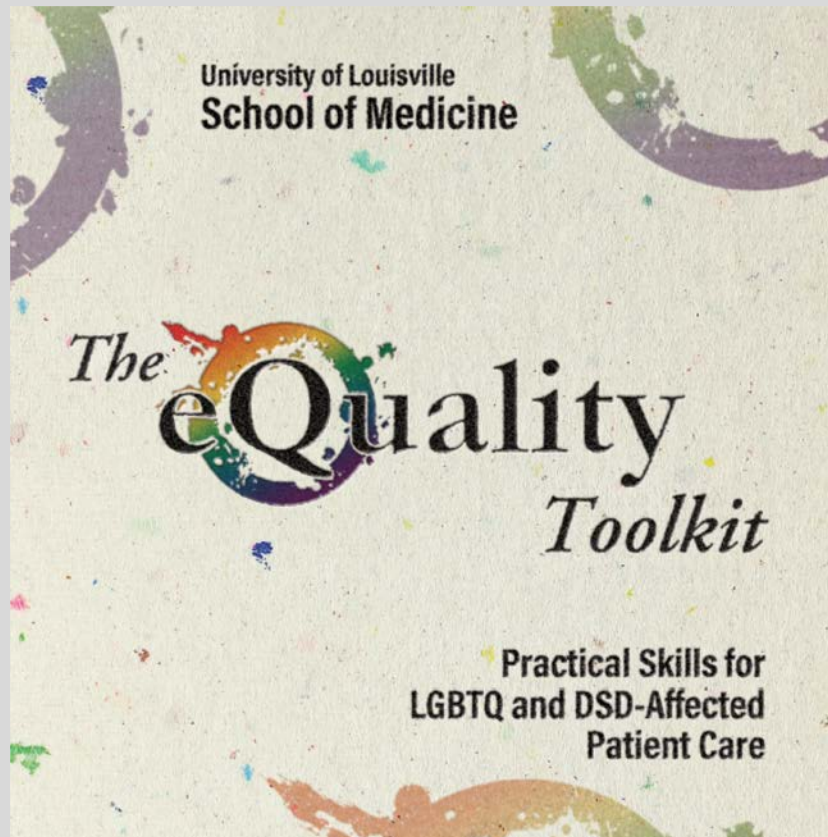


# The Role of the Medical Education Community in Addressing LGBTQ Health Disparities

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**Available as a FREE Open-Access Resource Here:**

[https://ir.library.louisville.edu/medicine\\_ume/1/](https://ir.library.louisville.edu/medicine_ume/1/)

**FREE Medicine and Nursing CME here:**

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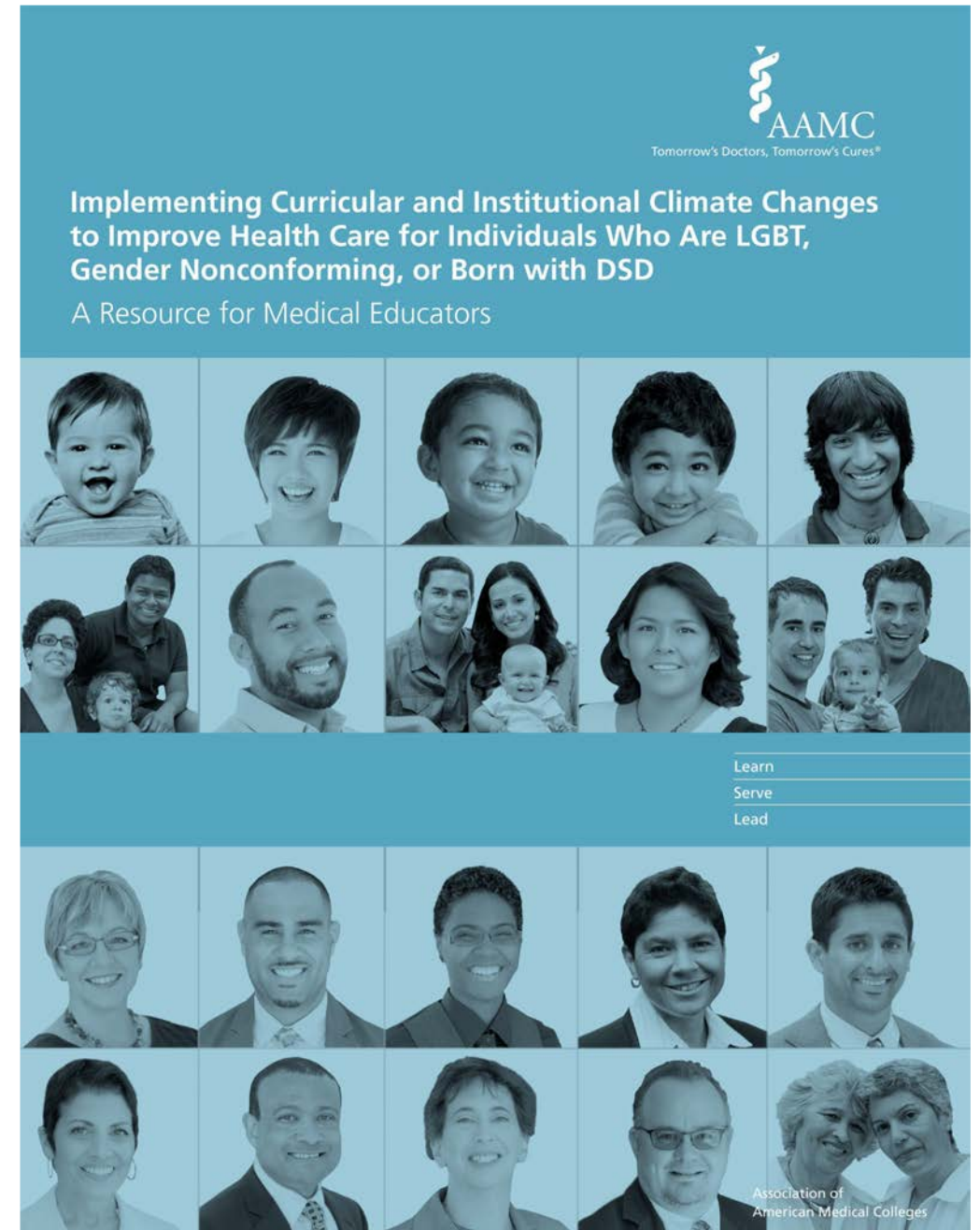
High levels of implicit bias

Gaps in knowledge and skills

Insufficient dedicated time

Faculty readiness to deliver key  
content

JAMA 2011;306:971-977



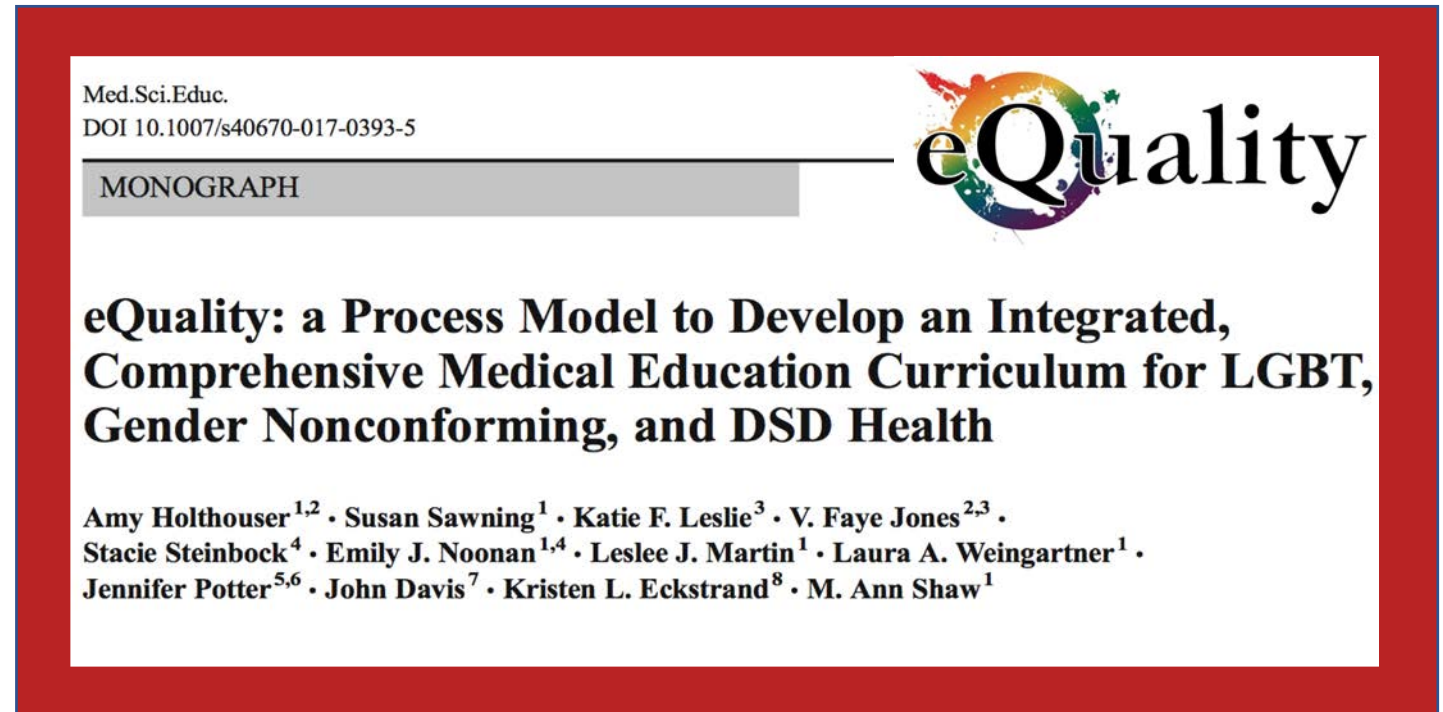
**SGM community members**  
**integrally involved**

**Learners interact frequently**  
**with SGM individuals**

**Clinical skills training and**  
**assessment integrated across**  
**all four years of training**

**Faculty development**  
**paramount**

*Acad Med* 2015;90:1-17. *J Gen Intern Med* 2017;32:1193-201.



Medical Science Educator. 2017;27(2):371-383.

# Overview of eQuality



- Integrated educational model – not separate electives
- Teach AND assess
- Implement pilot in 2015-2016 = 50.5 eQuality curriculum hours
- Faculty development needed - Involved 23 teaching faculty
- Include multiple direct student- patient interactions
- Community Advisory Panel reviews and refines curriculum
- Improve organizational climate
- Develop curriculum first, then clinical capacity
- All stages of project overseen and approved by Steering Committee

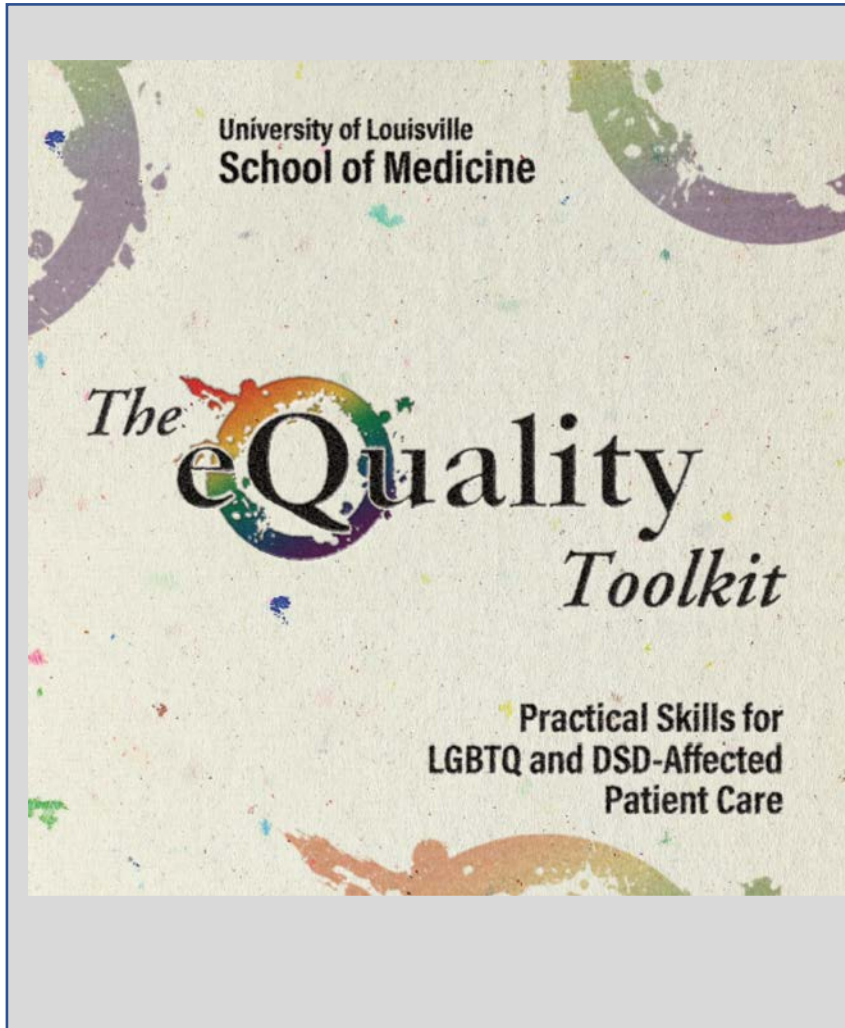
# How?



1. Assemble Key Advocates to Establish Program Vision that is Inclusive of Community and Institution Needs
2. Demonstrate a Need
3. Identify and Engage Content Experts
4. Establish Steering Committee
5. Engage Champions and Stakeholders
6. Engage Faculty
7. Develop Interventions, Assessment, and Research Aims
8. Disseminate Results
9. Engage Faculty/Learners/Community in Quality Improvement



# Clinical Skills Training



University of Louisville  
School of Medicine

*The* **eQuality**  
*Toolkit*

Practical Skills for  
LGBTQ and DSD-Affected  
Patient Care

- Inclusive Communication Skills
- Gender Affirming Care
- Preventive Care
- Social Determinants of Health
- Sensitive Physical Exams

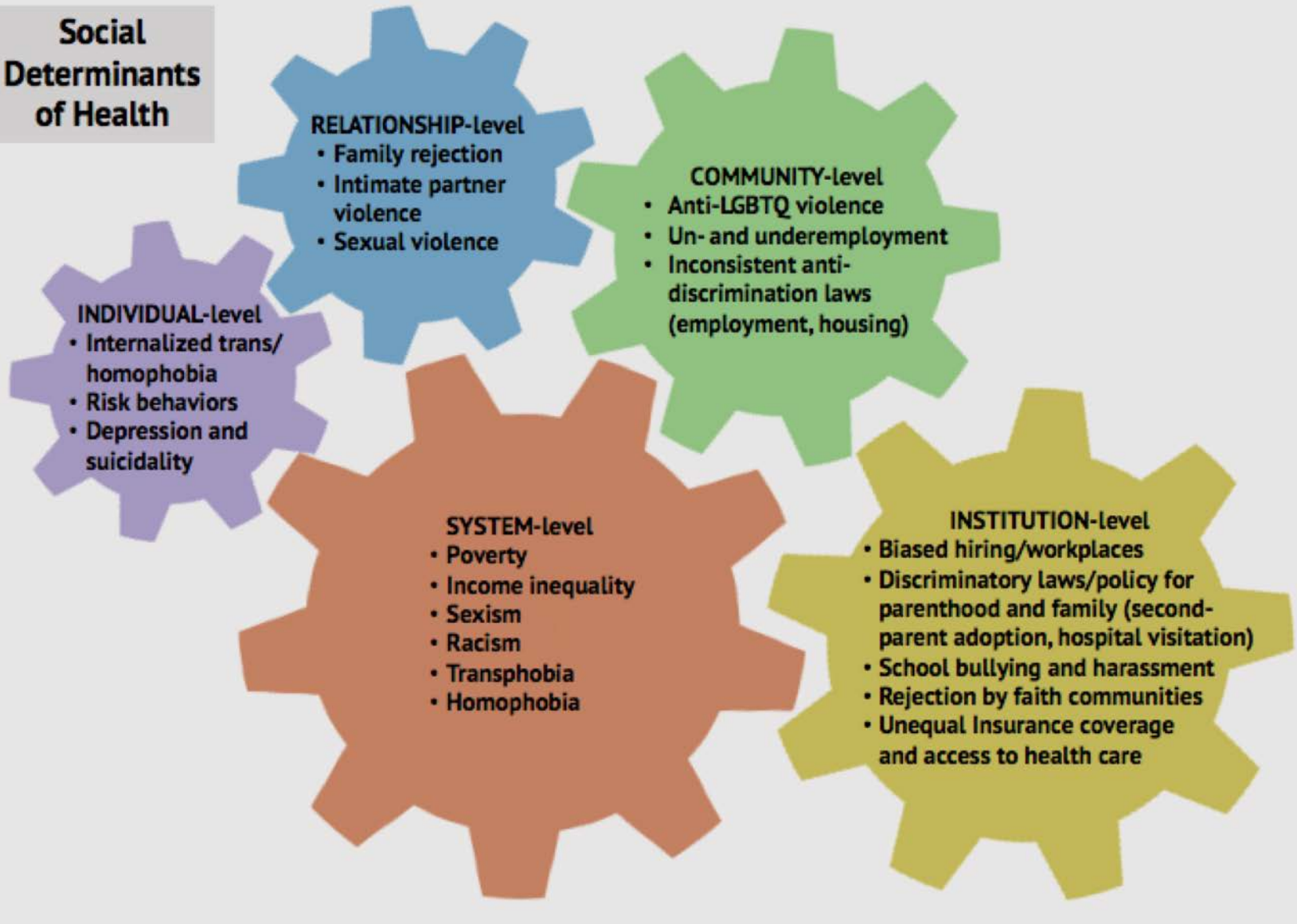
Question/Statement	Rationale for All Patients
<p><b>“How would you like me to address you?”</b></p>	<p>When providers ask this question first to all new patients, they avoid misidentifying or misgendering patients whose legal name differs from the name they actually use. New patients can be misgendered when honorific titles (Ms., Mr., etc.) are used in an introduction. Asking for a patient’s “real name” can also be unclear and/or demeaning. The phrasing provided here allows the patient to interpret the question and designate what name and/or title to use. In emergency settings, this is appropriate until a full history can be taken.</p>
<p><b>“I ask these questions to all of my new patients so that I can give you the best care possible.”</b></p>	<p>Approaching these topics with patients may seem difficult because they are not always included in medical histories. Introducing identity questions this way may help explain this process to those individuals who have not yet discussed these issues with providers.</p>
<p><b>“What was your sex assigned at birth?”</b></p>	<p>Understanding male/female sex assigned at birth (MSAAB/FSAAB) or intersex/DSD is crucial to understand the starting point of any sex-specific care that the patient will need (See Part III).</p>
<p><b>“What is your gender identity?”</b></p>	<p>This allows the provider to understand whether the patient’s gender identity matches their sex assigned at birth—e.g., whether the patient identifies as cisgender (match), transgender, on a spectrum, genderqueer, nonbinary, etc.</p>
<p><b>“What gender pronouns do you use?”</b></p>	<p>It is unlikely that the provider will refer to the patient with gender pronouns in person, but this information is important to fully represent the patient in later correspondence (chart notes or case presentations) and to educate other providers. Furthermore, asking gender pronouns is one of the most frequently cited steps that providers can take to make their practice more inclusive.<sup>24</sup></p>

<b>“Do you have sex with men, women, both, or anyone else?”</b>	“Men, women, or both” is a common phrase providers use, but this excludes identities outside of the gender binary—so providers should use the more inclusive wording here or in the next example.
<b>“Can you tell me more about the gender identities of your sex partners?”</b>	This is an open-ended version of the question directly above, with the intent to have the patient disclose rather than offering genders/identities of the patient’s partners. This breaks down a cisnormative assumption that gender identity (man/woman) also reveals sex assigned at birth (male/female), and differences can be important when considering preventive care.
<b>“Can you tell me more about the types of sex you are having?”</b>	This question allows the patient to describe the type(s) of sex they engage in. The provider should follow up with specific questions to clarify and fully understand each patient’s behaviors and thus risk factors (see next question).
<b>“What parts do you use when you and your partner(s) have sex?”</b>	All patients are capable of having oral and anal receptive intercourse and may therefore need related care/counseling. The only way to know for sure what risks a patient has is to ask about specific behaviors and body parts.
<b>“If your sexual activities change, you may need additional screenings.”</b>	People change, and behaviors that the patients do not report during one visit may be relevant in the future. This is true of all patients.
<b>“What is your relationship to the patient?”</b>	When a family member accompanies the patient, this open-ended question replaces questions such as “Are you the patient’s husband/wife?” which make assumptions about the patient’s relationship status and sexual orientation.

Cancer	Female Sex Assigned At Birth (FSAAB)		Male Sex Assigned At Birth (MSAAB)	
	Female-to-Male spectrum (includes trans men, FSAAB genderqueer, and other patients)	Cis Women (includes cis women who are lesbian, bi, queer, straight)	Male-to-Female spectrum (includes trans women, MSAAB genderqueer, and other patients)	Cis Men (includes cis men who are gay, bi, queer, straight)
<b>Anal</b>	Consider anal Pap test for <u>anyone</u> having anal receptive intercourse with additional consideration for the facility's ability to administer/follow up screening appropriately (capacity for this is rapidly evolving); <sup>51</sup> this applies to cis men and women, trans men and women, and any combination of gender identity when sexual practice includes anal receptive sex; anal warts are strongly associated. <sup>52</sup> Digital rectal exams do not reliably identify abnormalities and are thus not indicated for anal cancer screening. <sup>53</sup>			
<b>Breast</b>	Biennial mammography over age 50 (earlier for high-risk individuals), and clinical breast exam not indicated <sup>54</sup> <u>risk not eliminated with gender-affirming reduction</u> ; <sup>6</sup> effects of masculinizing hormone use are unclear. <sup>8</sup>	Biennial mammography over age 50 (earlier for high-risk individuals), and clinical breast exam not indicated. <sup>54</sup>	Without hormone use, consider breast exam for patients at high risk <u>only</u> (e.g., strong family history); over age 50 with 5-10 years of feminizing hormone use, biennial screening mammography. <sup>6</sup>	Consider breast exam for men at high risk <u>only</u> (e.g., strong family history). <sup>54</sup>
<b>Cervical</b>	Pap test every 3 years from age 21 to 65 years (guidelines under review) <sup>55</sup> or co-test age 30-65 with HPV DNA test every 5 years; <sup>56</sup> lowered risk if cervix removed with a total hysterectomy (as gender-affirming surgery or other conditions, such as fibroids or uterine prolapse), so no Pap test. <sup>55</sup> Bimanual pelvic exams are not indicated. <sup>57</sup>		Not applicable: no cervix, even after vaginoplasty; annual visual inspection of neovagina can identify other issues (warts, ulcers)	Not applicable
<b>Colorectal</b>	Colonoscopy should be considered beginning at age 50 years and every 10 years thereafter continuing until age 75 years, individual decisions for screening from then on. <sup>58</sup> Digital rectal exams not indicated. <sup>53</sup>			

<b>Lung</b>	Low-dose computed tomography (LDCT) considered in age 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. <sup>59</sup>	
<b>Oral</b>	Consider clinical oral-cavity examination based on tobacco/alcohol use, risk of oral HPV exposure. <sup>60</sup>	
<b>Ovarian</b>	No screening recommended; lowered risk if ovaries removed with oophorectomy as part of a total hysterectomy (for gender-affirming surgery or other conditions). <sup>61</sup>	Not applicable
<b>Prostate</b>	Not applicable	Inform patient aged 55-69 about potential benefits/harms of prostate-specific antigen (PSA)-based screening; <sup>62</sup> <u>note that prostate is intact after gender-affirming surgery.</u> <sup>6</sup>
<b>Skin</b>	Consider visual skin examination after assessing individual risk factors (familial syndrome, fair complexion, sun exposure, etc.). <sup>63</sup>	
<b>Testicular</b>	Not applicable	No screening recommended but potential risk <u>unless</u> orchiectomy (gender-affirming care, etc.); <sup>64</sup> monthly self-exam for history of cryptorchidism with no or post-puberty orchiopexy advised. <sup>65</sup>
<b>Uterine/ Endometrial</b>	No routine screening recommended; lowered risk if uterus removed with hysterectomy (for gender-affirming surgery or other conditions); <sup>66</sup> educate patients to report abnormal bleeding. Bimanual pelvic exams are not indicated for this screening. <sup>57</sup>	Not applicable

## Social Determinants of Health

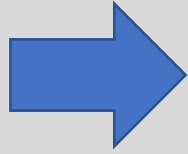


# Teaching the eQuality Toolkit



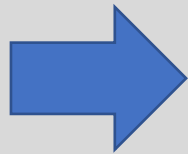
2<sup>nd</sup> Year Medical Students: Completed 50.5 Hours eQuality

**Online  
learning  
activity**



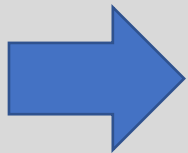
- Softchalk™ Online Lessons
- **Goal:** Engage w/ eQuality Toolkit Prior to Class Session

**Small-  
group  
role play**



- Small Groups of 12 with Facilitator
- 4 Unique Cases Involving Skills Application from Toolkit
- Physician, Patient, Observer Roles w/ Packet for Each Role
- **Goal:** Actual Skills Practice

**Whole-  
class  
debrief**



- Expert Clinician Debrief
- **Goal:** Highlight Important Points of Clinical Care/Answer Qs

# Clinical Skills Assessment

## Cohort of Gender Minority and Cisgender SPs 2017-18

**Transgender  
Women**  
3 SPs

**Transgender  
Men**  
4 SPs

**Genderqueer  
(Female SAAB)**  
6 SPs

**Cisgender  
Women**  
4 SPs

**Cisgender  
Men**  
3 SPs

**Genderqueer  
(Male SAAB)**  
0 SPs

- Developed a standardized patient (SP) case with iterations that varied only by gender identity and sex assigned at birth (SAAB – male or female).
- SPs establish primary care and report same health history to blinded students.

# Clinical Skills Assessment Tools



<b>SP Checklist</b>	<b>Video Coder Checklist</b>
<b>Student SOAP Note</b>	<b>Student Perceptions &amp; Recommendations</b>

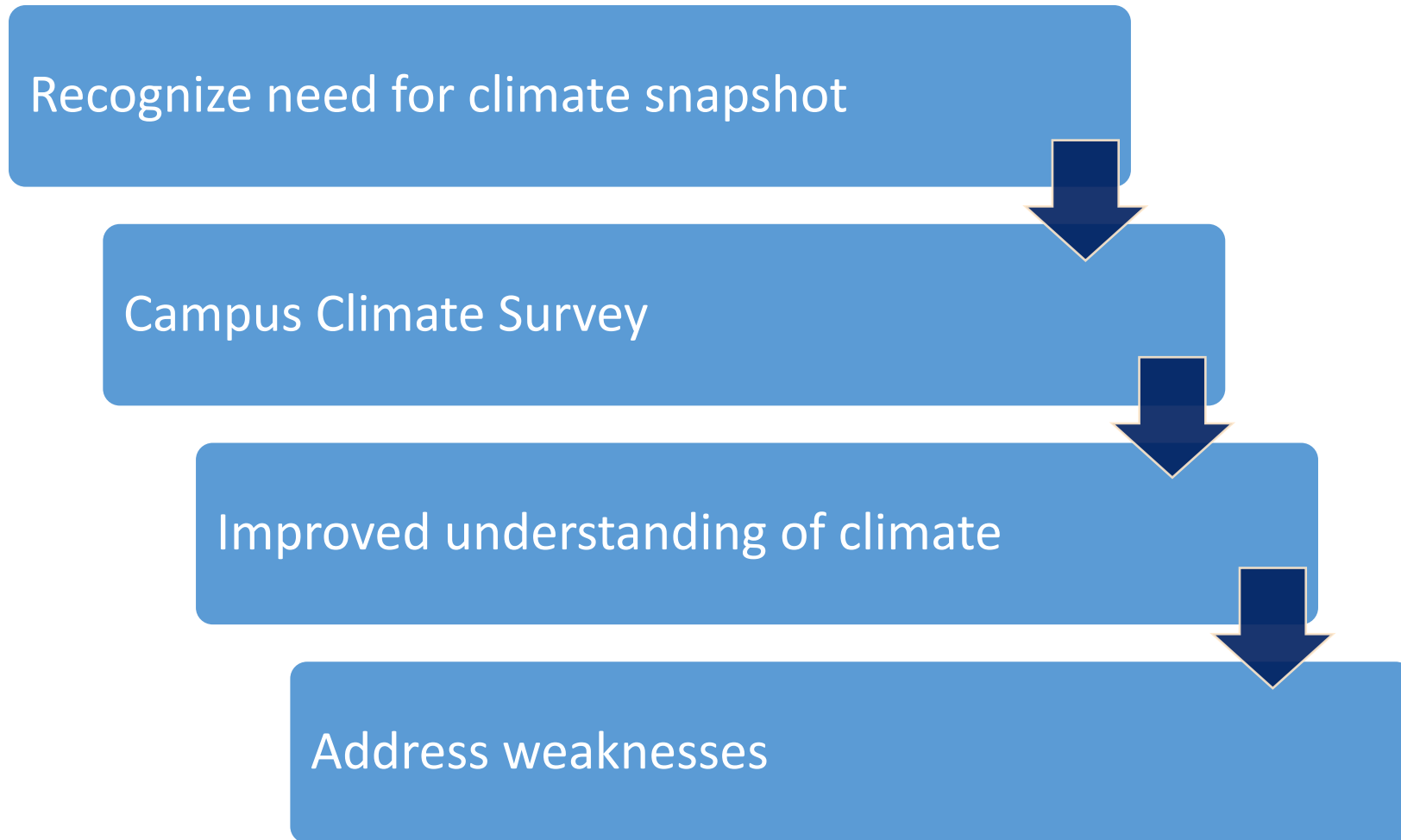
# SP Assessment Results



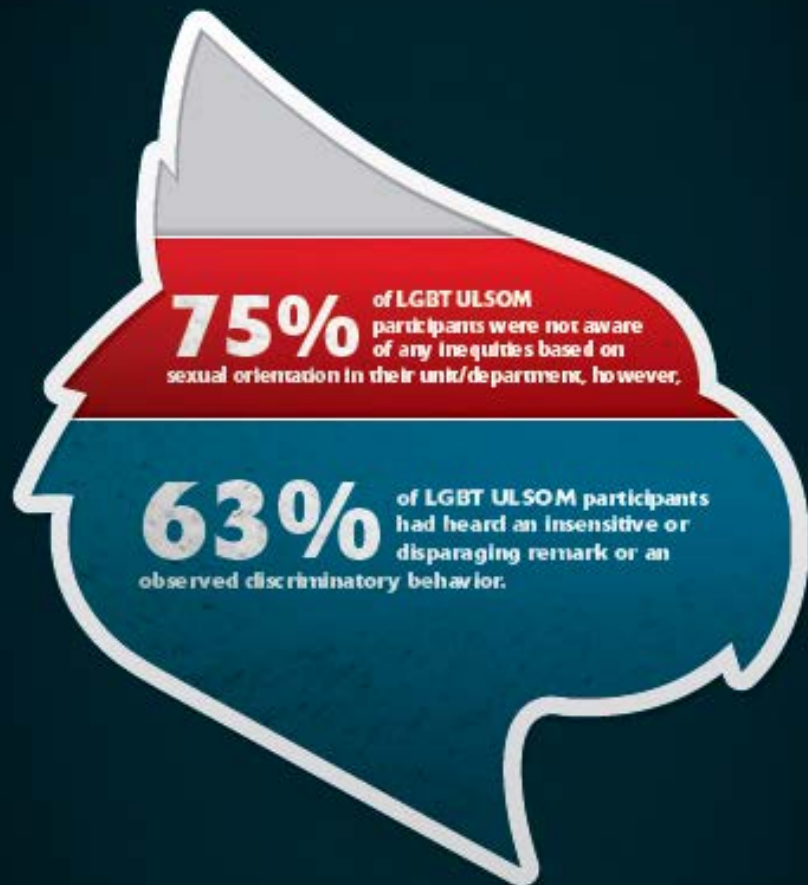
Clinical Skill	Comparison	Intervention
Ask about gender identity	27.0%	47.0% ↑
Ask about sexual orientation	23.4%	26.2% ≈
Ask about specific sexual behaviors	43.8%	67.1% ↑
Medically relevant HT discussions	63.5%	65.1% ≈
Willing to prescribe hormones to GM	67.7%	87.8% ↑

Following the intervention, SPs indicated that some skills for inclusive communication and gender affirming care improved.

# System Approaches to Change



# Inequities and Insensitivity



## Action For Improvement

UofL is developing and implementing bystander training to give individuals tools for interrupting potentially insensitive comments and discriminatory situations.

# Support for LGBT Students, Faculty & Staff



## Action For Improvement

UofL will convene focus groups to better understand the needs of faculty and staff to determine how to support them.

# Organizational Climate

Comfort with disclosure

- Ally campaign

Intervene in behavior

- Bystander/Upstander training

Perception of support for LGBT faculty/staff

- Focus groups with faculty and staff

Faculty Development

- Multiple, targeted trainings

SOMETIMES BECAUSE OF  
**HOW PEOPLE LOOK,**  
THEY AREN'T ALLOWED  
TO USE THE RESTROOM.

**WE CAN DO BETTER!**

In this bathroom we ask  
that no one will be stared  
at, questioned or asked to  
leave.

this bathroom is for  
everyone.



## **REAL IMPACTS**

There are real impacts when bathrooms are labeled for women or men only.

- Trans and Gender Non-Conforming people often face discrimination, harassment, arrest or violence in bathrooms!
- Everyone should get to do their makeup, change clothes, change their babies, and use the bathroom in peace.
- Everyone who needs help should be able to use the facilities with family members, friends and attendants.

It's important that we proactively work to

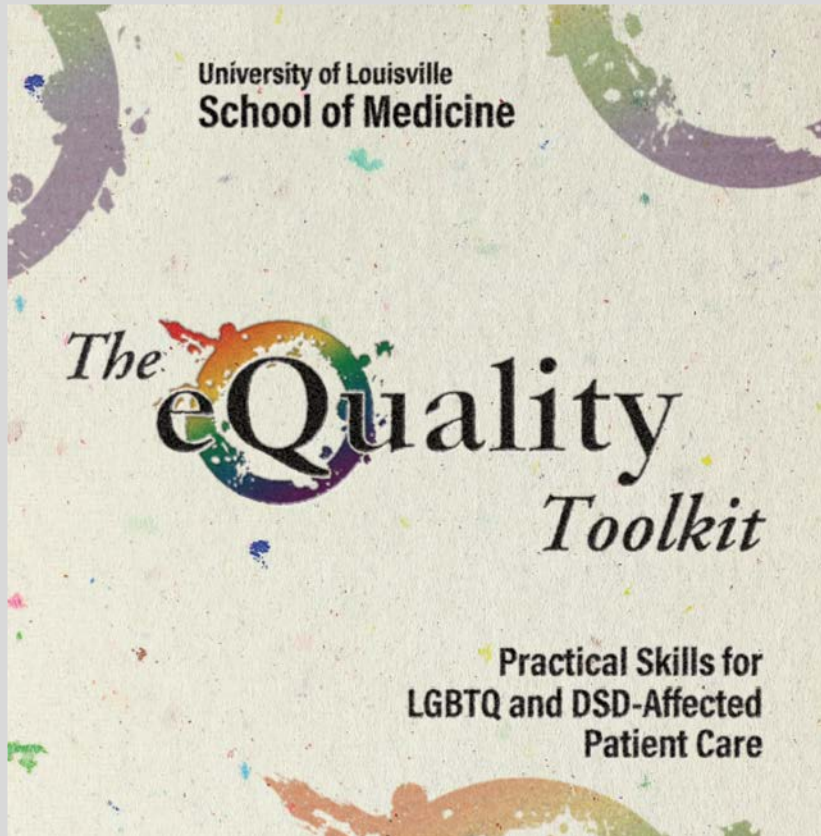
Students apply inclusive clinical skills after comprehensive LGBTQ curriculum.

Direct practice of LGBTQ clinical skills can address gaps + make broad improvements.

Addressing training gaps could decrease health disparities for patients.

Students need more opportunities to practice LGBTQ health skills for clinical impact.

# Thank You to Many Contributors!



**Available as a FREE open-access resource:**

[https://ir.library.louisville.edu/medicine\\_ume/1/](https://ir.library.louisville.edu/medicine_ume/1/)

**Print Copies** available (\$34.95) – University Press of Kentucky, all proceeds go to UofL LGBT Center

**Free CME (medicine/nursing):**

<http://bit.ly/eQuality19>

**Teaching materials available soon!**