appropriate for specific patient populations.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Patient Care	2. Providing effective primary care and anticipatory guidance by utilizing screening tests, preventive interventions, and health care maintenance for the populations described above (e.g., screening all individuals for inter-partner violence and abuse; assessing suicide risk in all youth who are gender nonconforming and/or identify as gay, lesbian, bisexual and/or transgender; and conducting screenings for transgender patients as appropriate to each patient's anatomical, physiological, and behavioral histories). - Performing screenings generally recommended for those of an individual's natal sex; for example, obtain Pap smears for all patients whose anatomy puts them at risk for cervical cancer, including women who have sex with women and transgender men who retain their cervixes. - Providing hepatitis vaccination for individuals who engage in receptive anal intercourse. - Determining whether a patient with a DSD history needs hormone replacement therapy (e.g., for osteoporosis prevention), reproductive cancer screening, or help understanding his/her medical history, etc.	Didactic: - Discuss the needs of these populations in lectures that cover vaccinations, screening tests, and preventive interventions. Case-Based Learning: - Ask hypothetical questions that elicit discussions of screening tests or preventive interventions for patients who are LGBT and/or born with DSD. For example, ask "In individuals whose gender identity and natal sex do not match, which preventive screenings should be performed?" Clinical Rotation: - Ensure that students in primary care rotations or students following patients longitudinally are aware of how recommendations might (or might not) change if a patient who identifies as LGBT or has a history of DSD.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Knowledge for Practice	1. Defining and describing the differences among: sex and gender; gender expression, and gender identity; gender discordance, gender nonconformity, and gender dysphoria; and sexual orientation, sexual identity, and sexual behavior. - Understanding basic definitions and concepts including that “sex” refers to an anatomical construct whereas “gender” reflects social constructs of what it means to be masculine or feminine within an environmental context. Cultures differ somewhat in their expectations of gender, and cultures evolve in gender expectations. - Recognizing that some other cultures have historically had more than two socially recognized gender categories (e.g., Samoa, India, parts of Mexico) and approach such situations with humility and sensitivity to the patients’ needs. - Understanding the concepts of gender expression, gender identity, gender dysphoria, and gender nonconformity and how they may or may not relate to each other for different individuals. For example, individuals who may feel “gender discordant” may not experience gender dysphoria and may live as an alternative gender without pursuing medical interventions to align their anatomy with their identity. - Understanding that individual patterns of sexual attraction and arousal may differ from how patients identify their sexual orientation and may not match their sexual histories. - Understanding that sexual identity is a broad general term under which sexual orientation, sexual behavior, and sexual fantasies all fall.	Didactic: - Describe the terminology of sex and gender during seminars on cultural diversity, health disparities, social policy, and/or identity development. Case-Based Learning: - Integrate definitions of broader terms (sexual behavior, sexuality, sexual identity, and sexual health) as an objective during a case that explores sexual health. Integrate more specific terms (sexual orientation, gender nonconforming, transgender, differences of sexual development) as an objective during a case with a variant identity. Integrate disparity terms (heterosexism, homophobia, transphobia, sexism) as an objective during a case when cultural diversity or sociocultural concepts are being portrayed. - Use a clinical scenario that illustrates the conflation of sex and gender or sexual orientation, identity, and behavior to address the concepts. Clinical Rotation: - Ensure that students demonstrate understanding of these concepts during initial history taking by asking multiple open-ended questions on sex development history, gender and sexuality, and by recognizing that these may change over time when following patients longitudinally.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Knowledge for Practice	2. Understanding typical (male and female) sex development and knowing the main etiologies of atypical sex development. - Describing how female-typical sex development ordinarily follows from an XX chromosomal complement at conception and how male-atypical sex development ordinarily follows from an XY chromosomal complement. - Reviewing the mechanisms for gonadal differentiation, development of the Mullerian and Wolffian structures, fetal genital development, development of secondary sex characteristics at puberty, and typical changes in sex characteristics in older age. - Understanding the basic etiology of DSD across all the conditions associated with it. - Considering and assessing exogenous and endogenous causes and their risks if a child, adolescent, or adult presents with atypical sex anatomy.	Didactic: - Address the genetic basis for sex differentiation and sex development, endocrinology, etc., during a lecture or module that focuses on typical embryological development. Case-Based Learning: - Incorporate this objective into any patient case that depicts a variant of typical embryological development (e.g., in a case covering cardiac malformations or abnormalities in sex chromosomes). Clinical Rotation: - Incorporate these concepts into a surgery or OB/GYN rotation through use of hypothetical discussion if a patient born with DSD does not present.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Knowledge for Practice	3. Understanding and explaining how stages of physical and identity development across the lifespan affect the above-described populations and how health care needs and clinical practice are affected by these processes. - Understanding that in some forms of DSD (e.g., ovotestes with ambiguous genitalia), gender identity may be particularly hard to guess at birth. In such cases, families may benefit from consulting with trained mental health professionals to gain understanding about gender identity development. - Understanding the context of sex development and that prepubertal children with gender variant identities may or may not ultimately identify as transgender. Assuming that they are transgender can unnecessarily introduce risk and harm; however, not addressing gender dysphoria in a sensitive and affirming way may also introduce risk and harm. - Recognizing that pubertal adolescents who identify as transgender are more likely to experience an anatomical incongruence with their gender identity throughout the remainder of their lifespan than prepubertal children with similar feelings considering pubertal advancement helps an individual understand their reaction to their body with more accuracy. - Understanding that adolescents who are exploring their sexualities may be more fluid in behavior and identification than adults. - Recognizing that older individuals who are LGBT may feel anxiety or loneliness stemming from isolation from their families, not having offspring to tend to their needs, and/or concern that their life partners will not be able to make decisions for them in the hospital in the event that they become ill (depending on the state's policies).	Didactic: - Address psychological issues that may arise in these populations during a course or module on behavioral health across the lifespan. - Address physical and identity development in childhood, adolescence, and adulthood in a course or module on life stages. Case-Based Learning: - Include cases that represent each of the major developmental phases throughout the lifespan (neonatal/infancy, pediatric, adolescence, adulthood, geriatric, end of life) to capture the varying needs of each population. - Add hypothetical questions to pre-existing cases that reinforce conventional stereotypical gender and sexuality constructs to help students understand these important concepts (for example asking "What if the boy in this case, instead of liking trucks and sports, preferred playing with dolls and girls?") Clinical Rotation: - Address issues of gender identity and discuss with students how to approach patients in each developmental stage who may be experiencing these (or an alternative form of these) issues. - Discuss typical gender and sex development in a child; sexual behaviors and identification in an adolescent; and relationship end-of-life issues in an advanced-age individual. - Introduce hypothetical situations that might come up for individuals who present with variant bodies, behaviors, or identities within the context of a pediatric rotation.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Knowledge for Practice	4. Understanding and describing historical, political, institutional, and sociocultural factors that may underlie health care disparities experienced by the populations described above. - Understanding the evolution of American medicine's approach to conceptualizing and labeling homosexuality, which initially was considered a "mental disorder" in need of a cure. Currently, major medical and mental health organizations strongly recommend against so-called "reparative" therapies for same-gender attraction. - Analyzing the history of clinical practice regarding people born with DSD and its effect on this population. For example, historically boys born with micropenis were sex- changed into girls as babies in order to make them appear more sexually typical of their gender assignment and then withholding this medical history from the patients when they got older. Today, consensus on DSD calls for full disclosure to patients with DSD medical histories and a more patient-centered, evidence-based approach to outcomes. - Recognizing that some patients' health insurance policies will actively discriminate against them on the basis of gender identity and/or sexual orientation including, for example, refusing spousal benefits to same-gender couples and refusing coverage of gender-affirming medical interventions that evidence shows may improve mental health. - Understanding that a gay man or lesbian woman who loses a bread-winning partner of decades may receive no Social Security survivor benefits, may be isolated from biological family because of being ostracized years before, and may simultaneously face grief, isolation, and extreme economic hardship, a combination that may lead to or exacerbate medical and/or mental health problems. - Knowing that local, state, and federal laws and policies that discriminate against or allow discrimination against people on the basis of sexual orientation can lead to victimization, marginalization, and isolation, all of which are associated with increased mental health risk for lesbian and gay youth, adults, and their families.	Didactic: - Address the history of health disparities in these populations during a seminar or module that focuses on policy development, cultural diversity, or the sociopolitical context of patient care. Case-Based Learning: - Include an example of an environmental, institutional, or social factor that leads to an adverse outcome in a pre-existing case by adding an objective that specifically instructs students to research an example of how these factors impact the care of individuals who may be LGBT, gender nonconforming, and/or born with DSD. Clinical Rotation: - Encourage students in the course of clinical care to identify the impact of historical, political, environmental, institutional, and/or social factors on health outcomes when they encounter an individual who identifies as LGBT or born with DSD, a patient whose sexual behaviors may differ from conventional definitions of their stated sexual identity, or an individual whose gender expression may not be congruent with their assigned gender or natal sex.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Knowledge for Practice	5. Recognizing the gaps in scientific knowledge (e.g., efficacy of various interventions for DSD in childhood; efficacy of various interventions for gender dysphoria in childhood) and identifying various harmful practices (e.g., historical practice of using “reparative” therapy to attempt to change sexual orientation; withholding hormone therapy from transgender individuals) that perpetuate the health disparities for the patients in the populations described above. - Understanding that reparative therapies aimed at changing an individual’s sexual orientation have been determined to be harmful. - Being aware of the lack of consensus about how health care professionals should support a prepubertal gender variant child and his or her family as they face various challenges (e.g., identifying as a new gender at school) and being aware of the lack of data on benefits and risks of gender transition, and specific circumstances when gender transition may or may not be indicated. - Recognizing there is little evidence to prevent physicians from supporting and affirming a child’s current gender identity and/or gender expression. However, physicians should do so in a way that encourages healthy gender exploration and does not pressure or externally influence the child’s later self-expression. - Recognizing that pubertal suppression, an intervention that was first used in the mid-2000s, shows evidence of mental health benefits in some transgender adolescents, but long-term outcomes are still being studied. - Recognizing the lack of evidence to support many genital “normalizing” surgeries, including “repair” of minor benign hypospadias, clitoroplasty to reduce clitoral size in girls born with large clitorises, etc. These practices may nonetheless persist out of an untested assumption that genital typicality is required for healthy psychosexual development.	Didactic: - Address these topics during a seminar or module that discusses health policy, the importance of evidence-based practice, and/or the effects of providing treatments that are associated with harmful outcomes and have no support from professional organizations. Case-Based Learning: - Incorporate into a case the importance of using evidence-based interventions. Ask students to identify an example of an intervention that could be harmful, that lacks professional society support, or that has no evidence to support its use. Clinical Rotation: - Address these topics in any setting when a student encounters a patient (or family) seeking an intervention that lacks professional society support or has been determined to be controversial. - Use the opportunity to raise issues facing LGBT and individuals born with DSD when relevant.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Practice-Based Learning and Improvement	1. Critically recognizing, assessing, and developing strategies to mitigate the inherent power imbalance between physician and patient, or between physician and parent/guardian, and recognizing how this imbalance may negatively affect the clinical encounter and health care outcomes for the individuals described above. - Employing principles of shared decision-making with talking to parents of a newborn who has ambiguous genitalia, recognizing that parents may feel pressure to follow the recommendation of physicians regarding elective genital “normalization” surgeries and that the decision to proceed with or avoid surgery might alter the course of treatment or impact quality of life for the patient. - Recognizing the lack of evidence for explicitly recommending that parents allow or not allow their prepubertal child to cross-dress, while realizing that parents might defer to a physician’s recommendation, regardless of what might be more beneficial for that specific child. - Appreciating that patients who are gender nonconforming (and parents or guardians) may feel shame and might not feel comfortable disclosing aspects of their behavior and/or identity to their physician. - Recognizing that a lesbian woman may not feel comfortable rejecting a physician’s recommendation that she does not need a Pap smear because she is not engaging in sex with men. - Considering the physician’s role in creating a clinical environment that supports patients’ active role in decision-making.	Didactic: - Address, during a lecture on the doctor-patient relationship, how patients in these populations may respond to the power imbalance between physician and patient (and/or parent/guardian). Case-Based Learning: - Provide examples within an existing case where patients automatically defer to physician expertise. Ask the students to extrapolate how the power imbalance might hypothetically affect the clinical care of a patient who is LGBT or born with DSD or that patient’s family. Clinical Rotation: - Address the power imbalance that a physician may have with a patient or family across all populations. Specifically mention the impact that this imbalance has in populations who may hide their sexual identities and/or behaviors. - Help students understand that the power imbalance would likely minimize its mitigating effects in the clinical treatment of all persons.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Practice-Based Learning and Improvement	2. Demonstrating the ability to elicit feedback from the individuals described above about their experience in health care systems and with practitioners, and identifying opportunities to incorporate this feedback as a means to improve care (e.g., modification of intake forms, providing access to single-stall gender-neutral bathrooms, etc.). - Conducting patient surveys and other assessments to identify ways to make the health care environment more welcoming for individuals in these populations, such as by making available gender-neutral or unisex bathrooms; modifying intake forms to include additional options for sex, gender, or sexual orientation or adding space for a preferred name in addition to legal name. - Reviewing intake forms to allow patients in these populations to record their medical histories accurately and receive information based on that rather than their gender and/or menopausal status (e.g., changing an intake form that asks only post menopausal females about use of HRT when some men and women born with DSD and lacking gonads will be on lifelong HRT for medical reasons).	Didactic: - Introduce these concepts when teaching about health care delivery, especially when covering the use of electronic health records and/or collecting patient information. Case-Based Learning: - Address how specific aspects of the health care system impact the delivery of care to these populations. Specifically discuss with students the environmental aspects of a clinic or hospital setting, intake questionnaires, documentation and electronic health record systems, and forms that require gender or sex markers, such as prescriptions. - Incorporate teaching points about improving these systems to help identify and support patients of all identities and variants in the sex development, sexual and gender realms. - Discuss how these populations may perceive the health care environment during any case in which a patient has a complaint about the clinic's environment or policies that are not inclusive. Clinical Rotation: - Provide students opportunities to identify how attitudes and practice environments may affect patient care and to suggest ways to improve specific settings.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Practice-Based Learning and Improvement	3. Identifying important clinical questions as they emerge in the context of caring for the individuals described above, and using technology to find evidence from scientific studies in the literature and/or existing clinical guidelines to inform clinical decision-making and improve health outcomes. Consulting reliable and appropriate resources when advising patients (and their families) at different life stages about gender-affirming therapies or management for DSD. (See Appendix C, Suggested Reading and Resources for specific recommendations.)	Didactic: - Address issues faced by these populations during a seminar or module on epidemiology, evidence-based practice, and/or performing a literature search. Case-Based Learning: - Raise these issues during an endocrine system module case, asking students to search for and critically analyze guidelines that offer hormone regimens for transgender people. - Raise these issues during a child and adolescent development case, asking students to search for and critically analyze guidelines that reflect the most current clinical practices regarding gender and sexuality development. - Discuss these points during a case that focuses on DSD or other anatomical variant, asking students to search for and critically analyze guidelines that reflect the most current expert consensus about the care of individuals born with DSD. Clinical Rotation: - Encourage students to search for evidence-based practices in the literature when they encounter a patient who identifies as LGBT or born with DSD. - Encourage students in the clinical setting to be aware of evidence-based practices available for the populations who are LGBT and/or born with DSD when issues arise around sex, sexuality, or gender. Interpersonal and Communication Skills

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Interpersonal and Communication Skills	1. Developing rapport with all individuals (patient, families, and/or members of the health care team) regardless of others' gender identities, gender expressions, body types, sexual identities, or sexual orientations, to promote respectful and affirming interpersonal exchanges, including by staying current with evolving terminology. • Checking clinic notes and adhering to name and pronoun preferences (without breaching confidentiality requests) if a patient's legal name and legal gender identity do not match the patient's self-expression; using patients' preferred pronouns and names in personal communications. • Displaying appropriate comfort or support for patients or colleagues who raise issues about a same-sex or opposite-sex partner. • Displaying appropriate interest when discussing issues pertaining to gender and/or sexuality with patients, families, and colleagues of all identities • Recognizing that display logos and pamphlets of LGBT and DSD patient advocacy organizations can indicate that a practice welcomes all patients.	Didactic: • Address these topics when teaching history taking or in a seminar about communicating with patients. Case-Based Learning: • Include discussions of social cues and strategies to develop rapport with individuals who may be LGBT, gender nonconforming or born with DSD during a case in which the provider displays overt verbal or covert nonverbal cues of discomfort when a patient presents with differences in sex anatomy, or gender identity/nonconformity. Clinical Rotation: • Demonstrate the ability to address sex, sexuality, and gender identity in a comfortable, empathic manner with all patients. • Ensure that students can professionally discuss specific issues with patients whose identities and/or behaviors do not match conventional societal expectations.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Interpersonal and Communication Skills	2. Recognizing and respecting the sensitivity of certain clinical information pertaining to the care of the patient populations described above, and involving the patient (or the guardian of a pediatric patient) in the decision of when and how to communicate such information to others. - Realizing that information related to gender identity (including legal name, preferred name and certain details of the medical history) may be particularly sensitive for some patients and may even put them at risk. - Approaching these areas of the medical record with care and understanding, for example, asking whether a patient feels safe having clinic records reflect that their legal name does not match the preferred name or gender identity or asking how a patient with a history of DSD prefers information about their anatomy and treatment history to be recorded in the chart.	Didactic: - Address these topics during a seminar or lecture on documentation. Case-Based Learning: - Encourage students to identify appropriate communication strategies by including examples of documentation and/or verbal communication exchanges that are inappropriate during a case or standardized patient. Clinical Rotation: - Ensure that students adhere to appropriate documentation strategies when a patient offers relevant information during a sexual and/or gender development history. - Ensure that communication about these issues is limited to patient preference and clinical relevance when a patient offers relevant information during a sexual and/or gender development history. - Ensure that students take steps to make sure communication of clinical information of about gender identity or sexual orientation does not lead to undue harm toward the patient. - Ensure that verbal presentation of clinical information is sensitive to the patient's affirmed gender identity and preserves confidentiality.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Interpersonal and Communication Skills	3. Understanding that implicit (i.e., automatic or unconscious) bias and assumptions about sexuality, gender, and sex anatomy may adversely affect verbal, nonverbal, and/or written communication strategies involved in patient care, and engaging in effective corrective self-reflection processes to mitigate those effects. - Asking all patients, "How would you prefer that I address you?" and respect the response, including in terms of name, title ("Mr.," "Ms.," "Mrs.," "Dr.," etc.), and pronoun. - Avoiding the questions that have gendered assumptions behind them such as, "Do you have a girlfriend?" - Asking individuals who appear gender nonconforming in a friendly tone, "With which pronoun do you feel most comfortable?" - Asking every patient when obtaining a sexual history: "Are you sexually attracted to men, women, both, or some alternative gender?" - Recognizing the importance of including a "name and pronoun" narrative section in documentation that justifies the name and pronoun used to refer to the patient (should it differ from the patient's legal name and pronoun of their natal sex). - Recognizing that a provider's response to the patient's sexual anatomy can have a profound effect on the patient. Providers should prepare themselves before a genital exam in which a patient's sexual anatomy may or may not be what they expect. - Acknowledging and apologizing for referring to someone by the wrong pronoun or title or for insensitive responses to a patient's genital or chest anatomy, etc.	Didactic: - Address these topics during a seminar on cultural competency, bias, and/or health disparities. - Raise the issues in small peer groups led by faculty members. Case-Based Learning: - Discuss during a case or standard patient experience in which issues are raised about how assumptions can affect a therapeutic alliance or ability to obtain accurate histories. - Instruct students to identify erroneous strategies and provide appropriate corrective strategies. Clinical Rotation: - Address these topics during history taking in any rotation. - Assess student-patient interactions where a sexual history is important, relevant, and/or necessary. - Review documentation strategies with students during clinical encounters with patients' whose natal sex and gender may be incongruent.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Interpersonal and Communication Skills	4. Identifying communication patterns in the health care setting that may adversely affect care of the described populations, and learning to effectively address those situations in order to protect patients from the harmful effects of implicit bias or acts of discrimination. • Recognizing the role of provider bias and assumptions on the quality of patient communications and the ability to care for people who do not adhere to societal norms. • Realizing that information on intake forms may lead providers to make erroneous assumptions about gender, sexual orientation, and sex development. For example, providers may mistakenly assume that a patient who checks a “married” box is heterosexual. • Ensuring that a provider offers family planning and contraception options to all patients and does not make assumptions based on sexual orientation, gender identity or history of DSD. • Showing respect (including respect for confidentiality) for how patients self-identify in terms of gender and sexual orientation. • Avoiding the use of stigmatizing and outdated terms, e.g. “pseudo-hermaphrodite” or “intersexual” for a patient born with DSD; “homosexual” for a gay man, and/or “tranny” for a transgender individual. Additionally, using “homosexual,” “heterosexual,” and “transgender” only as adjectives to describe the identities or behaviors of individuals, not as nouns.	Didactic: • Address these topics when teaching medical history taking. • Address these topics when teaching about discrimination, cultural competence, and/or bias in health care. • Explore these issues during small peer groups led by faculty members. Case-Based Learning: • Include case examples that help students identify situations in the health care setting where patient preferences about communication and documentation are not respected; encourage students to provide solutions. Clinical Rotation: • Include hypothetical discussions in team rounds that cover communication patterns in the health care setting that may adversely affect care of these populations or issues of cultural competence.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Professionalism	1. Recognizing and sensitively addressing all patients' and families' healing traditions and beliefs, including health-related beliefs, and understanding how these might shape reactions to diverse forms of sexuality, sexual behavior, sexual orientation, gender identity, gender expression, and sex development. - Recognizing that patients or family members may hold specific religious beliefs about sexual orientation or gender identity/ expression that are incongruent with the individual's innate sexual orientation and/or gender identity/ expression. - Realizing that patients from some ethnicities or cultures (such as those in which the individual defers to the family or to the parents) may feel ashamed or may feel they need to suppress an identity or behavior that might otherwise be accepted. - Understanding that a family may hold specific beliefs about spirituality and/or gender, or come from a culture with strong beliefs about gender, that makes them more inclined to raise a child born with ambiguous genitalia as either males, females, or without a gender.	Didactic: - Address these topics during a seminar or lectures on cultural competence, specifically noting the potential issues that might arise with respect to people who are or may be LGBT and/or born with DSD. Case-Based Learning: - Raise these specific issues within a case that already describes how healing traditions and beliefs may impact health outcomes, and ask students/providers to simulate interview methods that are respectful of individual and family beliefs, yet promote healthy physical and psychological outcomes. Clinical Rotation: - Discuss sex development, sexuality, and/or gender identity/ expression to help elicit strategies that students might take to provide respectful and evidenced-based care for a patient or family with specific health-related beliefs and/ or traditions about sexuality or gender roles.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Professionalism	2. Recognizing the unique aspects of confidentiality regarding gender, sex, and sexuality issues, especially for the patients described above, across the developmental spectrum, and by employing appropriate consent and assent practices. • Being aware that a patient may worry that a practice may divulge information to a spouse or family members, such as by leaving a message that uses a preferred pronoun or name when family members are unaware that the patient may be transgender. • Recognizing that a patient may have specific sensitivities about context, for example even if the record of a patient notes that he identifies as “gay,” he may not want to discuss his male partner when he presents at an office visit with his female spouse. • Ascertaining patient preference and concerns about how information about sex development, sexuality, and gender identity is shared in the clinical setting verbally, in writing, and/or electronically. • Being aware of the potential to break confidentiality inadvertently. For example, a medical student, resident, or physician who is excited to see a less common form of sex development may then talks with others about the case in ways that violate confidentiality and potentially expose the patient and his/her family to unwanted scrutiny and stigma. • Recognizing special concerns youth may have about confidentiality and how that might affect the information revealed by a patient during an office visit. For example, an adolescent may be afraid to share with the provider that she is attracted to other girls because she fears the provider will have to tell her parents. A provider can alleviate these fears and pave the way to more open interactions by reviewing legal parameters of confidentiality and explaining that aspects of sex, sexuality, and gender identity are to be kept confidential and are separate from a provider’s duty to break confidentiality if a safety-related concern is raised during treatment.	Didactic: • Address the special concerns of these populations during a module covering aspects of health care delivery and confidentiality, being sure to include similarities and differences in pediatric/adolescent patient populations, and specific examples of how gender, sex development, and sexuality issues should be addressed. Case-Based Learning: • Discuss confidentiality when it is relevant to clinical care. • Address the unique confidentiality needs of patients who are LGBT and/or born with DSD (ascertaining the degree to which specific details surrounding issues of sex development, sexuality and gender identity/ expression enter a medical record or verbal discussion) during any case where students are taught how to maintain confidentiality across different settings and developmental stages. • Explore these issues during a case involving teenage pregnancy and/or a sexual health related issue in an adolescent by bringing up hypothetical questions about the application of confidentiality to LGBT youth. Clinical Rotation: • Address the specific confidentiality needs of minors and specifically adolescents during a pediatric rotation when parameters of confidentiality are discussed. Ensure that students recognize that breaking confidentiality for safety reasons does not mean discussing sexual orientation and gender identity related issues with others (even if they are at the root of the issue leading the youth to feel or be unsafe). Clinical Rotation: • Discuss confidentiality as an important aspect of care with all patients across all clinical rotations. In any clinical rotation, students should have ample opportunity to demonstrate how to maintain confidentiality regarding sexual and gender-related issues, and then elicit an individual’s specific preferences with regard to confidentiality on sex development, sexuality, and gender identity issues should they arise.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Professionalism	3. Accepting shared responsibility for eliminating disparities, overt bias (e.g., discrimination), and developing policies and procedures that respect all patients' rights to self-determination. - Working with the administration in an institution to distinguish natal sex and gender identity in data collection and the medical record. - Working with the administration in an institution to offer patients nonbinary gender options in data collection and a way to portray that in the medical record. - Improving cultural competency for all staff in an institution by recommending and participating in diversity trainings to support the education of employees about sex, sexuality, and gender issues across all levels of interaction that staff may have with patients and families. - Identifying specific aspects of the clinical environment that may need improvement, such as the lack of a gender-neutral bathroom.	Didactic: - Address during a didactic seminar about data collection, gender differences, health care policy, and/or cultural competence. Case-Based Learning: - Address in a case involving a health disparity or an aspect of the health care environment that needs to be changed to meet patients' care needs. Clinical Rotation: - Explore during clinical encounters when reviewing documentation strategies or communicating with support staff about cultural competence. Students can integrate their knowledge of the specific health disparities that exist for patients who are LGBT and/or born with DSD into their clinical rotation across the various specialties to identify any specific corrective measures that may need to take place within the setting of the discipline they are learning at the time.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Professionalism	4. Understanding and addressing the special challenges faced by health professionals who identify with one or more of the populations described above in order to advance a health care environment that minimizes and/or eliminates the use of policies that perpetuate disparities. - Ensuring that the clinical and hospital settings have employee nondiscrimination policies for providers and staff who are LGBT. - Providing comprehensive domestic partner benefits to providers and staff who are LGBT. - Exploring and understanding the potential impact that personal self-disclosure may have on the clinical care of a patient when a provider's LGBT identity is known.	Didactic: - Address during a seminar or lecture on professionalism and/or provider disclosure. - Explore during small groups with faculty advisors when issues around provider identity and self-disclosure are raised for all students, regardless of the issue being sexuality and/or gender expression. Case-Based Learning: - Address during a case that includes aspects of how a physician's identity might impact the treatment relationship with a patient, and ultimately the health outcomes for that patient. Advise students to search the literature for articles on self-disclosure, impact of nondiscrimination policies for providers, and other legal issues that might affect the manner in which an LGBT physician is able to provide quality health care. Clinical Rotation: - Raise the issues during any clinical rotation where a provider experiences discrimination from policies and/or patients for any reason, using this opportunity to address the potential impact that these events might have on an LGBT provider.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Systems-Based Practice	1. Explaining and demonstrating how to navigate the special legal and policy issues (e.g., insurance limitations, lack of partner benefits, visitation and nondiscrimination policies, discrimination against children of same-sex parents, school bullying policies) encountered by the populations described above. • Recognizing state-specific insurance policies for covering (or not covering) treatments such as pubertal suppression, cross-sex hormone therapy, and/or gender-affirming surgeries. • Recognizing state-specific benefits (or lack thereof) for individuals with same-sex partners. • Understanding visitation and nondiscrimination policies for same-sex couples. • Knowing state-specific employee discrimination, hiring, and termination laws with respect to sexual orientation, gender identity, and gender expression. • Knowing which states have specific clauses protecting children and adolescents from bullying specifically stemming from sexual orientation, gender identity, and/or gender expression. • Recognizing laws that prohibit medical providers from withholding medical records from adult patients. • Recognizing laws that may protect children with DSD from interventions that may leave them sterile, and/or from unnecessary genital surgeries that may affect quality of life in the future.	Didactic: • Address when legal and policy issues are raised in the curriculum. • Address when cultural competence and/or health care delivery issues are discussed in the curriculum. Case-Based Learning: • Encourage students to research the state-specific policies and laws about sex (anatomy), sexual orientation, gender identity, and gender expression during a case where policy and legal issues are discussed. Clinical Rotation: • Address during a clinical experience where policy or legal issues are brought into question; direct students to research how legal and policy issues might affect the care of a patient who is LGBT, gender non-conforming, and/or born with DSD.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Systems-Based Practice	2. Identifying and appropriately utilizing special resources available to support the health of the individuals described above. - Knowing about targeted smoking cessation programs for LGBT individuals. - Researching substance abuse treatment programs that would be more sensitive to the needs of an LGBT individual and how their sexual behaviors might be associated with the use of certain substances. - Identifying behavioral health supports that recognize the unique aspects of life regarding these populations, including the concepts of coming out, internalized homophobia/transphobia, premature disclosure, etc. - Knowing about peer and family support programs for these populations such as: Parents, Families, and Friends of Lesbians and Gays (PFLAG) for parents of LGBT youth; Gay Lesbian Straight Educator Network (GLSEN) to help schools address LGBT issues; Crystal Methamphetamine Anonymous (CMA) for gay men struggling with this specific addiction; Hypospadias and Epispadias Association for patients with these DSDs; and the Androgen Insensitivity Syndrome, Disorders (Differences) of Sex Development (AIS-DSD) Support Group for other patients/families with this DSD.	Didactic: - Address during a seminar or lecture that covers the importance of utilizing community resources in providing quality care. Case-Based Learning: - Instruct students to identify community agencies, access online resources, and/or discover ways to consult with experts during any case where identifying resources for a specific patient population presents itself. Clinical Rotation: - Ensure that students demonstrate the ability to connect patients with LGBT-and DSD-specific resources when caring for these patient populations. - Ensure that a student demonstrates the ability to distinguish when it is absolutely crucial to connect an individual with a specific community resource versus when it may be helpful but not compulsory.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Systems-Based Practice	3. Identifying and partnering with community resources that provide support to the individuals described above (e.g., treatment centers, care providers, community activists, support groups, legal advocates) to help eliminate bias from health care and address community needs. - Connecting a transgender woman using street-bought hormones to an LGBT community and/or medical center with groups that may help provide education and support and prevent her from engaging in high-risk behaviors. - Seeking help from a professional organization online, such as the World Professional Association for Transgender Health, if the local community does not offer appropriate resources. - Consulting with a provider who has more experience in these areas when helping transgender individuals seeking medical and/or behavioral health treatment. - Referring a parent of a newborn with a difference in sex development to the website of Accord Alliance, which lists resources for parents and affected individuals. - Teaming up with allies in the school, school system (or Department of Education) of a child or adolescent who is being bullied for gender nonconforming behaviors or having DSD. - Referring parents who are struggling to accept their youth's gender expression, gender identity, and/or sexual orientation to a local PFLAG chapter. - Seeking out a behavioral health provider who identifies as LGBT-friendly for an LGBT patient who is depressed or anxious.	Didactic: - Address community resources during a module or seminar that discusses supporting or providing care for specific patient populations; discuss the importance of specific resources available for patients who may be LGBT, gender nonconforming and/or born with DSD. Case-Based Learning: - Include a hypothetical scenario with a gender identity/expression and/or sexuality theme during any case where identifying resources for a specific patient population plays a role in providing quality care. Encourage students to access online resources and research ways to consult with experts when the geographic area not include local LGBT-or DSD-supportive organizations or agencies. Clinical Rotation: - Require that a student demonstrate the ability to connect patients with LGBT and DSD community resources when exposed to patients who present with sex development, sexuality, and gender identity/expression variants.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Systems-Based Practice	4. Explaining how homophobia, transphobia, sexism, and heterosexism affect health care inequalities, costs, and outcomes. Note: These examples are from the Institute of Medicine 2011 report.* - Understanding that LGBT* youth experience homelessness, substance use disorders, and HIV at disproportionate rates when compared to their non-LGBT counterparts as a result of discrimination, victimization, and family rejection, leading to higher costs for mental health treatment. - Recognizing that lesbian and bisexual women may use preventive health services less frequently than heterosexual women and may be at greater risk of obesity and have higher rates of breast cancer than heterosexual women, which leads to higher costs and worse outcomes. - Knowing that LGB adults have a greater risk for the development of certain psychiatric disorders (depression and anxiety) than non-LGB adult counterparts. - Knowing that transgender individuals experience homelessness and certain sexually transmitted infections at much higher rates than the general population as a result of discrimination. - Recognizing that LGBT elders may experience social isolation and fear regarding discrimination in institutional care settings and that this can lead to poor health outcomes.	Didactic: - Address during a seminar on health care delivery, social policy, health care disparities, and/or cultural competencies; integrate points about how patients who may be LGBT, gender nonconforming and/or born with DSD experience discrimination in health care delivery and how that affects access, costs, and outcomes. Case-Based Learning: - Promote learning about these issues in any case that illustrates a health disparity, by specifically addressing how homophobia, transphobia, sexism, and heterosexism affect the populations described. Clinical Rotation: - Address the effect of disparities on health outcomes during specific rotations where patients who are LGBT, gender nonconforming and/or born with DSD face discrimination or particular risks. For example, within the psychiatry clerkship, students are exposed to patients with mood disorders, substance use, and anxiety disorders, for which these populations are at high risk. In primary care rotations preventive care is addressed and these populations may be less likely to receive optimal preventive care. Within these settings faculty should make students aware of the special health risks faced by these populations and how health care quality and access to care affects costs and outcomes. Students should consider these increased psychiatric and medical risks when formulating a differential diagnosis.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Systems-Based Practice	5. Describing strategies that can be used to enact reform within existing health care institutions to improve care to the populations described above, such as forming an LGBT support network, revising outdated nondiscrimination and employee benefits policies, developing dedicated care teams for patients who were born with DSD, etc. • Creating an LGBT support network of providers within an institution or community and having that network attend all institution-related events, including events sponsored by other groups within the institution or community. • Including an LGBT awareness day at an institution, particularly if these types of events occur for other minority groups. • Encouraging an institution to improve its Healthcare Equality Index as assessed by the Human Rights Campaign. • Including gender identity and natal sex information separately on health documents, questionnaires, and surveys, and offering more gender options to choose from outside the male-female binary. • Educating administrators and staff through the use of diversity trainings that incorporate gender, sex development, and sexuality issues by referring to professional and organizational mission and policy statements that relate to LGBT-and DSD-oriented issues. • Revising outdated nondiscrimination policies and employee benefits to ensure fair treatment of employees, students, and patients who may be LGBT, gender nonconforming, or born with DSD. • Advocating with insurance companies to cover treatment interventions that have historically not been covered for transgender individuals (e.g., hormone therapy, gender confirming surgeries). • Developing institutional policies that guide providers to critically evaluate the most current evidence base for interventions on infants and children with DSDs, some of which have been shown to be more harmful than helpful (e.g., vaginoplasties in early childhood on girls born with small or absent vaginas).	Didactic: • Address strategies affecting institutional policy relevant to LGBT and DSD-affected populations during a seminar or module on institutional culture, public policy, or health care reform. Case-Based Learning: • Raise awareness of these strategies during a clinical case that explores systems-based issues (institution policy, insurance policy, legal rights of patients, medical guidelines, medical consensus statements), by asking students to research how reforms in these areas may improve the patient's health care. Clinical Rotation: • Encourage students to appreciate the impact that evidence-supported reform might have on all patients, and subsequently require them to develop strategies that might lead to those changes • Ensure that students who encounter patients who are LGBT and/or born with DSD in the clinical rotation setting develop competence in understanding the specific reforms needed for these patient populations.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Systems-Based Practice	6. Demonstrating the ability to perform an appropriate risk/benefit analysis for interventions where evidence-based practice is lacking for the populations described above and across the developmental spectrum. - Guiding parents of six-year-old who displays significant gender nonconforming behaviors seeks guidance on whether to socially transition their child to the opposite gender, despite a lack of evidence-based support to do so, yet perceived risks in not doing so. - Informing an LGB individual (or parent of an individual) seeking a “cure” for variant sexual orientation that evidence shows these interventions do more harm than good and most major professional medical organizations do not support their use. - Appropriately weighing the pros and cons of pubertal suppression with a gender nonconforming early pubertal adolescent natal female who is premenarchal and has a neurodevelopmental disorder (ADHD) to buy time to explore her gender identity before taking testosterone. - Treating a middle-aged gender nonconforming lesbian-identified female seeking surgery “and a little bit of testosterone” to mildly masculinize her body, while still preferring to live as a masculine female. - Assisting a family that includes a 13-year-old girl newly diagnosed with complete androgen insensitivity syndrome to understand the risks and benefits of obtaining a bilateral orchiectomy immediately versus waiting and discussing the options for available cancer screening if the girl decides to delay orchiectomy.	Didactic: - Address gender development and the interventions that exist for gender nonconforming/transgender children and adolescents during a seminar on child development. - Address indications for surgical procedures in youth with DSD during a seminar in an embryology, endocrinology, or pediatric surgery module. - Explain the effects of and indications for hormonal interventions in the transgender population during an endocrine module. Case-Based Learning: - Bring up hypothetical questions in the realm of gender development (an area that has many scientific unknowns) during any case where there are no evidence-based interventions (e.g. experimental oncology treatments, new pharmacological interventions that lack FDA approval, etc.); - Ask students to research pros and cons for interventions for DSD-affected and/or gender nonconforming individuals across development that do not have evidence based support. Clinical Rotation: - Offer students the opportunity to consult with experts or seek out an elective in specialized clinics where these patient populations often seek treatment.

TABLE 4.3: INTEGRATING THE COMPETENCY OBJECTIVES INTO EDUCATIONAL CURRICULAR MODALITIES (CONTINUED)

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Interprofessional Collaboration	1. Valuing the importance of interprofessional communication and collaboration in providing culturally competent, patient-centered care to the individuals described above and participating effectively as a member of an interdisciplinary health care team. - Respecting confidentiality and patient preferences and conveying in the medical record only information necessary to ensure quality care. A patient may be concerned that disclosing aspects of his/her sexual behavior (e.g., engaging in same-sex sexual behavior) will be shared with an employer. - Working in a team of multidisciplinary providers that may consist of a behavioral health specialist, primary care physician, endocrinologist, and/or surgeon to appropriately meet the needs of a transgender patient seeking medical and/or surgical interventions for gender transition, including the coordination of the appropriate timing of such interventions. - Working in a team of multidisciplinary providers that may consist of a behavioral health specialist, urologist, and/or endocrinologist to address the needs of parents of an infant born with DSD (e.g., ambiguous genitalia) when making decisions about the impact of genital surgery. - Addressing the needs of LGBT youth in the school setting, by reaching out to school administration and teachers to address bullying and maximize protection for positive well-being of the patient. - Advocating for a gay or lesbian adult who requires a targeted treatment intervention (e.g., substance abuse program for LGB adults) that their insurance company declines coverage. - Calling ahead when referring a transgender patient for specialty care to inform the specialist of the patient's preferred name and pronoun.	Didactic: - Address these topics during a lecture on multidisciplinary treatment and interprofessional communication. Case-Based Learning: - Raise these issues and how they apply to LGBT and DSD-affected patients during an encounter with a standardized patient or during a case that requires a multidisciplinary team or referral to another physician. - Address with students how to respect confidentiality and patient preferences when referring patients to health care or community resources or discussing a patient with clinic staff. Clinical Rotation: - Ensure that students who encounter a patient from any of these populations knows how and when to share relevant information appropriately with others.

Domain	Competency Objectives Related to Patients Who Are or May Be LGBT, Gender Nonconforming and/or Born with DSD	Examples of Educational Modality Inclusion
Personal and Professional Development	1. Critically recognizing, assessing, and developing strategies to mitigate one's own implicit (i.e., automatic or unconscious) biases in providing care to the individuals described above, and recognizing the contribution of bias to increased iatrogenic risk and health disparities. - Recognizing that a physician's assumption of a "pure biological etiology" for an individual with a gender-variant identity might lead a provider to prematurely recommend hormonal (biological) treatments without consideration of the specific and important psychological needs of the patient. - Conversely, recognizing that a physician's assumption of a "pure psychological etiology" for an individual with a transgender identity might lead a provider to withhold biological treatments, such as hormonal intervention or gender-confirming surgery, when this could be life-saving. - Navigating assumptions and comfort levels with patients who present with gender expression that is not congruent with their natal sex. - Carefully examining the differences between variant, unhealthy, and pathological behaviors before assuming that sexual practices unfamiliar to the physician are unhealthy or pathological and diagnosing a mental disorder in a patient without adequate cause. - Realizing the assumption that sexual orientation minorities all engage in high-risk behaviors might lead a physician to communicate shame to such patients and inadvertently discourage these patients from being honest or even to seek medical care when needed. - Realizing that "biology" and "identity" do not always equate and that being born with DSD does not mean a person will necessarily be homosexual, bisexual, and/or transgender.	Didactic: - Incorporate an activity, either within a lecture or small group discussion, that leads to exploration of personal biases and ways that these have historically contributed to increased iatrogenic risk and health disparities. Case-Based Learning: - Provide hypothetical examples of "errors" in case-based discussions or simulations to help improve understanding of how biases and assumptions lead to increased iatrogenic risk and health disparities. In the clinical scenarios in Chapter 5, there are many examples that can be used to elicit discussion. Clinical Rotation: - Encourage routine provider self-reflection when encountering all patients, yet specifically address this when students treat a patient whose sexual identity, and/or gender identity/expression, and/or sex development history differs from their own.

Source: *Institute of Medicine. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, D.C.: The National Academies Press; 2011.

Conclusion

Addressing the health care needs and disparities faced by people who are or may be LGBT, gender nonconforming, and/or born with DSD is most successful when there is investment across all levels of medical education institutions. Medical schools can produce students who are competent to provide evidence-based, compassionate, patient-centered care for people who are or may be LGBT, gender nonconforming, and/or born with DSD. Addressing the disparities faced by these populations also enhances care for the broader population.

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Chapter 5

Clinical Scenarios and Discussion Points for Experiential Learning

Chapter Editor: Alice Dreger, Ph.D.

Clinical Scenarios and Discussion Points for Experiential Learning

Authors: Scott Leibowitz, M.D.; Alice Dreger, Ph.D.;
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Committee members developed these scenarios based on real clinical situations. In lieu of a complete instructional guide, we provide a list of possible discussion points with each case that can be narrowed or expanded as appropriate to student learning needs. A list of resources accompanies each scenario to point educators towards materials that support the teaching of the scenario. These scenarios can be integrated into curricula and assessed as discussed in **Chapter 4, How to Integrate Competencies into Medical School Curricula to Improve Care for People Who May Be LGBT, Gender Nonconforming, and/or Born with DSD**, and **Chapter 6, How to Assess Learners and Evaluate the Impact of Curricular and Climate Initiatives**.

Scenario 1

Gender Nonconformity in a Prepubertal Child

Author: Scott Leibowitz, M.D.

Jonny is a 7-year-old child who was born with anatomy consistent with the male sex. Ever since he could talk and express an interest in activities, his parents recall him preferring hobbies that were stereotypically feminine. For example, from a young age he preferred playing with dolls and taking dresses from his two older sisters' closets to wear. As he turned five years old, he would only play with female peers and threw tantrums every time his parents tried getting him to play soccer outside with the other boys. At that age, there were several instances when he seemed sad and when asked why, he would answer, "I wish I could be a girl" or "I just like the name Julia much better." This led to some disagreements between his mother and father over the best way to address his behaviors. His mother would wonder whether he might grow up to be transgender and she started buying him dolls and dresses, which made him very happy. His father, on the other hand, would try bringing Jonny to baseball games and would make statements to him such as, "Boys don't wear dresses." Now, at 7, Jonny insists on wearing his hair long, has only female friends, and continues to wear dresses in the comfort of his own home. Despite the fact that he wears stereotypical "boy clothes" at school, he still gets bullied by the boys and is often excluded from play with the girls.

Jonny's mother brings him in for a well-child visit with you, his pediatrician. Although his mother reports that Jonny has not made a statement that he wishes to be a girl in some time, he appears happy and comfortable wearing his favorite purple dress and happy playing with the dolls in the waiting room. As the mother and child are called back to the examination room, one of the nurses inadvertently refers to Jonny as "she" when telling Jonny's mother how adorable Jonny is. During the appointment, the mother shares several of her concerns with you and asks the following questions:

- "What is going to happen to Jonny?"
- "Is he transgender or gay?"
- "Is he simply a boy who likes 'girl things'?"
- "How can I best support him?"

When you ask Jonny about his friends in school, he quickly changes the subject to his favorite movie, *Cinderella*, and talks about his crush on the Prince. On physical exam, Jonny has Tanner 1 male genitals with no apparent abnormalities and displays no discomfort during the exam. At the end of the appointment, his mother asks if you could provide a note to excuse Jonny from gym: “He really doesn’t like gym and tends to be teased for not being as athletic as the other boys.” In response to this discussion, Jonny says, “I know I’m a boy, but sometimes I just wish I was a girl because I really like doing ‘girl things’.” The mother says in front of him, “I keep telling him that it’s ok if he wants to be a girl. I’ve seen plenty of documentaries on TV about boys who become girls.”

At that point, you politely interrupt and ask to meet with the mother alone—pulling her into a separate room—where she begins to cry and says that she and her husband are at odds over how to best support Jonny. She notes that her husband “thinks this is all a phase.” She recalls that her own brother was stereotypically feminine as a child, “but he grew up to be gay and not transgender, so I’m just really, really confused.” You offer counseling on how to best support Jonny by educating her on the lack of scientific data regarding the predictability of trajectories of gender nonconforming children and help her understand how to advocate for Jonny in the school setting and elsewhere. You also encourage her to support Jonny’s strengths and to minimize her use of language that creates shame or presumes future outcomes, and you assess whether a referral to a behavioral health provider (who is affirming and familiar with gender issues) is necessary.

Discussion Points

- Describe the difference between sex and gender, gender identity and gender expression, and gender nonconformity and gender dysphoria.
- Describe the possible meaning of gender identity, gender role, and sexual behaviors and feelings in a prepubertal child within the context of a child’s cognitive development. For example, what meaning should a clinician assume or not assume when a young child talks about a “crush”?
- Discuss psychosexual development and what potential identity outcomes may exist for a prepubertal gender nonconforming and/or child with gender dysphoria. Discuss ways to distinguish children who are exclusively gender nonconforming from those who are experiencing gender dysphoria.
- Outline the ways in which various medical disciplines could be helpful in their interactions with prepubertal children who are gender nonconforming and/or display gender dysphoria.
- Identify situations when interviewing parents and children separately might be useful. Also, identify situations when it would be appropriate to intervene in the event that parents are discussing issues in front of their child that may be inadvertently presumptuous and/or potentially lead to increased anxiety in the child. Identify language to help families use with their children that is open-ended and lacks assumptions.

- Describe logistical interventions in practice (e.g., ways for office staff to avoid being presumptuous about gender identity) that could be used to enhance comfort in patient interactions in the office between staff and families when a child's appearance differs from the listed natal sex in the medical record.
- Describe how to elicit children's and parents' ideas about gender roles and terminology preferences in a developmentally and culturally appropriate way.
- Identify specific risk factors and target areas for intervention that may lead to vulnerability in prepubertal gender nonconforming and/or gender dysphoric children.
- Outline a multimodal strategy to promote the psychological well-being of the child in this scenario, including naming specific target areas where psycho-education and sensitivity to gender issues should be reinforced.
- Outline current gaps in scientific knowledge about psychosexual development and discuss how those gaps affect our understanding of the pros and cons of various clinical intervention strategies that might be applied to a gender nonconforming child and how they might differ from the recommended approach to a child with gender dysphoria.
- Describe how bullying is addressed legally and through local policies for children in elementary and middle schools.

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Scenario 2

Gender Dysphoria in an Adolescent

Author: Scott Leibowitz, M.D.

Jaime is a 14-year-old adolescent who was born with anatomy consistent with the male sex whom you have been treating since he was a young child. You ask one of the clinical assistants to take his vital signs during a well-child visit. She reads your chart, including some background information and learns that, as a child, Jaime “always liked ‘girl things’ and felt like a girl inside, but did not think that it was possible to do anything because “all people with a penis must be a boy.” He was a rather happy and smart child, formed peer relationships easily, played with boys and girls equally, and flexibly adapted to whatever activity was available.

Two years ago (around the age of 12), at a routine visit, Jaime’s mother asked if you could provide a referral for a therapist. She felt that Jaime started to become sadder for “no apparent reason” and the grades in school started to slip. You sent them to a colleague who works well with depressed adolescents. Several months later, the therapist communicated to you, sounding alarmed, that Jaime mentioned in a session that he thought he was having crushes on other boys, and questioned the counselor whether he might be gay. The therapist’s comment to you: “I don’t really specialize in these issues.” The therapist also asked if you had performed an HIV test and STI screening, despite Jaime’s denial of any sexual relations with others.

Shortly thereafter, your staff received a call from Jaime’s school indicating that he had made a suicidal statement after an incident of bullying: “I just don’t know if I want to continue living anymore.” You learn that the therapist shared with the parents that “Jaime thinks he might be gay,” later stating that it was okay to break confidentiality “because a safety issue was at hand.” The parents repeatedly asked Jaime if he might be “going through a phase” for several months; however, in the year since, they have both come to be more supportive and to accept that Jaime might be gay.

Your clinical assistant goes to the waiting room and looks for a teen male but cannot identify one. After calling the name “Jaime,” an androgynous-appearing adolescent stands up wearing makeup, long pink hair, and tight-fitting jeans. The assistant acts surprised, and nervously states, “Oh, I was expecting a young man instead,” eliciting stares from other patients.

During your encounter, Jaime notes that his depression has gotten worse and discloses that, since he always felt so different from other boys, he concluded that he was simply gay. “But this is different. It’s about who I am, not who I am attracted to. I’m old enough to realize that now!”

Jaime asks you, “If I’m a girl on the inside and have crushes on boys, but still have a penis, does that make me gay or straight?” He asks you to use female pronouns—something that close friends have already been doing—and lets you know he (she) prefers to be called Martine, the name of a character from a movie he (she) likes. On physical exam, Jaime (Martine) is at Tanner Stage III and becomes tearful when you examine his (her) genital area. Jaime (Martine) says that he (she) is afraid of getting taller and developing a lot of body hair, and then proclaims, “I just wish I didn’t have to feel this way.” You are unsure how to respond. You are also asked to “keep this a secret” from Jaime (Martine’s) parents. Martine asks you many questions about “blocking puberty” and “hormones” and whether or not it will be possible to start them without her parents’ consent.

Discussion Points

- Describe the differences between sex and gender, sexual orientation and gender identity, sexual behavior and sexual identity, gender identity and gender role, and gender nonconformity and gender dysphoria. Explain whether a transgender person can identify as gay and explain how to describe sexual orientation based on affirmed gender identity, not natal sex.
- Explain how to obtain a sexual behavior, sexual identity, and gender identity history in an adolescent using open-ended questions that lack presumptions.
- Describe how the assessment and treatment needs of youth presenting with gender and/or sexuality issues are affected by the identity exploration and physical development that characterize adolescence. Note that there is no one specific “pathway” that all LGBT adolescents take in discovering and exploring these aspects of their identity (e.g. in the case example above, for example, this youth first conceptualized herself as a gay male, but ultimately realized that she was experiencing gender dysphoria as physical maturation proceeded through puberty).
- Describe logistical interventions in practice that could be used to enhance comfort in patient interactions between medical office staff and families when a gender nonconforming and/or transgender adolescent presents for care.
- Identify current and historical harmful practices and interactions in the health care setting that have led to negative health outcomes and poor provider-patient relationships for adolescents of diverse sexual orientations, gender identities, and/or gender expressions.
- Understand both the potential presence of and ability to assess for risk and resiliency factors in adolescent populations presenting with diverse sexual orientations, gender identities, and/or gender expressions. Explain the importance of screening for mental health co-morbidities (e.g. suicide) in these youth while noting the difference between pathology (ill health) and uncommon forms of identity (statistical differences).

- Recognize the unique concepts and issues that may be faced by adolescents with diverse sexual orientations, gender identities, and/or gender expressions that include, but are not limited to: coming out processes, premature disclosure, internalized homophobia, and internalized transphobia.
- Discuss aspects of confidentiality, informed consent, and assent policies that need to be considered when working with adolescents presenting with diverse sexual orientations, gender identities, and/or gender expressions.
- Explain the different medical and surgical treatment interventions that exist for gender dysphoria in adolescence, specify when they are indicated, know where evidence base gaps exist, and apply this information to creating a safe treatment plan for these patients.
- Outline the ways in which professionals of varying medical disciplines could be helpful during interprofessional discussions and during interactions with adolescents who are gender nonconforming and/or gender dysphoric.
- Discuss the factors that perpetuate health disparities for adolescents with diverse sexual orientations, gender identities, and/or gender expressions.
- Identify current clinical guidelines across behavioral health and medical disciplines when investigating the literature, particularly as they relate to providing competent care to adolescents with diverse sexual orientations, gender identities, and gender expressions.

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Scenario 3

Iatrogenic Trauma in a Man Born with DSD

Author: Alice Dreger, Ph.D.

Christopher Baldwin is a 45-year-old man who presents at his primary care physician's clinic (an internal medicine practice) concerned that he is developing pyelonephritis.

In preparation for the visit, you (a medical student doing an ambulatory rotation) review his medical records. You see that he often presents with urinary tract infections (UTIs). Notes from a history and physical exam indicate that when Mr. Baldwin was born, his penis was small, although not so small as to be classified as micropenis, and he had a case of midshaft hypospadias. His karyotype is 46,XY and the etiology for his difference of sex development (DSD) is unknown. At nine months of age and in good health, he was referred for multistage hypospadias surgical interventions in order to make his genitals look and function more male-typically. Complications from the surgeries, including fistulas and urethral strictures, led to more surgeries. To date, he has had nine urogenital surgeries. He suffers from frequent UTIs, genital pain, and generalized anxiety related to his condition. He often needs to self-catheterize in order to manage his condition.

You enter the exam room to find Mr. Baldwin looking anxious and physically uncomfortable. After you introduce yourself, he tells you that he's pretty sure he is developing pyelonephritis. A home OTC urine dip was positive for leucocytes and nitrites, and he now feels feverish and ill. You try to push him to give you a longer history that includes his urogenital surgeries but he says he's "had enough of these things to know this is a UTI turning into pyelo." You ask if you can examine him, and he agrees to let you but adds that he doesn't want you examining his genitals. He mumbles something like, "You don't need it to diagnose pyelo, and I'm tired of being the 'freak of the week' for you kids." He adds, "I wish Dr. Chang were here. He understands...."

You try to reassure him by saying that you understand it is difficult to be transgender and he huffs at you: "I'm not transgender! I was an intersex boy and I'm here because a bunch of surgeons mangled me!" He puts his hands over his face and mumbles an apology. You also apologize and ask him about whether he has sex with men, women, or both. He responds that he has poor sexual function and anxiety about getting into a sexual situation, and explains to you that just because he was born with intersex genitals doesn't mean he's bi or gay.

You proceed with the exam, taking great care to be as sensitive as possible. The patient's oral temperature is 38° C, blood pressure 132/84 mmHg, pulse 96 bpm and regular, respiration 20 breaths per minute. His oropharynx and mucus membranes are pink and moist and his skin turgor

is normal. The cardiovascular exam shows no murmurs or gallops, and lungs are clear to auscultation and percussion bilaterally. Extremities are warm and dry without edema. His abdomen is soft with no masses, guarding, or rigidity. There is some suprapubic tenderness. An examination of his back shows bilateral costovertebral angle tenderness. As you are concluding the physical exam, the patient tells you, “We have to do this outpatient. I’m not going to the hospital again.”

Discussion Points

- Explain how being born with difference of sex development (DSD) is different from being a transgender person.
- Outline key genetic, hormonal, and anatomic steps in female-typical and male-typical prenatal sex development.
- Describe the likely developmental pathways (genetic, hormonal, anatomic, gender identity, etc.) at birth and at sexual maturity for the following forms of DSD: 46,XX with ambiguous genitalia (including but not limited to congenital adrenal hyperplasia); 46,XY with ambiguous genitalia (including but not limited to partial androgen insensitivity syndrome); complete androgen insensitivity syndrome.
- Evaluate the evidence base for surgical “normalization” of atypical genitalia in terms of survival, quality of life, and mental health outcomes.
- Identify the possible physical and mental health needs particular to an adult born with DSD who was treated with “normalizing” procedures as a child.
- Describe how to record sex type, gender identity, and sexual orientation in the records of a patient who was born with DSD.
- Articulate the difference between typical and healthy, and explore how this difference should matter to a physician in the clinical setting.
- Outline steps that can be taken to make a patient who has suffered clinical trauma (e.g., iatrogenic physical harm or shame in the medical setting) feel safe and trusting during a medical visit.
- Discuss why thinking about resiliency of patients may change how a physician counsels and treats a patient, including a patient with a history of trauma.
- Describe the features of a health care team that would be welcoming to a family with a child born with DSD or to an adult born with DSD.
- Enumerate reasonable measures of quality care for individuals whose sex development has been atypical for males or females.

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Scenario 4

Possible DSD and Gender Dysphoria in an Adolescent

Author: Alice Dreger, Ph.D.

You are a medical student doing an ambulatory rotation in a family medicine practice. Joey is a 14-year old who has been brought by foster parents to this clinic, where they regularly go for primary care. Joey has been with these foster parents for two years, and they appear extremely loving and compassionate. Joey seems to trust them.

The foster parents' concern centers on how best to support Joey, who was identified as a boy at birth but now seems to be going through a somewhat feminine puberty and wishes to be socially identified as a female. Joey has had a difficult life, having been taken away from Joey's birth mother at the age of two. The current foster parents (a married man and woman) are the third set in Joey's life. Joey's foster parents make a reference in passing to abuse Joey suffered at the last home where Joey had been placed.

In an effort to understand Joey's sex and gender identity development, you elicit a history from Joey and the foster parents. You begin by asking Joey what gender pronoun Joey would like you to use, and Joey tells you "she." (You notice this is the pronoun her foster parents have been using to tell you about Joey.)

You learn that when Joey was born, she "didn't look right down there." Her birth mother, who was a single mother, thought there might be something wrong but was afraid to take her child, whom she saw as a boy, to specialists, both because she believed she could not afford it and because she was afraid of the medical system. Joey ended up in the foster care system after her mother was found to be unable to provide for the child. Joey says she seems to have one small "ball" and tells you that she's always hidden her "privates" because they don't look the same as boys' "privates" that she's seen.

When you ask Joey how long she's felt like a girl, she shrugs and says, "I dunno. For a while, I guess." She resists attempts to get her to be more specific. You notice that Joey seems to you more like a girl than a boy in the way she holds herself, moves, and talks.

Joey's foster parents tell you that she seemed to start puberty just after she came to them, about two years ago, because she's been getting taller, getting some acne, and her body seems to be maturing. But they say that it seems like her body is developing more like a girl's than a boy's. She seems to be getting rounded breasts and hips, her voice seems to be becoming more like an adult

woman's than an adult man's, and she has also let them know that she feels like she's a girl. Joey jumps in to say she feels like the changes in her body make sense for her: "I feel like I'm growing right."

Her foster parents indicate they are glad Joey feels safe enough with them to tell them how she is feeling, and they let you know they are there to make sure she gets the medical support she needs to be herself. Joey's foster parents are especially concerned that she might be subject to bullying, and they also worry that the foster care system might take Joey away from them before they can help her grow up safely.

Discussion Points

- Discuss how a health care professional should communicate with and about a patient whose gender self-identification differs from the gender listed on his or her legal and medical records. Explain how the patient's developmental stage, age, and social situation might influence this management of communication with the patient, with the patient's family and/or loved ones, and with other health care professionals (including in the chart).
- Describe how to conduct a history and physical exam that is appropriately sensitive for a patient who has had a relatively uncommon form of sex development or gender identity development. Take into consideration the age and developmental stage of the patient. Include, for example, a discussion of who should be present in the room, how requests for disrobing should occur, and what types of permission should be requested, including when and how to obtain that permission, etc.
- Explain the differences among gender identity, gender role, and gender assignment. Also explain how biological sex is different from gender identity, and how sexual orientation is different from biological sex and gender identity.
- Explain how a health care professional's assumptions about sex, gender, and sexual orientation can impede or improve the professional's ability to care for patients with diverse forms of sex development, gender, and sexual orientation.
- Explain how a patient's social history might cause a physician to bring certain assumptions or biases to a doctor-patient encounter, especially if a patient comes from a socioeconomically marginalized family. Also discuss how biases or assumptions might affect clinical outcomes.
- Enumerate factors that might make a child undergo a sex-atypical puberty, i.e., what exogenous and endogenous factors might cause a boy to develop more like a girl at puberty, and what exogenous and endogenous factors might cause a girl to develop more like a boy at puberty. (Consider various inborn differences of sex development, developmental pathologies like tumors, and intentional or unintentional environmental exposure to cross-sex hormones.)
- Explain why it is important for a child presenting with development atypical for his or her

assumed sex to be examined by a physician, and explain why in some cases specialists like pediatric endocrinologists, pediatric urologists, and medical geneticists might be needed to rule out serious medical risks like the potential for gonadal malignancies or adrenal crises.

- Describe the features of a health care team that would be welcoming to a family with a child born with DSD, or to an adolescent or adult with DSD and/or cross-gender self-identification.
- Enumerate reasonable measures of quality care for individuals born with DSD.
- Enumerate reasonable measures of quality care for individuals whose gender self-identification differs from the gender assigned to them at birth.

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Scenario 5: A Child with Two Lesbian Mothers and Two Gay Fathers

Author: Jennifer Potter, M.D.

During a family medicine rotation, one of your classmates interviews a lesbian couple presenting to clinic for a “meet and greet” visit to see if their needs can be met in the new practice, as their former family practitioner is retiring.

The couple currently has a three-year-old son, Jonah, whom they are co-parenting with a gay male couple. Jonah spends most of his time with his two mothers and every other weekend with his two fathers. According to an agreement all four parties signed prior to his conception, Jonah’s mothers are responsible for making all major decisions about his health and welfare and for supporting him financially; no additional legal arrangements have been discussed since his birth. Jonah was conceived via home insemination of Beth, his biological mother, using fresh semen from one of his fathers. His parents are now planning to begin a similar process to conceive a second child, except this time Jonah’s other mother, Rachel, will be inseminated using semen donated by his other father. During the visit, they describe a variety of challenges they have encountered in the past, including:

- Limited medical insurance options for Jonah (he is covered through the family plan provided by his biological mother’s employer)
- Intake forms listing limited parent categories that do not reflect their unique situation (multiple mothers and/or fathers)
- Refusal of a nurse to administer the flu vaccine to Jonah when the parent available to sign the consent was his nonbiological mother.
- A covering doctor who greeted the couple with “Which one of you is the mother?” when they brought Jonah in for a strep throat evaluation one weekend.

They are anxious to know:

1. If this is a practice that welcomes LGBT families.
2. If the practice will accept consent for Jonah's treatment from his nonbiological mother.
3. If the practice will advocate for their needs at the local hospital if Jonah ever requires admission.
4. If the practice can recommend a clinic that offers intrauterine insemination, as they have heard that this procedure has a higher success rate than intravaginal insemination and they hope to achieve conception soon.

After presenting the case during ambulatory rounds, your classmate comments: "I like to think I'm open-minded, but I can't help wondering what it would be like to grow up in a nontraditional family like this, whether it will expose a child like Jonah to extra teasing and bullying once he enters school, and how it will affect his sexual orientation."

Discussion Points

- Describe the epidemiology and structures of LGBT families in the United States.
- Explain the variety of ways in which LGBT people can become parents, including foster parenting, adoption, biological conception, donor insemination, and surrogacy.
- Counsel a lesbian patient (via role-play or using a standardized patient) regarding the pros and cons of using fresh donor semen compared to using frozen semen obtained from a sperm bank.
- Identify common challenges faced by prospective LGBT parents in achieving their parenting goals. Possible obstacles include lack of family support; overt and subtle discrimination by the foster care system, adoption agencies, reproductive endocrinology clinics, and labor and delivery units; financial cost of various parenting options; and legal barriers.
- Describe strategies that can be implemented at the practice level to make the medical office environment more welcoming and safe for LGBT parents and families. Include attention to intake forms, signage and educational brochures, and staff training.
- Analyze strategies that have been implemented at the organizational/policy level (e.g. use of the Healthcare Equality Index) to ensure that LGBT parents and families receive recognition, respect, and equal care.
- Assess the potential benefits and challenges of being raised by a parent or parents who may be gay, lesbian, bisexual or transgender. Include findings of research studies that have examined the psychosocial adjustment and development of children raised in LGBT families.

- Describe legal protections that permit nonbiological LGBT parents to consent to their children's medical treatment, visit their children in the hospital, and maintain custodial rights in the event of parental separation.
- Compile a list of national resources that provide psychosocial and legal support to LGBT parents and LGBT families.
- Recommend resources to support a student/trainee colleague who is troubled by witnessing inhospitable treatment of prospective LGBT parents by clinic staff but isn't sure how to effectively challenge the status quo and is afraid such an attempt may jeopardize his or her grade.

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Family Acceptance Project, San Francisco State University:

<http://familyproject.sfsu.edu/>

Family Equality Council:

http://www.familyequality.org/family_equality/about_us/

Gay and Lesbian Advocates and Defenders:

<http://www.glad.org/>

Lambda Legal Defense and Education Fund:

<http://www.lambdalegal.org/>

Parents, Families and Friends of Lesbians and Gays:

<http://community.pflag.org/Page.aspx?pid=194&srcid=-2>

Scenario 6

HIV Risk Behaviors in an Adult Man

Author: Andrés F. Sciolla, M.D.

Ismael is a 29 year-old male with history of HIV infection, depression, posttraumatic stress, and methamphetamine dependence who is presenting for a follow-up visit at an academic-based HIV specialty clinic where internal medicine residents rotate in their second year. The resident who previously cared for Ismael wrote in her off-service note that the team had decided to hold off on prescribing antiretroviral therapy to Ismael because “he’s currently noncompliant with meds, goes on meth binges periodically that include unprotected sex with anonymous partners, and may become homeless and lose the only social support he has if his partner kicks him out of the house.” Three years ago while adherent to his regimen, which included ritonavir 100 mg daily, atazanavir 300 mg daily, and daily Narcotics Anonymous (NA) meetings, Ismael’s viral load was <40 copies/mL and his CD4 count was above 500 cells/ μ L.

A month ago, a new resident asked Ismael, “When was the last time you used meth?” With boyish charm Ismael sheepishly ‘fessed up, “Last weekend.” With a mixture of exasperation, disbelief, and a wish to give Ismael one more chance, the resident referred Ismael to the clinic’s psychiatrist and drug counselor. After greeting him today, the first thing the resident asks Ismael is, “So...when was the last time you used meth?” When Ismael replies, “A month ago, right after I saw you,” the resident appears stunned and starts to read the note written by the psychiatrist without saying a word.

Born in Mexico, Ismael grew up on both sides of the U.S.-Mexico border, and lived for periods of time in both countries. He never met his biological father but his mother began to live with a man he considers his stepfather when he was 2 or 3 years old. Ismael loved his stepfather, a truck driver who would sit Ismael on his lap while pretending to be teaching him to drive. This game eventually led to overt fondling when Ismael was about 6 years old, an experience that filled Ismael with dread, shame, and confusion. His mother struggled with alcoholism, and, as far as he can remember, she abused him and his four siblings emotionally and physically. After his mother and stepfather separated and his mother abandoned the children, Ismael and his siblings lived in an orphanage where Ismael was bullied by other boys, and he woke up many times in the night when some of the older boys were touching him sexually and attempting penetration. While at the orphanage, Ismael met an American couple who visited him periodically. That couple eventually adopted him legally.

Although Ismael's material circumstances changed drastically when he moved in with his adoptive parents at the age of 14, he withdrew socially and his academic performance progressively worsened. A few credits short of graduating from high school, Ismael joined the military at age 18, and for a while was sexually active with both men and women. When he was 20 years old, he came out as a gay man, left the military, and moved in with a partner. Older and more experienced, this man introduced Ismael to methamphetamine. Ismael left him after a few years, tired of being controlled and subjected to bouts of domestic violence. He met his current partner more than two years ago through NA friends.

The resident stops reading and looks at Ismael, feeling unsure how this information may contribute to Ismael's HIV treatment. Ismael interrupts the resident's pondering and says, "I brought my NA sponsor, and he wants to meet you. Can he come in?"

Discussion Points

- Review peer-reviewed literature showing that the vast majority of patients who experienced adverse childhood experiences want their health care providers to be aware of and integrate this information into their treatment plans.
- Role-play to demonstrate empathic listening skills while taking a developmental history, including adverse childhood experiences.
- Summarize current treatment guidelines for HIV infection and review the relevant pharmacology and microbiology.
- Explain the proposed mechanisms linking exposure to adverse childhood experiences and increased risk of psychiatric and medical morbidity, including the disruption in stress regulation as well as immune and epigenetic mechanisms.
- Explain how the use of motivational interviewing techniques can help HIV-positive patients increase their adherence to treatment recommendations.
- Analyze how the resident in this case behaved, discuss what might motivate this kind of physician behavior, and suggest how the behavior could be improved.
- Develop a quality improvement project that could be used to co-locate mental health and care coordination services at outpatient clinics that provide services to HIV-positive patients.
- Describe how to effectively identify the presence of or need for LGBT-welcoming community resources for individuals with substance use problems.
- Discuss and summarize how the Affordable Care Act affects access to care for persons living with HIV/AIDS.

- Via role-play or using standardized patients.
- Educate individuals with histories of adverse childhood experiences about research linking childhood adversities to adult health outcomes.
- Counsel patients about the prevention of revictimization and transgenerational transmission of trauma and encourage patients to seek peer support and professional care to address substance use and psychiatric morbidity.

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Adverse Childhood Experiences Study, Centers for Disease Control:
<http://www.cdc.gov/ace/>

ACEs Connection:
<http://acesconnection.com/>

Scenario 7

A Straight Man Who Has Sex with Men and Women

Author: Andrés F. Sciolla, M.D.

Alan is a 43-year-old Filipino-American man with a history of mild hypertension that is well controlled with hydrochlorothiazide. You are Alan's primary care physician, and this is the second time you have met him. Eight months ago, Alan visited you for a sprained wrist that he suffered when he fell while playing soccer. You got along great, you thought, and it turned out you are both fans of the same football team. Today you will be seeing Alan for his annual checkup, so you have more time to get to know him better. He has no health complaints, and his left wrist has healed completely.

From the first visit, you know that Alan has been married to Patsy for 16 years, has two sons, Melvin and Ethan, and that he retired from the U.S. Marine Corps a year ago. After a career in the military as a critical care nurse, Alan now works in the emergency room at a local private hospital. In this visit, Alan surprises you with the news that he separated from Patsy and moved out of the family home four months ago. He adds that, for the past month or so, he has been going out with Lindsay, a divorced coworker. When you ask Alan about the reasons for the separation from Patsy, he tells you that she found a piece of paper with a phone number in his pants pocket while doing laundry. She became suspicious and, unbeknownst to Alan, checked his cell phone and found a couple of texts with sexual content sent from the same number. She confronted Alan and now she's seeking a divorce.

"Are the text messages from the same lady you're dating now?" you ask.

Alan pauses for a couple of seconds before saying, "Actually, they were from a guy I play soccer with."

"Oh, I see....I didn't know you are bisexual," you comment.

Alan seems rather offended when he replies, "Doc, so you know, I consider myself straight."

"Sorry," you say, "I understand....When was the last time you were tested for HIV?"

Alternative outcome A

“Are the text messages from the same lady you’re dating now?” you ask.

Alan pauses for a couple of seconds before saying, “Actually they were from a guy I play soccer with.”

“Oh, I see,” you answer. “Thank you for sharing this with me. I can tell that this is not something you share with just anybody. Please, tell me more about this guy...”

Alternative outcome B

“Are the text messages from the same lady you’re dating now?” you ask.

Alan pauses for a couple of seconds before saying, “Actually they were from a guy I play soccer with.”

“Oh, I see....I didn’t know you are bisexual,” you comment.

Alan seems rather offended when he replies, “Doc, so you know, I consider myself straight.”

“I’m sorry,” you answer, “I don’t mean to be disrespectful. Can you tell me more about your thoughts on this?”

Discussion Points

- Role-play the use of open-ended and gender-neutral language when taking a sexual history that includes sexual orientation and gender identity.
- Discuss the role of culture and socioeconomic status in the adherence to traditional masculine gender roles and the distinction between gender/sexual orientation identity and sexual attraction/behavior.
- Explain how sociocultural values pertinent to masculinity, family, religion, and the stigma attached to certain sexual activities determine how men negotiate identity, gender role and having sex with both men and women.
- Debate the ethical and sociocultural aspects of risk for HIV and other sexually transmitted infections (STIs) for women who are sexual partners of men who don’t disclose sexual activity with other men.
- Review the literature on strategies to identify primary care patients who may benefit from HIV pre-exposure prophylaxis, best practices for monitoring them, and their counseling to maximize adherence and reduce potential increases in risky behavior.

- Identify barriers and facilitators for primary care providers to provide a safe and nonjudgmental space where men, especially those from ethnic minorities, can disclose and receive counseling on their same-sex sexual behaviors.
- Lead a journal club to evaluate the literature identifying promising HIV risk-reduction interventions for behaviorally bisexual men.
- Discuss social and structural determinants of HIV and STI risks for women of color, and integrate information into culturally responsive counseling to address barriers and facilitators to decrease those risks for these women.
- Practice patient-centeredness by eliciting female patients' perceptions of their risks of unwanted pregnancy or STIs during role-play, standardized patient encounters or real patient visits.
- Examine the results of the Sexuality Implicit Association Test (Gay - Straight, available free of charge online at <https://implicit.harvard.edu/implicit/>) and reflect on how unconscious bias can affect patient care.
- Summarize the ethical arguments on respect for autonomy and beneficence/nonmaleficence regarding this case. How can the clinician in this case think through the conflict between patient confidentiality and the duty to warn? What information should the clinician gather to decide whether there is such duty, and if so, what would be the next steps?

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Relevant Websites

Bisexual Organizing Project:

<http://www.bisexualorganizingproject.org/>

Project Implicit:

<https://implicit.harvard.edu/implicit/education.html>

Scenario 8: A Transgender Man with a Pelvic Mass

Author: Jennifer Potter, M.D.

Mikal (preferred name; legal name, Michelle) Brown is a 65-year-old female-to-male (FtM) transgender man who presents alone to the Gynecology Oncology Clinic for treatment planning after being diagnosed with a pelvic mass.

In preparation for the visit, you (a medical student doing a surgery rotation) review his available medical records and learn that the mass was discovered when Mikal presented to the ER with 6 months of intermittent bloody discharge on his underwear and recent onset pelvic pain. Gynecological examination at that time revealed a friable cervical mass, and a CT scan showed extension into the pelvic sidewall with borderline hydronephrosis of the left kidney, consistent with stage IIIB cervical cancer. Mikal came out as transgender in his late 40s and has been receiving testosterone ever since from an outside endocrinologist who is well-versed in prescribing hormones for gender transitioning. He has undergone bilateral nipple-sparing mastectomies, but has not had any other gender-affirming surgeries.

In spite of the fact that Mikal retains natal pelvic anatomical structures (vagina, cervix, uterus, and ovaries) and has been encouraged to undergo routine preventive screenings by his endocrinologist, he has not had a Pap test in more than 20 years, because pelvic exams re-awaken the trauma of an adolescent sexual assault, and because he is loathe to reveal genitalia discordant with his gender identity. Previously, Pap tests were normal. He has never had mammograms or a colonoscopy. The remainder of his personal medical history is unremarkable. Other than transdermal testosterone, he takes no other medications and has no allergies. The family history is notable for a mother with postmenopausal breast cancer. He works in the IT department of a large company. He was in a long-term, self-identified lesbian relationship for many years, but his ex-partner ended the relationship when he came out as transgender, and he has been single ever since. He has smoked one pack of cigarettes a day for 50 years, but does not drink alcohol or use illicit drugs.

Before you knock on the exam room door, the medical assistant tells you the patient declined to remove “his, I mean, her” coat for a blood pressure check and “she, I mean he, seems upset”. On entering the room, you encounter a visibly anxious, bearded man standing by the door. After inviting him to sit down and inquiring as to the source of his distress, he recounts his experience on arrival to the clinic. The receptionist looked him up and down during check-in, appearing confused, and said, “This is a gynecology clinic, and we only see women here.” After insisting that he was in the right place, he took a seat in the waiting room, feeling intensely embarrassed and fearful that the women sitting there were scrutinizing him. Minutes later, a similar situation

occurred when the medical assistant called out his legal name; as he rose in response, she said, “I don’t think you heard me correctly... I’m looking for Michelle...You’re not Michelle, are you?” Once again, he had to explain himself publicly, and once again he felt mortified. He now says he isn’t sure he wants to stay to complete the evaluation and is having second thoughts about undergoing any treatment because, “What difference will it make, anyway?”

Discussion Points

- Identify health disparities and barriers to care experienced by transgender people.
- Inspect a health care environment through the eyes of an FtM adult seeking care and formulate a plan to make it feel more welcoming and safe. Include attention to intake forms, signage, educational materials, bathrooms, and staff training.
- Role-play taking a history inclusive of gender identity, taking care to explicitly discuss the patient’s preferences regarding means of address (e.g., preferred name and pronouns).
- Propose a preventive screening strategy for an FtM adult (via role-play or use of a standardized patient) that is appropriate to his age, genetic and behavioral risk factors, hormone status, presence or absence of natal anatomical structures, and personal preferences.
- Perform a pelvic exam/Pap test on an FtM adult (using simulation or a standardized patient) in a manner that is respectful of his body, sense of autonomy and control, and physical comfort.
- Explain the process by which a transgender person who desires hormonal therapy for gender transitioning can obtain a prescription.
- Counsel an FtM adult (via role-play or use of a standardized patient) presenting to initiate cross-hormone therapy regarding physical effects and risks, and recommend an appropriate clinical monitoring schedule.
- Inventory the range of gender-affirming surgical procedures that may be elected by an FtM adult who wants to achieve a body concordant with his gender identity.
- Debate the value of creating culture-specific vs. one-size-fits-all patient educational materials and evaluate resources on HPV infection and cervical cancer screening that have been developed for FtM patients.
- Describe the importance of designated support services for LGBT persons who are living with cancer and/or who are elderly, and prepare a list of resources that are welcoming to transgender patients.
- Design and deliver a peer teaching session that aims to enhance the sensitivity with which your colleagues interact with transgender patients.

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http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_res_resources_home. Accessed September 30, 2014.

Relevant Websites

National Resource Center on LGBT Aging:
<http://www.lgbtagingcenter.org/>

National LGBT Cancer Network:
<http://www.cancer-network.org/>

Chapter 6

How to Assess Learners and Evaluate the Impact of Curricular and Climate Initiatives

Chapter Editor: Jason Satterfield, Ph.D.

As previously described in **Chapter 2, The Role of Medical Education and Health Care Professionals in Eliminating Health Disparities**, training programs in the health professions are increasingly focused on assessing clinical competencies that demonstrate a learner's readiness for (and progression toward) unsupervised practice. Educators and training programs that employ this approach must track multiple competencies, including both concrete, observable procedures and more nuanced but essential health care skills, such as empathy, teamwork, and cultural sensitivity.¹

Health care competencies for patients who are or may be LGBT, gender nonconforming, and/or born with DSD present similar challenges. These competencies can be difficult to initiate and evaluate in a medical school setting—particularly when determining what performance milestones are appropriate for each learner's developmental level. Moreover, high-quality teaching and assessment tools focused on competencies related to issues faced by these populations often require an institutional culture that explicitly embraces diversity, social justice, and the care of the underserved. And, while competency evaluation data ultimately measure the success of both learners and programs, institutions should go further and use the results to drive curricular revisions and their own evolution and development.

This chapter provides guidance on how to design evaluation strategies to use in assessing curricula, learners, and institutional climate. First, we provide a brief overview of assessment and evaluation principles and models useful in planning assessments. Second, we discuss processes and tools that can be used to assess overall curricular and program performance using a case-based example of an LGBT-relevant curricular innovation. Next, we describe assessment methods and instrumentation that can be used to ensure that learners have the special skills needed to provide competent care for patients who are or may be LGBT, gender nonconforming, and/or born with DSD. Finally, we outline strategies useful in assessing an institution's broader cultural and climate characteristics that may help influence current and future curricular efforts.

Fundamental assessment principles and key assumptions underlie the materials presented in each section of this chapter. First, the members of the AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development believe that the evaluation of a curriculum's effectiveness is as important as the curriculum itself. Therefore, the evaluation tool should be designed along with the program, not treated as an afterthought. Second, educators should employ teaching strategies proven to work (i.e., evidence-based or best practices if evidence-based strategies have not been identified) rather than relying on local or discipline-based teaching traditions. There is a growing body of research to guide selection of teaching interventions, curricular timing and "dose," as well as the choice of valid and reliable assessment tools.² Finally, we believe that contextual factors such as institutional climate will affect nearly any curriculum in more profound and subtle ways than the simple awarding or denial of teaching funds or curricular hours would suggest.³ Consequently, achieving successful and sustainable curricular innovations typically requires interventions at the administrative level.

Assessment and Evaluation Planning

Careful planning is essential when evaluating curricula, learners, and institutional cultures. Factors to consider when designing an evaluation tool include:

- Available time
- Resources
- Instrument validity/reliability
- Target audience
- Cost effectiveness
- Systems change
- Impact on patient or clinical outcomes

Additionally, early evaluation planning will ensure that programmatic goals have been articulated, learning objectives are measurable, best approaches for evaluation have been identified, and the processes for evaluation are timed for best results. The following four questions highlight common issues to be considered during evaluation planning. Using a curricular example, **Table 6.1: Key Questions and Examples for Evaluation Development**, illustrates how to apply the following planning questions to curriculum, learner, and institutional climate evaluations.

- 1. What is the goal of the evaluation?** Will assessments target the curriculum, the learner, or the institution? Within each category, what attributes are to be assessed (e.g., knowledge, skills, or attitudes for learners; learner satisfaction for curricular evaluations; or explicit policies that promote equity within institutional cultures)? Is the goal to ensure a minimal level of competence or to identify the highest performers? What data would be most useful to collect considering how the results will be used (e.g., learner satisfaction, patient outcomes, cost effectiveness)?
- 2. Which theoretical models are the best choices to guide evaluation design and specific curricular content?** Medical education has been criticized for not considering what learning or assessment theories should guide curricular development and assessment. Models exist for each category of assessment (curriculum, learner, and institutional culture); administrators should select one based on how well it fits their assessment goals.
- 3. What are the available evaluation resources?** These resources may include time (faculty and/or learner), money, faculty/evaluator skills, and buy-in from program leaders and learners. Assessment options may range from time-, cost- and labor-intensive assessments using standardized patients to quicker and cheaper pencil-and-paper multiple-choice exams or satisfaction questionnaires. In other words, to derive a true picture of available resources,

TABLE 6.1: KEY QUESTIONS AND EXAMPLES FOR EVALUATION DEVELOPMENT

Example	Curricular/Program Evaluations	Learner Evaluations	Institutional Climate Evaluations
1. What is the goal of the evaluation?	Assess learner satisfaction with the new curriculum.	Assess learner acquisition of new knowledge.	Assess institutional promotion of equality.
2. Which theoretical models will best guide evaluation design and specific curricular content?	Kirkpatrick Hierarchy of Evaluation (See Figure 6.1)	Miller's Pyramid Dreyfus's Model of Skill Acquisition*	Organizational Profile Model**
3. What are the available evaluation resources?	Established electronic evaluation system (minimal cost, automated reminders)	Scheduled multiple-choice and essay examinations. Faculty who can write exam items.	Medical center's interest in institutional climate issues. Funding for surveys. Existing (and future) AAMC instruments (e.g., Graduation Questionnaire, Medical Student Life Survey).
4. What are the key methodological considerations?	Validity of responses (e.g., making surveys anonymous)	Consistency among preceptors.	Comprehensiveness and transparency (e.g. include both strengths and weaknesses). Accessibility to desired sample of target population. Security and privacy. Confidentiality and protection (e.g., if learners are being surveyed about institutional climate or policies, survey responses should not affect evaluations, grades, etc.

Sources:

* Dreyfus SE, Dreyfus HL. A five stage model of the mental activities involved in directed skill acquisition. University of California, Berkeley. Unpublished report, 1980.

** O'Reilly CA, Chatman J, Caldwell DF. People and organizational culture: A profile comparisons approach to assessing person-organization fit, *Academy of Management Journal*, 1991; 34(3): 487–516

administrators must consider both practical tools and materials and also the larger category of nontangibles such as expertise, evaluator time, administrative time, and existing processes to gather, store, and analyze data.

4. **What are the key methodological considerations?** While validity and reliability should be a consideration for any assessment, how the data will be used (and what sort of questions will be addressed) will also influence instrument selection and assessment design. Assessments can follow a randomized, controlled trial of a curricular intervention or, more commonly, they can target a single cohort using a pretest/posttest design. High-stakes exams require more rigor, while formative self-assessments place a higher value on qualitative feedback and learner growth. Unfortunately, well-validated assessment instruments are often not available, so evaluators should responsibly develop and test assessment innovations that further the field of educational scholarship and assessment.

Curriculum and Program Evaluation

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Accumulated learner assessment data show how well a program develops the knowledge, attitudes, and skills (KAS) of its graduates. However, program or curricular evaluations should also measure a program's institutional impact, cost, achievement of objectives or goals, and extent of unplanned impacts ("side effects"). As with learner assessments, program evaluation should ideally be designed concurrently with the program itself and not added on after the program has been designed or, more commonly, already operating. Program evaluation data can hold great value, acting as a final "report card" that highlights areas of strength and areas in need of improvement. An institution, in turn, can and should use these data to help refine curriculum where needed.

A simple program evaluation cycle begins with curricular planning and preparation and then moves to teaching, data collection, reflection, analysis, and revision. Although the terms "curriculum" and "program" are sometimes used interchangeably, the former often refers to a discrete, focused educational intervention like a seminar or lecture series, while the latter may include a number of different educational interventions linked by common content or theme like a multi-arm quality improvement initiative.

Curriculum evaluation models are helpful in determining exactly what type of data will be most useful – and even what sources of information could be considered data. The Kirkpatrick Hierarchy of Evaluation, a widely used measure of learner mastery, is shown in **Figure 6.1: Kirkpatrick's Hierarchy of Evaluation**.⁴ Although satisfaction surveys or assessments of learner reactions (Kirkpatrick Level 1) are most commonly used, they do not actually assess a program's success in improving learners' knowledge or skills. The Kirkpatrick Level 2 assessment (changes in attitudes, knowledge, or skills) moves closer to assessing true competence. However, it still fails to measure changes in actual learner behavior or, in our context, patient care. Level 3 assessment begins to tap into changes that emerge in the professional workplace (e.g., behaviors during clinic). Still, the effectiveness of those changed behaviors is not being assessed. Ideally, medical training programs want to reach Level 4 by showing that their training interventions affect learner behavior in the real world and ultimately influence patient outcomes.

The selected Kirkpatrick level and matched assessment tools for a given curricular assessment will depend on a variety of factors, including programmatic goals, resources, feasibility, audience, and preferred methodologies. In addition to the evaluation tools described under learner evaluations (e.g., Clinical Performance Exam, multiple choice questions), sources of evidence for program evaluation might include satisfaction surveys, graduation or exit interviews,^{5,6} focus groups, and ratings from experts or outside observers.⁷ **Appendix C: Suggested Additional Reading**, provides examples of curricular and learner assessment tools.

FIG. 6.1: KIRKPATRICK'S HIERARCHY OF EVALUATION



Source: Kirkpatrick DL, *Evaluating Training Programs*
San Francisco: Berrett-Koehler Publishers, Inc., 1994

Example of a Curriculum Intervention

To see how Kirkpatrick-rated assessment tools can be used to evaluate educational effectiveness of a novel curricular intervention, let's apply them to a scenario from **Chapter 5, Clinical Scenarios and Discussion Points for Experiential Learning**. In Scenario 5: A Child with Two Lesbian Mothers and Two Gay Fathers, the reader meets Jonah, a young boy whose mothers are seeking a new primary care practice and want to be sure all their health care needs will be met competently and sensitively.

From a clinical perspective, it quickly becomes apparent that the medical professionals described in the clinical scenario seem to be deficient in a number of key areas. Examples of deficits fall into the broad competency categories of Interpersonal and Communication Skills ("Which one is the mother?"—a problematic assumption when there are two legitimate mothers), Knowledge for Practice (demographics of LGBT families, intrauterine insemination procedures), Patient Care (conception counseling), Professionalism (stating sympathy for child in a "nontraditional family"—a heterosexist assumption that a child with two mothers requires special sympathy), and Systems-Based Practice (clinic forms, consent policies).

What happens when we consider the same scenario as a catalyst for curricular change at an institution? Using the scenario above, here is how curricular change and evaluation may play out in a medical school:

Curricular Scenario: After hearing about the couple's negative interaction with their prior pediatrician, combined with the comment of the covering physician ("Which one of you is the mother?"), Dr. XX, a well-respected preceptor for a nearby medical school, contacted the school's curriculum dean. Several phone calls and meetings later, a task force was formed to evaluate curriculum that teaches issues relevant to patients who may be LGBT or born with DSD, and new teaching materials were created and implemented. These materials included several new didactic lectures on LGBT health and DSD, two discussion groups on sexual orientation and health care disparities, a patient panel presentation, and revised materials for both obstetrics and family medicine seminars.

To ensure competent care of patients and families, the preceptor included "field experiences" that complemented in-class lectures and small groups with real-world clinic experiences and supervision. Assessments were planned that tap multiple Kirkpatrick levels (see **Figure 6.1**).

As this is a new curriculum that touches upon a "sensitive" topic, the dean was interested in student reaction (Kirkpatrick Level 1) and used an electronically administered Likert satisfaction scale with several items regarding quality, length, depth of content, value of each component, etc. She was also concerned there might be other instances of mistreatment of patients or families who may be LGBT, gender nonconforming, and/or born with DSD and so created an anonymous website where students could share either positive or negative stories about how patients were treated (taps into actual behavior—Kirkpatrick Level 3— and could potentially influence patient outcomes— Level 4).

Course directors and content experts were interested in establishing that new knowledge (content) had been acquired, so they assessed the students with multiple-choice exam questions after the content was covered (Kirkpatrick Level 2B). The pediatrics preceptor was most interested in changes in attitudes (Level 2A) and behavior (Level 3), so she also used a pre- and post-intervention attitude survey, an LGBT case in the end-of-year Objective Structured Clinical Exam, and required at least one direct observation of students taking a history with a relevant patient or family. Kirkpatrick Level 4 assessments were not possible due to the difficulty in linking patient outcomes to particular students.

Following a traditional curriculum evaluation and revision cycle, results from these evaluations will be used to identify program strengths and weaknesses (i.e., what improvements are noted and what competencies still have not been met). No initial curriculum is expected to “get it right the first time,” and those involved should create a culture that supports ongoing quality improvement.

Assessment of Learners

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This section considers the goals, conceptual models, and strategies used to evaluate knowledge, attitudes, skills, and competencies of learners—the aggregate results of which speak to the curriculum’s effectiveness. As a starting point, we return to the assessment planning questions presented in **Table 6.1: Key Questions and Examples for Evaluation Development** (i.e., goals, models/concepts, resources, and methodologies). Careful consideration of these assessment questions will help ensure that medical trainees acquire the knowledge, attitudes, and skills necessary to provide sensitive and comprehensive care to all patients, including those who may be LGBT, gender nonconforming, and/or born with DSD.

While we will provide a broad overview of the science of learner assessment, a detailed analysis is beyond the scope of this publication. For readers who desire more detail, we suggest the following: Holmboe and Hawkin’s *Practical Guide to the Evaluation of Clinical Competence*,⁸ Kern and colleagues’ comprehensive *Curriculum Development for Medical Education: A Six-Step Approach*,² Dent and Harden’s *A Practical Guide for Medical Teachers*,⁹ and Swanwick’s *Understanding Medical Education*.¹⁰ Helpful tools, organizations and online resources are listed in **Table 6.2: Learner Assessment Tools and Resources**.

What are the goals in assessing learners and what attributes should be assessed?

Learner assessment should encompass three important goals:

1. Provide direction and motivation for continuous improvement and lifelong learning.
2. Protect patients by upholding high professional standards and screening out learners who are incompetent or in need of remediation.
3. Provide a basis for choosing qualified applicants for advanced training and positions of leadership.

TABLE 6.2: LEARNER ASSESSMENT TOOLS AND RESOURCES

Assessment Tools: Online Resources
MedEdPORTAL® (AAMC searchable library) www.mededportal.org (see Chapter 7, Using AAMC’s MedEdPORTAL to Advance Curricular Change, for a complete description of the <i>Publications</i>, <i>iCollaborative</i>, and <i>CE Directory</i> sections of MedEdPORTAL) Family Medicine Digital Library www.fmdrl.org Alliance for Academic Internal Medicine www.im.org/toolbox/templatelibrary/Evaluation/Pages/default.aspx
Professional Organizations
Association of American Medical Colleges www.aamc.org Accreditation Council for Graduate Medical Education www.acgme.org American Board of Pediatrics www.abp.org American Educational Research Association www.aera.org Society for Teachers of Family Medicine www.stfm.org International Competency-based Medical Education Collaborators (ICBME) http://www.royalcollege.ca/portal/page/portal/rc/resources/icbme

When considered from the perspective of ultimately optimizing the care of patients who may be LGBT, gender nonconforming, and/or born with DSD, these goals may be restated as follows:

1. Instill the value and stimulate continual practices of self-reflection, examination of biases and assumptions, and patient-centered care.
2. Identify and institute corrective action for learners who do not manifest behaviors consistent with these values and/or who manifest insensitive behaviors.
3. Select learners who embody these values for visible positions as role models, teachers, and institutional leaders.

In selecting an optimal learner assessment strategy it is important to consider how results of the evaluation will be used—that is, to distinguish between formative and summative assessment. Formative assessment helps a learner improve performance by identifying areas of weakness and providing specific suggestions for improvement. This type of assessment promotes reflection, shapes values, guides future learning, and provides an opportunity for support and remediation when learners “fail.” The goal of summative assessment, on the other hand, is to judge competence, qualification for advancement to higher levels of responsibility, and fitness to practice (e.g., promotion and certification). While high-stakes summative assessments most strongly drive student behavior, both formative and summative assessments have powerful influences on student learning, motivating learners to maintain and improve their performance over time.¹¹ Ideally, all assessments should have a formative component even if used in a summative manner in order to provide feedback to students regarding strengths and areas in which they need to acquire more experience. Similar learning assessment methods may be used for both types of evaluation; however, high-fidelity (e.g., objective, valid, and reliable) methods, aligned with the desired behavioral outcomes, should always be chosen for high-stakes, summative assessments.

Once learner assessment goals are clarified, the next steps in designing an evaluation strategy are to identify the specific attributes of learning that will be assessed and decide when during training these assessments will take place. Kern et al. recommend asking the question “who will do how much (how well) by when” to guide these aspects of evaluation design.² Asking this question allows the evaluator to apportion the assessment process into clearly articulated learning objectives. Evaluators can measure attainment of objectives both subjectively and objectively at strategic points across the curriculum to promote ongoing learning and behavioral change.

Specific components of what will be assessed fall into three categories: knowledge, attitudes, and skills. The seamless integration of these demonstrates the ultimate goal of competence. In either formative or summative evaluations, performance criteria should be articulated to objectively assess how a learner performs. Evaluators may require special training for this, particularly in areas in which prevailing practices are not aligned with desired outcomes. Formative assessments can compare learners against an objective standard to highlight strengths and areas for improvement. In summative scenarios, performance milestones may be used to judge whether a learner is ready to progress to the next level or needs additional training before advancement.

Developing patient-centered and culturally competent communication and relationship skills is of paramount importance when caring for patients who are or may be LGBT, gender nonconforming, and/or born with DSD (indeed, when caring for *all* patients who are at high risk for experiencing bias and discrimination). Whenever possible, learner assessment should therefore include use of measurement tools with proven effectiveness in assessing learners’ explicit and implicit attitudes and verbal and nonverbal communication. As with other prejudices based on social categories, bias toward people who may be LGBT, gender nonconforming, and/or born with DSD is most easily addressed when it manifests overtly. Implicit bias is much more difficult to ascertain and measure, requires continual self-awareness and practice to compensate for, and often arises in interpersonal interactions at the level of so-called microaggressions (i.e., subtle, ongoing discrimination in the form of verbal, behavioral, and environmental slights and indignities).¹² Microaggressions may, without intensive self-reflection, elude the consciousness of the enactor, yet still harm the recipient.^{13,14}

Limited evidence suggests that educational programs that include so-called mindful communication can produce short-term and sustained improvements in attitudes associated with patient-centered care.^{15,16} These programs use instruction in mindfulness meditation, narrative in medicine, and appreciative inquiry practices to promote attentiveness, listening, honesty, and presence during clinician-patient interactions. Accordingly, we recommend design and use of learner assessment tools that focus specifically on the development of mindful and patient-centered practices, with specific inclusion of LGBT and DSD-related themes. As empathy has been shown to wane during the course of medical school and residency,¹⁷ we further suggest that assessment of patient-centeredness and other “soft” clinical skills be interspersed across each year of training.

What foundational concepts provide a framework to guide assessment?

Several developmental learning models provide a useful framework in considering trainee acquisition of knowledge, attitudes, and skills across the learning continuum. In 1990 psychologist George Miller proposed his assessment pyramid as a way to assess clinical competence.¹⁸ The pyramid’s lowest level is knowledge (“knows”), followed by learning-related knowledge and skills (“knows how”), performance (“shows how”), and action (“does”) at the peak. “Action” focuses on what occurs in clinical practice rather than what a student demonstrates in an artificial testing situation.

Assessment methods chosen to evaluate learning gains at each level must be congruent with learning objectives. For example, multiple choice and written tests are appropriate to test attainment of knowledge objectives, while observation sessions are appropriate for skills objectives. However, as noted by Miller himself, “No one assessment method can provide all the data required for anything so complex as the delivery of professional services by a successful physician.”¹⁸ Therefore, it is important to use a combination of multiple assessment methods and a variety of environments and contexts to capture different aspects of performance across the medical education trajectory. **Table 6.3** shows how different assessment methods align with Miller’s competency levels. **Table 6.2** contains a detailed description of each of these assessment methods and lists recommended textbooks and the resources.

TABLE 6.3: EXAMPLES OF ASSESSMENT METHODS ALIGNED WITH MILLER’S PYRAMID*

KNOWS Statement of facts, principles, theories, and beliefs	KNOWS HOW Ability to solve problems and describe procedures	SHOWS HOW Demonstration of skills in a controlled (educational) setting	SHOWS/DOES Behavior in real practice
• Multiple-choice exam (knowledge) • Pre-/post-questionnaires (attitudes) • Retrospective post-testing (attitudes; self-perceptions)	• Oral exam • Written exam • Case discussion • Clinical vignettes	• Chart-stimulated recall • Simulation with model or mannequin • Standardized patient exam • Objective Structured Clinical Exam (OSCE)	• Direct observation and/or videotaped performance with actual patient (mini-clinical evaluation exercise, or miniCEX) • Portfolios with reflection • 360-degree evaluation (including patients, peers, other members of the clinical team) • Medical record review • Problem-based learning initiative / Quality improvement project • Evaluation of learners as teachers • Unannounced standardized patient

* Source: Recommendations for Clinical Skills Curricula for Undergraduate Medical Education, 2008. Association of American Medical Colleges. Available at: https://www.aamc.org/download/130608/data/clinicalskills_oct09.qxd.pdf. Accessed February 25, 2014.

Two additional models that describe the incremental progression of learning include Pangaro’s RIME (Reporter, Interpreter, Master, and Educator) categorization of clinical learning roles¹⁹ and Dreyfus’s levels of skill performance (Novice, Advanced Beginner, Competent, Proficient, Expert, and Master).²⁰ The Dreyfus model emphasizes the importance of responsibility in the development of competence: learners must perceive an impact of their behaviors in order to move into higher levels of competence. In this model, workplace-based assessments, though often less convenient to implement, are critical.

Just as curricula should be designed so that learners progress through ever-increasing levels of complexity, assessment methods should evaluate behaviors appropriate to each developmental learning level. The Accreditation Council for Graduate Medical Education and American Board of Internal Medicine collaborative Milestones Project lays out developmental milestones on the journey from premedical student to medical student (undergraduate medical education) to resident (graduate medical education) to practicing physician (continuing medical education) levels.²¹ What is needed now is to have competencies and their associated learning objectives mapped to those developmental milestones. Then, assessments can be placed at appropriate points across the learning continuum. The milestones established in graduate medical education should be charted backward to articulate appropriate expectations among medical students; such efforts are underway in the undergraduate medical education community.

A complete mapping of competencies and objectives to improve the care of people who may be LGBT, gender nonconforming, and/or born with DSD onto trainee developmental milestones is beyond the scope of this publication. Moreover, it should be up to each school or training program to decide at what level (preclinical, clinical, residency, etc.) their students or residents should achieve mastery of specific learning objectives.

Table 6.4 provides an example of what such a competency mapping might look like based on the Patient Care competency domain of the Professional Competency Objectives for people who may be LGBT, gender nonconforming and/or born with DSD. We included the high level of detail to illustrate representative learning objectives for readers not yet expert in the clinical issues most relevant to patients who may be LGBT, gender nonconforming, and/or born with DSD. We may be able to use less specificity when developing milestones in the future, as the clinical content important for these patients becomes more widely available within medical education.

TABLE 6.4: EXAMPLE OF DESIRED DEVELOPMENTAL PATHWAYS FOR LGBT-DSD-RELATED COMPETENCIES BASED ON THE PATIENT CARE COMPETENCY DOMAIN

PRE-CLERKSHIP		
	Knows What are the expectations for a beginning trainee?	Knows How What are the expectations for a trainee who has advanced and will soon be entering clinical clerkships?
1 Sensitively and Effectively Eliciting Relevant Information	- Identify assumptions that are commonly made about patients who may be LGBT, gender nonconforming and/or born with DSD (e.g., regarding sexual orientation, gender identity, sexual behavior, genital anatomy, desire for gender affirmation surgery, etc.) - List open-ended questions that can be used with any patient to elicit a sensitive and accurate history without making assumptions.	During a simulation exercise (e.g., role play with a student peer), demonstrate how to obtain a complete history with regard to sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from any patient using open-ended language free of assumptions.
2 Performing a Complete and Accurate Physical Exam	With respect to patients of different ages who may be LGBT, gender non-conforming, and/or born with DSD: - Identify sensitive aspects of the physical exam. - Describe the potential psychological impact of performing sensitive aspects of the physical exam. - Explain when sensitive aspects of the physical exam need to be done and when they can be omitted. - Discuss what kinds of special considerations should be used when seeking to perform a chest, genital, or anorectal examination.	With respect to patients of different ages who may be LGBT, gender non-conforming, and/or born with DSD: - Describe how to perform a chest, genital, or anorectal exam in a manner that is respectful of patients' autonomy, sense of control, and physical comfort. - During a simulation exercise with an adult patient (e.g. using a pelvic model), demonstrate how to perform a chest, genital, or anorectal exam in a manner that is respectful of the patient's autonomy, sense of control, and physical comfort

PRE-CLERKSHIP		
	Knows What are the expectations for a beginning trainee?	Knows How What are the expectations for a trainee who has advanced and will soon be entering clinical clerkships?
3 Describing the Special Health Care Needs and Available Options for Quality Care	- Identify non-medical, medical, and surgical interventions patients may use to express their gender. - Describe and discuss the rationale for and prerequisite criteria to initiate medical and surgical interventions patients may use to affirm their gender. - Discuss the impact of assigning sex to infants with DSD.	- Describe the clinical effects, potential benefits, and potential adverse effects of nonmedical interventions patients may use to express their gender (e.g., chest binding, genital tucking, silicone injections). - Describe the clinical effects, potential benefits, and potential adverse effects of medical interventions patients may elect to affirm their gender (e.g., cross-sex hormones for transitioning; hormone replacement therapy (HRT) for patients who lack gonads). - Describe the clinical effects, potential benefits, and potential adverse effects of surgical interventions patients may elect to affirm their gender (e.g., breast implants and creation of a neovagina for an MtF transsexual). - Describe the potential adverse effects of not adhering to HRT (e.g., adrenal crisis with omission of replacement steroid doses in congenital adrenal hyperplasia) or not undergoing recommended surgeries (e.g., development of testicular cancer in an undescended testis) in some types of DSD.
4 Assessing Unique Needs and Tailoring the Physical Exam and Counseling and Treatment to Any Special Needs, Impairments, or Disabilities	Describe barriers to care faced by patients who may be LGBT, gender nonconforming, and/or born with DSD, who also have special needs or disabilities, such as deafness, visual, intellectual, and/or mobility impairments.	Formulate a list of community resources that provide services to assist patients who may be LGBT, gender nonconforming, and/or born with DSD and also have special needs or disabilities.

PRE-CLERKSHIP		
	Knows What are the expectations for a beginning trainee?	Knows How What are the expectations for a trainee who has advanced and will soon be entering clinical clerkships?
5 Recognizing the Unique Health Risks and Challenges and Tailoring Health Messages and Counseling Efforts to Boost Resilience and Reduce High-Risk Behaviors	With respect to patients with diverse sexual orientations, gender identities, and sex and gender histories: - Describe high-risk behaviors that are prevalent and explain why these behaviors are prevalent in these communities. - Describe factors that promote resilience and development of healthy coping skills. - Discuss unique barriers and facilitators to lifestyle behavior change.	With respect to patients who may be LGBT, gender nonconforming, and/or born with DSD: - Identify and examine tailored health messages and counseling efforts that have been shown to be effective (including harm-reduction strategies). - During a simulation exercise (e.g., role-play), demonstrate motivational interviewing techniques.
6 Providing Effective Primary Care and Anticipatory Guidance by Utilizing Screening Tests, Preventive Interventions, and Health Care Maintenance as Appropriate to Each Patient's Anatomical, Physiological, and Behavioral Histories	With respect to patients across the lifespan who may be transgender, gender nonconforming, and/or born with DSD: - Describe obstacles that may impede access to routine health care. - Identify strategies that have been implemented successfully at office and institutional levels to reduce barriers to care. - Describe recent changes in preventive health and their potential to change in the future (e.g., HPV vaccines for all individuals; use of pre-exposure prophylaxis or PreP; suicide screening for at-risk youth).	With respect to patients across the lifespan who may be transgender, gender nonconforming, and/or born with DSD: - Identify preventive interventions and screening tests appropriate to age, family history, risk behaviors and exposures, and presence of natal anatomy. - Propose an optimal clinical monitoring schedule for a patient who decides to initiate cross-sex hormones or HRT or who elects to have a gender-affirming surgical procedure.

PRE-CLERKSHIP

BENCHMARK

CLERKSHIP

CLERKSHIP		
	Shows How	Shows
1 Sensitively and Effectively Eliciting Relevant Information	- What are the expectations for a trainee during the first year of clinical clerkships? - What should the trainee be able to do well by the end of their third year of medical school?	- What are the attributes of a graduating trainee? - What additional knowledge, skills attitudes, and behaviors should the trainee demonstrate? - Is the trainee ready to advance to residency?
2 Performing a Complete and Accurate Physical Exam	- During an encounter with a standardized patient (SP) who may be LGBT, gender nonconforming, and/or born with DSD: a) Demonstrate how to obtain a complete history using open-ended language free of assumptions. b) Demonstrate how a clinician should respond to the patient when clinician inadvertently makes an assumption and/or causes offense.	- During an encounter with a real patient who may be LGBT, gender nonconforming, and /or born with DSD: a) Demonstrate how to obtain a complete history using open-ended language free of assumptions. b) Demonstrate how to respond to the patient when clinician inadvertently makes an assumption and/or causes offense. - Propose a strategy to make the practice environment more welcoming and safe.
3 Describing the Special Health Care Needs and Available Options for Quality Care	With respect to patients of different ages who may be LGBT, gender nonconforming, and/or born with DSD: - During a simulation exercise (e.g., role-play) demonstrate how to discuss the reasons for considering and the mechanics involved in performing a chest, genital, or anorectal exam. - During a simulation exercise (e.g., using a pelvic model), demonstrate how to tailor the physical exam as appropriate to an individual's history and exposure (e.g., anal Pap tests for individuals who engage in unprotected anal-receptive sex; examination of genital tissues that may have suffered iatrogenic harm from pediatric management of DSD).	During an encounter with a SP posing as a patient who is LGBT, gender non-conforming, and/or born with DSD: - Discuss the reasons for considering and the mechanics involved in performing a chest, genital, or anorectal exam. - Demonstrate how to perform a tailored exam using appropriate etiquette (e.g., using pronouns appropriate to the patient's gender and gender-free terminology such as 'chest' rather than 'breasts' and 'canal' rather than 'vagina') and technique (e.g., using methods to minimize physical discomfort and respecting the patient's right to stop the exam at any time).
	During a simulation exercise (e.g. role-play with a peer), demonstrate how to counsel a patient who may be transgender, gender non-conforming, and/or born with DSD in a sensitive manner regarding: Clinical effects, potential benefits, and potential adverse effects of nonmedical, medical, and surgical interventions patients may use to affirm their gender, including explaining risks of non-adherence and obtaining informed consent (see PRE-CLERKSHIP section).	During an encounter with a standardized patient (SP) posing as transgender, gender nonconforming, and/or born with DSD, demonstrate how to provide sensitive counseling regarding: Clinical effects, potential benefits, and potential adverse effects of medical, non-medical, and surgical interventions patients may use to affirm their gender, including explaining risks of non-adherence and obtaining informed consent (see PRE-CLERKSHIP section).

CLERKSHIP		
	Shows How	Shows
	- What are the expectations for a trainee during the first year of clinical clerkships? - What should the trainee be able to do well by the end of their third year of medical school?	- What are the attributes of a graduating trainee? - What additional knowledge, skills attitudes, and behaviors should the trainee demonstrate? - Is the trainee ready to advance to residency?
4 Assessing Unique Needs and Tailoring the Physical Exam and Counseling and Treatment to Any Special Needs, Impairments, or Disabilities	With respect to a patient who may be LGBT, gender nonconforming, and/or born with DSD and special needs or disabilities: During a simulation exercise (e.g., role play), demonstrate how to conduct a history, and describe how to perform a physical exam in a manner that is sensitive and respectful.	During an encounter with an SP posing as a patient who may be transgender, gender nonconforming, and/or born with DSD, and have special needs or disabilities: Demonstrate how to conduct a history and perform a physical exam in a manner that is sensitive and respectful.
5 Recognizing the Unique Health Risks and Challenges and Tailoring Health Messages and Counseling Efforts to Boost Resilience and Reduce High-Risk Behaviors	With respect to patients who may be LGBT, gender nonconforming, and/or born with DSD: During a simulation exercise (e.g., role play), demonstrate how to provide culturally relevant and patient-centered counseling to address high-risk behavior and boost resilience.	During an encounter with an SP posing as a patient who may be transgender, gender nonconforming, and/or born with DSD: Demonstrate culturally relevant and patient-centered counseling to address high-risk behavior and boost resilience.
6 Providing Effective Primary Care and Anticipatory Guidance by Utilizing Screening Tests, Preventive Interventions, and Health Care Maintenance as Appropriate to Each Patient's Anatomical, Physiological, and Behavioral Histories	With respect patients across the lifespan who may be transgender, gender nonconforming, or born with DSD: - During a simulation exercise (e.g. role-play), demonstrate how to counsel a patient in a sensitive manner regarding: - Optimal schedule for routine health maintenance and screening tests - Optimal clinical monitoring schedule for a patient who decides to initiate cross-sex hormones or HRT or who elects to have a gender-affirming surgical procedure.	During an encounter with an SP posing as a patient who may be transgender, gender nonconforming, or born with DSD: - Demonstrate how to counsel a patient in a sensitive manner regarding: - Optimal schedule for routine health maintenance and screening tests - Optimal clinical monitoring schedule for a patient who decides to initiate cross-sex hormones or HRT or who elects to have a gender-affirming surgical procedure.



RESIDENCY

	Shows/Does
	What behaviors are expected from a residency-level trainee who (with supervision) is capable of: a) Providing care to patients in the real world? b) Role modeling/ teaching junior colleagues?
1 Sensitively and Effectively Eliciting Relevant Information	With respect to patients who may be LGBT, gender nonconforming, and/or born with DSD: • Demonstrate and teach junior colleagues how to obtain a complete history using open-ended language free of assumptions. • Teach junior colleagues how to respond when a clinician inadvertently makes an assumption and/or causes offense to a patient. • Implement a strategy to make the practice environment more welcoming and safe.
2 Performing a Complete and Accurate Physical Exam	During an encounter with a real patient who is LGBT, gender nonconforming, and/or born with DSD: • Discuss the reasons for considering and the mechanics involved in performing a chest, genital, or anorectal exam, and perform a tailored exam (miniCEX) using appropriate etiquette and technique (see CLERKSHIP section). • Lead junior colleagues in discussion of the special considerations and the mechanics involved in performing a chest, genital, or anorectal exam, and model how to perform a tailored exam using appropriate etiquette and technique (see CLERKSHIP section).
3 Describing the Special Health Care Needs and Available Options for Quality Care	During an encounter with a real patient who is transgender, gender nonconforming, and/or born with DSD, provide sensitive counseling regarding: • Clinical effects, potential benefits, and potential adverse effects of non-medical, medical, and surgical interventions patients may use to affirm their gender, including explaining risks of non-adherence and obtaining informed consent (see PRE-CLERKSHIP section). • Teach junior colleagues how to provide such counseling.
4 Assessing Unique Needs and Tailoring the Physical Exam and Counseling and Treatment to Any Special Needs, Impairments, or Disabilities	During an encounter with a real patient who may be transgender, gender nonconforming, and/or born with DSD: • Conduct a history and perform a physical exam in a manner that is sensitive and respectful. • Teach junior colleagues how to conduct a history and perform a physical exam that is sensitive and respectful. • Advocate for patient needs with care teams and other health professionals.

RESIDENCY	
	Shows/Does
	What behaviors are expected from a residency-level trainee who (with supervision) is capable of: a) Providing care to patients in the real world? b) Role modeling/ teaching junior colleagues?
5 Recognizing the Unique Health Risks and Challenges and Tailoring Health Messages and Counseling Efforts to Boost Resilience and Reduce High-Risk Behaviors	During an encounter with a real patient who may be transgender, gender nonconforming, or born with DSD: • Perform culturally relevant and patient-centered counseling to address high-risk behavior and boost resilience. • Teach junior colleagues how to perform culturally relevant counseling to address high-risk behavior and boost resilience.
6 Providing Effective Primary Care and Anticipatory Guidance by Utilizing Screening Tests, Preventive Interventions, and Health Care Maintenance as Appropriate to Each Patient's Anatomical, Physiological, and Behavioral Histories	During an encounter with a real patient who may be transgender, gender nonconforming, or born with DSD: • Counsel the patient in a sensitive manner regarding: a) Optimal schedule for routine health maintenance and screening tests b) Optimal clinical monitoring schedule for a patient who desires to initiate cross-sex hormones or HRT or who elects to have a gender-affirming surgical procedure • Teach junior colleagues how to provide such counseling.

While it is important to keep developmental stages in mind, we caution against creating an overly linear evaluation protocol that artificially defines an entry-level student as a novice and a faculty member as an expert. When it comes to cultural competency regarding care for patients who may be LGBT, gender nonconforming, and/or born with DSD, a student who is a novice from an academic standpoint may, from personal experience or previous education, have greater awareness than a faculty member. It would also be incorrect to assume that a learner who identifies as LGBT, gender nonconforming, or born with DSD will be culturally competent solely because of that identity. For example, self-identified gay men can exhibit varying degrees of internalized,²² and negative attitudes toward one's own homosexuality can be implicit, i.e., automatic or unconscious.²³

Because students may enter medical school at different levels of competence, competency mapping should focus on identifying a path for learners to follow in order to achieve excellence regardless of their level upon entry. This path sets the desired outcome of excellence as the end goal and uses meaningful, objective performance measures to delineate benchmarks of performance (see **Table 6.5: Example of a Milestone Assessment Tool for an LGBT/DSD-related Competency**).

The wide variability in baseline knowledge, attitudes, and skills of all constituents must also be carefully considered when deciding who (faculty members, student peers, interprofessional team members, and/or patients) are most qualified to assess the sensitivity of a trainee-patient interaction.²⁴ This underscores the importance of embedding faculty development and the use of validated assessment tools into evaluation efforts.

Moreover, when it comes to cultural competency, none of us can ever really achieve true mastery, as it is human to make assumptions; at the core, we must commit to behaving respectfully, apologizing when we make mistakes, and becoming ever-increasingly aware of our biases over time. Thus, cultural humility has been advanced as foundational for cultural competence in medicine, given the concept of humility's emphasis on values and attitudes, in sharp contrast to the older notion of cultural competency, which required what amounted to an impossibly broad body of knowledge and skills.²⁵ Others have argued that, in addition to the attitude of cultural humility, generalized skills that facilitate competent care of diverse patients include learning to sensitively ask about social circumstances, language/literacy, religious or spiritual beliefs, sexual behavior, and self-identity.²⁶

In addition, innovative curricula may explicitly assign roles to beginning students that were traditionally reserved for more experienced trainees. For example, a novice may be expected to serve as a peer educator during a case-based tutorial. Such learner-as-teacher programs have been shown to improve clinical knowledge and skills, encourage self-directed learning, and may help students to incrementally accrue more robust teaching skills across the entire trajectory of their medical training, ultimately leading to the availability of more accomplished mid-career faculty role models and educators.^{27,28} Even at the preclinical undergraduate medical education (UME) level, where assessment has focused traditionally on the lower levels of Kirkpatrick's outcomes hierarchy, there is increasing evidence for the benefits of early student immersion in clinical and community settings²⁹ and interprofessional teamwork that focuses on making improvements in quality, safety and systems performance.^{30,31} Furthermore, the evaluation of learning gains via experiential activities, such as the application of didactic knowledge to a practice-based learning and improvement project, is aligned with the Institute for Healthcare Improvement's eight knowledge domains for health professional students.³² Such projects provide an excellent opportunity for trainees to contribute meaningfully to the quality of care at their own institutions for patients who may be LGBT, gender nonconforming, and/or born with DSD.

**TABLE 6.5: EXAMPLE OF A MILESTONE ASSESSMENT TOOL FOR AN
LGBT/DSD-RELATED COMPETENCY**

Patient Care: Competency 1		
Sensitively and effectively eliciting relevant information about sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from all patients in a developmentally appropriate manner.		
← Sensitivity of the Medical History →		
Unacceptable	Entry Level	Late Beginner*
- Does not sensitively approach patients who may be LGBT, gender non-conforming, and/or born with DSD - Makes assumptions about patient history, identity, or practices - Disruptive when asking questions - Dismissive of patient concerns - Unengaged during clinical encounter	- Identify assumptions that are commonly made about patients who may be LGBT, gender nonconforming, and/or born with DSD (e.g., regarding sexual orientation, gender identity, sexual behavior, genital anatomy, desire for gender-affirmation surgery, etc.) - List open-ended questions that can be used with any patient to elicit a sensitive and accurate history free of such assumptions.	During a simulation exercise (e.g., role play with a student peer), demonstrate use of open-ended language free of assumptions with regard to sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity.
- Does not understand the relevance of LGBT, gender nonconforming, or born with DSD status to health. - Does not elicit health concerns, including preventive and behavioral health, relevant to patients who are LGBT, gender nonconforming, and/or born with DSD that could lead to harm to the patient.	- Understand the relevance of LGBT, gender nonconforming, or born with DSD status to health. - Describe questions that may be used to obtain relevant information about the sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity of any patient.	During a simulation exercise (e.g., role play with a student peer), obtain a complete history with regard to sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from any patient.

Patient Care: Competency 1

Sensitively and effectively eliciting relevant information about sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity from all patients in a developmentally appropriate manner.

← Sensitivity of the Medical History →

Mid-Level	Advanced**	Aspirational
• During an encounter with a standardized patient (SP) who may be LGBT, gender nonconforming, and/or born with DSD: • Demonstrate use of open-ended language free of assumptions. • Demonstrate how to respond to the patient when inadvertently making an assumption and/or causing offense.	• During an encounter with a real patient who may be LGBT, gender nonconforming, and/or born with DSD: • Demonstrate use of open-ended language free of assumptions • Demonstrate how to respond to the patient when inadvertently making an assumption and/or causing offense. • Propose a strategy to make the trainee's own practice environment more welcoming and safe.	• With respect to patients who may be LGBT, gender nonconforming, and/or born with DSD: • Demonstrate and teach junior colleagues how to use open-ended language free of assumptions. • Demonstrate and teach junior colleagues how to respond to the patient when inadvertently making an assumption and/or causing offense. • Implement a strategy to make the trainee's own practice environment more welcoming and safe.
• During an encounter with a standardized patient (SP) who may be LGBT, born with DSD, or gender nonconforming, demonstrate how to obtain a complete history that includes relevant information about the patient's sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity.	• During an encounter with a real patient who may be LGBT, born with DSD, or gender nonconforming, demonstrate how to obtain a complete history that includes relevant information about the patient's sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity.	• With respect to patients who may be LGBT, gender nonconforming, and/or born with DSD demonstrate and teach junior colleagues how to obtain a complete history that includes relevant information about the patient's sex anatomy, sex development, sexual behavior, sexual history, sexual orientation, sexual identity, and gender identity.

Sources:

* Students are expected to perform at a late beginner level at the completion of their pre-clerkship training.

** Students are expected to perform at an advanced level as they approach the end of their undergraduate medical education.

What are the available assessment resources?

Practically speaking, time, money, expertise, and other factors often influence how institutions evaluate their learners. While some assessment approaches such as multiple-choice exams are relatively inexpensive and highly efficient, they may suffer from limited validity and are often unable to go beyond assessments of knowledge. Other tools, such as standardized patient examinations, are better able to assess clinical competence, but can be costly and require complex administrative systems and expertise to ensure reliability. Ultimately, a program must decide where to prioritize assessment resources while still adhering to the mandates of accrediting bodies such as ACGME or LCME. Another frequently overlooked resource is the learner's own capacity; students are strategic in devoting effort toward topics that they perceive as valued by the grading institution. Thus, institutions should be sure to align new initiatives with assessments that have an impact on the learner. When considering whether a trainee has achieved competencies to improve the care of patients who may be LGBT, gender nonconforming, and/or born with DSD, it may not be necessary to develop entirely new evaluation tools, as pre-existing methods used to assess medical knowledge, communication skills, and professionalism can often be enhanced or expanded for this purpose.

What measurement methods or tools should be used?

Keeping in mind the availability of resources, measurement tools used to assess the impact on learners of a curriculum focusing on the care of patients who may be LGBT, gender nonconforming, and/or born with DSD should:

- Take into account all stakeholders (e.g., examinees, faculty, and patients) in order to anticipate and address ethical concerns that might arise from participation in the assessment process (e.g., recognizing that repeated exposure to difficult memories or situations may negatively affect instructors or students who identify as LGBT, gender nonconforming or born with DSD).
- Align with learning objectives (i.e., measure what was intended to be taught) and type of instructional activity (e.g., multiple choice tests for knowledge objectives, observation sessions for skills objectives).
- Adjust with the level of the learner (i.e., be concordant with developmental milestones).
- Be accurate (i.e., validated in medical education settings), credible (i.e., objective measurements trump subjective ratings), and important (i.e., measure outcomes at the highest point possible on the assessment hierarchy).
- Include direct observation of trainees performing with patients to ensure meaningful evaluation (just as active engagement, experience, and practice ensures meaningful change).
- Incorporate the patient's voice via involvement of and evaluation by actual patients who are LGBT, gender nonconforming, and/or born with DSD, whenever possible to increase authenticity and trainee exposure.

- Provide timely feedback and mentoring to all trainees, including an appropriate remedial action plan, when needed.

In addition, optimal learner evaluation methods should be rigorously designed so that results of the assessment can be compiled and disseminated to establish best practices and promote effective evaluation tools in other venues. For example, methods should include a sufficient number of items or observations for statistical power, use a control or comparison group, include long-term follow-up, or use blind or well-calibrated raters, to yield significant results. They should also be accompanied by appropriate data analysis (e.g., multivariate analysis to account for confounding variables).

These recommendations notwithstanding, less rigorous or untested measurement tools can sometimes contribute to the overall evaluation of a learner when results of diverse assessments are considered in aggregate or when entirely new areas are being explored. Additionally, some aspects of learning—in particular, self-awareness and changes in implicit attitudes—are difficult and even impossible to measure objectively; therefore, guided self-assessment methods can be very useful in these situations.

Table 6.6: Sample Assessment Tools Categorized by Miller and Kirkpatrick, presents a spectrum of tools that can be used to assess learning at various levels of Miller’s pyramid and Kirkpatrick’s learning hierarchy. We have adapted Kirkpatrick levels to include Participation (Level 1A) and expanded categories of Behavior (3A: educational setting; 3B: professional practice) and Outcomes (4A: patient/local level; 4B: population/systems level). The table also includes a new category, Change in Attitudes (arbitrarily placed at Level 2A), to include the best available assessment scales for measuring attitude and cultural competency. However, as discussed above, meaningful evaluation of cultural competency requires repeated assessment across the entire continuum of learning, and evaluation should also employ a variety of higher-fidelity assessment tools, such as those described by Kogan et al.³³ and Jelovsek et al.³⁴ For high-fidelity cultural competency evaluations, tools such as global rating scales during observed performance with standardized or actual patients and 360-degree assessments that include feedback from patients, are particularly useful. Direct patient involvement in teaching and assessing intimate examination skills has also been shown to be effective.³⁵

Where available, we have included examples of LGBT-focused assessment tools that have been used in medical settings, as well as a list of corresponding validated assessment tools that might be adapted by educators for use in the evaluation of LGBT- and DSD-related learning objectives in situations where few evaluation instruments exist. A number of additional validated scales of attitudes toward people who may be LGBT are included in the reference section,³⁶⁻⁴² but omitted from the table because they are older or have not been validated specifically in medical education environments. Of 116 health professions-related educational assessments compiled collaboratively in October 2013 using AAMC’s MedEdPORTAL® *iCollaborative* and *CE Directory*, only a few were specifically oriented toward assessing clinical skills and attitudes of medical trainees with respect to caring for LGBT patients, and none addressed the care of patients born with DSD. There is clearly a need for development and validation of additional assessment tools that address learner acquisition of the knowledge, attitudes, and skills needed to provide comprehensive and sensitive care to these individuals.

We conclude this section on the assessment of learners by again referring the reader to **Chapter 5, Clinical Scenarios and Discussion Points for Experiential Learning**. This time, we will use Scenario 8: A Transgender Man with a Pelvic Mass and follow a rubric developed by Kern et al.² to describe how the learning objectives might be evaluated. Imagine that Mikal's case were to be included as a focal point during a core medicine clerkship. Using Miller's Pyramid, potential learning assessment strategies might include the following:

- **Knowledge**

(Knows/Knows How): Delivery of a multiple choice test at the start of the clerkship that evaluates the knowledge required to achieve the learning objectives pertinent to Scenario 8: A Transgender Man with a Pelvic Mass could provide a baseline measure of knowledge and focus students' learning on key content (formative assessment). Comparison of pre- and post-rotation scores on the same test could be used to assess the effectiveness of case-based instructional activities in achieving learner cognitive objectives (summative program evaluation). After repeated implementation, revision, and compilation of data demonstrating the case's effectiveness, Mikal's story and the accompanying pre- and post-tests could be submitted to MedEdPORTAL for peer review and consideration for publication as a case-based learning module. (For more about MedEdPORTAL submissions, see **Chapter 7, Using AAMC's MedEdPORTAL® to Advance Curricular Change**.)

- **Attitudes**

Knows/Believes: Comparison of anonymously reported, self-administered, pre- and post-rotation, online test scores of attitudes toward and comfort level caring for Female to Male (FtM) transgender patients could provide students with an opportunity to self-reflect (formative feedback) and could provide faculty with a measure of change in attitudes and/or willingness to change attitudes toward this population as might occur across the trajectory of the course (summative program evaluation). Existing attitude measurement scales could easily be adapted to suit this purpose. Anonymity would be important to increase the likelihood of honest reporting.

Shows How: Role-play exercises could be structured to include faculty and peer feedback regarding communication skills during clinical history taking that is inclusive of gender identity. These exercises could be supplemented with the provision of counseling on the how-to's, physical effects, and risks/benefits of cross-sex hormone therapy (formative assessment).

Shows How/Shows: A non-LGBT-specific global rating form could be adapted to permit patient and faculty assessment of communication skills and cultural competence after observing a student conducting a history and/or counseling session with a standardized OSCE or actual (miniCEX) FtM transgender patient (formative and summative assessment). In training standardized patients, an attempt should be made to reach out to true stakeholders (i.e., individuals who self-identify as FtM) to increase authenticity and to optimize the potential to provide feedback regarding microaggressions perceived during the encounter. Appropriate faculty development would need to be included to optimize the reliability of raters and the accuracy of their ratings. If resources permitted, a structured clinical coaching program could be undertaken to enhance the quality of faculty teaching and assessment.⁴³

- **Skills**

Shows How/Shows: A non-LGBT-specific pelvic examination checklist and global rating form could be adapted to permit faculty and/or patient assessment of communication skills/cultural competence and physical exam skills after observing a student conducting a pelvic examination with a model (simulation), standardized patient (OSCE), or actual (miniCEX) FtM transgender patient (formative and summative assessment). As mentioned above, a faculty development activity would again be highly desirable.

Knows How/Shows How: A multidisciplinary quality improvement project could be undertaken to inspect the surrounding health environment through the eyes of transgender patients and to develop a plan to make the environment feel safer and more welcoming. Including a patient or staff member who identifies as FtM could add value to the experience. The Quality Improvement Knowledge Assessment Tool (QIKAT)³¹ could be used to evaluate the student's application of quality improvement knowledge and a 360-degree evaluation appraisal⁴⁴ could be carried out after completion of the activity to obtain feedback on the student's contributions from all members of the quality improvement team (formative and summative assessment).

Shows How/Shows: After delivery of a student-as-teacher education session on an FtM transgender-related topic, a questionnaire could be administered to participants to assess their views of the presentation's organization, content, teaching methods, and overall quality of instruction. A standard, non-LGBT-focused evaluation tool could easily be adapted to work in this setting (formative and summative assessment).

Does: This category is not included here, since unsupervised, direct care responsibility is not expected at the medical student level of training.

TABLE 6.6: SAMPLE ASSESSMENT TOOLS CATEGORIZED BY MILLER AND KIRKPATRICK

Expanded Kirkpatrick Learning Hierarchy	Type of demonstrated learning (Miller model)	Description	Evaluation Method	LGBT/DSD Examples	Non-LGBT/DSD-specific Examples
Level 1A Participation and/or Exposure	No equivalent in the Miller model	Number of learners who participate in the educational activity	Attendance records Online tracking of: a) Number of exposures to patients who are LGBT/born with DSD b) Participation in educational activities focused on LGBT/DSD-related topics	No LGBT- or DSD-specific examples available	Number of HIV+ patients a provider must care for in order to qualify to take the American Academy of HIV Medicine (AAHIVM) certification exam. Number of procedures that must be documented in order for a trainee to be deemed competent in performing that procedure.
Level 1B Reaction and/or Satisfaction	No equivalent in the Miller model	Participants' views of the learning experience, its organization, presentation, content, teaching methods, and quality of instruction	Questionnaires and/or surveys completed by attendees after an educational activity Focus groups with learners	Education sessions on LGBT issues	Standard template for non-LGBT/DSD-oriented participant evaluation of educational activity.

Expanded Kirkpatrick Learning Hierarchy	Type of demonstrated learning (Miller model)	Description	Evaluation Method	LGBT/DSD Examples	Non-LGBT/DSD-specific Examples
Level 2A Change in Attitudes	Knows (believes)	Degree to which participants change attitudes or perceptions as a result of the educational activity	<i>Subjective:</i> self-reported attitudinal change (e.g., reflective portfolio; retrospective pre-/post-test change in attitudes² <i>Objective:</i> a) pre-/post-test comparisons of attitudes b) global ratings during observed performance with SPs or actual patients c) 360-degree assessments	LGBT-specific, validated attitude assessment scales (for older scales, please see text/ references) <i>Implicit Attitudes:</i> • Implicit Attitudes Test³ <i>Explicit Attitudes and Knowledge:</i> • 64-item survey of medical student knowledge, attitudes and clinical ability to care for LGBT patients⁴ • A critical intervention in LGBT health: knowledge and attitude outcomes among second-year medical students⁵ • Knowledge about Homosexuality Questionnaire⁶ • Attitudes towards Homosexuals Questionnaire⁷	Standard reflective portfolio template (no specific example) Measures of self-awareness, mindfulness, and empathy: • Jefferson Empathy Scale⁸ • Measures of psychological flexibility in medical students and residents⁹ Cultural competency attitude assessment tools: • Cultural Attitudes Survey, 26-item assessment of sociocultural attitudes; includes a section on interaction with individuals of diverse sexual orientation¹⁰ • Quick Discrimination Index^{11, 12} • Consultation and Relational Empathy (CARE) Measure; a patient survey measure¹³

Expanded Kirkpatrick Learning Hierarchy	Type of demonstrated learning (Miller model)	Description	Evaluation Method	LGBT/DSD Examples	Non-LGBT/DSD-specific Examples
Level 2B Change in Knowledge	Knows How	Degree to which participants accurately state what the educational activity intended them to know	Subjective: - self-reported knowledge gain (e.g., reflective portfolio) - retrospective pre-/post-test of knowledge gains² Objective: - pre-/post-comparisons in tests of knowledge	64-item survey of medical student knowledge, attitudes and clinical ability to care for LGBT patients ⁴	Standard reflective portfolio template (no specific example) Non-LGBT/DSD-focused tests of knowledge re: cultural competency: - Clinical Cultural Competency Questionnaire (CCCS)¹⁶ - Score on national, standardized certification examinations (e.g., USMLE (UME), ABIM (GME), AAHIVM HIV/AIDS certification exam (GME))
		Degree to which participants can state how to do what the educational activity intended them to know how to do		Measure of attitudes toward gay, lesbian, bisexual and transgender clients ¹⁴ Knowledge about Homosexuality Questionnaire (as modified by Rondahl) ⁶ Sex Education and Knowledge about Homosexuality Questionnaire ⁷ Health Education About LGBT Elders (HEALE) cultural competency assessment ¹⁵	

Expanded Kirkpatrick Learning Hierarchy	Type of demonstrated learning (Miller model)	Description	Evaluation Method	LGBT/DSD Examples	Non-LGBT/DSD-specific Examples
Level 3A Change in Behavior (Educational Setting)	Shows How	Degree to which participants show in an educational setting how to do what the educational activity intended them to be able to do	<i>Subjective:</i> - self-evaluation of behavior, intention to change <i>Objective:</i> - observation in educational setting (e.g. simulation or SP [global rating; checklists], chart-stimulated recall, clinical vignettes, multisource feedback)	LGBT-specific behavioral scales: - Homophobic Behavior of Students Scale¹⁷ - Gay Affirmative Practice Scale¹⁸ LGBT-specific checklists/rating scales and clinical vignettes: - An LGBTI-Inclusive Sexual History Taking Standardized Patient Case¹⁹ - A Same-Sex Couple Copes with End-of-Life Issues: A Case Materials Guide²⁰ DSD-specific behavioral scales needed	Non-LGBT/DSD-specific self-evaluation forms with action plan (no specific example). Non-LGBT/DSD-specific checklists, rating scales: OSCAR tool for measuring communication skills ²¹ Pediatric GYN simulation exam checklist ²² Non-LGBT/DSD-specific chart-stimulated recall instrument (no specific examples) Multisource feedback: Canadian 360degree evaluation toolkit—includes patient satisfaction survey ²³
	Shows/Does	Degree to which participants do what the educational activity intended them to be able to do in the real world Degree to which participants model/teach others what they have learned	<i>Subjective:</i> self-report of clinical performance and/or teaching skills, action plan for improvement <i>Objective:</i> - Clinical: direct observation in a clinical setting (e.g. miniCEX, chart audit, multisource feedback) - Educational: evaluation of teaching skills by independent raters	<i>LGBT/DSD-specific instruments needed</i>	Non-LGBT/DSD-specific miniCEX (no specific examples) Non-LGBT/DSD-specific chart audit instrument (no specific examples) Canadian 360-degree evaluation toolkit

Expanded Kirkpatrick Learning Hierarchy	Type of demonstrated learning (Miller model)	Description	Evaluation Method	LGBT/DSD Examples	Non-LGBT/DSD-specific Examples
Level 4A Change in outcomes (benefits at patient and local [e.g., office] levels)	Shows/Does	Degree to which the health status of patients improves due to changes in practice behavior of participants Degree to which the process of care improves due to changes in practice behavior of participants	<i>Subjective:</i> patient self-report of health status <i>Objective:</i> health status measures recorded in patient charts or administrative databases	LGBT/DSD-specific instruments needed.	Non-LGBT/DSD-specific patient self-report of health status Non-LGBT/DSD-specific quality improvement project Non-LGBT/DSD-specific quality improvement knowledge application tool (QIKAT) ^{24, 25}
Level 4B Change in outcomes (benefits at population and systems [e.g., organizational] levels)	Shows/Does	Degree to which the health status of a population of patients changes due to changes in the practice behavior of participants Degree to which the process of care improves due to changes in practice behavior of participants	<i>Subjective:</i> community self-report of health status <i>Objective:</i> • Pre-/post-project assessment of quality improvement knowledge application • Epidemiological data and reports	<i>LGBT/DSD-specific instruments needed</i>	Non-LGBT/DSD-specific population self-report of health status Non-LGBT/DSD-specific quality improvement project Non-LGBT/DSD-specific quality improvement knowledge application tool (QIKAT) ^{24, 25}

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Evaluating the Institution and the Institutional Climate

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Ensuring that competencies are met relies on curricular development, faculty development, and proper evaluation of learners, as well as an institution's commitment to creating an unbiased, welcoming climate. Even the highest-quality curriculum can be undermined by a climate that permits biases and promotes stigma. Just as curricula and learners benefit from assessment, institutional culture and climate also benefit from being assessed. The goals of such assessment should be to identify institutional strengths, needs, and opportunities for developing more effective and supportive practices.

The diversity of trainees, staff, faculty, and administrators reflects an institution's culture. Based on studies of race and ethnicity, diverse medical school environments train physicians who are more competent in caring for racially and ethnically diverse populations even when the trainees are not a member of a particular racial or ethnic minority.⁴⁵ Racial and ethnic concordance between patient and provider has improved patient satisfaction⁴⁶ and patient participation in their own health care decisions.⁴⁷ Exposure to LGBT content in medical education similarly supports improved student attitudes⁴⁸ and competency⁴⁹ in caring for LGBT patients, although extension of this work to providers and patient-provider interactions still needs to be done.

Diverse learning and working environments increase learning opportunities and enrich group work and personal reflection.⁵⁰ The AAMC's Group on Diversity and Inclusion promotes diversity as a core value that "embodies inclusiveness, mutual respect, and multiple perspectives, and serves as a catalyst for change resulting in health equity."⁵¹ Inclusion is thought to nurture "the climate and culture of the institution through professional development activities, education, policy, and practice."⁵¹

Institutional factors that support individuals who may be LGBT, gender nonconforming, and/or born with DSD can be broken down into five major categories, according to a formal working group developing a national tool to assess LGBT institutional culture and climate:

- Institutional efforts to educate
- Institutional protections against mistreatment
- Institutional promotion of equality

- Institutional leadership and commitment
- Welcoming patient care environment⁵²

Assessment tools have been developed to evaluate elements of these institutional efforts.⁵³ Use of these tools has created an evidence base for understanding how important it is for institutions to provide a welcoming culture and climate for LGBT individuals. There are no known tools to assess institutional climate for individuals born with DSD, which indicates a strong need for these instruments. Accordingly, this section focuses only on institutional climate for LGBT people.

Assessing Efforts to Educate

This section discusses how to assess efforts to educate students to provide quality patient care to diverse populations. As discussed in **Chapter 2, The Role of Medical Education and Health Care Professionals in Eliminating Health Disparities**, LGBT-related curricular content is lacking in medical education. This need for improved medical education content was the impetus for the Competency Domains presented in **Chapter 3, Professional Competency Objectives to Improve Health Care for People Who May Be LGBT, Gender Nonconforming and/or Born with DSD**.

Accreditation bodies play an important role in the assessment of curricula. The standards set forth by these bodies thus form the basis for content included in medical curricula. The Liaison Committee for Medical Education (LCME) requires diversity in its (re)accreditation standards,⁵⁴ although the specific diverse populations are not defined. The convenience of a readily available curriculum map easily facilitates analyses of topics and hours of instruction. (For more details, see sidebar, **Excerpts from the Liaison Committee on Medical Education (LCME): Functions and Structure of a Medical School**.) The AAMC's Curriculum Management and Information Tool⁵⁵ and Curriculum Inventory and Reports⁵⁶ enable such curricular analyses.

The applicability of these data is limited by the terminology and detail entered by participating institutions (*e.g.*, "LGBT health" versus "risk of HIV and other sexually transmitted infections among transgender youth"). Another limitation is the use of curricular hours as a unit of evaluation. Hours are often incorrectly estimated due to the integrated nature of medical curricula. Hours also do not provide an indication of teaching efficacy (*i.e.*, more hours does not equate to more competent providers), nor do they reflect the breadth of health-related topics taught (*i.e.*, more hours does not equate to more comprehensive instruction).

In addition to content, curricular quality depends on content delivery by knowledgeable faculty who model the desired competencies. In a small study, 36.8 percent of course directors believed the lack of faculty development was a barrier to including LGBT content in the curriculum.⁵⁷ This result was corroborated when more than 50 percent of deans of medical education reported training "faculty willing and able to teach LGBT-related curricular content" as a strategy to increase LGBT curricular content.⁵⁸

EXCERPTS FROM THE LIAISON COMMITTEE ON MEDICAL EDUCATION (LCME): FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL, EFFECTIVE JULY 1, 2015

Standard 3: Academic and Learning Environments

- 3.3 Diversity/Pipeline Programs and Partnerships: a medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.
- 3.4 Anti-Discrimination Policy: a medical school does not discriminate on the basis of age, creed, gender identity, national origin, race, sex, or sexual orientation.
- 3.5 Learning Environment/Professionalism: a medical school ensures that the learning environment of its medical education program is conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations and is one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to identify positive and negative influences on the maintenance of professional standards, develop and conduct appropriate strategies to enhance positive and mitigate negative influences, and identify and promptly correct violations of professional standards.

Standard 7: Curricular Content

- 7.6 Cultural Competence/Health Care Disparities/Personal Bias: the faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction regarding:
 - The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.
 - The basic principles of culturally competent health care.
 - The recognition and development of solutions for health care disparities.
 - The importance of meeting the health care needs of medically underserved populations.
 - The development of core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensionally diverse society.

Another mechanism for attracting participation in LGBT curricular content and tracking learner development is by offering Continuing Medical Education (CME) and Continuing Education Units (CEU) for LGBT health-related courses. Such credits are being increasingly offered at conferences focusing on LGBT health (e.g., GLMA: Health Professionals Advancing LGBT Equality Annual Conference, LGBT Health Workforce Conference, Society for the Scientific Study of Sexuality) and through online webinar series (e.g., The National LGBT Health Education Center). For more about these programs, see **Appendix B, Medical School Programs and Other Resources**.

Assessing Mistreatment and Protections Against Mistreatment

Higher education environments aim to promote the exchange of ideas in a setting of mutual respect among all participants in the enterprise. Challenges that arise during these exchanges can lead to inappropriate or unprofessional behaviors, such as humiliation, discrimination, harassment, and misuse of assessment/grading. People who may be LGBT are a vulnerable population, as they have historically been and continue to be targets of widespread stigma and discrimination.⁵⁹⁻⁶² To protect all vulnerable populations, it is critical that institutions assess both instances of mistreatment and their protections against mistreatment for trainees, employees and faculty, and patients.

Trainees

Several studies report mistreatment against LGBT medical students. In 2005-2006, the AAMC Group on Student Affairs and the Organization of Student Representatives surveyed student affairs deans and medical students to assess mistreatment, the presence or absence of LGBT-welcoming learning environments, and awareness of nondiscrimination statements.⁶³ Among deans of student affairs, 15 percent were aware of mistreatment towards LGBT students, 7 percent described their learning environments as “hostile” towards LGBT-identified students, and 34 percent were unaware of existing statements protecting against sexual orientation discrimination. Among medical students, 17 percent of LGBT-identified students described their learning environments as “hostile” and 53 percent were unaware of sexual orientation protection by their schools’ nondiscrimination statements.

Because of these survey results, the AAMC now solicits information about mistreatment based on perceived sexual orientation via the Graduation Questionnaire (GQ), the annual national questionnaire administered to all graduating medical students at all LCME-accredited medical schools. The AAMC GQ 2013 results showed that 2.3 percent of 13,072 respondents reported they were “subjected to offensive remarks/names related to sexual orientation.” As a result of such discrimination, many LGBT trainees choose not to disclose their sexual orientation or gender identity during the medical school and residency application process.⁶⁴

As the LCME does with curricula, it also evaluates learning environments as they relate to diversity and specifically calls for student nondiscrimination policies to include language regarding sexual orientation and gender identity. Given the LGBT-specific mistreatment data, many institutions have implemented nondiscrimination policies that include sexual orientation and gender identity as well as zero-tolerance policies with procedures and penalties for violations, and

whistleblower protections. In 2013, 88.2 percent of graduating medical students reported they were aware that their schools had “policies regarding the mistreatment of medical students” and 71.1 percent agreed they knew “the procedures at your school for reporting the mistreatment of students.”⁴

Implementing comprehensive nondiscrimination policies, zero-tolerance policies, and whistleblower protection requires minimal resource investment from medical schools. Nevertheless, medical students often rotate at various clinics, hospitals, and community health centers. The policies and protections at these facilities may differ from those of their medical schools. Consequently, medical schools can choose to jointly develop appropriate and comprehensive policies and procedures to ensure that LGBT students are protected at all educational sites. Clinical rotations in other nations, particularly in the developing world, can present unique challenges. Some countries provide no legal protection against discrimination and may even criminalize homosexuality or the support of homosexuality.⁶⁵ These unstable sociopolitical landscapes relating to LGBT issues may create environments that jeopardize the safety, health, and well-being of LGBT students. Protection against mistreatment may require forfeiting rotations at sites where policies do not provide protection concordant with those of the medical school. The University of California, San Francisco recently announced a policy in which no student can be required to rotate in any country with active anti-homosexual laws.⁶⁶ Learners may only “opt-in” to these rotations to prevent LGBT students who are not “out” from being placed in potentially dangerous environments.

Each institution’s office of medical education is usually charged with ensuring student safety and well-being, including reviewing the nondiscrimination, zero-tolerance, and whistleblower policies at all sites. Formalized interval reviews of all appropriate policies at all affiliated sites, and vigilance regarding international politics, helps ensure that protections for learners are equivalent to those they have come to expect at their home institutions. Emergency ad hoc response teams composed of faculty, learners, and discrimination experts may assist in promptly analyzing acute crises, including widespread incidents of bias and developing policies needed for properly protecting learners whenever concerning new situations arise.

These advances for protecting LGBT trainees hold promise, and there continues to be progress. In 2001, the North Carolina-based nonprofit organization Campus Pride launched the Campus Pride Index (CPI, www.campusprideindex.org). CPI is a unique evaluation tool for undergraduate college campuses that gauges LGBT policies, programs, and practices with a comprehensive self-assessment questionnaire that evaluates eight areas, including housing, campus safety, academic life, and policy inclusion. A medical school-specific edition of the Campus Pride Index is currently under development and may prove to be the most in-depth assessment of LGBT inclusion in medical school operations.⁵²

Faculty and Staff

Faculty and staff members who are LGBT, gender nonconforming, and/or born with DSD may also experience mistreatment. LGBT-identified people in academic medicine have reported that they were denied recommendations from advisers, encouraged to remain “in the closet,” and

experienced prejudice among colleagues that affected their ability to provide quality patient care.⁶⁷ In a survey of LGBT physicians, 15 percent report harassment by heterosexual colleagues, 65 percent have heard derogatory statements about LGBT people in the workplace, and 22 percent report being socially ostracized.⁶¹ LGBT-identified providers may also face discrimination from patients. Indeed, one study reported that 30.4 percent of patients would change providers if their provider were gay or lesbian.⁶⁸

Discrimination in the work place continues despite the fact that LGBT staff members are also protected by institutional nondiscrimination policies and procedures with whistleblower protection. Accurate assessment of and appropriate consequences for bias experienced by faculty and staff can be challenging because respondents may fear verbal assault, loss of insurance or other benefits, lost opportunities for promotion, or job loss as a result of reporting discrimination.

A thorough understanding of the issues surrounding discrimination requires institutional commitment to improve institutions for LGBT faculty and staff. This begins with the willingness to ask the demographic questions of sexual orientation and gender identity and continues with evaluations of how different groups experience the campus climate. In 2012-2013, the entire University of California system conducted the largest university climate study with more than 386,000 participants.⁶⁹ In this study, “transgender and genderqueer respondents were less comfortable with the overall climate at their campus/location than were women and men respondents,” and “LGBQ respondents were less comfortable with the overall climate...compared with heterosexual respondents.”⁷⁰ Similar results are likely to be found at most institutions, particularly those in rural or demographically homogenous areas.

In addition to nondiscrimination policies and protections, institutions can encourage formation of LGBT social groups and advisory committees to support and promote LGBT staff and faculty. Institutions demonstrate commitment to a diverse faculty through increasing recruitment of LGBT employees and the retention of LGBT trainees as faculty.

Patients

Several national assessment tools have been developed to examine protections against patient mistreatment. In recent years, the Human Rights Campaign Foundation’s Healthcare Equality Index (HEI) has become a popular tool for hospitals and health care systems to assess policies and training that address LGBT issues. In the HEI, hospitals and health care systems self-report their patient and employee nondiscrimination policies, patient visitation policies, and training programs in LGBT patient-centered care. To be designated a “Leader in LGBT Healthcare Equality,” facilities must include protections on the basis of sexual orientation and gender identity in both their patient and employment nondiscrimination policies, explicitly include equal patient visitation policies, and document that management-level staff across five distinct work areas (facility leadership, nursing, patient relations/services, admitting/registration, and human resources) have received at least 90 minutes of LGBT health training. Using this framework, the HEI easily outlines the steps hospitals and health care systems can take to demonstrate basic competence in providing equitable care to LGBT patients. The HEI has consequently become the unified source of information for American health care facilities with active LGBT-friendly nondiscrimination and visitation policies.

In 2011, The Joint Commission, which accredits hospitals and other health care organizations, developed a field guide for LGBT health to provide a focused discussion of the issues facing LGBT patients and their families in today's patient care settings. It also provides tools to help health care organizations review relevant standards relating to communication, cultural competence, and patient- and family-centered care of LGBT patients.⁷¹

While these resources provide recommendations and opportunities for assessment that may improve the institutional climate for patients, the true measure of an inclusive environment comes from patients themselves. Institutions should therefore have an easily accessible mechanism to report mistreatment based on LGBT identity, and these complaints should be quickly investigated quickly and thoroughly to prevent future incidents.

Assessing Institutional Promotion of Equality

After ensuring protection against mistreatment, the next step for institutions is the promotion of equality in terms of benefits, visibility, institutional attention, and social support for people who may be LGBT, gender nonconforming, and/or born with DSD.

Benefits: Equal benefits for same-sex partners (i.e., offering the same employee benefits as different-sex partners receive) is often the most recognized effort in the institutional promotion of equality. Such benefits include equal health, dental, and vision insurance coverage; family medical leave; and retirement plans. Until recently, the costs associated with gender-affirming health care have been paid out-of-pocket by transgender individuals. Benefits coverage for transgender individuals are still at the discretion of individual institutions and their selected insurance plans; however, more institutions are showing their commitment to meaningful transgender inclusion.

Many institutions offer specific subsidized housing and tuition remission to students and employees. Family housing and same-sex parental leave policies should be offered to same-sex couples and their children, and transgender individuals should be offered appropriate housing consistent with their self-reported gender identities. Broadly speaking, all policies provided to straight individuals, couples, and families should also be afforded to LGBT individuals, couples, and families.

Visibility: Promoting the visibility of LGBT individuals demonstrates an institution's commitment to equality and to treating these individuals as valued members of the community. Institutions that provide LGBT-specific admissions materials, especially when they combine these with LGBT-specific training for their interviewers, indicate to potential applicants that they are welcome to discuss their sexual orientations and/or gender identities and that sexual and gender minorities contribute to the diversity of the student body. Including "out" LGBT individuals in orientations, panels, and other events demonstrates that these individuals are integral and valued members of the school's community.

Many institutions have developed an "Out List," a publicly available listing of LGBT people who are comfortable disclosing their LGBT statuses so that prospective students and employees can contact

LGBT community members to discuss the educational and institutional climate and culture. The development of a successful “Out List” requires institutional policies and procedures to create a positive educational experience with protection against mistreatment.

Visibility of LGBT-related research, patient care, and quality improvement projects also highlights an institution’s commitment to equality. Valuing and promoting the efforts of institutional members engaged in promoting LGBT equality, such as highlighting them in institutional publications and online materials, validates this work and encourages others to get involved. Additionally, the external LGBT community can view these publications, increasing the institution’s visibility among the general population in its care for LGBT individuals, which helps it further engage the community.

Institutional Attention: When institutional administrators listen and attend to the interests and needs of LGBT individuals, they promote equality. By adding sexual orientation and gender identity self-identification questions to institutional surveys, administrators can then identify the LGBT populations at the institution and assess the experiences and needs of these populations. As discussed throughout this chapter, understanding the need for change is the first step in attending to the needs of LGBT community.

Although the change produced from listening to the community’s needs is often reward enough for the champions of change, institutions can further encourage these champions by acknowledging their efforts. Many institutions have developed annual awards to recognize the contributions that these individuals (including straight and cisgender allies) have made to improve the institutional climate for LGBT people.

Social Support: Promoting and enhancing social supports first requires an understanding of the experiences of LGBT trainees and employees. The AAMC recently piloted the 2013 Medical Student Life Survey (MSLS), an anonymous, second-year medical student questionnaire, to assess the learning climate and learner well-being. This is the first AAMC-administered questionnaire that includes questions about sexual orientation and gender identity. Of nearly 3,500 respondents to the pilot survey, 5.9 percent identified as lesbian, gay, or bisexual and 0.12 percent identified as transgender.⁷² Compared with their heterosexual counterparts, students identifying as LGB were more likely to report stress, social isolation, and financial concerns, as well as decreased social support and a negative emotional climate. This may indicate that a significant percentage of today’s LGBT-identified medical students continue to face mistreatment and suffer psychosocial consequences on the basis of their sexual orientation and gender identity. The sexual orientation item nonresponse rate was <1 percent, indicating a willingness by learners to participate in self-identification by sexual orientation.⁷³ Tracking data obtained from the MSLS in conjunction with other AAMC-administered questionnaires may help medical schools identify specific areas of concern for LGBT medical student well-being and may help prioritize efforts to improve the institutional climate both in and out of the classroom.

Encouraging the development of social and support networks for LGBT individuals exhibits an institution’s commitment to equality and may improve students’ well-being. This includes supporting LGBT student and employee and faculty groups with institutional funds and access to

the same resources (physical space, information technology, etc.) as other groups. LGBT-focused email distribution lists can offer a forum for sharing related institutional, local, national, and international news, publicizing social events, and developing programs for continuous climate improvement. Just as other minority groups have population-specific “holidays,” celebrating LGBT-related commemorations like National Coming Out Day and National Transgender Day of Remembrance provide excellent opportunities to highlight an institution’s commitment to equality, to increase awareness, and to announce new programs or policies.

Assessing Leadership and Institutional Commitment

Having institutional champions to support the development of positive learning and working environments is a vital component for continued success in ensuring the safety, respect, and inclusion of LGBT people. These champions, no matter how well-intentioned, may face challenges effecting change without the support of the institution and its leadership. Many medical schools have institution-wide offices supporting diversity. While these offices have historically focused on racial and ethnic minority diversity, many institutions are now broadening the mission of these offices and including programs and support for LGBT students, staff, and faculty (e.g., Office of Multicultural Affairs, Harvard Medical School). Other institutions have dedicated offices or centers to provide campus-wide support for members of the LGBT communities (e.g., LGBT Resource Center, University of California, San Francisco). Recently, several medical centers have founded dedicated LGBT health programs that not only support LGBT students, staff, and faculty but also advocate for policy changes and best clinical practices in all institutional-affiliated patient care settings (e.g., Penn Medicine Program for LGBT Health; Vanderbilt University School of Medicine Program in LGBTI Health). The institutional diversity officer’s budget typically funds diversity offices as well as institution-wide programs, often with some component of private philanthropy (usually from alumni) for the more robust programs. (For more about these programs, see **Appendix B, Medical School Programs and Related Resources.**)

Instead of ‘bundling’ LGBT issues with all issues of diversity, some institutions have created standing committees (composed of students, staff, and faculty) charged with examining LGBT-related issues (including incidents of bias and discrimination) and creating new programs and policies to improve quality of life for LGBT people on campus. Indicating a commitment to their faculty, some institutions have also created specific groups for LGBT faculty development (e.g., Boston University School of Medicine and Weill Cornell Medical College).

Finally, institutional commitments to ensuring a diverse LGBT campus community often come in the form of equal benefits and protections (as described above). The AAMC has supported practices that ensure a “pipeline of physicians better equipped through personal experience and a diverse learning environments to provide treatment and discover cures for diseases that disproportionately impact minority populations.”⁷⁴ In order to create these diverse learning environments, widespread assessment of applicants’ (including potential matriculants and staff/faculty) sexual orientation and gender identity, similar to now commonly asked race and ethnicity questions, is likely coming soon. For the first time, applicants to the University of California, San Francisco School of Medicine will be explicitly asked their sexual orientation and gender identity on the school’s

secondary application in order to collect more data about their applicants and show the institution's commitment to a diverse campus environment.⁷⁵

Providing a Welcoming Patient Care Environment

An institution's commitment to providing a welcoming care environment for patients who may be LGBT, gender nonconforming, and/or born with DSD is easily as important as supporting its students and employees. Patients interact with many individuals while they receive health care services. Mistreatment during any of these interactions has the potential to not only negatively affect the care of that patient but also to damage the reputation of the institution. A transgender woman, for example, may be new to the clinic and new to her gender identity so that she has not yet changed her legal name. Inappropriate or insensitive questioning by staff when she presents her identification or health insurance card may be embarrassing, result in a discrimination complaint, and alienate her from seeking medical care anywhere.

Training all staff with any patient contact (including in-person, telephone, or email) to provide appropriate, competent care for LGBT people may help ensure that all patient-staff interactions are positive. This training has ongoing effects as others (including learners) observe these improved interactions by staff, who serve as positive role models. Several organizations, including The Fenway Institute's National LGBT Health Education Center (www.lgbthealtheducation.org) and the Human Rights Foundation's Healthcare Equality Index (www.hrc.org/heii/), offer free or low-cost online educational opportunities in addition to on-site, in-person training.

Incorporating correct language and questions for LGBT populations on clinical intake forms and waiting room pamphlets provides a visible statement that the institution has made specific, concerted efforts to welcome and care for these patients. Publicly displaying or distributing the institution's nondiscrimination policy can also serve as a powerful indicator of support. Evaluating and modifying the patient flow in a clinic can identify areas where well-meaning, sensitive, competent discussions with staff result in an inadvertent and unwanted disclosure of information to others in the vicinity (e.g., in a waiting room).

Many institutions and health care organizations have made efforts to convert at least one bathroom in every building (or more in large buildings) to a gender-neutral bathroom in order for transgender patients to feel more comfortable. While this process may require physical plant modifications, sometimes it only requires a change of signage and the addition of a door lock. Websites and mobile apps like Safe2Pee can aid transgender individuals locate gender-neutral bathrooms.

Displaying welcoming symbols well-known to LGBT populations (e.g., rainbow) can also show an institution's or individual's support for these populations. Health care institutions have launched campaigns for employees and trainees to display these symbols on their name badges, clinic front desks, office windows, etc. Besides creating a welcoming environment for patients, such symbols convey a powerful message of support to employees, learners, and interviewees. Additionally, some institutions have developed "Safe Space" programs, which include training members of

the institution (regardless of their sexual orientation or gender identity) about the challenges, experiences, and resiliencies of LGBT people.⁷⁶ This network of trained people supportive of LGBT people typically display a “Safe Space” sticker on their desk, office door, etc. to convey that LGBT people can approach them to discuss LGBT-related issues with comfort. For more about this program, see **Appendix B, Medical School Programs and Related Resources**.

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Chapter 7

Using AAMC's MedEdPORTAL® to Advance Curricular Change

Chapter Editor: Sara Hunt Sullivan

Using AAMC's MedEdPORTAL® to Advance Curricular Change

Author: Emily A. Cahill, M.P.H.

MedEdPORTAL® (www.mededportal.org), a free, online service provided by the Association of American Medical Colleges (AAMC), is a powerful resource for sharing knowledge, publishing peer-reviewed health education tools and, ultimately, transforming health education. Through its three services – *Publications*, *iCollaborative*, and the *CE Directory* – MedEdPORTAL® provides health educators opportunities to access and publish educational materials that prepare tomorrow's physicians to provide better care to their patients, including individuals who may be LGBT, gender nonconforming, and/or born with DSD.

As an integrated learning platform, MedEdPORTAL®'s three services use the same controlled vocabulary to index content, which allows for cross-referencing and coordination across the system. However, each service also offers a unique set of educational tools that are delivered through a distinct instructional methodology. For example, *Publications* features peer-reviewed, classroom-tested educational materials that have been prepared to facilitate instructor-led learning. In contrast, *iCollaborative* supports peer-to-peer learning by sharing educational innovations and ideas still in development. Finally, the *CE Directory* encourages self-guided learning by listing certified continuing education activities available online. MedEdPORTAL® users can submit and access content at no cost.

MedEdPORTAL® offers a convenient way to publish and disseminate curricula and other educational materials for use by health educators around the world who are leading the way towards equality of care for patients who may be LGBT, gender nonconforming, and/or born with DSD. These resources are displayed on the MedEdPORTAL® website available at <https://www.mededportal.org/about/initiatives/lgbt>.

Below are descriptions of the three MedEdPORTAL® services and how institutions and individuals can use these resources to advance their understandings of the current issues in health education—and contribute to a stronger health care system that delivers quality care to all patients.

Note: Each of the sections below contain samples of resources available on the MedEdPORTAL® website. The descriptions of these resources are written by the authors of the work, so the language and terminology may differ from the rest of this publication.

Publications

www.mededportal.org

Publications functions as a formal publication service and is backed by a rigorous peer review policy and process that mirrors editorial procedures used by traditional journals. Rather than publishing research-based manuscripts, *Publications* peer reviews and publishes educational modules that represent various methodologies including standardized patient cases, team-based learning activities, faculty development sessions, assessment tools, and many others. The result is two-fold: it provides a venue for teaching faculty to receive scholarly recognition for their peer-reviewed educational works and it also creates a platform for educators to access and implement stand-alone, complete learning modules that have been vetted and classroom-tested without having to spend the time and resources to create curricular pieces on their own.

Publications champions teaching faculty in their efforts to receive recognition for their educational scholarship by providing a distinct, formal publication citation that may be included in their curriculum vitae, which may bolster their applications for promotion and tenure. In addition, published authors have real-time access to usage impact reports. These reports demonstrate the adoption of resources by others, showing the number of times the publication has been accessed and providing specific information about who accessed the article, including institutional affiliation, country of residence, and reason for download.

As a reputable source for high quality educational modules, *Publications* ensures that consistent submission standards are met while using a peer review framework grounded in recognized tenets of scholarship. In 2005, an AAMC working group explored the six criteria outlined in *Scholarship Assessed: Evaluation of the Professoriate*¹ to develop a guide for faculty as they prepare their educational resources for publication. These criteria reflect fundamentals of educational scholarship and illustrate how peer-reviewed educational resources are a form of scholarship comparable to manuscripts that are published in traditional journals. Peer reviewers and authors are asked to evaluate or prepare materials based the same considerations:

- Clear goals
- Adequate preparation
- Appropriate methods
- Significant results
- Effective presentation
- Reflective critique

Accepted publications remain citable and searchable within MedEdPORTAL® *Publications* indefinitely. If a publication contains time-sensitive information, the author is encouraged to submit updated versions to supplement the original.

MedEdPORTAL® *Publications* currently contains several peer-reviewed modules aimed at improving knowledge about and care for patients who may be LGBT, gender nonconforming, and/or born with DSD. AAMC encourages individuals and institutions to add to this body of knowledge by submitting classroom-tested and complete educational tools for peer review and publication.

Sample Publications' Peer Reviewed Modules

1. Mehringer J, Bacon E, Cizek S, Kanters A, Fennimore T. Preparing Future Physicians to Care for LGBT Patients: A Medical School Curriculum. MedEdPORTAL Publications; 2013. Available from:
www.mededportal.org/publication/9342
http://dx.dor.org/10.15766/mep_2374-8265.9342

Educational Format: Presentation and Case Discussion

This module describes a two-hour medical school activity that improves students' knowledge of health care disparities facing LGBT individuals and ultimately makes students feel more comfortable when caring for LGBT patients. The activity includes a brief lecture presentation, an interactive patient panel, and small group case-based learning:

Brief Lecture Presentation: The lecture presentation serves as an introduction to the teaching session. It reviews the concepts of gender identity and sexual orientation and highlights the health care disparities that are faced by LGBT individuals.

Patient-based panel discussion: The panel is composed of 2-4 individuals who identify as lesbian, gay, bisexual, and/or transgender. Panelists introduce themselves and share some of their experiences (both positive and negative) accessing and receiving health care as an LGBT-identified person. The panelists then accept audience questions.

Case-based learning in small groups: Students are divided into small groups, each with a faculty or upperclassman facilitator. Students are presented with two patient cases, each with questions that they must discuss and address to reach consensus. Students are expected to draw upon information gathered in the required pre-readings, the lecture presentation, the patient panel, and their own experiences. Facilitators are provided with a guide for stimulating student discussion and with suggested answers to discussion questions. As a group, the students are tasked with generating and submitting a list of 5-10 actions that they can take as future physicians towards improving care and reducing barriers for LGBT patients. At the end of the session, each student is asked to share his/her reaction to the session. Following the session, the action lists generated by each small group are compiled and shared.

2. Grubb H, Hutcherson H, Amiel J, Bogart J, Laird J. Cultural Humility with Lesbian, Gay, Bisexual, and Transgender Populations: A Novel Curriculum in LGBT Health for Clinical Medical Students. MedEdPORTAL Publications; 2013.

Available from:

www.mededportal.org/publication/9542 http://dx.dor.org/10.15766/mep_2374-8265.9542

Educational Format: Evaluation Tool and Presentation

Lesbian, gay, bisexual and transgender (LGBT) individuals encounter documented health disparities in the United States, perpetuated in part by limited LGBT-related content in medical education curricula. Myriad national medical associations acknowledge these curricular deficits and call for LGBT-related curricular content inclusion in undergraduate medical education. Furthermore, recognition of the effects of discrimination and stigma on LGBT communities has contributed to a resurgence of interest in the development of “cultural humility” among medical providers, which encompasses a lifelong process of self-examination and critique of the biases and assumptions that may perpetuate health disparities.

This two-hour lesson in LGBT health and cultural humility for clinical medical students is a response to these documented curricular deficits and health disparities. The curriculum includes pre-readings; a one-hour didactic lecture in PowerPoint format; and a one-hour “Patient as Professor” panel of LGBT-identified individuals, followed by an interactive question-and-answer session and public discussion. This resource also provides the opportunity to assess the activity’s impact with a pre- and post-curriculum survey of participants’ experiences, attitudes, and medical knowledge with respect to LGBT populations. Finally, an optional institutional needs assessment of gender and sexuality climate and curricular issues is included.

3. Croft C, Day H, Fulmer V, Pletcher J, Spagnoletti C, Steele R. A Same-Sex Couple Copes with End-of-Life Issues: A Case Materials Guide. MedEdPORTAL Publications; 2013.

Available from:

www.mededportal.org/publication/9438 http://dx.dor.org/10.15766/mep_2374-8265.9438

Educational Format: Case Discussion, Faculty Assessment, Peer Assessment

As of 2009, surveys showed that medical students in the United States receive a median of only five hours of instruction on LGBT-related health topics during medical school. The topics that are typically covered include medical conditions that disproportionately affect the sexual minority population, such as depression, anxiety, substance abuse, and certain sexually transmitted diseases. However, it is important to recognize that sexual minorities may face unique barriers to health care including discrimination and lack of access to providers who are sensitive to and competent in addressing their needs. Furthermore, policy surrounding medico-legal challenges, such as advanced directives and visitation rights, varies by region and institution and may not adequately represent the needs of same-sex couples.

This publication describes a standardized patient case featuring a same-sex couple facing end-of-life issues, including medico-legal challenges that are unique to same-sex couples. It was developed for the Advanced Medical Interviewing course for second-year medical students at the University of Pittsburgh School of Medicine.

iCollaborative

www.mededportal.org/icollaborative

iCollaborative aims to promote sharing of and collaboration on innovative health educational ideas. In contrast to materials featured in *Publications*, *iCollaborative* tools have not been through the MedEdPORTAL® peer review process and might not have been tested in the classroom. As such, they may not fully function as complete modules ready for implementation by others. The primary purpose of *iCollaborative* is to provide a platform for the easy sharing of materials across the health education community. Contributors to *iCollaborative* do not receive a formal citation, nor do they have access to the same detailed download metrics made available to *Publications*' authors. Instead, users are encouraged to use the 5-star rating feature and commentary capabilities located within each *iCollaborative* posting. AAMC provides resource download counts and all user comments to the owner of the *iCollaborative* content. Three years after each resource is posted to *iCollaborative*, MedEdPORTAL® staff remove it from the site and encourage its contributor to submit a more current version.

The following are some of the materials currently available in *iCollaborative* that address the needs of patients who may be LGBT, gender nonconforming, and/or born with DSD. AAMC encourages faculty, students, and administrators to submit their innovative ideas and materials for inclusion in this helpful resource.

Sample iCollaborative Non-MedEdPORTAL® Peer-Reviewed Resources

1. Addressing a Neglected Healthcare Disparity - Assessing and Improving Lesbian, Gay, Bisexual, and Transgender-related Medical Curriculum
www.mededportal.org/icollaborative/resource/521

Educational Format: Poster, Reference, Evaluation Tool

To address the historic neglect in medical education of lesbian, gay, bisexual, and transgender (LGBT)-focused health topics, the authors developed a workshop for medical students, residents and physicians. The purpose is to collect data on prior LGBT health education and address the educational need by providing a unique format for relaying the information. An audience response system is used to engage a small group of participants on topics incorporating attitudes, clinical skills, and knowledge. A short handout is given with resources to support further learning. Results of two pilot groups demonstrate statistically significant improvement in scores on a knowledge test immediately before and after the workshop, as well as high acceptance and satisfaction with the workshop format and content.

2. Student-led Supplemental LGBT Curriculum www.mededportal.org/icollaborative/resource/267

Educational Format: Poster

When preclinical medical students at NYU were surveyed about their knowledge, attitudes, and confidence in caring for lesbian, gay, bisexual, and transgender (LGBT) patients, the mean score on the knowledge assessment was 59 percent. Many students expressed a lack of confidence in their ability to take a sexual history of an LGBT patient or properly address their specific health care needs. A four-lecture supplemental curriculum was developed with objectives to improve knowledge of: LGBT-related terminology, medical conditions that more commonly affect LGBT persons, and the sociocultural context for specific LGBT health care needs. The curriculum also seeks to improve the skills of taking an appropriate psychosocial history and screening and counseling LGBT patients on their unique health needs. The costs of beginning this program were relatively minimal, utilizing faculty and community volunteers and providing dinner for attendees. At the first lecture, more than one hundred medical students came and participated with strong, consistent attendance throughout the series. This innovation in medical education is still in progress, and its evaluation is not yet complete; however, we learned two important things about improving medical education in LGBT health care:

- A lecture series guided by a set of objectives is an important first step, and
- Incentives such as a school-sponsored certificate had a dramatic impact on student participation.
- Preliminary qualitative analysis suggests that all participants, regardless of differences across a variety of parameters, showed improved knowledge and confidence in their ability to care for LGBT patients.

3. Two Birds with One Stone: Teaching and Assessing Medical Students in Caring for LGBTQ Patients and Using Medical Interpreters www.mededportal.org/icollaborative/resource/583

Educational Format: Poster

We sought to teach and assess medical students in our year-long Principles of Clinical Medicine course on two topics:

- Care of LGBTQ patients.
- Cross-cultural communication and the use of medical interpreters for patients with limited English proficiency.

We developed two teaching sessions and one end-of-term Objective Structured Clinical Examination (OSCE) for these purposes. Student performance on the OSCE has been evaluated

with two checklists that are completed by the standardized patient actors (medical interpreter and patient) for each student after the OSCE. Student performance over the past three years has been variable. Higher performance has been demonstrated on basic communication and history taking skills, while lower performance has been shown with specific items such as mentioning the confidential nature of the visit, avoiding the presumption of heterosexuality, correctly identifying when to seek clarification from the interpreter after a provocation, and asking important sexual history questions. This project has assisted our course director team in evaluating student readiness for clinical clerkships, as well as targeting curriculum development in subsequent years.

4. Eliminating Hidden Medical Bias Against Gays Serving in Our Military www.mededportal.org/icollaborative/resource/196

Educational Format: Tutorial

Repeal of the Don't Ask Don't Tell policy eliminates obstacles for gays serving in our military, but does not remove hidden medical bias that impacts their care—both on the front as well as at home. This unique approach prepares residents and physicians to take care of gays in the military and helps create an environment free of cultural bias. It integrates three important principles of patient care:

- Care must be patient-centered (and not the traditional disease-centered model).
- The best education for this model comes from patients themselves.
- To be effective, one has to develop an all-inclusive model of care that involves the patients, their partners, and families to truly eliminate bias.

5. Successful Strategies for LGBTQ Climate Change in Two Southern Academic Health Centers www.mededportal.org/icollaborative/resource/670

Educational Format: Poster

This poster facilitates continued discussion and sharing of best practices regarding the creation of a campus climate that is more inclusive of the LGBTQ community. By highlighting the strategies that worked successfully in two academic health centers in the South, the Medical College of Georgia (MCG) and Morehouse School of Medicine (MSM), this poster will contribute to the discussion on best practices by providing specific examples of successful initiatives as well as strategic planning advice and relevant resources. Through an overview of the specific initiatives that MCG and MSM enacted and a more detailed sharing of lessons learned, the poster continues to feed the momentum gained at the LGBT Summit during the AAMC Annual Meeting in San Francisco in 2012. The poster focuses on the multi-pronged collaborative strategies employed by the two academic health centers to overcome institutional barriers in order to enact positive institutional climate change, and answers the questions:

- “Why is this topic important to our academic health center?”

- “What barriers do we face?”
- “What resources do we have?”
- “How do we measure impact?”

For example, geographical location plays a role in institutional climate at both the Medical College of Georgia and Morehouse School of Medicine, a historically Black institution. As part of the southern Bible Belt region and with a large African American population, race and religion can be important factors in negative climate regarding LGBTQ issues, not only within the two institutions themselves, but also within the local communities in which the institutions are situated. Despite these barriers, success at both institutions hinged upon the use of strategies focused on networking between on- and off-campus groups, generating leadership involvement and engagement, undertaking policy review as well as designing outreach and educational initiatives to raise awareness within the academic health center community.

Morehouse School of Medicine created a student organization (MSM Alliance) to increase cultural competence and awareness of health disparities related to gender, gender identity, gender expression, and sexual orientation. They also formed a diversity committee and changed the Equal Employment Opportunity policy to include gender identity and expression. The Medical College of Georgia hosted a Come Out for Health Week, infused education around LGBTQ-focused health disparities into the curriculum for sponsored summer programs, and facilitated a workshop on providing LGBTQ-inclusive care for the Department of Family Medicine. These are just a few of the successful initiatives that the two institutions have implemented. These strategies may be applicable to most academic health centers because they involve advocacy, mentoring, fulfillment of LCME requirements, training and awareness-raising activities. The poster also shares advice regarding lessons learned, both positive and negative, for other institutions to keep in mind during their own strategic planning and implementation of initiatives for creating a more inclusive institutional climate.

CE Directory

www.mededportal.org/cedirectory

The *CE Directory* offers a listing of online continuing education activities developed by faculty or staff at a noncommercial health institution. These CE programs are officially certified by an accrediting body and may be completed in their entirety through the online learning format. Activity postings in the *CE Directory* include information about credit awarded and costs as well as direct links to the website of the institution hosting the online course. The activities listed in the *CE Directory* are removed from the site when the online courses end.

At the time of this publication, there were no activities listed within the *CE Directory* that explicitly addressed competent care delivery for patients who are LGBT, gender nonconforming, and/or born

with DSD. The committee encourages all CE providers to submit activities for inclusion in the *CE Directory* to improve patient care for these populations and to increase visibility and traffic to their institution's website.

Sample CE Directory Online Continuing Education Activities

Although not directly related to health care for patients who are LGBT, gender nonconforming, and/or born with DSD, the following entries provide examples of activity postings in the *CE Directory*.

1. Part Two: Defining Bias and its Manifestations and Impact of Bias on Health and Health Care www.mededportal.org/continuingeducation/activity/1235

Expires April 15, 2016: This series of CME activities is designed to: a) bring awareness to members of the health care community about the impact of conscious and unconscious bias on health care and how bias contributes to health care disparities; and b) increase knowledge of how to recognize and mitigate bias in the diagnosis, treatment, and management of lupus for diverse patient populations. Part two of the series, *Defining Bias and its Manifestations and Impact of Bias on Health and Health Care*, introduces bias, both unconscious and conscious, and how both impact practitioners and their patients. Participants will read a variety of essays and view videos of experts in the fields of rheumatology, lupus, and cultural competency online. It is estimated that this module will take participants one hour to complete.

2. Cultural Competency Lecture www.mededportal.org/continuingeducation/activity/677

CME series featuring lecture on cultural competency presented by Rafael Perez-Escamilla, Ph.D., Department of Epidemiology and Public Health, Yale School of Medicine. Objectives include: 1) Review conclusions from IOM *Unequal Treatment* Report, 2) Define CLAS Standards and Cultural Competency, and 3) Practice cultural competency skills through "cultural brokering" exercises.

3. The Role of Leaders in Driving Transformational Change www.mededportal.org/continuingeducation/activity/1129

This session was captured at the 2011 UKHC Leadership Week and is designed to enhance the skills of existing and future UK HealthCare leaders to assist them in reaching their full potential in the Enterprise. This year's focus is on engaging and preparing leaders to drive transformational change in the areas of quality, safety and service. The Kansas University Hospital CEO and COO/CNO are providing a case study on leading a large cultural transformation resulting in significant improvements in patient satisfaction, quality and safety of care, and employee satisfaction.

4. Engaging Members of the Medical Staff to Measure and Improve Quality www.mededportal.org/continuingeducation/activity/1269

Presented by the Organized Medical Staff Section (OMSS) of the American Medical Association. Dr. Griffin will review the multiple methodologies utilized by Memorial Hermann and their 3,500 member IPA to engage members of the medical staff to measure and improve quality throughout the 11 hospital system. He will review Memorial Hermann's measurement methodologies and successful incentive alignments utilized to produce measureable improvements in staff participation and engagement around quality initiatives. He will discuss ongoing programs being used within the IPA to support medical staff engagement in targeted specialties.

References:

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Chapter 8

Future Directions

Chapter Editor: Alice Dreger, Ph.D.

Future Directions

Authors: AAMC Advisory Committee on Sexual Orientation,
Gender Identity, and Sex Development

To date, the movement among medical educators towards LGBT-inclusive programming has been strong yet informal, and there has been relatively little attention paid to medical education on the topics of DSD and gender nonconformity. The committee hopes this publication will accelerate change toward a new era of organized and intentional efforts to enhance medical curricula, create a positive and welcoming institutional climate, and reduce the disproportionate harms experienced by people who are or may be LGBT, gender nonconforming, and/or born with DSD.

The work and ideas we present in this publication can be extended in a number of ways to achieve these goals. We encourage individuals at the AAMC's member institutions to consider these suggestions for next steps:

1. Identify, recruit, and support institutional champions and resources to lead curricular and climate change initiatives.
2. Produce specific knowledge, attitudes, and skills (KAS) based learning objectives, milestones, and learner and curriculum assessment strategies appropriate to the undergraduate medical education level.
3. Define and evaluate entrusted professional activities as related to the above milestones.
4. Develop innovative curricular programs to incorporate patients' voices, develop students-as-teachers, promote interprofessional learning, and address real-time challenges that arise when caring for people who are or may be LGBT, gender nonconforming, and/or born with DSD.
5. Develop pedagogically robust curricular assessment tools, including innovative methods to meaningfully assess attitudinal change regarding the care of people who are or may be LGBT, gender nonconforming, and/or born with DSD.
6. Develop curricula and assessment tools for resource-limited settings (e.g., student-run, underserved community, or rural clinics) and for particular health care delivery modalities (e.g., telemedicine, extensive use of nonphysician providers).

7. Create sharable and accessible faculty development initiatives to assist faculty in achieving the requisite KAS to implement effective teaching in the care of patients who are or may be LGBT, gender nonconforming, and/or born with DSD.
8. Develop demonstration projects at medical schools that show both how and where to intercalate LGBT and DSD-focused content into existing educational modalities at preclerkship and clerkship levels and how and where to introduce novel instructional content and methods.
9. Share successes and lessons learned during demonstration projects via conferences and/or dedicated preconference workshops and via academic publications, including dedicated special issues of journals.
10. Collaborate with other institutions to facilitate comparative work and gather larger datasets on the effectiveness of various educational interventions.
11. Focus efforts on dramatically increasing the number of MedEdPORTAL® submissions of curricula and assessment tools focused on improving care for people who are or may be LGBT, gender nonconforming, and/or born with DSD.
12. Expand all efforts listed above into graduate medical education and continuing medical education arenas.
13. Expand efforts into the realm of interprofessional education/practice and academic collaboration.
14. Include questions relating to the care of patients who are LGBT, gender nonconforming, and/or born with DSD on certification and licensing exams.
15. Review and revise this committee's recommended competencies regularly, based on feedback and progress in the field.
16. Survey medical educators regarding the degree to which they are using curricular content that addresses the various competencies developed in this publication, or map curricular content to the competencies.
17. Pursue systematic quality improvement of existing health care quality metrics to ensure substantive and meaningful progress.
18. Target funding to support relevant initiatives.

As institutions and organizations adopt the strategies outlined in this publication, positive transformation toward more formal curricular and climate inclusion for all individuals who are LGBT, gender nonconforming, and/or born with DSD will occur. This committee deeply believes that these overdue changes will lead to improved care for patients who are or may be LGBT, gender nonconforming, and/or born with DSD. Indeed, we believe these changes may lead to improved care for all patients.

Appendix A

Glossary of Terms

These definitions were developed by consensus of the AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development with the understanding that they are not meant to replace conversations with patients about sexual orientation, sexual practices, gender, etc. In other words, a woman might identify as a lesbian, but that does not explain in full her sexual orientation, sexual practices, etc.

Affirming Interactions: person-to-person encounters that leave individuals feeling acknowledged and respected regarding their self-identities.

Asexual: usually refers to a person who feels no sexual desires.

Bisexual: usually refers to a person who has a sexual attraction to both males and females.

Cisgender: usually refers to a person whose gender identity aligns with the gender label given at birth (i.e., the term refers to people who are not transgender).

Competencies: measurable or observable behaviors that combine knowledge, skills, and attitudes related to specific professional activities.

Competency-Based Education: an educational system in which student performance and progression towards a degree, certificate, etc., depends on the student's ability to demonstrate real-world skills, called "competencies." Whereas in traditional education curricula focus on the amount of time a learner will spend studying a particular discipline, in competency-based education, curricula and assessments focus on helping students achieve milestones or benchmarks that move them toward being competent to practice. Within medical education, the acronym CBME (competency-based medical education) is in widespread use as this educational model supplants the older model of academic medical education.

Competency Domain: a grouping of competencies organized around a theme.

Difference of Sex Development (DSD): an emerging umbrella term to replace "disorders of sex development" (see separate entry). Note: "DSD" functions as both singular and plural; one says: "people born with DSD" and "a person born with DSD" and "when a person is born with DSD..." etc., without using the article "a" before it, and without adding an "s" to the end. See the "Notes on Terminology" section of **Chapter 1, Laying the Foundation for Inclusion and Equality**, for further discussion of this term.

Disorders of Sex Development (DSD): an umbrella term for a wide variety of congenital conditions in which the development of chromosomal, gonadal, and/or anatomical sex is atypical. Replaced "intersex" and terms based on the root "hermaphrodite" in 2006 by consensus of pediatric endocrinologists; the term may in turn soon be supplanted by "differences of sex development." See the "Notes on Terminology" section of **Chapter 1, Laying the Foundation for Inclusion and Equality**, for further discussion of this term.

Entrustable Professional Activities (EPAs): essential professional tasks or responsibilities in which a trainee should demonstrate competence before being allowed to practice unsupervised.

Female-to-Male (FtM): usually refers to a transgender person who was identified as female at birth but who identifies as a male in terms of his gender identity.

Formative Assessment: an evaluation designed to improve performance by identifying areas of weakness and providing specific suggestions for improvement. This type of assessment promotes reflection, shapes values, guides future learning, and provides opportunities for support and remediation.

Gay: usually refers to a person who identifies his or her primary romantic feelings, sexual attractions, and/or arousal patterns as being toward someone of the same gender or sex.

Gender: psychological, behavioral, and cultural characteristics that are believed to be associated with maleness and femaleness.

Gender-Affirming: an adjective used to refer to behaviors or interventions that affirm a transgender person's gender identity. For example, the use of cross-sex hormones for a transgender person may be called a gender-affirming intervention. Use of the correctly gendered pronoun can also be a gender-affirming behavior.

Gender Discordance: a mismatch between natal sex and felt gender identity. For example, when a male-bodied individual identifies as female.

Gender Dysphoria: significant subjective internal distress arising from a mismatch between natal sex and one's personal sense of gender identity that leads an individual to desire some form of gender transition through social, hormonal, and/or surgical means. For example, when an adolescent identifies as female but has a male body. Gender dysphoria also refers to the diagnostic classification of this experience in the *Diagnostic and Statistical Manual*, made up of several criteria within two distinct developmental subcategories: Childhood and Adolescence/Adulthood.

Gender Expression: mannerisms, personal traits, clothing choices, etc., that serve to communicate a person's identity as they relate to a particular societal gender role.

Gender Identity: an individual's personal and subjective inner sense of self as belonging to a particular gender (e.g. being a boy/man, girl/woman, genderqueer, transmasculine spectrum, transfeminine spectrum).

Gender Nonconforming: a person who does not conform to prevailing gendered behaviors or roles within a specific society. People who are gender nonconforming may not take part in activities conventionally thought to be associated with their assigned gender. For example, a gender nonconforming male child might wish to dress in girls' clothing and to play exclusively with girls. The term **gender variant** has been used synonymously.

Gender Role: the role a person plays or is expected to play socially in terms of gender within a specific society, conventionally referred to along a masculine-feminine spectrum.

Genderqueer: an umbrella category for people whose gender identities are something other than male or female. People who are genderqueer may identify as: having an overlap or indefinite lines between gender identity and sexual and romantic orientation; being two or more genders; being without a gender; or moving between genders or having a fluid gender identity.

Heterosexism: a system of attitudes, bias, and discrimination favoring opposite-sex sexuality and relationships and stigmatizing same-sex sexuality and relationships. Heterosexism can include the presumptions that people are heterosexual and that opposite-sex attractions and relationships are “normal” or superior.

Heterosexual: literally “other sex” or “different sex,” usually used as an adjective to refer to relations between a man and a woman. Although “heterosexual” was also historically used as a noun to refer to a straight person, that use has now fallen out of favor.

Homophobia: a range of aversive reactions to homosexuality, homosexual behavior, and people with same-gender attraction or behavior.

Homosexual: literally “same-sex,” usually used as an adjective to refer to same-gendered relations. Although “homosexual” was also historically used also as a noun to refer to a gay person, that use has now fallen out of favor.

Iatrogenic: caused by medical examination or medical treatment. The term is usually used to refer to harms caused by medical practice.

Intersex: historically, a term used in biology and, later, in medicine to refer to beings (including people) whose sex development falls between the male-typical and female-typical forms. The use of the term as an identity label is currently in flux; See the “Notes on Terminology” section of **Chapter 1, Laying the Foundation for Inclusion and Equality**, for further discussion of this term. (See also “differences of sex development” and “disorders of sex development.”)

Learning Objectives: brief statements that describe what students should be expected to learn.

Lesbian: usually refers to a female person who identifies her primary romantic feelings, sexual attractions, and/or arousal patterns as being toward a person of the same gender or sex.

Male-to-Female (MtF): usually refers to a transgender person who was identified as male at birth but who identifies as a female in terms of her gender identity.

Microaggression: subtle, ongoing discrimination in the form of verbal, behavioral, and environmental slights and indignities.

Natal Sex: usually refers to the sex karyotype (XX, XY, XO, XXY, etc.) and sex phenotype (external genitals, gonads, internal sex organs) with which a person was born. Natal sex is typically what is used to give a baby a gender assignment as boy or girl.

Objectives: see “learning objectives”.

Pubertal Suppression: a medical practice using GnRH analogs to reversibly suppress puberty in younger adolescents who are gender dysphoric to allow for further exploration of gender identity issues while minimizing the potential for worsening psychiatric symptomatology before considering more irreversible interventions that may include cross-sex hormones and/or gender-affirming surgeries.

Reparative Therapy: a now-discredited treatment approach in which the desired outcome was to make a person heterosexual.

Sex: the aggregate of an individual’s biological traits (genotypical and phenotypical) as those traits map to male/female differentiation and the male-female anatomical and physiological spectrum (see also “natal sex”).

Sexual Behavior: the sexual acts in which humans engage. An individual’s sexual behaviors may not reflect that person’s sexual orientation or sexual identity.

Sex-Change: historically used to refer to when a transgender person undertook what are now called gender-affirming procedures.

Sexual Dysfunction: the experience, by an individual or a couple, of difficulty with sexuality. Dysfunction may include, for example, discomfort and/or difficulties with desire, arousal, orgasm.

Sexual Identity: how people think of themselves or others in terms of romantic and sexual attractions. A person’s sexual identity may not match that person’s sexual orientation and/or sexual behaviors.

Sexual Orientation: an individual’s inclination to feel sexual attraction or arousal to a particular body type or identity. Relatively common forms of sexual orientation include heterosexuality (opposite-sex or opposite-gender attraction), homosexuality (same-sex or same-gender attraction) or bisexuality (attraction to people who are the opposite sex or gender along with attraction to people who are the same sex or gender).

Standardized Patients: actors who are trained to simulate real patients in order for students to learn and practice clinical skills.

Straight: usually refers to a person who identifies her or his primary romantic feelings, sexual attractions, and/or arousal patterns as being toward a person of the opposite gender or sex.

Summative Assessment: an evaluation designed to judge learner competence, qualification for advancement to higher levels of responsibility, and fitness to practice (e.g., promotion and certification).

Transgender: individuals who have gender identities that do not align with the gender labels they were assigned at birth.

Transitioning: the process undertaken by a transgender individual of adopting a social gender identity that is different from the gender assigned to that individual at birth. Transitioning may or may not include changes in physical expression (e.g., chest binding, genital tucking, modes of dress), medical and surgical interventions (e.g., cross-sex hormones and gender-affirming surgeries), and/or changes in legal documents.

Transphobia: a range of aversive reactions towards gender nonconforming and/or transgender people.

Transsexual: historically a term used to refer to a person who has undergone what today are called gender-affirming interventions.

Appendix B

Medical School Programs and Related Resources

The information compiled below describes medical schools that have implemented educational programs, established elective educational experiences, or provide health care clinics that focus on the education and care relating to people who may be LGBT, gender nonconforming, and/or born with DSD. This appendix also provides information about medical schools or organizations that have established working committees to maintain or facilitate an institutional climate that supports people who may be LGBT, including students, faculty, administration, and staff.

Finally, this compilation includes information about organizations that serve as valuable resources for health care and health care education for people who may be LGBT, gender nonconforming, and/or born with DSD. The information included in this list results from a search of the literature and responses to a national call to medical schools through the AAMC and the DR-ED listserv (sponsored by the Michigan State University College of Human Medicine) and is not meant to be all-inclusive.

Note: Because the following descriptions of these programs come directly from the medical schools or their websites, they may not use the same terminology and abbreviations as used elsewhere in this publication.

Examples of Schools with Integrated LGBT Medical Education Programs

Case Western Reserve University

CWRU Programming for LGBT Health

(Website not established at time of publication)

CWRU has the vision to provide and promote high quality health care for LGBT patients, their families, and their communities through an ongoing integrated program of LGBT-related health research, provider education, workforce diversity, community partnership, and multi-level advocacy. The Program seeks to improve LGBT health through:

1. The identification and implementation of best practices in the delivery of health care services to LGBT populations.
2. The development of researchers committed to the investigation of LGBT-related health and health service issues.
3. The development, implementation, delivery, and evaluation of educational programs at all levels designed to enhance directly or indirectly LGBT patient care and the workforce environment for LGBT health care and health science professionals.

4. The formulation of and advocacy for policies and programs at the local, state, and national level that are designed to enhance directly or indirectly LGBT health, the delivery of health care to LGBT patients, and the workforce environment for LGBT health care and health science professionals.

Contact Information:

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Florida State University College of Medicine

www.med.fsu.edu

At FSUCOM, education about sexual orientation and gender identity begins in the first year, where students learn interviewing techniques and have a small group session with LGBT persons.

In the second year Doctoring course, LGBT themes are infused into standardized patient cases. A two-hour module discussing LGBT health disparities followed by a panel of LGBT patients, providers, and other professionals has been a successful part of our curriculum.

In year three, we use an OSCE case involving a transgender person.

Contact Information:

Florida State University College of Medicine
1115 W. Call Street, Suite 3140-J
Tallahassee, FL 32306-4300
850-645-1227
Jonathan.appelbaum@med.fsu.edu

Michigan State University College of Human Medicine

<http://humanmedicine.msu.edu>

Michigan State University's College of Human Medicine admissions process uses a balanced and holistic approach that considers an applicant's academic metrics, experiences, and personal characteristics in an attempt to achieve the educational benefits of a diverse student body. The process is driven by the mission of the College, which includes "promoting the dignity and inclusion of all people."

Since instituting a multiple mini-interview (MMI) assessment tool as a formal part of the admissions process, interview scenarios addressing LGBTQI issues have been included not only as a mechanism of assessing favorable applicant characteristics (such as cultural competency), but also as a means of demonstrating a favorable college climate for applicants from the LGBTQI community and their allies. For example, during the MMI, in the period when applicants are asked to make an argument for or against a controversial stance, the topic may be having government-issued civil unions available to all adults while “marriage” is left to religions/cultures to oversee. In the MMI section that involves demonstrating how one would coach a peer, applicants may be asked to coach an actor playing a gay teen who is an minority/ethnic adoptee who has recently been kicked out of his/her house by parents after coming out to them.

Using these kinds of scenarios in the admissions MMI format signals to applicants that diversity issues matter within medicine and signals to LGBTQI applicants that the school values, promotes, and teaches cultural competency in these areas.

Contact Information:

Joel Maurer, M.D.
Assistant Dean for Admissions
College of Human Medicine
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East Lansing, MI 48824
517- 353-9620
MDadmissions@msu.edu

Morehouse School of Medicine

www.msm.edu

Morehouse School of Medicine is addressing the health of people who may be LGBT and individuals with differences of sex development (DSD) in a number of ways including:

1. Didactic and experiential learning integrated through Fundamentals of Medicine I, II, and III, as well as the fourth year Human Sexuality Elective, 4th year sexually transmitted diseases (STD) Elective, fourth year Adolescent Medicine Elective, and the Pediatric Residency Program.
2. The student Alliance Group and events with community-based organizations in the metro-Atlanta area.
3. The institution’s Equity and Diversity Committee.
4. Morehouse School of Medicine is dedicated to improving the health and well-being of individuals and communities.

5. Increasing the diversity of the health professional and scientific workforce.
6. Addressing primary health care needs through programs in education, research, and service, with emphasis on people of color and the underserved urban and rural populations in Georgia and the nation.

Contact Information:
Morehouse School of Medicine
720 Westview Dr SW
Atlanta, GA 30310
404-752-1500

Oakland University William Beaumont School of Medicine (OUWB)

OUWB Diversity and Inclusion

<https://www.oakland.edu/medicine>

Topics ranging from health disparities, cultural competence, social determinants of health, and LGBT health education are covered throughout the spectrum of our students' medical school experience. Clinical exposure with standardized patients and patient panels allow our students additional learning opportunities to work with a diverse patient population. OUWB's Diversity and Inclusion program has sponsored a Safe Space training program to identify LGBT allies within OUWB in response to the need for an inclusive climate for LGBT persons in academic medicine. In addition, OUWB has developed partnerships both in the Oakland University campus and the surrounding communities of Southeast Michigan to create pipeline programs to recruit diverse applicants to OUWB for a sustainable diverse school climate.

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Diversity and Inclusion
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diversity.med@oakland.edu

Stanford School of Medicine

LGBT Medical Education Research Group

<http://med.stanford.edu/lgbt/>

Comprehensive research is lacking on the current state of LGBT-related content in undergraduate medical curricula. The Lesbian, Gay, Bisexual, & Transgender Medical Education Research Group (LGBT MERG) seeks to address this lack of research. LGBT MERG is concomitantly engaged in studies such as the LGBT Health Stories project. It is hoped that the results of MERG's research will contribute to improvements in LGBT-related curricula, enhancement of provider competencies in caring for LGBT patients, and reductions in the health disparities we see in LGBT patient populations. MERG works to be a significant contributor to the field of LGBT health by creating and communicating new knowledge through innovative research, by influencing health and educational policies, and by advocating for LGBT patients and providers.

Contact Information:

Lesbian, Gay, Bisexual, & Transgender Medical Education Research Group
Stanford University School of Medicine
300 Pasteur Drive
MSOB X3C01
Stanford, CA 94304-5404
lgbt@med.stanford.edu

University of California, San Francisco

UCSF LGBT Resource Center, Office of Diversity and Outreach

LGBT Collaborative on Education, Research, & Clinical Care

lgbt.ucsf.edu

The LGBT Resource Center, a division of the Office of Diversity and Outreach, works with the LGBT Collaborative on Education, Research, and Clinical Care, to deliver high quality, culturally competent education to our learners from four professional schools (Medicine, Nursing, Pharmacy, and Dentistry). The vision of our collaborative is to improve health care and minimize health disparities for LGBT people. Students are given numerous opportunities to learn about LGBT issues in health care. In year one, LGBT patient cases are included in Foundations of Patient Care, a block that covers clinical skills and reasoning, doctor-patient interaction, ethics, and professional development. In year two, an entire session of the Life Cycle/Epilogue block is devoted to LGBT issues. This is an opportunity for students to review and integrate concepts through case-based study in large and small groups. Epilogue also provides coordinated preparation for the USMLE Step 1 Exam that concludes the second year. Additionally, the School of Medicine offers an elective in the winter quarter devoted to transgender health issues. Learners are given additional

elective credit for attending the annual LGBTQI Health Forum. At this forum, LGBTQI health care specialists present on a wide range of topics including transgender health, bisexual invisibility, lesbian health, intersex awareness, gay men's health, youth and aging issues, and LGBTQI parenting. As this event is co-sponsored by our LGBTQ Student Association, students from across professional schools have the opportunity to network, build community, and gain leadership experience in coordinating a large educational forum. This is part of our goal in creating a safe, inclusive, and equitable environment for our LGBT learners.

Contact Information:

UCSF LGBT Resource Center
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San Francisco, CA 94118
415-502-2516
larry.lariosa@ucsf.edu

University of Pennsylvania Medical School

Penn Medicine Program for Lesbian, Gay, Bisexual, and Transgender Health

<http://www.pennmedicine.org/lgbt/>

The Penn Medicine Program for LGBT Health is an interdisciplinary program involving the Perelman School of Medicine, School of Nursing, School of Dental Medicine, and affiliated health systems. The vision of the Program for LGBT Health is to improve the care of LGBT populations by becoming a local and national leader in LGBT patient care, education, research, and advocacy. To meet this vision, the program focuses on five areas:

1. Institutional Climate and Visibility, nurturing and supporting diversity in the workplace, classroom, and health care settings.
2. Research, fostering research on the optimal ways to improve care for LGBT patients and families.
3. Patient Care, providing patient and family-centered care for LGBT patients and families.
4. Health Education, enhancing education of students, residents, and faculty in relation to LGBT health issues and health disparities.
5. and Community Outreach, increasing Penn Medicine's community involvement and partnering with community organizations to address LGBT health disparities and improve access to high quality care.

Contact Information:

Penn Medicine Program for LGBT Health
Blockley Hall, 423 Guardian Drive, Rm. 1004

Philadelphia, PA 19104
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dcalder@upenn.edu

University of Texas Health Sciences Center at Houston

UTHealth LGBTQ Curriculum

(Website not established at time of publication)

University of Texas Health works to offer a broad curriculum and support to increase student knowledge, improve patient care, and provide a safe, inclusive environment for students, residents/fellows, faculty and staff. The university has incorporated LGBTQ and DSD-affected curriculum into basic science, clinical clerkships, and resident/fellow didactics, in addition to providing an elective lecture series and community outreach through the Office of Diversity and Inclusion and the campus Gay-Straight Alliance.

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University of Vermont College of Medicine

<http://www.uvm.edu/medicine/>

UVM COM has become a national leader in the development of a patient-centered curriculum to improve the comprehensive and sensitive health care for LGBTQ populations of all ages. Starting in 2006, formal objectives for LGBTQ health care were expanded and now 30 hours of formal instruction are in the curriculum. The Vermont Integrated Curriculum (VIC) faculty collaborate with LGBTQA COM students and engage the LGBTQ Community to create and refine competency-based learning activities and assessment tools. Members of the LGBTQ community are an integral part of our standardized patient program and help develop LGBTQ cases. Ten percent of the standardized patient cases are LGBTQ identified to reflect local patient demographics. The VIC addresses knowledge, skill and attitudes from the following domains: knowledge for practice, communication skills, patient care, and practice-based learning, professionalism and system based practice. Feedback from stakeholders is solicited, evaluated, and acted upon and as a result the curriculum continues to be strengthened. As a result of community feedback, we recently piloted an addendum to the AAMC's Tool for Assessing Cultural Competence Training (TACCT) to ensure that our undergraduate medical curriculum adequately addresses LGBTQ health across the curriculum.

Contact Information:

Office of Medical Student Education
The Courtyard at Given N-100

89 Beaumont Avenue
Burlington, VT 05405
802-656-0722

Vanderbilt University School of Medicine

Program for LGBTI Health

<https://medschool.vanderbilt.edu/lgbti/>

The Vanderbilt University Medical Center Program for LGBTI health is an innovative effort to improve health care for LGBTI patients that is housed within the Office for Diversity in Medical Education. The Vanderbilt Program for LGBTI Health works to address disparities, improve the health of LGBTI patients, support education around LGBTI Health, and foster research on the optimal ways to care for LGBTI patients and families through the following goals:

1. Promote national leadership in providing excellent patient care.
2. Enhance education on LGBTI health.
3. Improve research into important topics related to LGBTI health.
4. Advocate for the LGBTI community.

Contact Information:
Vanderbilt University School of Medicine
215 Light Hall
Nashville, TN 37232
lgbti.health@vanderbilt.edu

Examples of Schools with Established Committees or Offices Dedicated to Institutional Diversity

Albert Einstein College of Medicine

Einstein LGBT Steering Committee

www.einstein.yu.edu/education/student-affairs/safe-zone

The mission of the Einstein LGBT Steering Committee of the Office of Student Affairs is to establish and maintain an environment to support the personal and professional development of LGBT students and to prepare all students to address LGBT-related health disparities and health care issues. Consistent with the mission of Einstein “to promote the pursuit of scientific excellence with the social mission to improve human health” our goals are to:

1. Help develop and attract qualified LGBT students and students interested in LGBT-related health care disparities and health care to Einstein’s academic programs.
2. Through mentorship, ensure the personal and professional development of LGBT students and students interested in LGBT-related health disparities and health care.
3. Create an institutional climate that supports all LGBT students, staff, faculty, and patients.
4. Raise an awareness of LGBT history and current challenges in promoting LGBT health equity.
5. Facilitate the development of future LGBT leaders by promoting student involvement in institutional, local, national, and international leadership roles.

Contact Information:

Albert Einstein College of Medicine
1300 Morris Park Avenue
Office of Student Affairs, Belfer 210
718-430-3060
LGBT.SteeringCommittee@einstein.yu.edu

Harvard Medical School LGBT Advisory Committee

The LGBT Advisory Committee

<https://mfdp.med.harvard.edu/dcp-programs/lgbt/who-are-we/lgbt-advisory-committee>

The LGBT Advisory Committee will identify key areas of importance, programmatic interventions, and resources that support LGBT issues. The advisory committee’s charge is to:

1. Make recommendations to the dean of the faculty of medicine about priorities related to LGBT students, staff, faculty, trainees and fellows at HMS and HSDM.
2. Identify concerns, resources and programmatic needs across the HMS/HSDM LGBT community.
3. Collaborate with University and HMS-related, offices, programs and groups that address the needs of the HMS/HSDM LGBT community.

Contact information:

LGBT Office
Office for Diversity Inclusion & Community Partnership
Harvard Medical School
25 Shattuck St.
Boston, MA 02115
617-432-7555
dcp_lgbt@hms.harvard.edu

Oakland University William Beaumont School of Medicine (OUWB)

OUWB Diversity and Inclusion

<https://www.oakland.edu/medicine>

OUWB's Diversity and Inclusion team and Diversity Council serve to provide oversight and recommendations for the integration of diversity, including LGBT issues, in institutional policies and programming at OUWB. The Diversity Council was formed to assist in carrying out the functions of the Diversity and Inclusion office, comprised of both faculty, staff and students at OUWB, to be responsible for the review of institutional goals and action steps to implement and integrate diversity in the following areas at OUWB, which will support the mission, values, and strategic goals of the medical school: institutional policy, educational resources (medical library and website presence), curriculum, faculty/student training in diversity topics, and faculty/student support.

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University of Louisville School of Medicine

LGBT Center at the Health Sciences Center

<http://louisville.edu/lgbt/programs-1/lgbt-center-at-health-sciences-campus>

The LGBT Center provides critical services that support the vision of the Health Sciences Campus to “achieve a world-class academic medical center” showcasing our School of Medicine, School of Dentistry, School of Public Health and Information Sciences and School of Nursing. Our office

coordinates LGBT health-related programming among these schools in order to improve the care of LGBT populations and foster supportive learning environments for students, faculty, staff, patients and alumni. The office provides the following services:

1. Improve Institutional Climate by providing Safe Zones training to faculty and staff; supporting LGBT and Allies student group; raising visibility of LGBT allies through an online “Allies List;” working closely with Student Affairs and Faculty groups to create and support LGBT-friendly policies; holding community celebrations during Pride week; contributing to student orientation activities; and hosting LGBT and Allies “networking nights” for health science students, faculty and community health professionals.
2. Expand Education by offering an LGBT Health Wellness Competency Certificate (free monthly educational seminars on LGBT health, health disparities, emerging topics, and cultural competency skills); providing in-class guest lectures; co-developing curricular modules in collaboration with faculty; and connecting experts on LGBT health with faculty to augment faculty education.

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LGBT Center
University of Louisville
Red Barn
Louisville, KY 40292
502-852-0696
lgbt@louisville.edu

University of Southern California

Medical Gay and Lesbian Organization (MedGlo)

<http://www-scf.usc.edu/-medglo>

MedGlo, the Medical Gay and Lesbian Organization for LGBTQI life at the USC Health Sciences Campus, supports lesbian gay, bisexual, transgender, questioning, intersex, and genderqueer students, faculty and staff at USC’s Health Sciences Campus. Through its student-organized confidential email list, social events, activism and programming, MedGlo strives to improve the educational environment for LGBTQI Providers-in-Training, to educate the student body about cultural competency in LGBTQI, and to improve the quality and access to health care for LGBTQI patients.

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University of Vermont College of Medicine

Office of Diversity and Inclusion

<http://www.uvm.edu/medicine/>

To further advance our comprehensive vision, the University of Vermont College of Medicine (UVM COM) Office of Diversity & Inclusion (ODI) supports initiatives that create a learning environment characterized by inclusion, respect and professionalism. Working collaboratively with all COM departments, clinical partners, and the UVM community, the ODI promotes the advancement of diversity, inclusion and cultural competence in the medical profession as core strategic priorities to contribute to the community's overall health through programs that decrease health disparities and increase health equity. ODI offers a range of resources and services to support students, faculty and staff embracing diversity in its broadest forms, encompassing and exploring the dimensions of not only racial and ethnic diversity, but also gender, gender identity, religion, sexual orientation, socioeconomic background, and life.

Contact Information:
Office of Diversity & Inclusion
E-125 Given Building
89 Beaumont Avenue
Burlington, VT 05405
802-656-2156 or 802-656-2156
meddiversity@med.uvm.edu

Examples of Medical School Elective Educational Experiences

Brown University School of Medicine

The LGBTQI Preclinical Healthcare Elective

<http://www.brown.edu/academics/medical/education/preclinical-electives/biol-6508>

The LGBTQI Preclinical Healthcare Elective explores the intricate health care needs of an underserved and vulnerable population, which consists of individuals who do not fall into gender or sexuality majorities. This course explores these health concerns with a lens that encompasses the relevant scientific, clinical and activist issues and examines the myriad ways in which gender and sexuality interplay with the health care system. This goal is accomplished through the use of guest lecturers who are experts in these various areas. Each class will consist of a lecture by a guest speaker, followed by a discussion on the topic of the week.

The Preclinical workshop on mental illness in sexual minority adolescents includes as its goals providing evidence-based data on the prevalence of psychiatric illness in sexual minority teens, discussing factors that place these adolescents at risk, presenting tips for effectively working with this population, offering specific ways that clinicians can initiate dialogue on sexual orientation, and presenting local and national resources.

Gender and Sexuality in Healthcare: Caring for All Patients teaches students about the intricate healthcare needs of individuals who do not fall into gender or sexuality majorities. While the needs of this underserved and vulnerable population are becoming more recognized, the understanding within medical practices is far from adequate. Additionally, as it stands, medical curriculum does little to recognize the needs of this increasingly visible community. Our class will delve into these often undiscussed health concerns with a lens that encompasses the relevant scientific, clinical and activist issues.

Georgetown University School of Medicine

Program Module for LGBT Health

<http://som.georgetown.edu/medicaleducation/curriculum/secondyearmodules/modulesreproduction>

The Georgetown University Program Module for LGBT Health is categorized by course and module objectives. By the end of the Human Sexuality course students will be able to:

1. Identify the health related information to be elicited from sexual minority (LGBT) patients.
2. Describe the barriers to accessing health care for sexual minority patients.
3. Identify the appropriate questions to ask patients when taking a sexual history.

The LGBT specific objectives are found in the second year Reproduction module within the Human Sexuality course and met through a series of lectures, small group discussions and a panel discussion—culminating in a Human Sexuality OSCE. The specific objectives are:

1. Discuss factors which can impact a patient's willingness to disclose and discuss sexual orientation.
2. Identify health disparities, barriers to accessing health care, and specific health issues that may affect LGBT patients.
3. Discuss health issues and concerns specific to men who have sex with men (MSM) and women who have sex with women (WSW).

4. Define different sexual practices and their associated risks as well as risk reduction strategies.
5. Define sex and gender terms.

New York University School of Medicine

The Gender and Health Elective

The Gender and Health elective is a four-week experience including elements of didactics and clinical exposure for students who have completed at least one primary rotation. This elective is organized into a variety of topic-based seminars as well as journal clubs that focus on the NYU Curriculum for the 21st Century medical education themes and how they are influenced by gender, sex, and sexuality. The three general focuses are women's health, men's health and LGBTQ health. Students have both classroom and clinical experience learning opportunities. The goals of this elective are:

1. To explore the influence of gender, sex, and sexuality as biomedical and psychosocial determinants of health and disease.
2. To assess gender, sex, and sexuality-based similarities and differences between provision and receipt of health care.
3. To illuminate aspects of LGBTQ health that are historically overlooked in the traditional medical curriculum.

By the end of the elective, the student will be able to:

1. Describe the influences of gender, sex, and sexuality on health and health care.
2. Identify major health disparities based on gender, sex, and sexuality.
3. Conduct a discussion with a patient on the risks and benefits of breast, cervical, & prostate cancer screening.
4. Perform an advanced-level, evidence-based and culturally competent pelvic exam.
5. Take a comprehensive sexual history from a transgender patient.

Northwestern University Feinberg School of Medicine

LGBT Lesbian, Gay, Bisexual, Transgender Safe Space Training

<http://www.feinberg.northwestern.edu/diversity/programs/safe%2Dspace/>

LGBT Lesbian, Gay, Bisexual, Transgender Safe Space Training is a course aimed at increasing the capacity of Northwestern University Feinberg School of Medicine to become a fully inclusive campus. The Safe Space Program is an initiative to educate allies who support LGBTQ individuals in our campus community.

University of Colorado

Foundations of Doctoring Curriculum

<http://somed.ucdenver.edu/cme/LGBTCME.html>

The University of Colorado has incorporated LGBT health content into the Foundations of Doctoring curriculum, the goals of which are to enable students to effectively communicate with diverse populations and around potentially socially complex topics, including patients with various sexual practices, sexual orientations, and gender identities. We also recognize an inclusive sexual history as one manner of demonstrating openness to sexual minorities and include education on LGBT health in this context. This program is held during the second year of medical school. Students are required to complete an online module (developed by Philipp Hannan, UCSOM Class of 2016). This module provides an overview on LGBT health issues, health disparities, and methods of improving care for LGBT patients. Students are encouraged to practice inclusive sexual history taking during their sessions with the physical exam training assistants. This is followed by a 40-minute lecture on inclusive sexual history taking, which covers broad topics on LGBT health followed by standardized patient interviews.

University of Louisville School of Medicine

Cultural Competency Workshop

<http://louisville.edu/medicine/diversity/HSC-cultural-competency-workshops>

The annual Cultural Competency Workshop exposes students to diverse people and beliefs that they will encounter later in their professional lives. It is intended to make them aware that the world is a diverse place. The workshop's website is updated each year when a new workshop is offered.

The Introduction to Clinical Medicine (ICM) Course

The Introduction to Clinical Medicine (ICM) course spans the first two years of medical school,

and has as its mission preparation for clinical clerkships, introduction to health care systems and processes, and training in the skills needed for lifelong learning. The course includes sections on history taking, physical examination, ethics, evidence-based medicine, and other areas. Included in these is a section for first year medical students on issues of culture and diversity in medicine. The ICM curriculum on LGBT issues is currently being developed and expanded. The components presently in place include:

1. Continuity standardized patient interactions wherein the standardized patient portrays a gay/lesbian patient.
2. Overview lectures for sexual health and obtaining a sexual history, including methods for sensitively obtaining histories from LGBT patients.
3. A brief fourth year student session on LGBT and other sexual health topics.

Planned upgrades include:

1. A second year student small group session focusing on LGBT health issues and patient interaction.
2. Expansion of the standardized patient cases across the medical training program to include more “diverse” standardized patients and cases including more LGBT patients.

University of Nebraska Medical Center

<http://ap1.unmc.edu/fammed/LGBT>

The LGBT C3 Program at UNMC consists of extracurricular (non-credit) experiences in which students obtain knowledge and clinical skills to become culturally and clinically competent to address LGBT health care disparities and health care needs. The program is open to any student enrolled at the University of Nebraska Medical Center. Two types of certificates are offered: Basic Knowledge and Advanced Skills. The Basic Knowledge certificate requires completion of online reading assignments and participation in discussion groups on various topics during eight, three-week blocks throughout the fall and spring semesters (four each semester). Participants are expected to write responses to the discussion question(s) using the recommended resources and at least one peer-reviewed publication relevant to that topic. The Advanced Skills certificate complements the topics covered in the Basic Knowledge certificate program with small group seminar sessions. The seminars incorporate a variety of activities, such as interviewing standardized patients, panel presentations, discussions, etc. The Basic Knowledge program can be taken by itself or concurrently with the Advanced Skills programs. Alternatively, the two programs can be completed separately in different years but successful completion of the Basic Knowledge program must precede the Advanced Skills program. Besides receiving a certificate of completion, student participation forms part of a student’s portfolio.

University of Southern California, Keck School of Medicine

http://keck.usc.edu/en/Education/Degrees_and_Programs/Professional_Degrees/MD_MD_Program/Medical_Curriculum/Year_I-II_Continuum/PPM.aspx

The purpose of the Professionalism and the Practice of Medicine (PPM) course is to create a learning community and social context to provide, identify and facilitate learning alongside professional role models. Students are introduced to the nature of professionalism and the ways it is manifested in their own lives. The PPM course encourages self-initiative and leadership in the process of learning, encourages greater professional maturity, and increases sensitivity and skills in relation to professional issues in medicine such as integrity, humanism, collaboration, cultural competence and ethical decision making. The students gain skills and competence in the broad areas of communication, social and community context of health care, ethical judgment, self-awareness, self-care and personal growth, professionalism and life-long learning. As part of the PPM course, students take a two-hour session as part of the first year curriculum entitled Cultural Competence III: An Introduction to Culturally Competent Health Care for Lesbian, Gay, Bisexual, and Transgender (LGBT) Patients. By the end of this session, students are expected to be able to:

1. Identify several ways that sexual identity may affect the delivery of health care to LGBT patients.
2. Describe health issues and diseases that disproportionately affect the LGBT population.
3. Learn practical strategies that can help reduce these disparities.
4. Describe ways in which one can make a clinical practice more LGBT-inclusive.

University of Washington Medical School

LGBTQ Health and Health Disparities

<https://catalyst.uw.edu/workspace/racansky/19139/114495>

LGBTQ Health and Health Disparities is a course that builds on the experiences of physicians, patients, activists and other providers who work actively with LGBTQ individuals to help medical students become better primary care providers for LGBTQ communities. This course is designed to help students better understand and more effectively respond to the health care needs of members of the LGBTQ community.

UTEST

<http://sasgcc.org/hivtesting>

UTEST is a medical student-run outreach HIV testing program serving the LGBT community of Seattle. UTEST's mission is to provide student-run, culturally excellent HIV testing services to the Seattle community and equip future physicians with the tools to better integrate regular HIV testing in their future practices and to better serve LGBT patients. Medical students are trained in HIV testing, counseling, risk reduction, and LGBT cultural competency and provide free rapid HIV testing on a weekly basis at Seattle Area Support Groups and at Lifelong AIDS Alliance. UTEST is a collaboration between the University of Washington School of Medicine's Family Medicine and QMedicine LGBTQ Student Interest Groups, Seattle King County Public Health, Seattle Area support groups and Lifelong AIDS Alliance, with support provided by the Pride Foundation

Examples of Medical School Health Care Clinics

Mount Sinai, Beth Israel

LGBT Health Services

Mount Sinai Beth Israel LGBT Health Services is committed to meeting the special health care needs of LGBT communities by providing an array of health, referral and educational services, promoting LGBT health equity and access to care, and developing effective partnerships with LGBT organizations, agencies and allies. The staff meet this commitment by offering the following:

1. Information
2. Referral and patient navigation for LGBT patients and consumers.
3. Outreach and health education for LGBT organizations and communities.
4. Professional education and training for providers in LGBT health care topics.
5. Advocacy for LGBT health equity with local and national health policymakers, researchers and educators.
6. Sponsorship of LGBT events and activities.

Contact Information:

Mount Sinai Beth Israel
First Avenue at 16th Street
New York, NY 10003
Phone: (212) 844-6389

University of Iowa

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ) Clinic

<http://www.uihealthcare.org/lgbt>

The University of Iowa LGBTQ Clinic offers comprehensive primary care for adult and child (over age 10) LGBTQ patients delivered by providers and staff with expertise in the needs of the lesbian, gay, bisexual, transgender, and queer communities. Services include routine physical exams, chronic disease management, sexually transmitted infection testing and treatment, hormone therapy, and post-surgical care for those who have undergone gender affirming surgery. The UI LGBTQ Clinic utilizes a multidisciplinary team approach to provide excellent care for their patients. The clinic partners with faculty in Family and Couple Therapy, Pediatric Endocrinology, Pediatric Psychiatry, Urology, Plastic Surgery, Gynecology, Reproductive Endocrinology, Dermatology and the College of Law.

Contact Information:

The University of Iowa LGBTQ Clinic
Iowa River Landing
105 E. 9th St.
Coralville, IA 52241
319-384-7444 or 855-467-3700

Organizations and Web Resources

Accord Alliance

<http://www.accordalliance.org>

Accord Alliance's mission is to promote comprehensive and integrated approaches to care that enhance the health and well-being of people and families affected by DSD by fostering collaboration among all stakeholders. Accord Alliance works with children's hospitals across the United States to promote evidence-based, patient-centered, team care for children and families affected by DSD. Their website includes FAQs and links to educational materials and peer support groups, as well as the books Clinical Guidelines and a Handbook for Parents.

AIS-DSD Support Group

<http://aisdsd.org>

AIS-DSD Support Group is a nonprofit organization that offers support of various forms including resources about various differences of sex development, newsletters, and most importantly, the ability to connect with similarly situated others. Each year they hold an annual conference where medical professionals speak to members about scientific advancements, parents discuss their experiences with other parents, and adults with intersex traits share their thoughts and feelings in private sessions. AIS-DSD Support Group offers a day of professional development for medical and behavioral health providers and researchers which consists of seminar topics covering the latest advances in DSD care and research, effective DSD clinic and team development, as well as panels of affected individuals who offer their perspectives to treatment professionals

American Association of Sexuality Educators, Counselors, and Therapists (AASECT)

<http://www.aasect.org>

AASECT is a not-for-profit, interdisciplinary professional organization that is devoted to the promotion of sexual health by the development and advancement of the fields of sexual therapy, counseling, and education. In addition to sexuality educators, sexuality counselors and sex therapists, AASECT members include physicians, nurses, social workers, psychologists, allied health professionals, clergy members, lawyers, sociologists, marriage and family counselors and therapists, family planning specialists and researchers, as well as students in various relevant professional disciplines.

American Medical Association (AMA)

Advisory Committee on Lesbian, Gay, Bisexual and Transgender (LGBT) Issues

<http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-t-advisory-committee.page>

The American Medical Association (AMA) Advisory Committee on Lesbian, Gay, Bisexual and Transgender (LGBT) Issues provides a forum within the AMA to address the needs of LGBT physicians, medical students, and patients. The Advisory Committee provides advice and counsel to the Board of Trustees and to AMA staff when appropriate on policy matters that bear directly on LGBT physicians, students, and patients and on developing strategies, programs and policies to better serve AMA members and potential members.

The goals and objectives of the Advisory Committee are include, but not be limited, to:

1. Providing a dedicated forum for involvement, mentoring, and networking for LGBT physicians and medical students.
2. Increasing the membership and participation of LGBT physicians in the AMA.
3. Enhancing AMA policy, advocacy, and education on LGBT health and professional issues.
4. Strengthening liaison with GLMA and other groups with mutual concerns.

American Medical Student Association Committee on Gender and Sexuality

<http://www.amsa.org/AMSA/Homepage/About/Committees/GenderandSexuality.aspx>

The AMSA Gender and Sexuality Committee is dedicated to assuring equal access to medical care and equality within medical education through leadership on issues affecting the health of women, intersex and the LGBT communities and support initiatives to improve policy at the institutional, local, state, and federal levels. AMSA advocates for patients by promoting curricular improvement, increased physician education, research and the development of health-related resources. AMSA provides the following resources and information:

Local Projects in a Box – providing a list of projects that are modeled after successful events from experienced local chapters. These are packaged with instructions on how to run the event, a power point presentation to help facilitate discussion, video clip suggestions and other materials, as well as handouts to complement the event.

Improve Curriculum at Your School – downloadable documents to assist in bringing about changes in medical school curriculum, downloadable reference cards with terminology to assist in history taking, and information about how to create preclinical electives.

GLMA: Health Professionals Advancing LGBT Equality

<http://www.glma.org>

GLMA: Health Professionals Advancing LGBT Equality is the world's largest and oldest association of lesbian, gay, bisexual and transgender (LGBT) health care professionals. GLMA was founded in 1981 as the American Association of Physicians for Human Rights, with the mission of ensuring equality in health care for LGBT individuals and health care professionals. Today, there is still considerable ignorance about LGBT health issues and over the past three decades; GLMA has tackled many initiatives and projects. As the climate and culture have changed, GLMA has become a leader in public policy advocacy related to LGBT health. GLMA now represents the interests of tens of thousands of LGBT health professionals of all kinds, as well as millions of LGBT patients and families.

Global Forum on MSM & HIV (MSMGF)

Promoting the Health of Men Who Have Sex With Men Worldwide:

A Training Curriculum for Providers

<http://www.msmsgf.org/promotinghealth>

Developed by MSMGF, in partnership with Johns Hopkins University (JHU), this curriculum aims to arm local community groups serving gay men and other men who have sex with men (MSM) with the ability to independently implement training programs to build cultural and clinical competency among health care providers serving their communities. With a strong focus on sex positivity, the curriculum shifts away from the disease model, and instead centers on a sexual health and harm reduction framework. Organized across nine distinct modules, the curriculum is designed for easy use by trainers to impact health care providers' level of knowledge, attitude and skill on a range of clinically relevant topics. Available for download as a set of training tools are the following nine modules:

1. Understanding Gay Men and Other MSM
2. Sexuality and Health
3. Barriers to Health
4. Creating a Friendlier Environment
5. Promoting Mental Health
6. Taking a Sexual History
7. Supporting Gay Men and Other MSM Who Use Drugs and Alcohol
8. Interventions for HIV and STI Prevention
9. Clinical Care for HIV and Other STIs

The Human Rights Campaign Healthcare Equality Index (HRC HEI)

<http://www.hrc.org/hei>

The Healthcare Equality Index (HEI) is a unique and invaluable resource for health care organizations seeking to provide equitable, inclusive care to LGBT Americans—and for LGBT Americans seeking health care organizations with a demonstrated commitment to their care. This free online survey, offered annually since 2007, has been widely praised for transforming LGBT health care nationwide.

Hypospadias/Epispadias Support Group

<http://www.heainfo.org>

The Hypospadias and Epispadias Association (HEA) founded for the education and support of people born with hypospadias or epispadias, their families, and loved ones. The Association is open to anyone affected by or interested in the physical and emotional issues stemming from these congenital conditions and is committed to providing the following services to our members, friends and the general public:

1. Creating and nourishing a community that erodes the isolation and shame brought about by hypospadias and epispadias.
2. Acting as a center of information and experience for parents and adults who are considering the available treatment options.
3. Providing a forum for an open exchange of information between the hypospadiac/epispadiac community and our health care providers.
4. Educating the public at large about the prevalence of these conditions and remove their stigma.

The National LGBT Health Education Center, The Fenway Institute

<http://www.lgbthealtheducation.org>
<http://thefenwayinstitute.org/education-training>

The National LGBT Health Education Center (HEC), a part of The Fenway Institute, provides educational programs, resources, and consultation to health care organizations with the goal of optimizing quality, cost-effective health care for LGBT people. Their programs follow the principles of adult learning, recognizing that adults are self-directed, goal-oriented learners that need to see the relevance of the educational material and be able to apply it to their everyday practice. The HEC offers a range of educational programs designed to meet the different learning styles, needs, and time constraints of their audiences. In order to ensure that these materials are disseminated widely, most of these programs are free. In addition, a growing number of our educational programs offer Continuing Medical Education (CME) and Continuing Education Units (CEU). The HEC's educational programs include:

1. Online Learning Modules
Slidesets and handouts to help facilitate the teaching and learning of LGBT health topics to health care professionals and students.
2. Webinars
Live and On-Demand webinars on how to improve the health care of LGBT people.

3. Online Courses
Self-directed courses on LGBT health topics.
4. Grand Rounds
Live presentations for academic and community hospitals.
5. Live Education and Training Programs
The HEC currently provides in-person trainings at regional, state, and national meetings, and through partnerships with other organizations, such as Primary Care Associations, State Departments of Public Health, Academic Medical Centers, Health Center Consortia, Professional Societies, and others.

The National Center for Transgender Equality

<http://transequality.org/Issues/health.html>

Transgender people face significantly disproportionate job loss and job fragility and, therefore, a much higher than average lack of insurance. Additionally, most public and private health insurance plans, when they are available to transgender people at all, have discriminatory exclusions for transgender-related care that often is used to exclude virtually all care. Finally, due to the lack of research data about transgender people there is a lack of funding for transgender health care that often precludes effective public health services. The National Center for Transgender Equality is focused on working to implement policies that will give transgender people equal access to health care.

National Coalition for LGBT Health

<http://lgbthealth.webolutionary.com>

The Coalition is committed to improving the health and well-being of lesbian, gay, bisexual, and transgender individuals through federal advocacy that is focused on research, policy, education, and training.

Services & Advocacy for Gay, Lesbian, Bisexual & Transgender Elders (SAGE)

<http://www.sageusa.org>

SAGE is the country's largest and oldest organization dedicated to improving the lives of LGBT older adults. Founded in 1978 and headquartered in New York City, SAGE is a national organization that offers supportive services and consumer resources for LGBT older adults and their caregivers, advocates for public policy changes that address the needs of LGBT older people, and provides training for aging providers and LGBT organizations.

Society for the Study of Sexuality (SSSS)

<http://www.sexscience.org>

SSSS is an international organization dedicated to the advancement of knowledge about sexuality. It is the oldest organization of professionals interested in the study of sexuality in the United States and brings together an interdisciplinary group of professionals who believe in the importance of both the production of quality research and the clinical, educational, and social applications of research related to all aspects of sexuality.

Substance Abuse and Mental Health Services Administration (SAMHSA)

LGBT Training Curricula for Behavioral Health and Primary Care Practitioners

<http://www.samhsa.gov/lgbt/curricula.aspx>

SAMHSA provides a list of six training curricula for behavioral health and primary care practitioners to help them assess, treat, and refer LGBT clients in a culturally sensitive manner. The list was compiled by SAMHSA and Health Resources and Services Administration, and is a result of a commitment made by the Department of Health and Human Services to improve LGBT health and well-being. Topics include:

1. Effective Communication Tools
2. HIV/AIDS and Substance Use Disorders in Ethnic Minority Men Who Have Sex with Men
3. National LGBT Health Education Center Continuing Education
4. Nurses Health Education About LGBT Elders Curriculum
5. A Provider's Introduction to Substance Abuse Treatment for LGBT Individuals
6. Removing the Barriers

Additional Resources:

Hsieh S, Leininger J. Clinical Care Programs for Gender-Nonconforming Children and Adolescents. *Pediatric Annals*. 2014; 43(6), 238 – 244]

This publication provides a resource list to help clinicians access the most up-to-date information on gender-nonconforming children and adolescents.

Appendix C

Suggested Additional Reading

The following is a list of articles, journals, and online resources that are recommended for readers interested in gaining a more in-depth understanding of many of the issues discussed in this publication.

LGBT Health Articles and Reports

LGBT Population Estimates

Gates G

How Many People are Gay, Lesbian, Bisexual and Transgender?

The Williams Institute, 2011

<http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/how-many-people-are-lesbian-gay-bisexual-and-transgender/>

Gates G, J Newport F

Special Report: 3.4% of U.S. Adults Identify as LGBT

Washington, DC Gallup, October 2012

<http://www.gallup.com/poll/158066/special-report-adults-identify-lgbt.aspx>

Ward BW, Dahlhamer JM, Galinsky AM, Joestl SS

Sexual Orientation and Health Among U.S. Adults

National Health Interview Survey, 2013

National Health Statistics Reports. No. 77, July 15, 2014

<http://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf>

LGBT Health Disparities

Boehmer U, Miao X, Ozonoff A

Cancer Survivorship and Sexual Orientation

Cancer, 2011; 117(16): 3796-3804

Committee on Lesbian, Gay, Bisexual, Transgender Health Issues, Research Gaps, and Opportunities; Board on the Health of Select Populations

Institute of Medicine: Washington, DC

The Health of Lesbian, Gay, Bisexual, and Transgender People:

Building a Foundation for Better Understanding, 2011

http://www.nap.edu/catalog.php?record_id=13128 (Accessed on July 18, 2014)

Gay and Lesbian Medical Association and LGBT Health Experts

San Francisco: Gay and Lesbian Medical Association

Healthy People, 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health, 2001
http://www.glma.org/_data/n_0001/resources/live/HealthyCompanionDoc3.pdf (Accessed on July 18, 2014)

Haas AP, Eliason M, Mays VM, et al

Suicide and Suicide Risk in Lesbian, Gay, Bisexual, and Transgender Populations:
Review and Recommendations

J Homosex, 2011; 58(1): 10-51

Hatzenbuehler ML, Bellatorre A, Lee Y, Finch BK, Muennig P, Fiscella K

Structural Stigma and All-Cause Mortality in Sexual Minority Populations

Soc Sci Med, February, 2014; 103: 33-41

National Women's Law Center

Health Care Refusals Harm Patients: The Threat to LGBT People and Individuals Living with HIV/AIDS, 2014
<http://www.nwlc.org/resource/health-care-refusals-harm-patients-threat-lgbt-people-and-individuals-living-hiv-aids/>

Lambda Legal

When Health Care Isn't Caring:

Lambda Legal's Survey of Discrimination Against LGBT People and People with HIV

New York: Lambda Legal, 2010

<http://www.lambdalegal.org/health-care-report> (Accessed on July 18, 2014)

LGBT Medical Education

Adelson S, Walter H, Bukstein O, et al

Practice Parameter on Gay, Lesbian or Bisexual Sexual Orientation,
Gender-Nonconformity, and Gender Discordance in Children and Adolescents

J Amer Acad Child Adolesc Psy, September, 2012; 51(9): 957-974

American Medical Student Association

New Chapter Handbook: Paint Your School Pink

<http://www.amsa.org/AMSA/Homepage/About/Committees/GenderandSexualityLGBTHandbook.aspx> (Accessed on July 25, 2014)

Dohrenwend, Anne

A Grand Challenge to Academic Medicine: Speak Out on Gay Rights

Acad Med, 2009; 84: 788-792

Grbic D, Sondheimer H

Association of American Medical Colleges: Washington, DC

Personal Well-Being Among Medical Students: Findings from an AAMC Pilot Survey, April, 2014

https://www.aamc.org/download/377520/data/april2014aib_personalwellbeingamongmedicalstudents.pdf

Hembree W, Cohen-Kettenis PT, Delemarre-van de Waal HA, et al

Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline

J Clin Endoc Metab, 2009; 94(9): 3132-3154

Metzl JM, Hansen H

Structural Competency: Theorizing a New Medical Engagement with Stigma and Inequality

Soc Sci Med, February, 2014; 103: 126-133

Obedin-Maliver J, Goldsmith ES, Stewart L, White W, Tran E, Brenman S, et al

Lesbian, Gay, Bisexual, and Transgender-Related Content in Undergraduate Medical Education

JAMA, 2011; 306(9): 971-7

<http://jama.jamanetwork.com/article.aspx?articleid=1104294>

Snowdon S

Washington, DC: GLMA: Health Professionals Advancing LGBT Equality

Recommendations for Enhancing the Climate for LGBT Students and Employees in Health Professional Schools: A GLMA White Paper, 2013

LGBT Discrimination in Medicine

Association of American Medical Colleges

Medical School Graduation Questionnaire

All Schools Report, 2013 (Revised August, 2013)

<https://www.aamc.org/download/350998/data/2013gqallschoolssummaryreport.pdf>

Burgess D, van Ryn M, Dovidio J, Saha S

Reducing Racial Bias among Health Care Providers: Lessons from Social-Cognitive Psychology

J Gen Intern Med, June, 2007; 22(6): 882-887

Croskerry P, Singhal G, Mamede S

Cognitive Debiasing 1: Origins of Bias and Theory of Debiasing

BMJ Qual Saf, October, 2013; 22 Suppl 2: ii58-ii64

Croskerry P, Singhal G, Mamede S

Cognitive Debiasing 2: Impediments to and Strategies for Change

BMJ Qual Saf, October, 2013; 22 Suppl 2: ii65-ii72

Croskerry P

From Mindless to Mindful Practice-Cognitive Bias and Clinical Decision Making
N Engl J Med, June 27, 2013; 368(26): 2445-2448

Eliason MJ, Dibble SL, Robertson PA

Lesbian, Gay, Bisexual, and Transgender (LGBT) Physicians' Experiences in the Workplace
J Homosex, 2011; 58(10): 1355-1371

Lee RS, Melhado TV, Chacko KM, White KJ, Huebschmann AG, Crane LA

The Dilemma of Disclosure: Patient Perspectives on Gay and Lesbian Providers
J Gen Intern Med, 2008; 23(2): 142-147

Merchant RC, Jongco AM 3rd, Woodward L

Disclosure of Sexual Orientation by Medical Students and Residency Applicants
Acad Med, 2005; 80(8): 786

Resilience and Protective Factors for LGBT Health and Well-Being

Kosciw JG, Palmer NA, Kull RM

Reflecting Resiliency: Openness About Sexual Orientation and/or Gender Identity
and Its Relationship to Well-Being and Educational Outcomes for LGBT Students
Am J Community Psychol, April, 2014

Meyer IH

Identity, Stress, and Resilience in Lesbians, Gay Men, and Bisexuals of Color
Couns Psychol, April, 2010; 38(3)

LGBT Health, Children and Youth

Eisenberg ME, Resnick MD

Suicidality Among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors
J Adolesc Health, 2006; 39(5): 662-668
[http://www.jahonline.org/article/S1054-139X\(06\)00171-6/pdf](http://www.jahonline.org/article/S1054-139X(06)00171-6/pdf)

Needham BL, Austin EL

Sexual Orientation, Parental Support, and Health During the Transition to Young Adulthood
J Youth Adolesc, 2010; 39(10): 1189-1198
<http://www.ncbi.nlm.nih.gov/pubmed/20383570>

Ryan C, Russell ST, Huebner D, Diaz R, Sanchez J

Family Acceptance in Adolescence and the Health of LGBT Young Adults
J Child Adolesc Psychiatr Nurs, November, 2010; 23(4): 205-213
<http://onlinelibrary.wiley.com/doi/10.1111/j.1744-6171.2010.00246.x/full>

Woodford MR, Kulick A, Sinco BR, Hong JS

Contemporary Heterosexism on Campus and Psychological Distress Among LGBT Students:
The Mediating Role of Self-Acceptance

Am J Orthopsychiatry, 2014

http://www.unboundmedicine.com/medline/citation/25110975/Contemporary_Heterosexism_on_Campus_and_Psychological_Distress_Among_LGBQ_Students:_The_Mediating_Role_of_Self_Acceptance_

LGBT Health, Adults

Carter II LW, Mollen D, Smith NG

Locus of Control, Minority Stress, and Psychological Distress Among Lesbian, Gay, and Bisexual
Individuals

J Couns Psychol, 2014; 61(1): 169

<http://www.ncbi.nlm.nih.gov/pubmed/24188657>

Luhtanen RK

Identity, Stigma Management, and Well-Being: A Comparison of Lesbians/Bisexual Women and
Gay/Bisexual Men

J Lesbian Stud, 2002; 7(1): 85-100

<http://psycnet.apa.org/psycinfo/2003-06724-006>

Moody C, Smith NG

Suicide Protective Factors Among Trans Adults

Arch Sex Behav, 2013; 42(5): 739-752

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3722435/>

Riggle ED, Rostosky SS, Horne SG

Psychological Distress, Well-Being, and Legal Recognition in Same-Sex Couple Relationships

J Fam Psychol, 2010; 24(1): 82

<http://www.ncbi.nlm.nih.gov/pubmed/20175612>

LGBT Health, Older Adults

Emlet CA, Fredriksen-Goldsen KI, Kim H-J

Risk and Protective Factors Associated with Health-Related Quality of Life
Among Older Gay and Bisexual Men Living with HIV Disease

Gerontologist, 2013; 53(6): 963-972

<http://gerontologist.oxfordjournals.org/content/53/6/963.abstract>

Grossman AH, D'Augelli AR, Hershberger SL

Social Support Networks of Lesbian, Gay, and Bisexual Adults 60 Years of Age and Older

J Gerontol B Psychol Sci Soc Sci, 2000; 55(3): 171-179

<http://psychsocgerontology.oxfordjournals.org/content/55/3/P171.short>

Journals Specializing in LGBT Health

Archives of Sexual Behavior

Gender & Development

GLQ: A Journal of Lesbian and Gay Studies

Identities

International Journal on Transgenderism

Journal of Bisexuality

Journal of GLBT Family Studies

Journal of Gay and Lesbian Mental Health

Journal of Gay and Lesbian Social Services

Journal of Gender Studies

Journal of Homosexuality

Journal of LGBT Health Research

Journal of LGBT Issues in Counseling

Journal of LGBT Youth

Journal of Lesbian Studies

Journal of Sex Research

LGBT Health

Psychology & Sexuality

Online Resources for LGBT Health and Medical Education

Educational Evaluation

Alliance for Academic Internal Medicine (AAIM)

www.im.org/toolbox/templatelibrary/Evaluation/Pages/default.aspx

Association of American Medical Colleges

www.aamc.org

Accreditation Council for Graduate Medical Education

www.acgme.org

American Board of Pediatrics

www.abp.org

American Educational Research Association

www.aera.org

Association for Academic Psychiatry

www.academicpsychiatry.org

Association for the Behavioral Sciences and Medical Education

www.absame.org/

Family Medicine Digital Library

www.fmdrl.org

Society for Teachers of Family Medicine

www.stfm.org

Public Policy, Advocacy & Law

The Williams Institute

williamsinstitute.law.ucla.edu

Community Activism and Cultural Diversity

Bay Area American Indians Two-Spirits

www.baaits.org

The American Institute of Bisexuality

www.americaninstituteofbisexuality.org

Association of Gay and Lesbian Psychiatrists

<http://www.aglp.org>

Center for Black Equity

www.centerforblackequity.org

Gay Asian Pacific Alliance

www.gapa.org

Gay Asian Pacific Support Network

www.gapsn.org

Latino LGBT History Project

www.latinoglbthistory.org

National Black Justice Coalition

www.nbjc.org

Native American LGBT/Two-Spirit educational resources, multimedia, and news

www.nativeout.com

DSD-Affected Health

Consensus Statements on DSD

Accord Alliance

Consortium on the Management of Disorders of Sex Development

Clinical Guidelines for the Management of Disorders of Sex Development in Childhood, 2006

<http://www.accordalliance.org/dsd-guidelines/>

Pediatric Endocrine Society and Society for the European Society for Pediatric Endocrinology: Lee PA, Houk CP, Ahmed SF, Hughes IA

Consensus Statement on the Management of Intersex Disorders

Pediatrics, August, 2006; 118(2): e488-e500

Swiss National Advisory Commission on Biomedical Ethics

On the Management of Differences of Sex Development:

Ethical Issues Relating to "Intersexuality," Opinion, November 20, 2012

[http://www.nek-cne.ch/fileadmin/nek-cne-dateien/Themen/Stellungnahmen/en/NEK_](http://www.nek-cne.ch/fileadmin/nek-cne-dateien/Themen/Stellungnahmen/en/NEK_Intersexualitaet_En.pdf)
[Intersexualitaet_En.pdf](http://www.nek-cne.ch/fileadmin/nek-cne-dateien/Themen/Stellungnahmen/en/NEK_Intersexualitaet_En.pdf)

Additional Reading on DSD

Accord Alliance

Handbook for Parents, 2006

<http://www.accordalliance.org/dsd-guidelines>

Chrissman HP, Warner L, Gardner M, et al

Children with Disorders of Sex Development: A Qualitative Study of Early Parental Experience

Int J Pediatr Endocrinol, 2011: 10

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3223129>

Crouch NS, Creighton SM

Transition of Care for Adolescents with Disorders of Sex Development

Nature Reviews Endocrinology, 2014; 10(7): 436-442

Kogan BA, Gardner M, Alpern AN, et al

Challenges of DSD: Diverse Perceptions Across Stakeholders

Horm Res Paediatr, 2012; 78: 40-46

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3478759>

Magritte E.

Working Together in Placing the Long Term Interests of the Child at the Heart of the DSD Evaluation
Journal of Pediatric Urology, 2012; 8(6): 571-575

Sandberg DE, Gardener M, Cohen-Kettenis PT.

Psychological Aspects of the Treatment of Patients with Disorders of Sex Development
Seminars in Reproductive Medicine, 2012; 30(5): 443-452
<http://www.ncbi.nlm.nih.gov/pubmed/23044882>

Sandberg DE, Mazur T.

A Non Categorical Approach to the Psychosocial Care of Persons with DSD and Their Families In:
Kreukels BPC, Steensma TD, de Vries ALC, eds.
*Gender Dysphoria and Disorders of Sex Development:
Progress in Care and Knowledge*, New York: Springer, 2014: 93-114

Steuli JC, Vayena E, Cavicchia-Balmer Y, Huber J.

Shaping Parents: Impact of Contrasting Professional Counseling
on Parents' Decision Making for Children with Disorders of Sex Development
Journal of Sexual Medicine, 2013; 10(8): 1953-1960

Online Resources for DSD

Accord Alliance

<http://www.accordalliance.org>

AIS-DSD Support Group

<http://www.aisdsd.org>

Hypospadias & Epispadias Association, Inc.

<http://www.aisdsd.org/>

**Educational Animations of Sex Development, Including DSD Development,
From The Hospital for Sick Children, Toronto**

<http://www.aboutkidshealth.ca/En/HowTheBodyWorks/SexDevelopmentAnOverview/Pages/default.aspx>

Appendix D

Committee Members and Other Contributors

AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development



Carey Roth Bayer, Ed.D., R.N., C.S.E.

Carey Roth Bayer earned a Bachelor of Science in nursing from Xavier University, and a master's in adult education and a doctorate in human sexuality education from Widener University. She is an American Association of Sexuality Educators, Counselors, and Therapists (AASECT) Certified Sexuality Educator and has served in numerous leadership capacities with AASECT, the Society for the Scientific Study of Sexuality (SSSS), and the AAMC. Dr. Bayer serves on the Editorial Board of *Sexuality Research and Social Policy*, and reviews submissions for the *Journal of Sex Research*, *Journal of Healthcare for the Poor and Underserved*, and *Journal of Gay and Lesbian Mental Health*.

Dr. Bayer was named an Emerging Professional in the field of Sexology in 2007 by SSSS and received the AASECT 2009 Professional Standard of Excellence Award for her leadership in developing and running the Center of Excellence for Sexual Health Scholars' Program at Morehouse School of Medicine. She was also recognized as a 2009 Woman of Inspiration by the WNBA's Atlanta Dream.

Dr. Bayer teaches medical students, residents, postdoctoral fellows, public health students, and community students. She serves as the faculty advisor for the MSM Alliance, a student group focusing on cultural competency related to gender identity, gender expression, and sexual orientation. Her scholarship focuses on training health professionals to address human sexuality with patients across the lifespan. She is a faculty member at Morehouse School of Medicine and Widener University.



Alice Dreger, Ph.D.

Alice Dreger is professor of clinical medical humanities and bioethics at Northwestern University's Feinberg School of Medicine in Chicago. She is an historian of medicine and a patient advocate, with a Ph.D. in history and philosophy of science from Indiana University. Much of Dr. Dreger's work has focused on the social and medical treatment of people born with bodies that challenge social norms, particularly people born with sex development different from the standard male or female types. Her authored books include *Hermaphrodites and the Medical Invention of Sex* (1998) and *One of Us: Conjoined Twins and the Future of Normal* (2004), both with Harvard University Press. Her edited books include *Intersex in the Age of Ethics* (University Publishing Group, 1999) as well as a pair of guidebooks on the pediatric management of disorders of sex development (DSD) published in 2006 and now available for free through the website of Accord Alliance. Those guidebooks, *Clinical Guidelines* and *Handbook for Parents*, represent the first and still only consensus of all the major stakeholder groups in DSD.

Dr. Dreger served as chair of the board of directors and/or director of medical education of the Intersex Society of North America (ISNA), the predecessor organization to Accord Alliance, and continues to promote improved care for these families, often delivering grand rounds on the subject. In 2011, Dr. Dreger led a team examining how the Feinberg School of Medicine could increase and improve the teaching of LGBT patient care and of human sexuality. The resulting white paper, coauthored with Jerry Chen and Sarah Rodriguez, provides a model for how medical schools can scrutinize and improve local medical education around these issues.

In addition to conducting academic research, Dr. Dreger writes for many mainstream publications about health, medicine, and science. Her most recent book (Penguin Press, 2014) is *Galileo's Middle Finger: Heretics, Activists, and the Search for Justice in Science*.



Kristen L. Eckstrand, Ph.D. (Chair)

Kristen L. Eckstrand holds her Ph.D. in neuroscience from Vanderbilt University, and is currently completing the final year of her medical degree at the Vanderbilt University School of Medicine through the Vanderbilt Medical Scientist Training Program. She is pursuing further training in Child and Adolescent Psychiatry.

Throughout her career, Dr. Eckstrand has advocated for the needs of LGBT individuals. Dr. Eckstrand has been working on LGBT medical education since 2008, when she initiated curriculum reform at Vanderbilt. This project led to the foundation of the Vanderbilt Program for LGBTI Health in 2012, the second program in the country housed within an academic medical center to address the needs of LGBTI patients, trainees, staff, and faculty. As co-director of the Vanderbilt Program for LGBTI Health, Dr. Eckstrand continues her efforts in medical education and oversees medical center-wide LGBTI quality improvement efforts through Vanderbilt's LGBTI Leadership Committee and Cultural/Linguistics Council. Dr. Eckstrand has published on these efforts in AAMC's MedEdPORTAL and other journals, and has recently edited the book *Lesbian, Gay, Bisexual, and Transgender Patient Health: A Clinical Guide to Preventative, Primary, and Specialist Care*, to be published by Springer in early 2015.

In addition to chairing the AAMC Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development, Dr. Eckstrand serves as Vice President of Education for the board of directors of GLMA: Health Professionals Advancing LGBT Equality and as a member of the American Medical Association's LGBT Advisory Committee. Dr. Eckstrand has been recognized for her commitment to diversity by the 2011 Vanderbilt Levi Watkins Jr. Award, the 2013 American Medical Association's Foundation in Excellence Leadership Award, and the 2013 AMSA/GLMA Health Achievement Award for leadership in LGBT health.



Andrew D. Hollenbach, Ph.D.

Andrew D. Hollenbach completed his Ph.D. in biochemistry at Johns Hopkins University in 1994 and conducted his postdoctoral training in the Department of Genetics at St. Jude Children's Research Hospital. He is on the faculty of the Department of Genetics at Louisiana State University Health Sciences Center (LSUHSC) in New Orleans, where his research focuses on understanding the biological mechanisms by which genetic alterations lead to the development of a childhood solid muscle tumor. He also researches the contributions chronic alcohol consumption makes to muscle wasting.

At LSUHSC, Dr. Hollenbach is the course director for two of the five core first-year graduate school courses and the course director for an upper-level graduate course in cancer genetics. He also teaches medical students in several different capacities and sits on the School of Graduate Studies Curriculum Committee and the School of Medicine Curriculum Renewal Committee. He has served as the primary mentor for multiple doctoral students in his lab and throughout the School of Medicine, has trained postdoctoral researchers, and serves as senior mentor for multiple junior faculty members at the School of Medicine and nearby Xavier University. Dr. Hollenbach serves on both the School of Medicine and the School of Graduate Studies Committees on Multiculturalism and Diversity and was key in assisting students at LSUHSC in forming the student-run organization LGBT+Ally Organization for Cultural Understanding in the Health Sciences (LOCUS). He presently serves as LOCUS's primary faculty advisor.

Dr. Hollenbach was recognized for his teaching and other contributions to LSUHSC by being awarded the Alumni Association Award for teaching in 2012. He is author of *A Practical Guide to Writing a Ruth L. Kirschstein NRSA Grant* (Academic Press) and is a regular contributing author to *ASBMB Today*, the monthly news magazine for the American Society of Biochemistry and Molecular Biology.



Brian Hurley, M.D., M.B.A.

Brian Hurley is currently a Veterans Administration National Quality Scholar affiliated with the University of California, Los Angeles at the VA Greater Los Angeles Healthcare System, and will be a 2015-2017 Robert Wood Johnson Foundation Clinical Scholar at the University of California, Los Angeles. He completed a fellowship program in addiction psychiatry at New York University School of Medicine after residency training at the Massachusetts General Hospital and McLean Hospital (MGH-McLean), where he was Chief Resident in Addiction Psychiatry, a resident co-representative on the board of MGH's LGBT Employee Resource Group, and the resident representative to the Massachusetts Medical Society's Committee on LGBT matters.

Dr. Hurley graduated from the University of Southern California's Keck School of Medicine and Marshall School of Business with combined M.D./M.B.A. degrees. Prior to matriculating at MGH-McLean, Dr. Hurley served as the national president of the American Medical Student Association (AMSA). He currently serves as the Gay and Lesbian Medical Association (GLMA's) delegate to the American Medical Association's (AMA's) House of Delegates, and he is also serving a 2012-2016 term as GLMA's representative to the LGBT Advisory Committee to the AMA Board of Trustees.

Dr. Hurley previously served as resident and trainee representative on GLMA's board and co-chair of GLMA's student and trainee committee. He was instrumental in initiating and co-planning GLMA's 2012 student and trainee focused post-conference summit. He has served on the board of trustees of the American Psychiatric Association (APA) as the representative for APA's Public Psychiatry Fellowship. Additionally he was awarded the 2012 American College of Psychiatrists' Laughlin Fellowship.

Dr. Hurley currently serves as co-chair of the membership committee for the American Society of Addiction Medicine (ASAM), and serves in an ex-officio capacity on ASAM's board of directors. He previously served as the CME chair for the Massachusetts Society of Addiction Medicine (MASAM), and as co-chair of the Massachusetts Psychiatric Society's Committee on Alcoholism and the Addictions. Dr. Hurley has dedicated his career to demonstrating the transformative impact addiction medicine can have when integrated throughout health care.



Scott Leibowitz, M.D.

Scott Leibowitz is a child and adolescent psychiatrist at Ann & Robert H. Lurie Children's Hospital of Chicago in the Gender and Sex Development Program, which provides multidisciplinary services to gender-nonconforming and transgender youth across the developmental spectrum. He also serves on faculty at the Northwestern University Feinberg School of Medicine, where he is a member of their LGBT education taskforce.

Dr. Leibowitz completed his child and adolescent psychiatry training at Boston Children's Hospital/Harvard Medical School in 2010, where he served on faculty until 2013 working to develop a psychosocial consultative clinic for LGBT youth in conjunction with other medical services in the hospital. He is the co-chair of the American Academy of Child and Adolescent Psychiatry's (AACAP) Sexual Orientation and Gender Identity Issues Committee (SOGIIC) and is a member of the World Professional Association for Transgender Health (WPATH). Dr. Leibowitz also serves on the faculty of the National LGBT Health Education Center for The Fenway Institute.

Originally from Long Island, Dr. Leibowitz completed his undergraduate studies at Cornell University before pursuing his medical degree in Tel Aviv, Israel, at the Sackler School of Medicine/New York State American program. He completed his general psychiatry residency training at the Albert Einstein College of Medicine program at Long Island Jewish Medical Center in Queens, New York, where he served as chief resident before moving to Boston in 2008 for his child psychiatry training.



Jennifer Potter, M.D.

An associate professor of medicine at Harvard Medical School (HMS) and director of women's health programs at two HMS teaching affiliates, Jennifer Potter has more than 24 years of experience caring for members of the LGBT community and is widely recognized as a leader in curriculum development to enhance care for underserved women, sexual and gender minorities, people with disabilities, and cancer survivors. She is also deeply committed to supporting the next generation of medical trainees to lead curricular inclusion and institutional climate change efforts.

Dr. Potter's national collaborations include the Women's Health Care Competencies for Medical Students Task Force of the Association of Professors of Gynecology and Obstetrics (APGO), the Committee to Advance the Health of Minority Women of the Harvard Center of Excellence in Women's Health, and the Women with Disabilities Education Project. She is involved in curriculum development for an innovative HIV-LGBT Primary Care Track for the residency program at Beth Israel Deaconess Medical Center and Fenway Health. She is looking forward to working collectively to enhance institutional climate as a member of a newly formed LGBT Advisory Committee at Harvard Medical School. Dr. Potter was recently named associate editor for AAMC's MedEdPORTAL LGBT collection.

Dr. Potter is the champion of numerous ongoing clinical quality improvement initiatives, many of which include representative numbers of sexual and gender minority individuals. Examples include efforts to 1) optimize conception rates among sexual minority women presenting for alternative insemination, and 2) increase overall clinic rates of HPV vaccination; prescription of long-acting, reversible contraception; and screening for inter-partner violence, chlamydia infection, and cervical and breast cancer.

Dr. Potter has written about her own experiences as a lesbian physician and patient, as well as about her research on disparities in cervical cancer screening among patients on the FtM spectrum and the impact of sexual orientation on the experience of cancer survivorship. Dr. Potter is also a co-editor of the *Fenway Guide to LGBT Health*, a seminal textbook for health professions trainees. She has received numerous awards, including the 2008 Susan Love Award for her contributions to advancing women's health and the 2009 Harold Amos Award for advancing diversity at HMS.



Jason M. Satterfield, Ph.D.

Jason M. Satterfield is professor of clinical medicine, director of social and behavioral sciences, and director of behavioral medicine in the Division of General Internal Medicine at the University of California, San Francisco. He received his Ph.D. in clinical psychology from the University of Pennsylvania, where he worked with Dr. Martin Seligman and Dr. Aaron T. Beck on cognitive models of bias, risk taking, depression, and aggression. Dr. Satterfield's work has included adaptations to cognitive-behavioral therapy (CBT) groups for LGBTI and other underserved, medically ill populations and CBT interventions for patients at the "beginning of the end" of life.

Dr. Satterfield's current interests include the integration of behavioral science into medical education, dissemination and implementation of evidence-based behavioral practices, and educational strategies to address health care disparities. His current projects include integrated behavioral health models for primary care, screening and brief interventions for substance abuse, and the integration of social and behavioral sciences into medical school and residency curricula. He is currently a member of the NIH Social and Behavioral Sciences Curriculum Consortium and the NIH Evidence-Based Practice Training Council. He co-authored the AAMC Behavioral Science report and serves on the behavioral science subcommittee for MCAT® exam revisions. He divides his time evenly between ongoing patient care, teaching, and clinical research.



Andrés F. Sciolla, M.D.

After obtaining his medical degree and postgraduate training in psychiatry from the University of Chile, Dr. Andrés F. Sciolla pursued postdoctoral research experience at the University of California, San Diego Human Circadian Pacemaker Laboratory, the HIV Neurobehavioral Research Center, and the Geriatric Psychiatry Clinical Research Center. He conducted studies and published in the areas of HIV-associated sleep disorder, psychiatric morbidity among populations at risk for HIV, and health-related quality of life among older patients with psychosis.

Subsequently Dr. Sciolla completed residency training at UCSD and joined its faculty. At UCSD, he established himself as an excellent clinician educator at the undergraduate and postgraduate levels. In the former, he became course director for Clinical Foundations and in the latter, associate residency training director. Dr. Sciolla has received multiple departmental, institutional, and national teaching awards and recognitions, such as the Irma Bland Award for Excellence in Teaching Residents of the American Psychiatric Association and the Junior Faculty Fellowship of Association for Academic Psychiatry.

In 2012, Dr. Sciolla moved to the University of California, Davis and became an Instructor of Record for Doctoring 2 and medical director at a community mental health clinic. At UC Davis Dr. Sciolla quickly became a champion of diversity and inclusion issues, joining the Task Force for the Inclusion of Sexual Orientation and Gender Identity in the Electronic Health Record at the UC Davis Health Systems and the Dean's Lesbian, Gay, Bisexual, Transgender, Queer and Intersex Advisory Council.

Dr. Sciolla's current interests focus on the provision of culturally responsive and integrative mental health care to socioeconomically disadvantaged groups, including ethnic and sexual minorities, and the behavioral and neurobiological outcomes of adult survivors of childhood trauma, with an emphasis on Latino men who have sex with men.

Associate Editors



Emily Paulsen

Emily Paulsen is a writer and editor focusing on health and health care topics. Her special interests are patient education, health information technology, health disparities, complementary medicine, and improving the health care experience for patients and professionals alike. She has experience developing books, articles, fact sheets, toolkits, case studies, research summaries, and continuing medical education (CME) materials. Her clients include publishing companies, health organizations, nonprofit associations, and government agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, National Geographic Books, and Duke Medicine.

In addition to her experience as a freelance writer and editor, Emily served as public relations manager of a progressive rural health system in Northeastern Pennsylvania and as editor of several trade magazines for healthcare professionals.

Emily currently lives outside Washington DC and is a member of the National Association of Science Writers, Association of Health Care Journalists, and the American Society of Journalists and Authors. She is co-chair of the DC-area chapter of ASJA.



Darcy Lewis

Chicago-based writer and editor Darcy Lewis specializes in health, medicine, and health care. A medium- and long-form specialist, she writes and edits reports, case studies, white papers, annual reports, articles, books, and other documents. Her coverage areas include cardiovascular health, women's health, cardiology, gastroenterology, endocrinology, dermatology, plastic surgery, bariatrics, orthopedics, neurology, neurosurgery, urology, public health, practice management, behavioral change in primary care, alternative care delivery models, careers in medicine and more.

Darcy has worked for leading organizations including the American Heart Association, the American Gastroenterological Association, the American National Standards Institute, the National Safety Council, NORC at the University of Chicago, numerous leading health systems, and several government agencies. A member of the Association of Health Care Journalists, her health- and medicine-related articles have been published in leading websites, newspapers, and magazines for consumers and members of the medical profession. She also serves on the board of the Chicago chapter of a national association for trade magazine writers and editors.



Tiffani St.Cloud, C.P.C.

Tiffani St.Cloud joined the AAMC in 2005 as the program assistant for the Section on Student, Institutional, and Faculty Services and Studies. She managed the Human Subjects Research Protection Program and served as the chief project manager for teams focused on improving the quality of AAMC's data services. In 2007 she became the staff specialist for data resources and studies and her portfolio expanded to include the review of all AAMC surveys and research proposals.

In 2009 she transitioned to the Office of the President as a program management specialist. During her tenure, she planned governance and leadership meetings for the board of directors, Medical Center Leaders Caucus, and managed the office's research portfolio. In 2010, she became the senior program management specialist for the Office of the President and became a lead on the management of the AAMC Constituent Orientation program and annual AAMC Capitol Hill Advocacy reception.

In 2011 she became the lead program management specialist for diversity policy and programs. In her current role, she is responsible for the management of the annual Diversity and Inclusion Innovation Forum, the AAMC Healthcare Executive Diversity and Inclusion Certificate program, the Diversity 3.0 Learning Series, and serves as the project manager for the AAMC Sexual Orientation, Gender Identity, and Sex Development Project. Tiffani holds a B.A. in sociology from Smith College, is a certified life coach, and holds diplomas in Spanish Language and Culture and Italian Language and Culture from the Universidad de Alicante and the Università per Stranieri di Perugia.

Additional Contributors



Emily Cahill, M.P.H.

Emily Cahill is the lead specialist for implementation research and policy at the AAMC. In this role, Emily is responsible for enhancing collaboration among researchers and their health systems as they aim to approve the health of their patients and community. Emily supports the Research on Care Community, a group of academic medicine leaders and their teams who are committed to the use of research to enhance health equity, quality, safety and the implementation of best practices to improve health care. Previously, Emily served as Director and Managing Editor for MedEdPORTAL, a cross-indexed suite of services provided by the AAMC. Through *Publications*, *iCollaborative* and the *CE Directory*, MedEdPORTAL equips health care professionals across the continuum with effective and efficient educational tools to improve patient care. Prior to joining the AAMC in 2008, Emily received her B.S. in Biology from Villanova University and her M.P.H. degree in health care management and policy from Drexel University.



Sara Hunt Sullivan

Sara Hunt Sullivan is the managing editor of MedEdPORTAL Publications, a free publication venue where educators across the health professions may publish and share works of high quality educational scholarship. Sara joined the MedEdPORTAL team in 2010 as a quality control specialist and most recently served as lead staff editor. Prior to joining MedEdPORTAL, Sara worked at Georgetown University School of Medicine on curricular reform.

Sara received her undergraduate degree in philosophy and ethics from Trinity University in Washington, DC, and is working towards a masters in liberal studies and ethics from Georgetown University. She is a member of the American Society for Bioethics and Humanities and the American Society of Law, Medicine, and Ethics.

Sara currently resides in Dallas, Texas with her husband, Brandon, and two young daughters, Noa and Rowan.



Mitchell (Mitch) R. Lunn, M.D.

Mitch is a long-standing advocate for the lesbian, gay, bisexual, and transgender (LGBT) communities and their inclusion in higher education settings. As a college student, he played integral roles in the Safe Colleges Conference, the largest LGBT collegiate conference in New England with a focus on creating diverse, welcoming, and safe environments for LGBT college students. As a medical student, Mitch and his colleagues founded the LGBT Medical Education Research Group at Stanford University School of Medicine. Their seminal study on LGBT health-related content in medical school curricula has influenced individual institutions and national organizations to examine their policies, procedures, educational environments, and curricular content to improve the culture of academic medicine for LGBT people.

Dr. Lunn is currently a clinical research fellow in the Division of Nephrology in the Department of Medicine at the University of California, San Francisco where he is also co-principal investigator of The PRIDE (Population Research in Identity and Demographics for Equality) Study. As the first longitudinal cohort study for sexual and gender minority adults in the United States, The PRIDE Study aims to uncover unique health disparities and to identify the factors that positively and negatively influence the health and well-being of these populations. At UCSF, he also serves on the UCSF Subcommittee on LGBT Issues in the Curriculum. Dr. Lunn has been honored with several awards during his residency and fellowship recognizing his teaching and mentorship abilities.

Originally from Bismarck, North Dakota, Dr. Lunn earned his Bachelor of Science degree in biology and French from Tufts University in 2004 before moving to Stanford University School of Medicine, where he earned his Doctor of Medicine degree with a concentration in the molecular basis of medicine in 2010. He completed internal medicine residency training at Brigham and Women's Hospital in Boston in 2013 and is a Diplomate of the American Board of Internal Medicine.



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