EDITORIAL: PART II

Teaching LGBT Health in Medical School?

Richard E. Greene, MD

Dr. Greene is assistant professor at the New York University School of Medicine. He can be reached at richard.greene@nyumc.org.

When I begin to discuss lesbian, gay, bisexual, and transgendered (LGBT) health with medical students, the most common reaction I get is: "Oh, please! I'm totally fine with gay people." I must say this is a refreshing change from the late 1980's when one third of physicians thought gay people were unnatural and were uncomfortable taking care of them.[1] However, I am left to answer the questions: Is being open to talking about LGBT issues in a non-judgmental way enough? Is it enough for our monumentally open-minded and accepting medical students of today to report feeling comfortable talking about LGBT issues as long as patients bring them up?

Many practicing physicians suggest that simply taking a comprehensive sexual history should illuminate sexual risk. The issue here is that LGBT health care disparities extend beyond the sexual history into cultural beliefs about health care and perceived risk of illness. Further, patients who identify with the LGBT community are only a subset of the patients who are sexually active with people of their own gender (so-called "men who have sex with men" or "MSM"). We are challenged on a daily basis to care for *all* of these patients, whether we are aware of them or not.

So given that we, as practicing clinicians and educators, have not fully integrated the care of LGBT patients into our practice, how do we teach the next generation the "right way" to care for them? One major resistance to adding LGBT issues to the curriculum is how to accomplish this. It would be unfair to recommend that every medical school add another five hours of curriculum to the pre-clinical years to discuss LGBT health, as important a subject as it may be. So where do we put it?

Most medical schools at this point have a lecture about the sexual history in which they mention (to varying degrees) the LGBT patient. Some have panel discussions with LGBT patients or providers during which students can hear firsthand the struggles some of these patients have faced. For better or worse, the other most common location of LGBT health in the curriculum is gay men or MSM in regard to HIV and sexually transmitted infections. While the inclusion here is appropriate and essential, it is glaring that one of the only mentions of LGBT patients is to reference gay men as vectors of disease.

So what more can we add? Quite a bit actually, and here's how to do it.

Teach a non-judgmental sexual history. First, and most importantly, medical students must learn to take a thorough and non-judgmental sexual history. The sexual history challenges many experienced practicing physicians. At its most complicated, it can feel intrusive or voyeuristic, leaving the physician vulnerable to perceived charges of impropriety. A fear exists that if we question a heterosexual patient about the possibility of a same-sex sexual partner, we are implying something about their sexuality. Another fear is that a patient may reference a sexual act with which we are unfamiliar, which may leave us feeling uninformed or foolish. However, by not asking clear and direct questions, crucial information may be missed.

So we teach all of the techniques to lessen this discomfort: Asking permission ("Is it alright with you if I ask some questions about sex and sexuality?"), normalizing statements ("I ask all my patients these questions."), and using non-heteronormative questions ("Are you sexually active? With men, women, or both?"). It is then essential to let the student practice this history to get comfortable with the discomfort of asking such questions. Initially, practice with a standardized patient may be one low-stakes opportunity for medical students to practice, perhaps even with a video recording, so they may review their performance with some distance from the history. It bears noting that a good non-judgmental sexual history may be useful to both our LGBT patients and our heterosexual patients who engage in anal intercourse, thereby increasing their risk of infections or trauma.

Infuse the existing curriculum with information about LGBT patients. Delivering the content on LGBT health could demand inserting hours of previously untaught material into the curriculum. The answer here is not to demand additional hours or new lectures but instead to infuse LGBT relevant clinical pearls into pre-existing lectures. For example, Tang et al. reported that lesbians are 70% more likely to smoke than their heterosexual counterparts.[2] Rather than try to include this fact in a lecture about the sexual history, perhaps it can be included as one line in the pulmonary or cardiac lecture that discusses smoking. We do this already with African Americans and hypertension, so the precedent exists.

Ensure exposure to LGBT patients during clinical rotations. In the clinical years, Observed Structured Clinical Exams (OSCEs) have become a popular tool for assessing student performance. What if a standardized patient on the OB/GYN clerkship happened to be a lesbian who was pregnant? What if a transgendered patient on testosterone was being treated for heart disease on the ambulatory care clerkship?

continued on page 2

EDITORIAL: PART II

continued from page 1

Gather new data. The final and most challenging aspect to this is that we need more information—specifically, surveillance data to show that the issues facing the LGBT community lead to poor health outcomes and outcomes data to show that our interventions change this. We have made some progress in this area. We know that the 25% of people infected with HIV who are unaware of their status are responsible for 50% of new infections and that the majority of these involve men who have sex with men.

When my medical students remind me of how "cool" they are with gay people, I remember one young first-year medical student in a lecture I gave on LGBT health disparities who raised her hand in front of the whole class and asked timidly, "What if I just don't feel comfortable asking these questions? Can I just refer the patient to someone else?" My answer for her is my answer for all of us: Challenge yourself. If we make this effort and infuse our curricula with information about LGBT health, will we improve the long-term health outcomes for our LGBT patients? The obvious answer is: It certainly can't hurt.

References

1. Gerbert B, et al. Primary care physicians and AIDS: attitudinal and structural barriers to care. JAMA 1991; 266:2837-42.
2. Tang H. Cigarette smoking among lesbians, gays, and bisexuals: how serious a problem? (United States). Cancer Causes & Control 2004; 15(8):797-803.

SGIM