



**The Place of Human Sexuality and LGBT Issues
in the Feinberg School of Medicine Curriculum**

**Analysis and Recommendations
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Executive Summary

We provide here a preliminary analysis of the Feinberg School of Medicine (FSM) curriculum with regard to the teaching and learning of issues of human sexuality, sex, and gender. We pay special attention to the healthcare needs of lesbian, gay, bisexual, and transgender (LGBT) individuals because LGBT patients have historically suffered and still suffer relatively high levels of discrimination, inattention, and neglect within US healthcare systems.

As noted in the 2011 Institute of Medicine report on *The Health of Lesbian, Gay, Bisexual, and Transgender People*, “Contemporary health disparities based on sexual orientation and gender identity are rooted in and reflect the historical stigmatization of LGBT people” (IoM 2011, 32). Working to address these health disparities is in keeping with many of the values of FSM – including especially the provision of patient-centered care – and also acknowledges to the FSM community the critical role to be played by medical professionals in achieving social justice for LGBT people.

In this project, in addition to learning from the published literature, we have directly engaged consultants from the medical schools of UCSF, Vanderbilt University, Stanford University, and Brown University. We have also benefited from innumerable conversations with FSM administrators, faculty, and staff, and from having an FSM student (Jerry Chen) as a key member of our team. We have especially benefited from an extremely supportive environment for this work. Members of FSM with whom we have consulted have universally been eager to work with us on analysis and improvement.

Whereas at other institutions, medical school curricular changes in LGBT issues have often been initiated by students – that is, change has been led from bottom-up – FSM’s initiative in this area originates from its administration, particularly the office of Raymond Curry, MD, vice dean for education. Thus, FSM enjoys the substantial advantage of having an administration and key group of teaching faculty already attitudinally committed to the importance of improving education in these areas. The curriculum renewal with which FSM is currently engaged has clearly contributed to the vibrant, can-do attitude with regard to improving our educational efforts around human sexuality and LGBT patient care.

Section 1 of this paper discusses the scope, rationale, methods, and limitations of this project. Section 2 includes a brief review of the literature in this area and reports on some innovative steps other medical schools are taking.

In Section 3, we detail the following relevant institutional features already in place at FSM:

- FSM Office of Diversity (which includes many LGBT efforts in its scope, as detailed below);
- Safe Space Training;
- Queers and Allies (Q&A), a recognized medical student group;
- the Out Network, a campus- and affiliate-wide networking group for LGBT-identified individuals and allies;

- Northwestern Memorial Hospital’s recent achievement of listing in the Human Rights Campaign Healthcare Equality Index, indicating commitment to “promoting equitable and inclusive care for LGBT patients and their families”;
- domestic partner benefits as provided by Northwestern University and (for residents and fellows) the McGaw Medical Center of Northwestern University.

As also noted in section 3, our inquiries indicate that the following curricular facets are already in place at FSM, or will be effected this academic year:

- Orientation included discussion of the essay “On Being Gay in Medicine,” by Mark Schuster and a discussion of the standard media view of physicians as heterosexual;
- Clinical Medicine (M1) will include an expanded sexual-history taking unit, including how to take a sexual history from LGBT patients;
- The Health and Society course will include a component that sends students into Chicago neighborhoods (including the LGBT-heavy areas of Lakeview and Andersonville) and will include specific instructions to students to consider health data on LGBT community subgroups;
- standardized patients will include actors who present as gay or lesbian;
- Reproductive Medicine (starts December 2013) will likely have significant LGBT content;
- the new Areas of Scholarly Concentration program will include an AoSC in human sexuality.

In section 4 of our report, we make the following recommendations, which we divide into the categories of “curricular and extracurricular” and “structural”:

Curricular and extracurricular:

- add more LGBT content to various components of orientation week;
- further develop a dedicated unit within clinical skills on LGBT issues;
- teach basic vocabulary important to understanding LGBT issues;
- teach differences and risks within LGBT populations;
- present an interactive discussion with a panel of LGBT patients early in students’ education;
- provide students structured opportunities to talk with knowledgeable providers about LGBT issues;
- institute an explicitly LGBT-inclusive approach to sexual history-taking;
- institutionalize inclusion of simulated/standardized LGBT patients;

- include LGBT “patients” in problem-based learning (PBL) cases;
- create a faculty-driven elective in LGBT health;
- connect content/improvements specifically to the FSM core competencies;
- support the Area of Scholarly Concentration in Human Sexuality;
- focus attention to LGBT populations within the Health and Society course;
- connect to Sex Week, preferably with a presentation on transgender healthcare issues.

Structural:

- designate a staff or faculty member as a diversity-allies coordinator to work with LGBT community member helpers (e.g., people willing to be panelists);
- conduct a focused inventory of sex, sexuality, gender, and LGBT health issues in the renewed preclinical and clinical curricula (e.g., using eMERG);
- identify curricular champion(s) to push these efforts;
- create and encourage use of a mechanism for reporting hostile climate;
- provide for faculty development in LGBT health and human sexuality issues;
- develop a shorter Safe Space Training for FSM students, faculty, and staff; encourage all to take the training and require it of all leaders of curricular activities (including, e.g., clerkship and course directors and all education deans’ office personnel);
- conduct surveys to obtain clearer baseline readings on climate around LGBT issues;
- expand our welcoming climate through substantial support of the Out Network and Q&A;
- encourage student leaders (or would-be leaders) to participate in this curricular and structural reform, including by convening a focus group of present and past FSM students to discuss these issues and to provide their insights;
- designate a staff or faculty “point person” to oversee follow-up of this white paper’s recommendations and translation into a clear action plan.

In section 5, we recommend these additional/longer-term ideas for follow-up:

Curricular:

- Watch for related reports forthcoming from the GLMA and AAMC and review the recommendations made therein.
- Consider expansion of this work into GME and CME.

- Develop targeted assessments of curricular changes and faculty development in order to ascertain effectiveness of interventions.
- Re-analyze whether we have a clear curricular thread in human sexuality.
- Develop curricular components to address DSD and the needs of children and adolescents who present as gender variant.
- Engage in a dedicated discussion about the place of LGBT social justice issues in the FSM curriculum.

Structural:

- Conduct an institutional self-assessment for LGBT concerns in medical education as described in the “Tool for Institutional Self-Assessment.”
- Conduct a review of clinical policies, forms, and materials to ensure they demonstrate cultural competence in LGBT health issues.
- Watch for/review AAMC-developed materials on climate and assessment of medical schools regarding LGBT and diversity issues.
- Develop and deploy targeted assessments with regard to climate around LGBT issues at FSM and our associate institutions (i.e., hospitals and clinics).
- Encourage development of presentations and publications to share FSM experiences, learning, and insights with colleagues.

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Section 1: Introduction

Scope and limitations:

This report chiefly provides a preliminary analysis of the teaching of issues of LGBT health, and of human sex, gender, and sexuality, in the FSM curriculum. Although it certainly is worth examining all aspects of learning around all forms of human sex, gender, and sexuality – including as they relate to the special healthcare needs of patients with many diverse identities – here we pay particular attention to undergraduate medical student learning around adult and adolescent LGBT health issues. We focus on these areas for two pragmatic reasons: (1) LGBT patients are particularly vulnerable in society and in healthcare systems (see, e.g., IoM 2011; Lambda 2010); and (2) there is a growing literature on LGBT health and healthcare education available to us.

As we have worked on this project, we have been very aware of the challenges of appropriately framing this work so that we adequately recognize the differences and tensions between the two major categories implicated by this work: “human sexuality” and “LGBT health.” Although some medical education experts working in these areas have tried to “solve” these tensions by subsuming these (quite different) categories under some singular term such as “sexual health,” we have explicitly worked to *avoid* that collapse or conflation.

This is because the work of our Northwestern sociology colleague Steve Epstein has made us particularly sensitive to the problem of subsuming many different healthcare concerns under the phrase “sexual health.” Pitfalls of the “sexual health” trope include: imparting to students overly simplistic notions of sexuality that limit thinking to problematic dichotomies of function and dysfunction; counting up many teaching hours ostensibly dedicated to issues of “sexual health” education without noticing what is missing from those educational hours; and assuming that all special healthcare needs of LGBT people consist of sexual issues.

Shane Snowdon, Director of Health and Aging at Human Rights Campaign, encouraged us in her review of our draft report to highlight this last point; many of the healthcare challenges faced by LGBT people – including, for example, the stress that results from social discrimination – are not really “sexual” in nature. (See, for example, the concerns of the AAP with regard to the stress experienced among children of same-sex parents whose legal status is tenuous; Pawelski et al. 2006.) Truly caring for LGBT people means understanding how their identity-based healthcare needs are about more than their sexual orientations and/or gender identities per se. Indeed, *all* patients can benefit from our producing new physicians who are capable of nuanced considerations of the roles sex anatomy, sexual orientation, and gender identity – and cultural assumptions about them – play in all patients’ health and lives.

With this in mind, we seek in this report to answer three specific questions:

1. How are other institutions, including national organizations and other medical schools, advancing in these areas, and what have they learned? (We answer this primarily in Section 2.)
2. What presently exists in the FSM curriculum with regard to these issues? (We answer this in Section 3.)

3. How could FSM's educational efforts in these areas be improved? (We answer this in Sections 4 and 5.)

Recognizing that climate affects educational efforts and vice versa – and that both affect what we really care about, i.e., patient care – we have attempted in this report, where appropriate, to make suggestions about improving climate for LGBT members of our community, including students, staff, faculty, and patients.

When we began this project, we had also hoped to address FSM education around disorders of sex development (i.e., congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical) and gender nonconformity in children. We found, however, that this resulted in too many moving parts for this four-month project, particularly as our administration and faculty have been working intensively on our curriculum renewal. In sections 4 and 5, we include recommendations to attend to these issues sometime in the near future.

Rationale:

A national movement is now underway to improve patient care for people who are lesbian, gay, bisexual, and/or transgender (LGBT), for individuals who were born with disorders of sex development (DSD), and for children and young adults who are gender nonconforming. While some patients in these categories have received excellent and supportive care from healthcare professionals, historically many patients in these groups have suffered discrimination, marginalization, and sometimes even outright harm within American healthcare institutions. Success of the movement to improve care for these populations depends in large part on improved medical education. As elaborated below, experts in these areas believe that improved education in these areas can also contribute to general improvement of climate not only for LGBT patients, but also LGBT providers, faculty, staff, and students. Many also reasonably believe that educational innovations in this area require a welcoming climate (AAMC 2007; Coker, Austin, and Schuster 2009; IoM 2011; Joint Commission 2011; Lambda 2010).

This document seeks to specify what we can do locally, and in doing so also suggests what we might provide in terms of a national model. The intended audience of this paper includes FSM's administration, faculty, staff, and students, although we have intentionally constructed this document so that it may be shared with other medical schools also seeking to improve in these areas.

Methods:

This project has been undertaken under the auspices of a grant from the Northwestern University Office of the Provost, entitled *Expanding the Understanding of Human Sexual Orientation in Science and Medicine*, P.I. Alice Dreger, PhD, Professor of Clinical Medical Humanities and Bioethics in FSM. Dr. Dreger led the project and drew in part on her work with the Association of American Medical Colleges' (AAMC's) new LGBTI Patient Care Task Force. Jerry Chen, FSM (class of 2015) conducted the bulk of the primary research and was funded by the grant via the Medical Student Summer Research Program (MSSRP). Mr. Chen's research included direct consulting with FSM

administrators, faculty, staff, and students, as well as with LGBT curriculum leaders from the medical schools of Brown University, UCSF, Stanford University, and Vanderbilt University. Sarah Rodriguez, PhD, also of the Medical Humanities and Bioethics Program, functioned as research project coordinator and co-author. Mr. Chen and Dr. Rodriguez conducted an extensive literature review, taking into account medical journal articles, publications by national organizations like the Human Rights Campaign and the Institute of Medicine, government reports, the AAMC's MedEdPortal, and substantial unpublished curriculum materials obtained via our consultants. Numerous generous individuals reviewed a draft of this paper.

Summary of findings:

Whereas many medical school curricular changes in LGBT issues have been initiated by students – that is, change has been led from bottom-up – FSM's initiative in this area originates from its administration, particularly the office of Raymond Curry, MD, vice dean for education. Indeed, FSM enjoys the substantial advantage of having an administration and faculty already attitudinally committed to the importance of improving education in these areas. FSM administrators and faculty with whom we consulted on our project unanimously expressed enthusiasm. This pervasive positive attitude should make improvement significantly less difficult and significantly faster than would be the case at some institutions. We hope that, as a result of this project, FSM students will come to see for themselves an active role in effecting improvements, and we hope that the administration and faculty will find ways to specifically engage student leaders (or would-be leaders) in these efforts.

To date, FSM's curricular treatment of these issues appears to have been relatively light and somewhat irregular. That said, our conversations with FSM staff and faculty about this project have led to many productive plans for improvements in this area in the renewed curriculum. In this sense, this project seems to have been perfectly timed, if perfectly timed by accident. When we began this work, we had much less to list in section 3 (“what currently exists at FSM”) than we now do. Section 4 of this paper provides our further specific recommendations. We believe some of these changes are already in the works, but we wanted to record them as recommendations so that we can keep track of progress. Section 5 suggests possible opportunities for follow-up of this project in terms of further research and assessment. Section 6 provides full references to works cited, and Section 7 includes as appendices documents that we believe will be very useful in these ongoing efforts.

Section 2: Literature Review

Unique and Specific Health Concerns for LGBT Populations:

LGBT individuals constitute a diverse group with varied backgrounds, attitudes, experiences, and behaviors but are nonetheless united in their mistreatment, including mistreatment as a patient population. As outlined in the recent Institute of Medicine (IoM) report, the people who make up the LGBT population have very diverse healthcare needs throughout their life course. This report found that, during childhood/adolescence, LGBT youth experienced elevated levels of violence and harassment and comprise a disproportionate number of homeless youth. LGBT youth are also at increased risk for suicide attempts and depression as well as elevated HIV rates particularly among young men who have sex with men. Furthermore, during early/middle adulthood, LGBT adults are more at risk for mood and anxiety disorders compared to heterosexual adults, and they suffer from higher rates of smoking, alcohol use, and substance abuse. Lesbian and bisexual women are more at risk for obesity and breast cancer. Further, LGBT elderly face unique chronic disease concerns. The IoM report strongly advocates additional research in regard to LGBT health at various stages of life in order to better understand the needs of the extremely diverse LGBT community (IoM 2011; see also Kaiser Permanente 2004; Joint Commission 2011; GLMA 2001).

Climate, Social Stigma, Discrimination, and Health:

As outlined in the IoM report, the historical effects of stigma, discrimination, bias, and other factors that function as barriers to care have contributed significantly to LGBT health disparities. From the inclusion of homosexuality in the *Diagnostic and Statistical Manual* as a “mental disorder” until 1973, to current day laws prohibiting marriage between same-sex couples in the majority of states and federally, the LGBT community has both historically been, and continues to be, mistreated in ways that impact the population’s health and well-being.

In a recent national survey by Lambda Legal of LGBT and HIV-affected individuals, almost 56 percent of LGB and 70 percent of transgender respondents reported having experienced some form of discrimination in their healthcare. Furthermore, 8 percent of HIV-infected LGBT individuals reported being denied care outright and over 12 percent of LGB respondents reported being blamed for their health status (Lambda Legal 2010). The 2010 National Transgender Discrimination Survey’s results further illustrate the barriers to care for transgender patients, including: 19% have experienced refusal of care; 28% have experienced harassment in medical settings; and 50% reported having to teach their medical providers about transgender care (Grant, Mottet, and Tanis 2010).

Fears of poor or mis-treatment for being an out patient may exist even for other physicians; Harvey Makadon, MD, in a 2006 essay for the *New England Journal of Medicine* described how, at age 40, he decided to inform his new physician that he was gay, only to be “disappointed by the lack of discussion following my emotionally difficult statement about my sexual orientation.” Makadon was disappointed, but also not surprised, at the failure of his physician to ask follow-up questions, writing that “otherwise knowledgeable providers are often uninformed about basic issues that are essential to providing high-quality care to this [the LGBT] population” (Makadon, 2006, p. 895).

Given these experiences, it comes as no great surprise that many LGBT respondents reported a high degree of anticipation that they would face further discriminatory care in subsequent healthcare visits, thus creating an unfortunate scenario where people in desperate need of health care are afraid to seek it out (Grant, Mottet, and Tanis 2010). Indeed, LGBT individuals are more likely to delay/avoid care due to fear of harassment and discrimination (Fenway n.d.; IoM 2011)

Such bias and discrimination within a health care setting does not only affect LGBT people when they are patients. A recent survey by the AAMC found instances of discrimination and mistreatment of LGBT individuals in medical schools. According to a survey conducted during the 2005-2006 academic year, approximately 15% of respondents reported knowing about mistreatment of an LGBT student during the preceding academic year. Moreover, many LGBT students in medical school wait till they finish medical school before they come out (Wynn 2010). In a June 2010 article for *The New Physician*, “Waiting to Come Out,” then-2nd year student FSM student Brian Holoyda was quoted as saying: “There are some students who are out to themselves, but I’m the only student in the second-year class who is out to fellow classmates, professors and patients.” And a former FSM medical student, who spoke on the condition of anonymity, said he remained in the closet out of fear he would be discriminated against. “Being outed really scared me,” he told *The New Physician* (Wynn 2010). It is for these reasons that LGBT health is recognized as a key area in need of improvement in healthcare, particularly in medical school curricula.

The Medical Community’s Recognition of LGBT Health and Health Care Issues:

Sixteen years ago, the AMA noted the importance of addressing the specific healthcare needs of gay men and lesbian women in the United States, and also noted that the specific needs of these populations were not being adequately addressed (AMA 1996). More recently, last year’s IoM report acknowledged a number of current health and health care challenges facing LGBT populations not being sufficiently addressed, including a lack of providers who are knowledgeable about LGBT health needs, a significant barrier to quality health care (IoM 2011).

Others who have examined the health and healthcare of LGBT adults and adolescents also found significant LGBT health care disparities and problems accessing care, suggesting a strong need for clinicians to improve their outreach to and care of LGBT populations (Coker, Austin, and Schuster 2009; Coker, Austin, and Schuster 2010; Obedin-Maliver et al. 2011; Grant, Mottet, and Tanis 2010; Lambda Legal 2010; Makadon 2006). But as our own Raymond Curry noted in a 2011 *JAMA* commentary, “Even absent the health and health care disparities, it would still be important for physicians to understand the full range of human sexual behavior and to address the related psychosocial as well as overtly medical needs of the patients in their care” (Curry 2011, 998).

What Medical Schools Currently Teach About Sexual Health and the Health of Sexual Minorities:

A study published in 2003 that examined the extent to which medical schools in the United States and Canada prepared future physicians to diagnose and treat sexual problems found the majority only spent between 3-10 hours on sexual health (Solursh et al. 2003). Some schools provide more; for

example, in 2003 the University of Massachusetts reported that more than 20 hours were spent in the medical school curriculum teaching students about sexuality (Ferrara et al. 2003). Malhotra et al. found in their 2008 study that 44% of US medical schools lacked a formal sexual health curricula. The research group concluded, “There are significant deficiencies in medical students’ training on sexual health” (Malhotra et al 2008, 1097).

According to a more recent overview of medical school curriculum in the U.S. conducted by representatives of Morehouse University, in their teaching about human sexuality, most medical school curricula focus upon reproductive health, with an emphasis on disease and dysfunction (Morehouse 2009). This lack of teaching about sexual health is problematic, since many patients view sexuality as an important quality of life issue, and want to discuss it with their physicians, but wait for their physicians to initiate discussion (Ferrara et al 2003).

Medical schools are not alone, among health professional schools, in under-teaching issues of human sexuality. When it comes specifically to the sexual health of sexual minorities, a recent study by Corliss, Shankle, and Moyer found few public health schools taught much beyond the basics of HIV and AIDS (Corliss, Shankle, and Moyer 2007). Within medical schools, a 1991 survey of U.S. medical school curriculum found the mean number of hours spent on teaching about homosexuality was 3 hours and 26 minutes and that this part of the curriculum was marginalized. The authors of this study stressed that the subject needed to be wholly integrated into the curriculum (Wallick, Cambre, and Townsend 1992). A 1998 survey of family medicine departments in U.S. medical schools found that the average time spent on LGBT health issues was 2.5 hours across the 4 years, although half of the departments that reported said they spent 0 hours on LGBT health issues (Tesar and Rovi 1998).

A 2006 review of undergraduate medical school education curriculum found that most did not “adequately prepare future physicians to care for LGB patients” (Boyd et al. 2006, 68). A more recent survey of LGBT issues in medical school curriculums published last year in JAMA found the median time spent now is 5 hours, with more time spent in preclinical than clinical (Obedin-Maliver et al. 2011). This study, conducted out of Stanford University, showed that medical schools neglected teaching about LGBT health needs. But as Curry pointed out in his commentary on Obedin-Maliver et al. last year, “the 85% response rate [to the Stanford survey] alone is indicative of a high level of interest” in adding LGBT health and health care issues to the medical school curriculum (Curry 2011, 997).

As the Stanford survey revealed, many medical schools have added some LGBT health and health care issues to their curriculum, but over the past two decades only a few studies have evaluated how medical schools teach LGBT health issues. In 2006, Sanchez et al. systematically assessed a group of medical students’ attitudes, knowledge, and clinical skills pertaining to LGBT patients. They concluded that medical students with greater exposure to LGBT patients were more likely to learn a patient’s sexual orientation and that early intervention by instructors to teach the appropriate questions during sexual history taking may increase the likelihood of eliciting this information from patient encounters (Sanchez et al. 2006). In 2008, Kelley et al. described the efficacy of the focused intervention curriculum at UCSF regarding LGBT health issues in changing the knowledge and attitudes of medical students toward LGBT people (Kelley et al. 2008).

Meanwhile, McGarry et al. found that even limited seminars for residents can positively impact residents’ sense of readiness and comfort in terms of handling the unique health needs of LGBT populations. They further noted that, “Possibly more promising is that the seminar helped those

residents who initially expressed discomfort in dealing with homosexuality because these are the individuals who we are trying to influence most with an educational intervention” (McGarry et al. 2002, 247).

Incorporating LGBT Health Issues into the Medical School Curriculum:

In 1996, the AMA recommended a greater educational focus on the health needs of gay men and lesbians (AMA 1996). Since then, the AAMC has made recommendations for the incorporation of educational programs and activities about LGBT health concerns into the medical curriculum (AAMC 2007).

Many schools are doing much in the way of LGBT education, both in terms of formal and co-curricular activities (such as LGBT patient panels, talks on transgender health, and meet and greet activities with out faculty). In this section we outline just the formal curricular activities. Several schools appear clearly in the forefront in formally teaching about LGBT healthcare needs, including UCSF, Vanderbilt University, NYU, University of Washington, and Brown University.

UCSF has long been one of the pioneers in regards to LGBT-related undergraduate medical education and appears to be the only medical school with an established LGBT resource center in the country, founded by Shane Snowdon. Several notable curricular features at UCSF include lesbian and intersex problem-based learning (PBL) cases, LGBT presentations during various clinical clerkships, an LGBT elective, and a dedicated 3-hour LGBT session during which all second year students read a syllabus, hear a lecture, attend a LGBT panel, and breakout into small groups led by 14 LGBT faculty (Kelley et al. 2008). One of us (Jerry Chen) met with Dr. Jason Satterfield of UCSF as well as Shane Snowdon and was provided curricular materials from UCSF as well as guides for developing successful LGBT curricula (see Appendix).

Vanderbilt University has also been emerging as a leader in LGBT health largely through student-initiated efforts by Kristen Eckstrand, an MD/PhD student. This year, Vanderbilt opened a formal Program for LGBTI Health. Eckstrand and other students successfully worked with faculty at Vanderbilt to revise courses to integrate LGBT health into the curriculum. The amount of additional content varied from adding entire lectures to inserting additional bullet points in existing lectures. However, this initiative led to the development of two clinical, rather than pre-clinical, LGBT-focused teaching sessions. Kristen Eckstrand has also developed a clinical third-year elective on LGBT issues which she estimates to be attended by 8-10% of M3s, due to start in 2013.

Brown University’s success in developing its LGBTI curricula also is largely the result of student initiatives with significant faculty support. The most notable feature in Brown’s curriculum is their LGBTI elective offered once every two years consisting of eight two-hour sessions on various LGBTI topics (Dean et al. 2011). Furthermore, in discussion with our research team, Dr. Julie Taylor, Director of the Clinical Curriculum at Brown University’s school of medicine, mentioned that Brown also has an extremely high percentage of standardized patients cases that are LGBT. According to Dana Zink at Brown, during M1, of the 8 social history cases, 4 standardized patients present as heterosexual and 4 standardized patients present as LGBT. In addition, according to Zink, during M4, 28 of the standardized patients present as heterosexual and 7 present as LGBT. Brown has about 10-15 hours of LGBT content in their formal curriculum.

Like Brown University, other schools have developed elective courses covering LGBT health. NYU has a 4-week clinical elective that awards a certificate upon completion. In 2011, among the four seminars sessions offered were “LGBT Health in Society: A Sociocultural Context” and “Transgender Health 101.” The University of Washington School of Medicine has an elective modeled off the Fenway Guide to Lesbian, Gay, Bisexual & Transgender Health. The course consists of lectures, panels made up of physicians, community advocates, and patients, as well as small group discussions. Stanford University also has a preclinical elective that has been successfully run for 10 years.

These schools have implemented change through diverse methods. Brown and Vanderbilt, for example, were student-lead initiatives, and Brown’s LGBT elective course remains student-led. In many of these institutions, students unsatisfied with the current level of LGBT material in the curriculum sought the support of willing faculty and administration to develop LGBT related content. In our interview, Brown’s Dr. Taylor attributed their success largely to student-driven initiatives with diverse faculty and student support. At UCSF, the LGBT resource center, students, and staff drove initiatives.

In summary, these schools are working toward Integrating competency regarding the recognition of “bias, prejudice, and discrimination” toward LGBT patients, and this, McGarry et al. argued, is “one small step toward creating a healthcare system that responds to the needs of our gay and lesbian patients” (McGarry 2002, 245).

Section 3: What Currently Exists at FSM

The AAMC recommended in 2007 “medical school curricula ensure that students master the knowledge, skills, and attitudes necessary to provide excellent, comprehensive care for [LGBT] patients” (AAMC 2007). Our work on this project has indicated widespread agreement with this recommendation among the administration, staff, and faculty of FSM. Indeed, the Office of the Provost has provided substantial support to our ongoing efforts to expand the understanding of human sexuality in FSM, and our Vice Dean for Education Raymond Curry envisioned and made possible this very white paper. In his 2011 commentary on the Stanford LGBT curricula study, Dr. Curry specifically spoke to a vision “of ongoing attention to human sexuality, sexual behavior, and the accompanying medical implications as integral to the curriculum” (Curry 2011).

As we have been in conversation with other administrators, staff, and faculty at FSM about this project, we have met with universal enthusiasm and much encouragement. The education and business literature suggests that if we want change to occur in a particular arena, it is best to first have attitudinal buy-in. It seems clear to us that we have buy-in, meaning we have fertile ground in which to plant. As we outline in the next section of this paper, there is plenty more we can “plant.” In this section, we seek to articulate what we believe currently exists at FSM in its education surrounding human sex, sexuality, and gender.

FSM already has substantial institutional infrastructure in place to support LGBT people – whether they are faculty, students, patients, or staff – and to support those who serve this population as educators and health care professionals:

- The FSM Office of Diversity, led by Dr. John Franklin and directed by Sunny Gibson, connects LGBT students to physician mentors and surrounding support networks.
- The FSM Office of Diversity offers Safe Space Training to the Feinberg community.
- With the support of the Office of Diversity, our medical student body maintains Queers & Allies (Q&A), a group that “promotes the acceptances of LGBT students, faculty, and staff through education and discussion of LGBT issues and rights.”
- The Office of Diversity works to signal a welcoming environment to LGBT student-applicants, including by offering applicants the opportunity to meet with Q&A during their interview visit and by providing special opportunities during follow-ups, including “second look” weekend.
- The Office of Diversity ensures that FSM GME programs include LGBT in their definition of those “underrepresented in medicine” so that LGBT students are eligible to apply for funded clerkships at FSM and for travel stipends to attend our annual residency showcase.
- The Office of Diversity ensures that FSM GME recruitment documents signal a special welcome to LGBT applicants.
- The Office of Diversity provides professional development support for students from underrepresented groups, and this includes funding Q&A leaders to attend GLMA meetings, LGBT graduate student conferences, or other conferences relevant to networking and professional development.
- The Out Network constitutes a campus- and affiliate-wide networking group for LGBT identified individuals and allies. The Out Network’s “collective hope [is] that providing a

sponsorship for faculty, staff, and students who identify as LGBT or allies will ensure that our campus and affiliates have welcoming and inclusive environments.”

- Northwestern Memorial Hospital just achieved listing on the Human Rights Campaign Healthcare Equality Index, indicating that NMH has committed to “promoting equitable and inclusive care for LGBT patients and their families.” The Healthcare Equality Index specifically indicates a hospital has attended to (1) patient non-discrimination policies; (2) visitation policies; (3) employment non-discrimination policies; and (4) training in LGBT patient-centered care. (Note that this does not mean that there is not substantial work left to be done on these issues at NMH.)
- Northwestern University offers domestic partner benefits, a sign of welcoming families led by same-gender couples. The McGaw Medical Center of Northwestern University, a separate not-for-profit entity managing all Northwestern graduate medical education programs, has for several years also provided domestic partner benefits.

Although Northwestern University and Northwestern Medicine have been making strides toward more just treatment of LGBT faculty, staff, students, and patients, we do not mean to suggest that this institutional work is complete. We also want to explicitly acknowledge the many oppressive institutional governmental systems that exist, within our state and our nation, subjecting LGBT people and sometimes their loved ones daily to unjust discrimination and the social, financial, psychological, and medical sequelae of that discrimination.

In terms of what exists in our curriculum, because FSM is in the midst of a major curriculum renewal, it has been somewhat difficult for us to determine precisely what teaching of human sexuality, sex/sexual development, and gender identity is set to occur in the new curriculum. The last iteration of the curriculum included two specific lectures, one on DSD with Dr. Wendy Brickman, and one on the development of sexuality and sexual disorders with Dr. Richard Carroll. It is unclear whether these lectures will be maintained in the new curriculum.

Based on conversations with various FSM faculty and staff, we feel confident reporting that the following components are or will be found in the revised curriculum:

- During Orientation, new students read and discussed the essay “On Being Gay in Medicine” (Schuster 2012).
- Students will learn in the Clinical Medicine course how to take a sexual history from LGBT patients, as well as others.
- According to Marsha Kaye, who will be coordinating standardized patients, several of the standardized patients will present as gay or lesbian.
- The Health and Society course will include a component that sends students into Chicago neighborhoods (including the LGBT-heavy areas of Lakeview and Andersonville) and will include specific instructions to students to consider health data on LGBT community subgroups.
- In the Reproductive Medicine unit (currently scheduled for December 2013), it is likely there will be significant, focused LGBT content.
- The new Areas of Scholarly Concentration program will include an AoSC in human sexuality.

In the next section of this paper, we make specific recommendations with regard to expansion and enhancement of these programs and activities.

Section 4: Our Recommendations for FSM

We provide here our recommendations for possible changes within the FSM curriculum and the structures in which the curriculum exists in order to improve the teaching and learning of LGBT health and of human sexuality, sex, and gender. We have aimed to be practical – to provide specific suggestions that we think are doable within the near future. In the next section, we suggest additional changes and projects that FSM might want to consider in the longer-term. We have divided these recommendations into the broad categories of “curricular and extra-curricular” and “structural.”

As we have reviewed various approaches to teaching LGBT health and of human sex, sexuality, and gender within medical schools, it seems that there are two basic styles of improvement in this area: a “saturated” approach that tries to make sure these issues are covered everywhere they logically could be within classes and clerkships; and a “focused” approach that provides dedicated modules, such as electives on LGBT health care and lectures on the care of children with DSD.

While the saturated approach is likely to be more effective in terms of creating doctors who are thinking frequently about sex and gender (and identities based in sexual orientation and gender identity) as they provide care, it is also a more difficult model to implement quickly. We therefore suggest that we start with adding some focused interventions, and consider in the longer term how we might achieve a curriculum that even more broadly incorporates teaching and learning on these issues. As the group working on the LGBT elective at Brown University observed, “it is only by making these topics a norm in medical education that will, over time, change physicians’ attitudes and behaviors to provide accessible, adequate and knowledgeable medical care to this [i.e., LGBT] underserved population” (Dean et al. 2011, 837).

The recommendation that probably should be followed first in time comes last in the following written list, so we want to bring attention to it here: **a “point person” should be designated to follow-up this white paper, beginning with translation of this report into a clear “action plan.”**

4.1: Curricular and Extracurricular

Expand efforts within M1 orientation:

The stated goals of FSM’s new orientation program include: (1) to introduce core topics of professionalism and professional development, and (2) to facilitate bonding and connecting with classmates. Introducing LGBT identities and issues during orientation signals to new students that FSM faculty positively acknowledges LGBT people and their health care needs – that we see the compassionate treatment of all people, including socially-disadvantaged populations as a core issue of professionalism – and also signals to any LGBT new students that our welcome to “bond and connect” really means to include them.

For the session on the history of medical education on the Monday of orientation, Dr. Dreger had the students read “On Being Gay in Medicine” (Schuster 2012). For the session on the public image of the medical profession, Dr. Rodriguez noted that from the early 1950s, when the first television doctor shows began airing, to the present, this influential medium has fairly consistently cast the role of the physician as male, white, and heterosexual, though some more recent shows such as *ER* have begun showing a greater diversity in who is seen as a doctor. Because the new orientation was still being assembled as we were writing this document, we are not sure exactly what else has generally been planned in the new orientation on LGBT issues, but it would seem quite straightforward to add LGBT content – at least via brief mention – in many other sessions planned for orientation, if this has not already been done. For example, The session on “personal responsibility and self care” – which we note is set to include “diversity issues” – could include an out lesbian or gay physician who talks about how her or his own experiences compare to Mark Schuster’s as described in “On Being Gay in Medicine.” (Medical trainees’ attitudes towards LGBT people appear to be improved by being introduced to an out FSM role model faculty member, and LGBT students can benefit because it signals a climate of openness and sensitivity.)

Additionally, during orientation, the panel “on being a medical student” could include an out LGBT student. “The doctor-patient relationship” could include conversations about how physicians care for people whose identities are not their own, and whose identities may even be quite unfamiliar, as is often still the case transgender patients. “Responsibilities as an advocate” could include acknowledgment of pediatricians who work with at-risk LGBT youth.

It seems worth introducing students early and often to the fact that many patients (including many straight patients) want to talk about sex with their doctors, but that they are often hesitant to do so, while doctors are often hesitant to ask (Ferrara et al. 2003, S46).

Develop a dedicated unit within clinical skills for LGBT issues:

Dr. Heather Heiman has already expressed an intention to work on this, and we have offered assistance. A clinical skills unit on LGBT issues would presumably incorporate a number of components, several of which we elaborate below, on teaching vocabulary, special healthcare risks and needs, an expanded approach to sexual-history taking, and the use of simulated LGBT patients.

Teach basic vocabulary and differences and risks within LGBT populations:

Although here for convenience we refer to “LGBT” as if this is a single population, in fact the acronym subsumes populations with key differences (in identity bases, political histories, etc.) and varying risk profiles. We would recommend finding somewhere in the FSM curriculum, preferably relatively early in the learning curve, wherein students learn some of the basics in this area, including basics in vocabulary (e.g., “transgender”; “homophobia”). UCSF employed this type of learning module as part of their curricular intervention (Kelley et al. 2003). The recent IoM report on LGBT healthcare contains extremely useful summaries of population-specific health risks that could be used for teaching. We attach one such section in our appendix.

Provide panel of LGBT patients and/or LGBT-knowledgeable providers:

A recent report on LGBT healthcare experiences from Lambda indicated that “more than half of all respondents reported they have experienced at least one of the following types of discrimination in care: being refused needed care; health care professionals refusing to touch them or using excessive precautions; health care professionals using harsh or abusive language; being blamed for their health status; or health care professionals being physically rough or abusive” (Lambda Legal 2010). Transgender individuals “reported experiencing the highest rate of discrimination and barriers to care.” The National Transgender Discrimination Survey Report on Health and Healthcare actually found that “If medical providers were aware of the patient’s transgender status, the likelihood of that person experiencing discrimination increased” (Grant, Mottet, and Tanis 2010). This speaks to the degree to which we have work to do in terms of educating the next generation of physicians.

We can teach these survey results to our students, but research and instinct suggest that putting real faces on these issues will have a much more powerful and lasting effect (McGarry et al. 2002). Studies of homophobia have shown “that lack of personal contact with gay and lesbian people is highly correlated with negative attitudes. Studies show that teaching and promoting tolerance by designing discussion forums where students may voice their opinions and feelings about these encounters and listen to others do the same can result in change” (Sanchez et al. 2006, 25).

Understanding that “prior studies indicate that direct contact with patients helps medical students form more positive impressions of marginalized patient populations” (Kelley et al. 2008, 249), UCSF has used an interesting approach, namely having a panel of LGBT patients interact with students in a large-group setting followed by small-group break-out discussions with out providers (Kelley et al. 2003). Following their intervention, “Students [at UCSF] demonstrated increased knowledge about access to health care and LGBT relationships, increased willingness to treat patients with gender identity issues, and enhanced awareness that sexual identity and practices are clinically relevant” (Kelley et al. 2008).

According to Shane Snowdon, who was partly responsible for organizing these panels and break-out sessions at UCSF, the patient panel is a very successful component of this unit, although it is critical to choose panelists carefully. Vetting potential panelists with a mock session may be an extra step worth taking.

While it might seem that we would not have enough out providers to do break-out sessions effectively with an entire class, we think that if we were to reach not only within FSM but out to the larger Chicagoland community, we could find enough out providers to do the patient-panel with provider-led break-out groups even within the context of the extraordinary challenge in terms of scheduling this many providers. This kind of panel with break-out might even be an exercise worth conducting during orientation week, as it would seem to address many issues of professionalism through this lens.

Institute an explicitly LGBT-inclusive approach to sexual history-taking:

It seems especially important to ensure that students learn the difference between sexual attraction, sexual behavior, and sexual identity (Coker, Austin, and Schuster 2012; note that the Fenway

Modules are particularly useful for this pedagogical work.) A patient may identify as a straight man but be having sex with men; a woman may identify as straight and be monogamous but experience attractions primarily towards women: these examples signal the ways in which good care requires asking patients about all three components of sexuality.

Our research suggests that, while many medical students (including those at FSM) are today taught to ask patients, “Do you have sex with men, women, or both?”, they are not adequately taught where to go from there. Kristen Eckstrand of Vanderbilt University has provided us a useful tool she developed for teaching how to take a better sexual history (see Appendix). We have already provided that document to Dr. Heather Heiman, who has said it “looks excellent in general” and is thinking revamping it slightly for use at FSM. Dr. Heiman has also indicated that FSM is adopting a module about sexuality from doc.com, a communication skills teaching tool from Drexel University College of Medicine and the American Academy on Communication in Healthcare. The AMA and Fenway also provide excellent resources for teaching sexual history taking, and Kristen Eckstrand has also recommended the ARHP Core Website for faculty working in this area.

Institutionalize inclusion of simulated/standardized LGBT patients:

Marsha Kaye has indicated that standardized patients who present as LGBT will continue to be employed at FSM. This inclusion allows students to practice sexual history taking with patients from these populations, also serving to remind students of the diversity that exists within clinical populations. According to Ms. Kaye, the SP trainer whom FSM employs is knowledgeable in LGBT issues, suggesting perhaps that we could tap the trainer for ideas about how to improve in this area. An LGBT-knowledgeable physician or provider could also regularly review cases involving presentation of LGBT “patients.” Because it seems important that all students practice attending to lesbian, gay, and transgender patients, it would seem advisable to standardize the standardized patients enough to ensure that all students are assigned at least one “patient” representing the LGBT populace.

Enable comparative demographic learning in problem-based learning modules:

As with Orientation Week, PBL seems to also offer a relatively straightforward opportunity for inclusion of LGBT materials, as “patients” in PBL are described as having particular demographics. Highlighting the relative risks and special needs of LGBT people might be achieved by varying the demographics for the patient within a single PBL, and then having groups of students compare how the demographic variance changed how they thought about the case in terms of attitude, assumptions about risk, and treatment plans. So, PBL student groups A, B, C, and D might all have a PBL case featuring a 45-year-old with symptoms x, but group A’s patient would be described as an African-American lesbian, group B’s patient would be described as an Asian-American straight man, and so forth. Students could come together, after working the PBL, to talk about the social determinants of health by examining how the demographics matter.

Develop a faculty-led elective course in LGBT health (and perhaps open it up to students in other health professional programs):

As noted in Section 2, a number of medical schools – including Brown University, NYU, the University of Washington, and Vanderbilt University – now have student-organized, for-credit electives in LGBT health (see, e.g., Dean et al. 2011). According to those who have developed such electives, there are numerous benefits, even beyond the added education enrolled students received. The problem with student-run electives is, of course, that they are difficult to sustain as students move on.

We would therefore suggest that FSM’s administration designate an individual on staff or faculty to develop and serve as course director for an LGBT healthcare elective. This individual might be the same person as the diversity-allies coordinator. Ideally, the elective would include a number of faculty from disparate fields, both because this would broaden the education but also because such faculty might then use what they have developed to teach more about these issues in required FSM courses. The course could include shadowing a physician or other healthcare professional at a clinic (like Howard Brown) dedicated to LGBT populations.

According to Shane Snowdon, who until recently directed the LGBT Resource Center at UCSF, UCSF has a well-established elective course, now in its fifth year, that consists of a 2-day forum presented by the LGBT Resource Center with student assistance. Interestingly, the UCSF forum draws over two hundred health professional students from throughout the west. The course draws on local and regional expertise in order to teach the large number of topics covered. FSM might serve the greater Chicago region by developing a program akin to this.

We recommend that if FSM develops an elective in LGBT healthcare, it use a system like certificates to motivate and recognize student participation. Students who complete the NYU elective receive a certificate acknowledging their participation in this educational enhancement, and we have been given to understand this functions as a motivator for participation.

Connect content/improvements to FSM core competencies and learning objectives:

Just to state the obvious, clear connections need to be drawn between existing and added content and the FSM core competencies and associated learning objectives. It may be necessary and helpful to create new learning objectives that address the concerns outlined in this document. Under “structural” recommendations, below, we recommend designating a staff person to oversee follow-up of this document. That person would make a logical individual to coordinate this type of work.

Support the new area of scholarly concentration in human sexuality:

We mentioned this in the last section as “existing” but describe more fully here the plan. FSM is this year introducing a required area of scholarly concentration (AoSC). In May, a proposal was developed by Dr. Dreger in consultation with Drs. Rich Green, Tod Chambers, and Ray Curry to designate a coordinator for an AoSC in human sexuality. This AoSC will give FSM students the

opportunity to develop graduate-level research projects examining aspects of human sexuality in conjunction with mentors from FSM and Evanston, including potentially from Psychology, Psychiatry, Sociology, Anthropology, Medical Social Sciences, Pediatrics, Medical Humanities and Bioethics, and Genetics. We believe these students and their projects will act as bridges to bring more of the research involving sex, gender, and sexuality into the FSM learning environment. Dr. Sarah Rodriguez is functioning as the first coordinator for this AoSC while she also serves as coordinator of the AoSC in Medical Humanities.

Focus Attention to LGBT populations within the Health and Society course:

As with the AoSC, we believe this is already planned but we describe more fully the plan here: FSM is instituting a new program this year within the “Health and Society” course. This program will help students to understand the ways in which health data map onto geography and culture. Twenty-one groups of eight students each will conduct health assessments for one of 77 community areas in Chicago. Among the communities included will be portions of Lakeview and Andersonville, areas with higher-than-average LGBT populations. According to Dr. Becky Wurtz, students will be asked to examine the health risks and healthcare needs of various subgroups, including LGBT people.

Connect to Sex Week:

Sex Week is a designated week in the spring at Northwestern meant to encourage focus of attention on issues of sex. According to the organizers, “Sex Week is meant to provide students with fun, provocative, and informative opportunities to explore the role of sex and sexuality in our lives.” We suggest that FSM consider connecting with Sex Week, i.e., offering extracurricular presentations and workshops to our students during that week, perhaps co-sponsoring programs with Evanston groups.

Our external consultants have suggested that the topic of transgender tends to draw wide audiences; given this and the fact that the transgender population has had a relatively dismal history of interactions with medicine, we recommend considering providing one or more sessions on compassionate care for transgender patients. Doing so in the context of “sex week” risks inappropriately sexualizing transgender individuals, but this issue could be well-managed if directly addressed as part of a presentation on the special healthcare needs of the transgender population.

4.2: Structural

Designate a diversity-allies coordinator:

We expect that the work of engaging people willing and able to serve as LGBT patient panelists and out provider-mentors, along with the work of engaging people willing and able to serve as representatives of other historically marginalized populations in other arenas, comes to a substantial

amount. Moreover, recruiting people for this kind of work requires establishment of warm, respectful relationships. We therefore suggest that, if it has not already done so, FSM designate a specific person to manage this kind of work. We also recommend this work be recognized with a specifically named FTE percentage. The budget for the provost-supported grant (“Expanding the Understanding of Human Sexual Orientation in Science and Medicine”) might be used as a starter-base for this position.

Inventory the renewed preclinical and clinical curriculum:

Medical schools that have most been most successful at injecting substantial amounts of teaching on LGBT issues have been those that have had one or more people specifically inventory the preclinical and clinical curriculum and work with course and clerkship directors to provide specific teaching tools (videos, readings, speakers). This makes it much easier for the course and clerkship directors to make improvements quickly and well. As we settle into the renewed FSM curriculum, we would recommend that two or three individuals be given and supported in this task. (The authors of this report are interested in pursuing this work, although we do not think it has to be us.) We provide in our appendix examples from Vanderbilt and UCSF showing how they have achieved specific course and clerkship improvements. We would hope that the availability of course information on eMERG would make inventorying the curriculum a fairly straightforward task. (This is, of course, only possible if faculty “tag” eMERG entries in a way that makes this kind of inventorying possible.)

As part of this curriculum development, FSM might also seek to develop clerkships or clerkship modules that would increase the likelihood of students being exposed to LGBT patients. Sanchez et al. in 2006 showed that “medical students with increased clinical exposure to LGBT patients tended to perform more comprehensive histories, hold more positive attitudes toward LGBT patients, and possess greater knowledge of LGBT health care concerns than students with little or no clinical exposure.”

Identify “curricular champions”: “Curricular champions” should be identified and supported; these are individuals (we envision MD’s) who have the inclination and the skills necessary to track how this work is playing out within curricular development. Such champions may be the people tapped to do the specific work suggested here, particularly in terms of curricular inventory and in terms of working with course and clerkship directors to improve teaching in these areas quickly and effectively.

Develop clear mechanisms for reporting hostile climate:

A major concern continues to be the potential for a “hidden curriculum” that tolerates or accepts hostility to, discomfort with, or rejection of LGBT individuals and families. We strongly recommend development of a confidential reporting system that enables students to report such things as disparaging remarks made about LGBT people by clinical faculty, staff, and fellow students, refusal to treat or mockery of LGBT people, etc. Students should be encouraged to report problems

whether or not they feel personally affronted or oppressed. A system ought to exist wherein problems are addressed and tracked and students are encouraged to report, not retaliated against for reporting. We have had trouble locating such a reporting system within FSM.

A reporting system of this type would need to be coordinated with existing systems at Northwestern for dealing with discrimination, harassment (including sexual harassment), and hostile work environments.

Provide for faculty development:

As Case Western Reserve School of Medicine worked to increase learning around sexual health, they provided faculty development so that pre-clinical faculty and attendings in the clinics became more knowledgeable and confident in the teaching of sexual issues (Kingsberg et al. 2003). FSM might similarly consider substantial faculty development in this area. (If the development includes some sensitivity training of the Safe Space variety, an added benefit might be improvement in climate within the clinics.) Funding could be provided to attend relevant conferences and workshops, such as the conferences of the GLMA and LGBT-related workshops at the annual AAMC conference.

Expand Safe Space training (and expand Safe Spaces by labeling nametags of those trained):

Safe Space training is available to members of the FSM community through our Office of Diversity. The goal is “to increase our collective capacity in becoming a fully inclusive campus.” In the course of this work, one member of the dean’s office told us an interesting anecdote: He had recently put a “Safe Space” sticker on his door, and shortly after that, a student came in to talk to him about something else, but in seeing the sticker, felt it was safe to talk with him about concerns she had regarding LGBT issues. Although we may tend to assume our students understand us to be LGBT-friendly, it would help to show them, with these simple stickers, that we care enough about the issues to have sought formal training for sensitivity.

According to Sunny Gibson, Director of the Office of Diversity, the training is now accredited with the FSM Continuing Medical Education office for up to 4 hours AMA PRA Category 1 credit. Conversations with Ms. Gibson suggest that a tailored, more abbreviated Safe Space training program could be implemented with administrative support. A major barrier to Safe Space training within FSM does seem to be the perception that the four-hour training is unnecessarily time-consuming and that the same training can be conveyed to this population in less time.

Therefore, we recommend: that a shorter FSM-specific Safe Space training be developed; that significantly more administrators, staff, and faculty be encouraged to do Safe Space training; and that all curricular leaders – including, for example, clerkship and course directors and education deans’ personnel – be required to complete Safe Space training.

Jason Satterfield of UCSF told us of an interesting approach at UCSF: faculty and staff who have taken Safe Space training put “Safe Space” sticker on their nametags, making even more visible (and mobile) the medical school’s “safe spaces.” This also seems like an idea worth pursuing at FSM.

Conduct surveys to obtain clearer baseline readings on climate around LGBT issues:

Because we are about to institute a number of changes within the curriculum that are likely to effect climate (hopefully positively), and because a good curriculum in a bad climate is a weakened curriculum, we encourage the FSM Office of Diversity – if they are not already doing so – to do a basic climate survey among our community members with regard to LGBT issues. A quantitative survey would allow us a baseline against which we can later compare; a qualitative survey might allow us to find fixable problems.

Provide substantial, visible support for the Out Network and Q&A:

Dr. Eric Boberg, Executive Director for Research and the facilitator of the Out Network, has recently been working with the Office of Diversity “about possible ways that the Out Network can be more visible and supportive on campus, especially for students” (email 3 July 2012). Dr. Boberg recently polled Out Network FSM students, faculty, and staff to determine those who would be willing to be listed on the FSM website as out members of the LGBT communities. He has received about 50 positive responses, about one-third of those being from faculty. The plan is to have this group be made more visible at the FSM website and to connect students with mentors.

We recommend an increase in active and visible support from the FSM administration for our student group, Queers and Allies (Q&A), and for the Out Network. For example, modest additional financial investment in the Out Network’s mentoring program could encourage faculty to provide social opportunities to students. Introducing members of Q&A during orientation week would increase visibility of the organization as well as signaling pride in our inclusion of out LGBT students. If we are not already doing so, mentioning Q&A the Out Network in all recruitment material could convey our sense of pride in having staff, faculty, and students who identify at LGBT. The administration could also help to articulate how Q&A and the Out Network might be tapped to achieve some of the recommendations made in this paper.

The 2007 AAMC recommendation on LGBT issues observed that a safe learning environment means that “admissions deans and admission committees be made aware of the bias and prejudice concerning sexual orientation and gender identity are important issues in the learning environment for medical students” (AAMC 2007). While this may seem obvious, we might nevertheless ask admissions personnel to engage in an open conversation about how we might be displaying bias or prejudice regarding sexual orientation and gender identity within our admissions processes.

Encourage student leaders (or would-be leaders) to participate in this work, and begin with convening a focus group:

Several reviewers of drafts of this report expressed concern that students at FSM appear to be relatively less engaged in these efforts than might benefit the community. We therefore recommend those of us working in these efforts find ways to encourage student leaders, or students who might become leaders in this area, to actively work with us on these plans.

We also recommend a focus group of present and past FSM students with interests in these areas be convened so that those continuing this work can collect our students' experiences and insights to take forward.

Designate a staff or faculty “point person” for white paper follow-up, and create an action plan:

Particularly in light of the curriculum renewal ongoing at FSM and the reports on LGBT medical education likely to emerge soon from the Gay and Lesbian Medical Association (GLMA) and the AAMC, we recommend that someone be specifically charged with following-up on the substance of this white paper, particularly this academic year (2012-13). The approved budget for the “Expanding the Understanding” grant includes \$15,000 for AY 2012-13 for a “faculty MD curriculum leader.” This would seem a logical use of such funds. The first task of this point person would likely be to oversee translation of this white paper’s recommendations into a clear action plan. Although this person might ultimately be the kind of “curricular champion” mentioned above, we imagine that it is most important for this point person to understand how to realistically take this document and turn it into a manageable action plan for FSM.

Section 5: Recommended Additional/Longer-Term Follow-Up

In section 4, we provided our recommendations for changes, projects, and enhancements that we believe could be executed relatively soon, as deemed appropriate by the FSM administration. We would also recommend the following curricular and structural improvements also be considered, in some cases in the longer-term:

Curricular:

- Watch for the report on LGBT medical education from GLMA due out in Fall 2012, and review the recommendations made therein.
- Watch for the monograph on LGBT medical education from the AAMC LGBT Patient Care Task Force due out in 2013, and review the recommendations made therein.
- Consider development of human sexuality education within Graduate Medical Education (GME) at FSM.
- Consider development of LGBT health issues education within Graduate Medical Education (GME) at FSM.
- Consider development of Continuing Medical Education (CME) in human sexuality at FSM.
- Consider development of Continuing Medical Education (CME) in LGBT health issues at FSM.
- Develop targeted assessments of curricular changes and faculty development in order to ascertain effectiveness of interventions.
- Re-analyze whether we have a clear curricular thread in human sexuality, and consider refinements to achieve a solid thread.
- Develop curricular components to address DSD.
- Develop curricular components to address the needs of children and adolescents who present as gender variant.
- Engage in a dedicated discussion about the place of LGBT social justice issues in the FSM curriculum.

Structural:

- Conduct an institutional self-assessment for LGBT concerns in medical education as described in the “Tool for Institutional Self-Assessment” prepared by the UCSF LGBT Center (reproduced in our Appendix).
- Conduct a review of clinical policies, forms, and materials to ensure they demonstrate cultural competence in LGBT health issues.
- Watch for AAMC-developed materials on climate and assessment of medical schools regarding LGBT and diversity issues, and review/implement recommendations.
- Develop and deploy targeted assessments with regard to climate around LGBT issues at FSM and our associate institutions (i.e., hospitals and clinics) and attempt to understand better what positively and negatively affects climate.
- Encourage development of presentations and publications to share FSM experiences, learning, and insights with colleagues.

We believe that, with continued pervasive support for and attention to these issues within our medical school, FSM has the potential to be a national leader in educating the next generation of physicians in issues of LGBT patient care, and also in diverse issues of human sex, sexuality, and gender identity.

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Section 7: Appendices

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B. Key Websites and Publications (*not included in Dropbox*)

C. Items in Dropbox

Appendix A: People Who Can Help

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Appendix B: Key Websites and Publications (not included in Dropbox)

(modified from a list assembled by Shane Snowden)

General Information about LGBT People and Issues:

- National Gay and Lesbian Taskforce: www.nglhf.org
- Human Rights Campaign: www.hcr.org
- National Center for Transgender Equality: www.nctequality.org
- National Black Justice Coalition: www.nbjc.org
- The National Latin@ LGBT Human Rights Organization: <http://www.unidoslgbt.com/>
- Trikone LGBT South Asians: www.trikone.org/index.shtml
- SAGE (Senior Action in A Gay Environment): www.sageusa.org

Resources for Allies, Friends, and Family Members of LGBT People:

- Parents, Families, & Friends of Lesbians and Gays (PFLAG): www.pflag.org

Key Publications in LGBT Health:

- *The Fenway Guide to Lesbian, Gay, Bisexual, & Transgender Health*:
- <http://www.lgbthealtheducation.org/publications/fenway-guide-to-lgbt-health/>
- The Fenway Institute, National LGBT Health Education Center Learning Modules:
- <http://www.lgbthealtheducation.org/training/learning-modules/>
- Kaiser Permanente, *Provider's Handbook on Culturally Competent Care: LGBT Populations*.
- Gay & Lesbian Medical Association Clinical Guidelines for Care of LGBT Patients: <http://allies.sdes.ucf.edu/docs/glma-guidelines.pdf>
- AMA Virtual Mentor Issue on LGBT Health (August 2010):
- <http://virtualmentor.ama-assn.org/2010/08/pdf/medu1-1008.pdf>
- National Healthcare Equality Index (HRC's annual hospital survey): www.hrc.org/hei
- Joint Commission, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual, and Transgender (LGBT) Community: A Field Guide*, <http://www.jointcommission.org/lgbt/>

National LGBT Health Initiatives and Organizations:

- Gay & Lesbian Medical Association: www.glma.org

- Fenway Institute:
http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_ins_fenway_home
- National LGBT Health Coalition: <http://lgbthealth.webolutionary.com/>
- Straight for Equality in Healthcare: <http://community.pflag.org/sfe-test/page.aspx?pid=1599#.UA7AIY6ypUQ>
- American Medical Association GLBT Advisory Committee: <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/glb-adv-committee.page>
- IoM Committee on LGBT Health Issues and Research Gaps and Opportunities:
<http://www.iom.edu/Activities/SelectPops/LGBTHealthIssues.aspx>

National LGBT Medical Education Initiatives and Organizations:

- AMSA Gender and Sexuality Committee:
<http://www.amsa.org/AMSA/Homepage/About/Committees/GenderandSexuality.aspx>
- Stanford LGBT Medical Education Research Group (MERG):
<http://med.stanford.edu/lgbt/>
- AAMC GLBT Information Guide:
https://www.aamc.org/members/gsa/54702/gsa_glb.html

Major Reports on LGBT Health Disparities:

- Lambda Legal Health Care Discrimination Report:
<http://www.lambdalegal.org/publications/when-health-care-isnt-caring/>
- CAP Report LGBT Health Disparities:
http://www.americanprogress.org/issues/2009/12/lgbt_health_disparities.html

Population-Specific LGBT Health Information:

- *Lesbian Health 101: A Clinician's Guide*, Patty Robertson, MD, and Sue Dibble, DNSc, eds.,
- UCSF Lesbian Health and Research Center: <http://www.lesbianhealthinfo.org/index.html>
- Health Care Screening for Men Who Have Sex with Men, Daniel Knight, MD:
<http://www.aafp.org/afp/2004/0501/p2149.html>
- *The Ins and Outs of Gay Sex*, Stephen Goldstone, MD
- Bisexual Health: An Introduction and Model Practices:
http://www.thetaskforce.org/reports_and_research/bisexual_health
- Clinical Guidelines for Transgender Care, Trans Care Project, Vancouver, Canada:
<http://transhealth.vch.ca/resources/library/tcpdocs/projectanalysis.pdf>
- UCSF Center for Excellence for Transgender Health: <http://www.transhealth.ucsf.edu/>

Appendix C: Items in Dropbox*

- UCSF Checklist for LGBT Climate Equity and Inclusion
- UCSF Checklist for LGBT Curriculum Inclusion
- UCSF Core LGBT Competencies for Medical Students
- UCSF Institutional Self-Assessment
- UCSF LGBT Curriculum Overview (Years 1-4)
- UCSF Tool for Assessing Cultural Competence Training (TAACT)
- Vanderbilt Sexual History Flowchart
- Institute of Medicine: *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*
- Kelley, et al. A Critical Intervention in Lesbian, Gay, Bisexual, and Transgender Health: Knowledge and Attitude Outcomes Among Second-Year Medical Students (2008)
- Dean, et al. Successful implementation of an LGBTQI health elective into a medical school curriculum: a tool to increase culturally-sensitive care in person-centered medicine (2011)

*Link Here: <https://www.dropbox.com/sh/iqun102hmrqm877/esb7PA7t-X>