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Part of the Solution to Address Sexual and Gender Minority Health and Health Care Disparities: Inclusive Professional Education

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Abstract

Background and Purpose. The public health perspective regarding sexual and gender minority health has continued to expand beyond the hallmark AIDS crisis in the 1980s. Sexual and gender minorities experience various health and healthcare disparities for a variety of reasons. A 2017 national survey indicated that 8% of lesbian, gay, bisexual, and queer (LGBQ) respondents had been refused care by a health care provider in the last year because of their sexual orientation, and 29% of transgender identified individuals were refused care.[1] Healthcare provider attitudes and behaviors contribute significantly to some of these disparities. This perspective piece provides a synopsis of the public health/population health challenge with health disparities in these populations and a call for action to have professional health education be more inclusive of content pertinent to the health and treatment of sexual and gender minorities. This perspective also provides a summary of educational recommendations and sample curricular objectives to assist ease of integration into health professional education, regardless of discipline. A framework of pedagogy and delivery of curricula is beyond the scope of this perspective piece. **Position and Rationale.** In seeking solutions to impactful ways of achieving health and healthcare equity in these communities, one solution has to be on the educational and academic side of health professions. In its broadest sense, the literature suggests a strong positive association between education and health from a socioecological model perspective. This perspective piece speaks directly to the subset of how education can have a direct impact on health disparities through the health care provider's interpretation and use of information learned/not learned. **Discussion and Conclusion.** Based on pedagogical principles in education and literature suggesting positive associations between impact on health disparities and health professional education,[2] it is concluded that health professional education - regardless of discipline - should be inclusive of sexual and gender minority content to address this significant gap in knowledge, awareness, and skill in health delivery for these populations.

Introduction

From an educational and population health perspective, the foundation of health care professional education has been non-inclusive of health care discussions regarding sexual and gender minorities (SGM) and the health disparities that exist within these populations.[3–6] In fact, the inclusion of this content has not been included or studied in all health disciplines, but where it has, it reveals a significant gap.[7–9] In the last decade, the medical literature has started to unravel and discover the very real health care needs that go along with these identities. Since sexual and/or gender identities are not a required demographic data point to collect, data and research in healthcare regarding discrimination and health disparities is markedly limited. From the latest demographic statistics that we do have, conservative estimates put the collective populations within these spectrums at ~ 4.1% of the U.S. population; however it's important to note this number is not inclusive of all identities within these populations.[10] The data around

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health disparities/equity that we do have indicates pervasive and statistically significant numbers of both discrimination and health disparities among these populations.[11,12]

The literature also supports the very real correlate of healthcare provider discrimination and bias to perpetuation of health disparities in these populations, specifically in delaying health care or not seeking health care altogether.[13–16] While the educational research is mixed on the impact of cultural competency education in translating to improved healthcare delivery, it does indicate a positive association in acquiring new knowledge, improved attitudes and skills, and enhanced patient experience.[17,18] We also have limited to no data regarding sexual and gender minority inclusive cultural competency education for health care professional education and its impact.[17] Cohen and Syme advocated for more research exploring to what extent educational interventions can address health inequities, noting that this is an area of infancy in the research realm.[19] Alcaraz and colleagues go further in describing a framework to help advance research and interventions focused on health equity, inclusive of sexual and gender minority health.[20] Cameron et al., also take a deeper dive into structural competency and delivery of educational curricula in a context that hopes to expand identity-based health needs in a meaningful and truly impactful way.[21]

Throughout the professional educational curricula in healthcare (physical therapy, medical, nursing, occupational therapy, speech, chiropractic, etc.) there is limited to no time dedicated to learning about cultural competency or health disparities regarding these populations.[22] That has to change. Some programs dedicate numerous hours and lectures to rare diseases and conditions; the likelihood of encountering one of these in one's professional career are minimal. However, healthcare professionals will all treat patients with identities in sexual and gender minorities. Most professionals likely won't be comfortable doing so and may identify a lack of preparation in the professional curriculum as one reason. Implicit and explicit bias has also been identified in the literature as a contributor to discriminatory practice among healthcare providers.[14,16,23] When looking at these gaps in curricula for our healthcare professionals, one can argue that the approach to fill them should be multi-faceted, and at minimum start with requiring professional education to be inclusive of these populations' health needs and characteristics. The American Association of Medical Colleges (AAMC) has published a monograph with sexual and gender minority competencies for medical professional curricula, which this author summarizes for generalization to all disciplines.[14] This commentary establishes the necessity of healthcare professional education to be inclusive of sexual and gender minority content to specifically address the healthcare disparities that providers directly contribute to: implicit/explicit bias, discrimination, and cultural incompetence.

The Literature and SGM Health Disparities

Operationally, this author speaks to lesbian, gay, bisexual, and transgender (LGBT) health disparities because some of the identities included in the inclusive terms "sexual and gender minorities" have not been studied to date. The literature specifically speaks to the following identities in health disparity research: LGBT. It is purported that LGBT health disparities stem from a sociocultural environment that devalues these minority identities.[24] Meyer and Frost apply the minority stress model to health outcomes: minority stress is based on the premise that prejudice and stigma directed toward sexual and gender minorities brings about unique stressors and these cause adverse health outcomes manifested as health disparities.[25] This commentary speaks specifically to education being a public health answer to having an impact on these

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disparities, primarily because provider behaviors and attitudes have a direct correlation on disparities in these communities.[1] As we gain more insight into the health of these populations, we continue to note drastic and significant health disparities across the spectrums of these communities. Of note, there is strong literature looking into resilience factors as attributes of positive contributors to health in these communities.[26–30] Table 1 provides a summary of some key health and health care disparities, which this author has adapted from the AAMC publication.[14]

Table 1: Overview of Health and Health Care Disparities in Sexual and Gender Minority Populations (Adapted and Modified from AAMC, 2014)

Health Disparity	Prevalence/Statistic	Populations Affected
Obesity	2x risk compared with heterosexual women[31]	Lesbian and bisexual women
Asthma	1.5 times the risk compared to heterosexual counterparts	LGB adults
Cardiovascular disease	>2 times the risk compared to heterosexual counterparts[32]	LGB adults
	Significant elevations in biomarkers of cardiovascular disease compared to heterosexual men	Young GB men
Smoking	>2 times the risk compared to heterosexual counterparts[33]	Bisexual individuals
	Higher prevalence versus population as whole[32]	LGBT population
Physical disability	Increased likelihood at younger age than heterosexual counterparts[34]	LGB individuals
	2x the risk compared to heterosexual women	Lesbian women
	3x the risk compared to heterosexual men and women	Bisexual men and women
HIV/AIDS and other STIs	Elevated risk for HIV/AIDs and other STIs[35]	Gay men and transgender women
Cancer	Increased anal cancer rates primarily due to increased risk for HPV[36]	Gay and bisexual men and men who have sex with men
	Increased breast cancer; increased fatal breast cancer	Lesbian and bisexual women
	Cervical cancer primarily due to elevated risk for HPV	Lesbian and bisexual women
	Colon and rectal cancer primarily due to elevated risk factors	Lesbian and bisexual women
	Lung cancer; further research needed as to reason	LGBTQ individuals

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	Prostate cancer; further research needed as to reason	Men who have sex with men
Lifetime risk of violent victimization and maltreatment; Lifetime exposure to traumatic experiences	Higher risk than heterosexual and cisgender individuals[37–40]	LGBTQ individuals
Substance use/abuse	>2x more likely to have used any illicit drug in past year[41]	Lesbian, gay, bisexual individuals
	Increased binge-drinking[41]	Adult LGBT individuals
	90% more likely to use substances than heterosexual adolescents[42,43]	LGB adolescents
Risk behavior likelihood	Less likely to practice safer sex than heterosexual counterparts[44]	Young gay men
	>4x incidence of risky sexual practices/unsafe practices compared to white peers[45]	Lesbian and bisexual youth who identify as "mixed" race/ethnicity
	>1/3 prevalence in hazardous weight control behaviors[46]	LGB youth
	Less engagement in moderate/vigorous physical activity or participation in sports than non-LGBT counterparts[47]	LGBT youth
Depression, anxiety	Significantly increased risk than non-LGB counterparts[48]	GB adult men and LGB youth
	~4x risk of depression[49]	Non-treated transgender individuals
Suicide ideation / attempts	2-4x risk of suicide ideation compared with heterosexual men[50]	GB men
	2x more likely to have suicide ideation and 4x more likely to make serious suicide attempts requiring medical attention than heterosexual counterparts[51]	LGB youth
	14% prior suicide attempt; 50.8% transgender male suicide attempts; 41.8% nonbinary individuals; 29.9% transgender females; 27.9% questioning individuals; 17.6% females; 9.8% males[52]	LGBTQ youth
Healthcare discrimination and mistreatment	33% of transgender respondents experienced a negative interaction with a healthcare provider[53]	Transgender individuals
	Refusal of Care: 8% LGB respondents experienced refusal of care;	LGBT individuals

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	29% of transgender respondents experienced refusal of care[54]	

The Literature and SGM Content in Health Professional Education

Two recent systematic reviews of sexual and gender minority inclusive education in the health professions reinforce the conclusions that education and training of healthcare providers and students will improve skills and ultimately may lead to improved quality of healthcare for sexual and gender minorities.[6,7] These systematic reviews also concluded that our professional education curricula have a long way to go to be inclusive of this content, consistent with delivery of this content in all disciplines, and establishing a conceptual model for best practice of curricula implementation. In the AAMC monograph, the authors discuss numerous challenges and advancements to education reform in this area. Of note in the barriers and challenges is that they are multi-factorial, and combine both lack of mentoring/modeling in clinical practice with absence of faculty willing and able to teach relevant content in the didactic curriculum.[14] There is no current requirement of this content in health professional literature as a stand-out component, rather, it is often implied as covered under other areas, such as cultural competency or domains of competency for history taking, etc. The literature suggests is that this is not nearly comprehensive enough to address the core knowledge and skills needed to provide patient-centered care for these populations. Most of the literature supporting the necessity and preliminary effectiveness of sexual and gender minority inclusive curricula has been done in the medical community. All health disciplines need to follow suit in opening their curricula and their research to supporting these communities in their health. Given the direct and significant contribution to health disparities by provider discrimination and bias, health professional education can serve to increase awareness and knowledge of these communities to help inform best practices in health delivery and help foster a more affirming climate and approach in training and delivery.

The author fully acknowledges the complexity and numerous other aspects around culture and climate that also need to be addressed when making curricular shifts. This commentary is meant to be a succinct snapshot of advocating for educational interventions to be one of the public health answers to health disparities in SGM communities, fully recognizing the many layers of implementation challenges from societal to individual level barriers. It is beyond the scope of this commentary to discuss delivery recommendations, curricular models, pedagogical influences to delivery. This commentary aims to provide a summary of recommendations for content and scope only. There is no best-practice model validated to date regarding curricula integration. One of the most comprehensive models/guides to date is AAMC's 2014 publication utilizing competency domains for medical education. That publication is the foundation for the summary below, given that it extensively synthesized the available literature and utilized a broad panel of experts. Table 2 provides a summary of recommendations for health professional educational curricular threads, regardless of discipline. This content crosses all health disciplines, and can be individualized and contextualized discipline-specific, however, the curricular threads noted in this summary are considered integral to all disciplines.

Table 2. Summary of Recommendations for Health Professional Education Curricular Threads

(Expanded Upon from AAMC, 2014)

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Area of Domain of Practice	Recommendations for Content	Sample Objectives for Outcomes of Education
Patient Care	Include terminology and practices specific to SGM populations	Develop effective rapport with all patients utilizing inclusive language and practices that avoid assumption-based terminology.
	Teach health disparities and health equity specific to SGM populations	
Knowledge for Practice	Apply biophysical scientific principles fundamental to health	“Define and describe the differences among: sex and gender; gender expression and gender identity; gender nonconformity, and gender dysphoria; and sexual orientation, sexual identity, and sexual behavior.[14]”
	Apply principles of social-behavioral sciences to principles of patient care	“Understand and describe historical, political, institutional, and sociocultural factors that may underlie health care disparities experienced by SGM populations.[14]”
	Teach investigatory and analytic approach to clinical situations inclusive of sexual and gender minorities	“Recognize the gaps in scientific knowledge and identify various harmful practices that perpetuate the health disparities for patients in the SGM populations.[14]”
Practice-Based Learning and Improvement	Teach self-awareness and reflection to identify strengths, deficiencies and limits in one’s knowledge and expertise	“Demonstrate the ability to elicit feedback from individuals who identify within SGM populations about their health experiences and identify opportunities for change to improve care (e.g. inclusive language on intake forms).[14]”
	Teach critical appraisal and application of evidence related to patient health	Include important clinical questions pertinent to SGM populations as they emerge when seeking the literature to inform clinical decisions.
Interpersonal and Communication Skills	Cultural humility and competency content inclusive of these populations	Demonstrate knowledge of current terminology respectful of SGM populations when describing patient care or establishing rapport with patients.
	Teach trauma-informed care and practices	
	Skill based content on demonstrating insight and understanding about emotions and human responses to emotions that	“Understand that implicit bias and assumptions about sexuality, gender, and sex anatomy may adversely affect verbal, nonverbal, and/or written communication strategies involved in patient care, and engage in effective corrective self-

Area of Domain of Practice	Recommendations for Content	Sample Objectives for Outcomes of Education
	allow self-development in interpersonal interactions	reflection processes to mitigate those effects.[14]"
Professionalism	Cultural humility and competency content and behaviors inclusive of these populations.	Recognize and sensitively address all patients' and families' health traditions and beliefs, and understand the possible effect on diverse forms of sexuality and gender/gender identity.
	Confidentiality and patient privacy with circumstances unique to these populations	Recognize and follow the unique aspects of confidentiality with SGM populations and utilize appropriate consent practices.
	Ethics and accountability to patients, society, and the profession	"Accept shared responsibility for eliminating disparities, overt bias, and develop policies and procedures that respect all patients' rights to self-determination.[14]"
Systems-Based Practice	Teach advocacy for quality patient care and patient care systems	Demonstrate knowledge about legal and systemic barriers to health and resultant discriminatory practices that inhibit optimal health outcomes for SGM populations.
	Teach the coordination of patient care to specifically target disparity impact	"Identify and partner with community resources that provide support to SGM populations to help eliminate bias from health care and address community needs.[14]"
	Teach practices to effect change on behalf of SGM populations on a systems level	"Explain how homophobia, transphobia, heterosexism, and sexism affect health care inequalities, costs, and outcomes.[14]"
Interprofessional Collaboration	IPE cultural competency practices relative to establishing and maintaining respectful climates/cultures, dignity, diversity, and ethical integrity	Utilize interprofessional communication and collaboration in providing culturally competent, patient-centered care to the SGM populations and participate effectively as a member of an interdisciplinary health care team.
Personal and Professional Development	Self-reflection content thread regarding personal and professional development goals	"Critically recognize, assess, and develop strategies to mitigate one's own implicit biases in providing care to SGM individuals and recognize the contribution of bias to increased iatrogenic risk and health disparities.[14]"

Conclusion

The cultural shift in education is great, however, the alternative to this cultural shift is not acceptable. Romanelli provides a candid summary: "the root causes of system-level barriers were

all attributed to social-structural factors that worked to exclude and erase LGBT people from the institutions that shape the health and mental health systems[55].” This commentary establishes the necessity for all health professional discipline education to be inclusive of a sexual and gender minority thread throughout all content domains, however, assessment of that learning and direct impact to patient care is not necessarily addressed here. There is a paucity of literature on true assessment and direct patient impact of cultural competency education, and essentially no literature on the impact of sexual and gender minority inclusive education. Ethics are not optional when you are a healthcare provider, and it is long past due that we include all patient populations in the education and training of health care professionals. The four principles of health care ethics - autonomy, beneficence, non-maleficence, and justice - do not stop short of inclusion of sexual and gender minority patients. There is no doubt, we have to do better in every aspect of health with these populations, and one public health answer is to ensure that our professional education curricula are inclusive and outcome based for patient-centered care with these populations.

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