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Discussion

It's not alphabet soup – supporting the inclusion of inclusive queer curricula in medical education

DISCUSSION

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ABSTRACT

Medical curricula have undergone somewhat of a change in response to the landscape of health and social care within the UK. One group that is particularly underrepresented within medical curricula is the LGBTQIA+ community; marginalising the community and potentially perpetuating the well-documented health inequalities experienced by LGBTQIA+ individuals. This article discusses the current representation of the LGTBQIA+ community within medical curricula and presents recommendations for more inclusive, contemporary practice. The authors champion for the creation of a culture centred upon education and advocacy. Co-creation of curricula is an important consideration ensuring that the burden does not fall to those with lived experiences to educate others. Health curricula need to evolve to represent the diversification of society and the associated healthcare and workforce needs. This discussion article serves to challenge the heteronormative assumptions within healthcare and proposes strategies for training the future workforce to deliver inclusive and supportive healthcare. It is pivotal to afford healthcare students with the opportunity to develop their communication and consultation skills, especially with regard to sensitive subject matters including sexuality, gender identity and sexual histories. By setting aside time for students to develop their professional scripts, there will be direct benefits for the patient community and those marginalised by current healthcare practices.

This discussion starter includes voices from both those with lived experience and advocates for the community, medical students and medical educators.

INTRODUCTION

The term queer has come to prominence within recent years, yet it remains widely misunderstood. As evidence regarding disparity of experience for minority groups mounts, now more than ever there must be a call to arms to ensure inclusive curricula. This article serves to advocate for a reimagining of medical curricula, as well as providing an introduction to some of the contemporary terminology and arguments regarding gender and sexuality, noting that educational curricula are typically heteronormative. This is not an issue of semantics or political correctness, but a public health issue, given the health inequalities that exist for the LGBTQIA+ community. The 2018 Stonewall report cited that 13% of LGBTQIA+ people had experienced unequal treatment due to sexuality and/or gender identity. (1) Further, 10% LGBTQIA+ people had been outed without consent in front of staff or other patients. The need for inclusive curricula has never been more important.

Terminology

Queer is an umbrella term used to describe individuals who are from sexual or gender minority groups. Typically, it is a term used by individuals who do not identify as heterosexual or cisgender. Historically, the term was used pejoratively but it has since become a re-appropriated term that is deemed inclusive by many, conveying both identity and community. However, it cannot be assumed that the term resonates with all individuals, nor should it be designated to people. Queer encompasses a plethora of identities, some defined, some yet to be defined. LGBTQIA+ is a widely accepted acronym that captures the range of gender and sexualities within the queer community. However, ignorance often results in the acronym wrongly being dismissed as "alphabet soup". The acronym LGBTQIA+, and terms relevant to queer culture, are defined in Table 1.

The need for inclusive queer curricula in medical education

It is well documented that sexual minority status is linked to stigma, stress, and health disparities(2). There is a need to both educate about, and be educated by, the queer community. Although internationally we are witnessing somewhat of a gender revolution, evidenced by the increased visibility and discussion of gender within politics and media(3), education has not kept pace. Medical education is no exception.

Research suggests that queer individuals face health disparities linked to societal stigma, discrimination, and denial of civil and human rights (4); this further serves to necessitate the need for critical analysis of medical education curricula. (3, 5-8) It is estimated that 2% of the UK population identify as LGBTQIA+(9), equating to roughly 1.4 million individuals accessing healthcare. A 2018 report showed that, of LGBT people surveyed, 1 in 7 (14%) avoided seeking healthcare for fear of discrimination of staff and that LGBT people face widespread discrimination in healthcare settings. This cements the need for comprehensive medical education surrounding the LGBTQIA+ community. This must extend beyond reducing individuals to increased health risks they may face, e.g. centring teaching on HIV around gay men, to a holistic educational approach which allows insight and understanding of LGBTQIA+ identities as a whole. (1)

There are also issues of inequality within the medical workforce. In 2016, The British Medical Association (BMA) and The Association of LGBTQ+ Doctors & Dentists (GLADD) co-authored a report concluding that a significant number of LGBTQIA+ NHS staff experience a negative working environment(10). Over 70% of respondents recounted negative experiences based upon their sexuality, reporting harassment and homophobic slurs(10). Adequate education and representation in medical schools, therefore, may also serve to normalise queer identities amongst peers and colleagues, improving experiences for LGBTQIA+ patients and staff.

The UK is behind - in 2007 The Association of American Medical Colleges (AAMC) recommended that "medical school curricula ensure that students master the knowledge, skills, and attitudes necessary to provide excellent, comprehensive care for [LGBT] patients" by including "comprehensive content addressing the specific healthcare needs of [LGBT] patients" and "training in communication skills with patients and colleagues regarding issues of sexual orientation and gender identity". (11) The UK's General Medical Council (GMC) is less explicit. Their guidance on transgender healthcare, for example, refers only to broad and all-encompassing principles of professionalism. (12) While the statements in Good Medical Practice are broadly inclusive, they are not explicit in their direct inclusion of non-binary or non-conforming identities. More troublesome is that, while the GMC advocate for keeping skills up to date, it refers to illness and disability in its guidance rather than identity and sexuality - this has potential to perpetuate negative connotations and contributes to the pathologising of LGBTQIA+ identities.

There is a clear need for more inclusive, gender-aware curricula that encourage students to sensitively explore the nuances of working with people who identify as LGBTQIA+.

Communication, consultation skills and curricular components

Communication and consultation skills

Communication and consultation skills are essential parts of medical curricula which require further attention to ensure inclusivity. In a study by Laughey et al., medical students' communication skills were criticised, specifically with regard to assumptions being made about patients' sexualities, typically heteronormative assumptions. (13-15) Students often cite discomfort in gathering information from patients with respect to their gender, sexual orientation and sexual history (13), and a similar phenomenon is reported with doctors. (16) We propose that providing students with more opportunities to rehearse and develop their professional scripts would go some way towards countering their discomfort.

Professional scripts are a rehearsed way of asking questions, seeking

Table 1

Glossary of key terms.

Key term	Definition
LGBTQIA+	An acronym which stands for: Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and Plus, which denotes the spectrum of gender and sexuality, and includes terms which are yet to exist. Importantly, some people also use the Q to refer to questioning, as well as queer; and not everyone in the Intersex Community identifies as LGBTQIA+.
Lesbian	Refers to a woman who is romantically or sexually orientated towards other women. Some non-binary people may identify with and also use this term.
Gay	Refers to a man who is romantically or sexually oriented towards other men. Can also be used as an umbrella term for lesbian and gay sexuality. Some non-binary people may also identify with and use this term.
Bi	This is an umbrella term used to describe someone’s romantic or sexual orientation towards more than one gender. Some people will use the term pan synonymously with bi.
Trans	This is an umbrella term for people whose gender is not the same as the sex they were assigned at birth. There are a variety of terms that people who identify as trans may use to describe themselves including (but not limited to): transgender, gender-queer, gender-fluid, non-binary, agender, trans man and trans women.
Queer	Queer can describe anyone in the LGBTQIA+ umbrella and encompasses an intersection of identities. It may be used by those who reject specific labels that describe their romantic or sexual orientation, or gender identity. The term has its origins in a slur, and though largely reclaimed by the LGBTQIA+ community in the 1980s, it is still not embraced as a term by all.
Intersex	Intersex people are individuals whose anatomy or physiology differ from cultural stereotypes of what constitutes a male and female. Intersex people may be male, female or non-binary and can have any sexual orientation and they may not identify as LGBT+. In medical education, variations in sex characteristics are often taught as 'Disorders of Sexual Development', but this term has been rejected and pathologises what is simply a variation of normal.
Asexual	Asexual is an umbrella term used to describe a variation in levels of romantic and/or sexual attraction, including a lack of attraction. Asexual people often adopt the term ‘ace’ to describe themselves. Ace people may describe themselves using one or more of a wide variety of terms, including, but not limited to, asexual, aromantic, demis and gray or grey-As.
+	LGBTQIA is not an exhaustive list. There are infinite ways to think about and communicate gender identity and sexual orientation. The + indicates acceptance, celebration, support and solidarity with anyone whose gender identity or sexual orientation is beyond societal, cultural and community norms.
Cisgender or Cis	Someone whose gender identity is the same as the sex they were assigned at birth.
Heteronormativ e	The belief that heterosexuality, based on the gender binary, is the default or normal sexual orientation.
Cisnormative	The assumption that all people are cisgender.
Pronouns	Pronouns are defined as a word that when used by itself refers to either participants in a conversation or to someone mentioned elsewhere in a conversation with examples being she, they and him. More specifically to the LGBTQIA+ community these are known are gender pronouns. Examples include she/her, he/him, they/them, ze/zir and more. Ze/zir are often used by the non-binary and transgender community.
Gender	A complex social construct that usually refers to someone’s gender identity. Although often expressed in terms of masculinity and femininity, gender exists on a spectrum and is not limited to the male/female binary.
Sex	Assigned to people, often at birth, as a result of their external genitalia. Often used interchangeably with gender, though the terms and concepts do differ.
Transitioning	The steps someone who is trans may undertake to live in accordance with the gender with which they identify. This can involve social transition (e.g. changing one’s name or dressing in a certain way) or medical transitions (e.g. hormonal therapy, surgery). Everyone’s transition will be unique to them and transition can involve many different elements. Importantly, no part of transition is required to justify being ‘trans’ and concepts like the notion of “passing”, where people who are transgender can’t be distinguished from those who are cisgender, contribute to a cis-heteronormative society.
Gender dysphoria	Negative feelings or emotions associated with a mismatch between someone’s gender identity and the sex they were assigned at birth.
MSM	Men who have sex with men, or MSM, is used to describe a group of individuals that may include those who do not identify as homosexual or bisexual, who engage in sexual activity with other men.

consent or describing procedures. For example, students develop their own way to ask a patient to undress to an appropriate level relative to the physical examination about to be performed. By rehearsing and finding their own 'style' the student becomes more confident and comfortable. Script formation is often neglected by communication skills training. Medical schools must provide opportunities for students to develop and rehearse appropriate professional scripts to aid them in liaising with LGBTQIA+ patients.

Providing safe spaces for students to develop their comfort and lexicon is reported as advantageous for preparing students to professionally handle difficult or embarrassing situations (17-20). Such opportunities do not need to reside solely within the formal curriculum, many institutions use the arts and humanities as a way to provide informal opportunities for growth and development. (21) Body painting, for example, is well utilised as a tool to diffuse embarrassment and promote active and fun learning, whilst simultaneously providing students with opportunities to rehearse doctor-patient interactions. (17, 20) Medical students advocate for informal opportunities where they can 'perform the role of a doctor' within a safe place with peer support, devoid of the pressure of assessments such as OSCEs or judgement from faculty.

While modalities such as body painting have been typically used for surface anatomy education (22), as well as for script development, they also prepare students for physical examinations. When delivering formal and informal teaching and learning opportunities, one must be cognisant of the potential impact of the hidden curriculum(23). The notion of 'teaching by stealth' has been reported with respect to the delivery of socio-cultural curricular elements, for example professionalism. However, the hidden curriculum is subjective and individualised so cannot be relied upon as a mechanism by which learning outcomes can be achieved. (23) That being said, it is documented that students observe and imitate role models; thus educators should be mindful of their tacit and implied messaging through biases, language and assumptions. This can include stereotyping in clinical cases or assessment items and by pathologising the sexual spectrum. Further, signposting negative behaviours, such as dismissive communication or making assumptions about sexuality, must occur within the curriculum in order to prevent biases and inequalities from perpetuating within the educational and clinical spaces. In addition, an awareness of the hidden curriculum enables faculties to be conscious of their role in professional identity formation and in providing a supportive environment for students and simulated patients or healthy volunteers who identify as LGBTQIA+. (24)

Importantly, moving away from a hetero-cis-normative status quo in how communication skills are taught is something that will benefit all patients. Entrenched gender binaries harm everyone - assumptions regarding sexuality and gender are not exclusively damaging to the LGBTQIA+ community. For example, assuming a woman has a husband may be damaging to rapport as she may have an unmarried partner, be widowed, single or be in a same sex relationship. What starts as a queer issue, is, therefore, everyone's problem.

Curricular components

Anatomy and clinical skills provide prime examples of curricular components that have not evolved in response to movement in societal norms. There are a number of key considerations with respect to the anatomical and clinical skills curricula. One is that anatomy is taught in a binary context of male and female. Females are typically presented as a variant of male anatomy. Further, the surface and transformed anatomy for post-operative transitioning individuals is not explicitly taught within curricula or advocated for inclusion by regulators or accrediting bodies. That being said, it must be noted that transitioning and surgery are not prerequisites of being transgender.

There are multiple examples which illustrate the need for awareness of transgender anatomy. (25) Firstly, one surgical consideration is that trans men who have undergone subcutaneous mastectomy are left with large scars sub-pectorally; these scars could be mistaken for clamshell lung transplant scarring. Another example for trans men is the need to differentiate between inflammation or infection in the clitoris and labia of a woman against the clitoromegaly and labia atrophy(26) of a trans man who has undergone hormone therapy. An example of a consideration for trans women is that It should be understood that after a trans female has had a vaginoplasty that their neovagina created is a blind cuff (26), lacking a cervix and fornices, in addition to lying more posteriorly; thus, they are better examined with an anoscope.

Importantly, much as it is essential to communicate key learning points such as the above, members of the LGBTQIA+ community ought to also feature in the curriculum, where this is not centred on their gender or sexual identity. This may appear as multiple-choice-question stems, e.g., where a same-sex couple present with a child, the question is not centred on them being same sex; or a transgender person presenting with the flu. The "trans broken arm syndrome" refers to the medical profession unnecessarily relating all aspects of healthcare to someone's gender identity, i.e. an arm is simply a broken arm, regardless if the person is cisgender or transgender. This highlights how a key part of awareness raising may also involve highlighting when it is not relevant to raise a patient's gender or sexual identity.

Pronouns matter

As a term which we use to refer to ourselves and others, pronouns are one way in which we communicate. Pronouns are defined as a word that, when used by itself, refer either to a participant within a conversation, or to someone mentioned elsewhere in a conversation. Examples of pronouns include she, him, they, and ze. More specifically to the LGBTQIA+ community these may be known as gender pronouns. They are used to help those who identify as genders other than those they are assigned at birth to feel more aligned and present within their roles and to reduce dysphoria. A person's pronouns may, or may not, align with their gender presentation.

There is, concerningly, stigma associated with the use of pronouns both within the LGBTQIA+ community, as well as from those not within the community. A study from 2018 shows positive effects by teaching cis gendered individuals about the use of pronouns, and demonstrates that such education gives rise to increases in empathy. (13) Using people's preferred pronouns demonstrates respect and encourages inclusivity. Ensuring correct pronoun usage when communicating with patients and peers helps individuals to feel welcomed and safe within healthcare. It can be difficult to know someone's pronouns just by looking at their face, but there are ways to make it easier to ask and to use the appropriate pronouns for each individual. A way of asking for someone else's pronouns is as simple as telling yours to them. This can encourage others to disclose their pronouns to you. Everyone can make mistakes; if you know you have misgendered someone there is no better way resolve the situation but to apologise, correct yourself and move on. It is not appropriate to dwell on the situation, as this can cause additional discomfort for the person who has been misgendered.

Gender neutral language is another way of promoting inclusivity. An example of a gendered terminology still in use today is the phrase "Hello, ladies and gentlemen". A more inclusive, gender-neutral way of addressing an audience is "Hello everyone". Through a small change in phrasing, anyone who doesn't identify with male or female genders is now represented within your address. Drawing on an example more specific to the field of medicine, the use of the term 'patient' rather than 'he' or 'she' can increase inclusivity in regard to communication when a person's pronouns aren't known. One area of medicine that is particularly gendered is obstetrics and gynaecology, yet women are not the only service users of this speciality - transgender men or non-binary individuals may also be in need of their services.

Never assuming someone's pronouns, and asking patients for their pronouns, even in traditionally gendered specialities, helps to reduce stigma. Other ways to help reduce stigma concerning pronouns include highlighting your pronouns in your email signature; displaying pronouns in your social media bios; and including them on work badges alongside name and role.

We propose the use of pronouns should be made a standard part of consultations, as integral as confirming name/date of birth, consent, and preferred name/title. Respecting pronouns is an essential part of patient care and, most importantly, suicide prevention; for trans and nonbinary youth who report having their pronouns respected by all or most people in their lives attempt suicide at half the rate of those who do not. (27)

Advocating for others

Advocacy involves speaking up and supporting others when they are faced with inequalities or barriers to living and working in a safe and supported way. (28) All trainee or qualified healthcare professionals have the responsibility to advocate for others, yet advocacy is often overlooked by medical curricula. A lack of attention to advocacy-affirming curricula elements creates a hidden curriculum (24) that sends a message to students that advocacy is not an important or essential part of their current and future practice. Offering formal advocacy-centred curricula components and training within medical schools would go some way to addressing this issue.

Though systemic change is necessary, there are also ways that individuals can improve their advocacy for members of the LGBTQIA+ community. In regard to working alongside, or with, individuals who identify as LGBTQIA+, speaking up against homophobic slurs represents one way to support inclusivity. An interesting source for ongoing data on the use of homophobic slurs is nohomophobes.com, an online social mirror that tracks the use of homophobic slurs on Twitter, created by the Institute of Sexual Minority Studies on Services at the University of Alberta. (29) Since the inception of nohomophobes.com in 2012 until 30th November 2020, the slur "Faggot" was used 25,518 times, "so gay" was used 24,212 times, "no Homo" was used 20,177 times, and "Dyke" was used 12,694 times. Though this only represents discussions on Twitter, it does encapsulate the views of people from all over the world, including those from a variety of socio-economic backgrounds, people of multiple genders, and of various education levels. (29) When you are a witness to the use of homophobic slurs, particularly in a professional capacity, you should speak up against their use and support the person who is subject to attack. Attempting to educate others who use homophobic slurs or outdated language which could propagate inequality is another component of advocacy.

As well as overt forms of homophobia, such as the use of slurs, an understanding of microaggressions must also be embedded into the medical curricula. Microaggressions are described as "brief and commonplace daily verbal, behavioural, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative...slights and insults". (30) Considering microaggressions as a framework for thinking about discrimination emerged in the 1970s with respect to racial discrimination but has since been applied to other protected characteristics. (31) Raising awareness of microaggressions in medical curricula is especially important as they may arise out of implicit bias, and, therefore, be unintentionally perpetrated by people who do not mean harm. This is key, microaggressions are not about intent, but about impact, and may involve assuming heteronormativity, expressing discomfort at LGBTQIA+ experiences or generalising LGBT experiences. Concerningly, microaggressions are linked to poorer psychological outcomes in LGBTQ people, can threaten the patient-doctor relationship, and are linked to stress-related health problems. (31) Further, microaggressions can contribute to discrimination in medical education which leads to minority students underperforming academically when compared with peers. (32) This highlights the need to increase awareness and implement zero-tolerance policies in regard to microaggressions within medical education, as well as encouraging the need for reflection on personal biases.

Advocacy can take many forms. It is not just speaking up when you witness an injustice, but also campaigning for change on a more systemic level - be that within healthcare or within education. We should all be advocates, as relying on people who have lived experience of the LGBTQIA+ community alone to advocate for change puts an unfair onus on members of the community. This can increase inequality, as advocacy can demand significant energy and time and is most often unpaid and unacknowledged work. In encouraging advocacy, it is therefore important that this does not create an additional emotional and academic toll on students who are members of underrepresented groups, because these already face greater stressors and differential attainment. Encouraging advocacy and active allyship in all medical students may be achieved through educational interventions such as active bystander training; and by ensuring that medical schools and educators do not perpetuate views of advocacy being seen as in contrast with professional values.

There have been issues with those who adopt prominent roles as advocates being viewed as 'unprofessional'. This issue derives from a traditionalist and oppressive definition of medical professionalism (24), and action must be two-fold. Firstly, professionalism as a concept must be explored in transparent and open discussions between institutions and students, and institutions must be willing to listen to the concerns of students and reflect upon their own biases in the use of this term. Secondly, there is strength in numbers - if more medical students take up the mantle of advocacy against inequality and injustices, medical schools will be forced to re-evaluate outdated, status quo-maintaining conceptualisations of professionalism.

Health Inequalities & contemporary issues

Consideration of health inequalities and contemporary issues should be given in order to inform curricula development. Stonewall recommends that medical schools engage in a review of their curricula, standards and training to ensure that teaching, and associated training, covers discrimination, including homophobic, biphobic and transphobic language, as well as acknowledging the health inequalities facing LGBT people. (1) Further, it advocates for training on providing LGBT-inclusive care, including specific information on providing trans-inclusive care. (1) An example for curricula inclusion can be taken from a recent study showing that lesbians can have an increased risk of breast cancer due to shared risk factors including not having children; having children later in life; whilst also having higher rates of obesity, smoking, and alcohol use than heterosexual women.(33) The aforementioned example provides significant scope for scenario and clinical case development, or as a springboard for a health inequalities discussion within the formal curriculum. Although it is beyond the scope of this commentary to detail all health inequalities and issues faced by the LGBTQ+ community, medical educators must consider these issues when designing curricula content.

Summary of recommendations for institutions, educators, and students

The integrated recommendations of this article have been summarised in an infographic, provided as Figure 1. This infographic highlights the key messages of this discussion article, and we hope will be used by institutions, educators and students to support the inclusion of queer curricula in medical education.

CONCLUSION

Through this discussion, it is hoped that queer curricula will receive more prominence within medical education. By taking a proactive approach, investing the time to educate the future clinical workforce, the queer lexicon will no longer be dismissed as alphabet soup. Through such education, there is an opportunity to bring about positive change in the experiences of LGBTQIA+ students and patients, reducing stigmatisation and improving health outcomes for these frequently marginalised groups. Further, creating a culture centred upon education and advocacy ensures that the burden does not fall to those with lived experiences to educate others. Health curricula need to evolve to represent the diversification of society.

Figure 1

Recommendations for institutions, educators and students to support the inclusion of inclusive queer curricula in medical education.

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