

Original Publication

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The Case of Ty Jackson: An Interactive Module on LGBT Health Employing Introspective Techniques and Video-Based Case Discussion

Samuel J. Gavzy, MS, Marc G. Berenson, Jilyan Decker, MD, Jason Domogauer, MD, PhD, Andreia Alexander, MD, PhD, Matthew Pulaski, Maria Soto-Greene, MD, MS-HPed, Nelson Sánchez, MD, John Paul Sánchez, MD, MPH*

*Corresponding author: jps304@njms.rutgers.edu

Citation: Gavzy SJ, Berenson MG, Decker J, et al. The case of Ty Jackson: an interactive module on LGBT health employing introspective techniques and video-based case discussion. *MedEdPORTAL*. 2019;15:10828.

https://doi.org/10.15766/mep_2374-8265.10828

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Abstract

Introduction: The Institute of Medicine's 2011 report on lesbian, gay, bisexual, and transgender (LGBT) health and the legalization of same-sex marriage are just two of the numerous milestones that have hastened medical schools' efforts to prepare trainees to address the needs of LGBT community members. Early awareness of sexual diversity through self- and peer introspection and video-based education can help trainees build a foundation towards providing affirming care to LGBT patients. **Methods:** The Kern model was used to develop, implement, and evaluate an interactive multimodal workshop to provide first-year medical students with a formative introduction to LGBT health. Learning objectives focused on comprehending the spectrum of human sexuality, health issues for LGBT patients, and better practices for promoting affirming care. The module consisted of a PowerPoint presentation, sexuality survey, videos of provider-patient encounters, and community-based resources. **Results:** The workshop was implemented among 178 first-year medical students in September 2018, with 93% completing the pre-/postworkshop evaluations. Comparison of evaluations showed an increase in confidence in addressing each of the three learning objectives. Over 85% rated the PowerPoint and videos as very good or excellent. **Discussion:** This workshop was effective in helping first-year medical students appreciate the spectrum of sexual diversity, health issues facing LGBT individuals, and better practices to promote affirming care. The real-time sexuality survey helped trainees appreciate sexual diversity through self-reflection and near-peer sharing. The videos and accompanying discussion provided real-life encounters, along with common pitfalls in and pearls for communicating with LGBT patients.

Keywords

Case-Based Learning, Preclinical Medical Education, LGBT Health Issues, Sexuality Survey, Video-Based Education

Appendices

- A. PPT Presentation.pptx
- B. Facilitator Guide.docx
- C. Genderbread Person Graphic.pdf
- D. Sexuality Survey.docx
- E. Callen-Lorde Intake Form .pdf
- F. Poor Patient-Provider Communication Video.mp4
- G. Competent Patient-Provider Communication Video.mp4
- H. Video Worksheet.docx
- I. Evaluation Form.doc

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

After completing this workshop, participants will be able to:

1. Define and compare terms related to sex assigned at birth, sexual orientation, gender identity, and gender expression.
2. Describe unique health issues and disparities for lesbian, gay, bisexual, and transgender (LGBT) individuals.
3. Develop better practices for promoting culturally competent and affirming care for LGBT individuals.

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 CORE

The Institute of Medicine's 2011 report on lesbian, gay, bisexual, and transgender (LGBT) health¹ and the legalization of same-sex marriage in 2015 by the U.S. Supreme Court² are just two of the numerous milestones that have hastened medical schools' efforts to better prepare trainees to address the needs

and disparities of LGBT community members. A major challenge to this effort has been the lack of faculty with expertise in this area, the lack of inclusion of this topic in many medical textbooks, and an underlying sentiment that LGBT health may be too controversial or sensitive a topic, or not as relevant as other topics, for inclusion in the standing curriculum.³

Among the multiple factors that contribute to the unique health issues and disparities experienced by LGBT community members, bias, prejudice, and stereotyping on the part of health care providers can lead to differences in care.⁴ Concurrently, research has shown that medical students with increased clinical exposure to LGBT patients tend 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.⁵ One could hypothesize that awareness of the sexual diversity of peers might help reduce prejudice towards sexual minorities, facilitate team dynamics, and enhance discussions of LGBT health in the learning and clinical environments.

Reviewing *MedEdPORTAL* publications since 2016 (the initiation of the Educational Summary Report) using the term *LGBT* disclosed 14 modules. Five of them were administered to and evaluated by first-year medical students.⁶⁻¹⁰ Module topic areas included LGBT health broadly, the effect of social determinants on LGBT health,^{9,11} sexual history taking,^{12,13} reproductive health issues,⁷ adolescent-specific health issues,^{14,15} and the health issues of transgender populations.^{16,17} Various educational modalities were used, including PowerPoint (PPT) presentation,^{6,8,11-13} case-based learning,^{6,8,9,14,17} standardized patients,^{12,15,16} and video education.^{15,18} Similar to prior publications, we utilize a PPT to provide a foundation for each of our three learning objectives. Our workshop includes the following innovations: a participant sexuality survey to facilitate introspection and awareness of participants' identity and comfort in discussing sexuality-related topics, a pair of complementary videos to showcase competent and poor communication between provider and patient, graphics to help learners distinguish four dimensions of human sexuality (sex assigned at birth, sexual orientation, gender identity, and gender expression), and a patient intake form highlighting best practices in eliciting sexuality information related to the aforementioned dimensions. Video-based education was chosen as a primary educational modality because it has been shown to help learners appreciate patient perspectives and is superior to text-based learning in teaching correct diagnostic and management skills.^{19,20}

At Rutgers New Jersey Medical School (NJMS), up until fall 2014, preclinical medical education on the health issues and disparities of LGBT community members was offered through elective workshops organized by the student-led LGBT group, Out@NJMS, or the American Medical Student Association's Sexual Health Leadership Course. This approach did not ensure an early, standardized introduction to LGBT health. An LGBT health taskforce committee, consisting of lesbian, gay, bisexual, transgender, queer, and ally students and faculty, was organized to help create, implement, and evaluate an interactive workshop for first-year medical students in their first semester of medical school. This publication describes an educational workshop utilizing published data, community-based resources, and video-based patient-provider encounters to raise medical students' awareness of the spectrum of human sexuality (as described through the dimensions of sex assigned at birth, gender identity, gender expression, and sexual attraction), health issues and disparities of LGBT community members, and better practices in providing culturally competent and affirming care.

The six-step Kern model²¹ was applied by the committee members as a framework for the design, implementation, and evaluation of this workshop, as indicated below:

1. Problem identification and general needs assessment: Trainees conducted a literature search of medical education efforts on LGBT health and undertook an inventory of where LGBT content had been integrated throughout the curriculum at NJMS. Within our curriculum, LGBT content had only been administered uniformly during the third-year obstetrics and gynecology rotation.
2. Targeted needs assessment: This was done via meetings with medical students over the four years to determine where there were inaccuracies and omissions in LGBT health content. Additionally, discussions were held with faculty members to assess their proficiency and comfort in teaching LGBT health.
3. Goals and objectives: Based on student feedback and a literature review, the overall goal of the workshop was to give trainees an appreciation of the spectrum of human sexuality and associated unique LGBT health issues and disparities.
4. Educational strategies: To stimulate an active learning environment, the material was presented in a multimodal fashion. For the discussion of the spectrum of human sexuality, students participated in a survey to share their own sexuality. Videos featuring a patient-physician encounter were incorporated for students to gain a greater appreciation of unique LGBT health issues and to learn how to communicate in a competent and affirming manner.
5. Implementation: The 2.5-hour workshop was administered during the first or second month of medical school matriculation. Small-group facilitators included LGBT and allied students and faculty from NJMS.
6. Evaluation and feedback: Workshop participants were asked to complete a pre- and postworkshop evaluation form.

This resource has been implemented as a mandatory workshop for first-year students since 2015. In 2017, it was integrated into a new course entitled Social Determinants of Health. The workshop introduces trainees to the spectrum of four dimensions of human sexuality and provides an opportunity for trainees to realize that their patients and peers are a part of the LGBT community. Information on unique issues and disparities of LGBT individuals is introduced not only by PPT but also through videos of patient-physician encounters. Additionally, discussion of the videos in a small-group interactive format allows learners to review unique LGBT health issues and better practices in creating a safe space for LGBT-identified patients.

Methods

This workshop features four educational strategies: (1) the use of the Genderbread Person graphic to help learners identify the four dimensions of human sexuality²²; (2) a sexuality survey for learners to reflect on and share their own sexual identity, comfort in discussing sexual health, and experiences with homophobia/transphobia with peers; (3) a didactic PPT presentation to review unique health issues and disparities for LGBT-identified individuals, contributory factors to unique health issues, and better practices to provide culturally competent, affirming care to LGBT-identified individuals; and (4) small-group sessions to view and analyze a pair of videos showcasing competent and poor communication between a provider and patient. Strategies 1-3 can be done in a large-group format; however, Strategy 4 should be implemented among smaller groups of 10-15 students to ensure safe and robust discussion.

This workshop can be presented to medical students, residents, faculty, and even other health professional trainees and faculty (e.g., dentistry). It may work best if one person serves as the main moderator. The ideal facilitator for the large session is a faculty member who is comfortable sharing their

own sexuality and has experience providing sexual health education to patients or community members. Given that small-group facilitators are not responsible for grading students, we believe that their disclosure of personal gender identity and sexual orientation normalizes this content and makes the topic more accessible to learners. For the small-group session, there is an opportunity to recruit a diverse set of facilitators, including medical students, residents, and faculty with various sexual, racial, and generational perspectives. One to two facilitators can implement Strategies 1-3. The optimal timing for the entire workshop is 2.5 hours. However, it can be shortened to 1.5 hours by having the facilitator(s) review the cases in a large-group format rather than using them as a small-group learning experience.

The following resources were used to implement our workshop:

- Appendix A. PPT Presentation: The PPT consists of 48 slides. It provides core content tied to each learning objective (e.g., description of health disparities for women who have sex with women) and introduces interactive exercises (e.g., sexuality survey) to reinforce new knowledge and skills.
- Appendix B. Facilitator Guide: The guide provides a thorough explanation of the content and flow of the PPT slides and the interactive exercises.
- Appendix C. Genderbread Person Graphic: The Genderbread Person graphic is used to help learners understand four dimensions of human sexuality. The image is provided in the PPT and can be distributed as a laminated card to students.
- Appendix D. Sexuality Survey: This survey is part of an introspective, interactive exercise whereby learners reflect on and share with peers, in an anonymous fashion, their own sexual identity, comfort in discussing sexual health, and experiences with homophobia/transphobia in their school setting. To allow for gender-based comparisons, learners can initially be split into two groups, with women (including those who identify as female, woman, transwoman, or transfemale) sitting on one side of the room and men (including those who identify as male, man, transman, or transmale) sitting on the other side, which facilitates survey collection and redistribution between groups. Individuals who do not identify with any of the terms above should be asked to join the side that most aligns with their identity. This approach is recommended in order to allow participation of all without requiring individuals to represent a singular, less common identity. Once the surveys have been completed, they are collected and then redistributed to learners sitting on the opposite side of the room. Students are then asked to stand if the randomly assigned survey now in front of them notes specific responses announced by the facilitator(s). Students should be unaware ahead of time that surveys will be collected and randomly distributed to the opposite sides of the room.
- Appendix E. Callen-Lorde Intake Form: This form is the intake registration form at Callen-Lorde Health Center, a community health clinic that has had experience caring for the LGBT community for the past 30+ years. The form can be utilized to show learners how information regarding sexuality identity can be collected in an efficient and affirming manner from patients. It can be reviewed in a large-group setting or printed out for students to complete for themselves (similar to the sexuality survey) or to circle questions related to sexual identity. Callen-Lorde has provided permission for use of this form.
- Appendix F. Poor Patient-Provider Communication Video: This 5:55-long video depicts a provider taking an initial history from an African American, masculine-expressive, lesbian-identified woman patient with a complaint of abdominal pain. After watching this video, learners are asked to utilize the video worksheet to note what was done poorly and what was done well by the provider in communicating with the patient. Learners are asked to reflect specifically on how the four dimensions of sexuality were addressed by the provider in communicating with the patient.

- Appendix G. Competent Patient-Provider Communication Video: This 7:17-long video depicts the same scenario as the prior video but showcases culturally competent practices in taking an initial history from the same patient with a complaint of abdominal pain. After watching this video, learners are asked to utilize the same video worksheet to note what was done poorly and what was done well by the provider. Learners are asked to reflect specifically on how the four dimensions of sexuality were addressed by the provider.
- Appendix H. Video Worksheet: The video worksheet is used in conjunction with the videos for learners to note what was done poorly and what was done well by the provider in communicating with the patient. The worksheet further stratifies the responses by what was done poorly and what was done well for all patients as well as for LGBT patients.
- Appendix I. Evaluation Form: The evaluation consists of pre- and postworkshop forms. These assess learners' confidence in addressing each of the learning objectives, allowing for a comparison of levels of confidence before and after the workshop. The preworkshop form provides a space for learners to pose questions to the facilitator(s). The postworkshop form includes questions to further assess satisfaction with the workshop, including rating various segments of it, and spaces to note what learners like and dislike about the workshop.

Materials

Additional materials needed to administer the workshop include pens, audiovisual equipment to show the PPT presentation and videos, chairs and tables to support 10-15 participants per table, and printed copies of the worksheet and evaluation forms. Optionally, school-specific LGBT pins can be distributed.

Results

Since 2015, this workshop has been implemented as a mandatory session for first-year medical students, during either August or September. Over these 4 years, the class size has been approximately 178 students. This section describes quantitative and qualitative data reported in the sexuality survey (for the years 2017 and 2018) and in the pre- and postworkshop evaluations (for the year 2018). We include 2 years of data for the sexuality survey to showcase the extent of homophobia and transphobia that may occur in the first few weeks of medical school.

Sexuality Survey Results and Students' Evaluation of Exercise

Data from the 2017 and 2018 sexuality surveys are included in the [Table](#). We found comparable results for most survey items between the 2 years and solely focus on the 2018 results in the following text. A total of 165 students completed the 2018 survey. Of those, 145 (87.9%) reported feeling open or somewhat open talking about sex generally, while 20 (12.1%) reported feeling somewhat inhibited or very inhibited. When responding to the question "In dealing with patients, I anticipate that I will be [blank] talking about sex," 150 (90.9%) students reported being comfortable or somewhat comfortable, with 15 (9.1%) students stating they would be uncomfortable or very uncomfortable. Twenty-three (13.9%) students reported having had sexual contact with someone of the same sex, with 10 students (6%) reporting having had sex with both men and women and 33 (20%) reporting never having had sex. The majority of students (146, 88.5%) reported their sexual orientation as straight, with eight students (4.8%) responding bisexual and the same amount responding gay, and only three students (1.8%) answering undifferentiated. Finally, the majority of students found the survey questions to be mostly appropriate or very appropriate (133, 80.6%), with only 22 students (13.3%) finding them somewhat intrusive and nine students (5.5%) finding them intrusive or inappropriate.

Table. Participants' Responses to Sexuality Survey, 2017 (N = 180) and 2018 (N = 165)

Question and Options	2017	2018
I consider myself [blank] in talking about sex generally		
Open	86	90
Somewhat open	67	55
Somewhat inhibited	23	18
Very inhibited	4	2
In dealing with patients, I anticipate I will be [blank] talking about sex		
Comfortable	90	83
Somewhat comfortable	80	67
Uncomfortable	9	14
Very uncomfortable	0	1
I [blank] had sexual contact with a same sex partner		
Have	22	23
Have never	158	141
I have had sex with		
Men	38	53
Women	73	66
Both	4	10
Never had sex with another person	23	33
My sexual orientation is		
Straight	170	146
Gay	4	8
Bisexual	4	8
Undifferentiated	2	3
Since starting medical school, have you heard a homophobic or transphobic comment while at [name of medical school], either on premises or with peers or colleagues off campus?		
Never	141	126
Only 1 time	16	10
1-5 times	17	4
>5 times	5	2
I found questions on this survey [blank] for medical students		
Intrusive/inappropriate	0	9
Somewhat intrusive	14	22
Mostly appropriate	69	58
Very appropriate	94	75

The final part of both the sexuality survey and postsession evaluation consisted of questions related to whether the students had heard homophobic or transphobic comments on school premises or at school-sponsored events. One hundred forty-one students (85.5%) successfully completed both the sexuality survey and postworkshop evaluation questions exploring the prevalence of homophobic or transphobic comments. When students were asked to describe the homophobic or transphobic comments that they had heard, a range of responses was noted. Six out of 13 student comments remarked on the offhand use of “That’s so gay” or the terms *gay* or *faggot* as an insult. One student reported hearing a remark about “someone whose pronouns did not match their gender expression.” Two students shared that they had heard classmates question the validity of the LGBT content’s inclusion in the curriculum, with one stating “that being gay is not biologically relevant so it should not be ‘a thing’; it was very upsetting” and another noting that a fellow student “did not believe asking about pronouns was important and took away from the [medical] exam.” Of note, one student made the following remark in a postsurvey: “Technically it’s not a school-sponsored event but it was the entire first-year class going . . . for a night out. I was the one who made the comment. . . . [They were] saying how a fellow student was good-looking and I said ‘Yea, he is a very good-looking guy, no homo.’ I felt like other people in the car may have got uncomfortable with the last part” (the term *no homo* being a common colloquialism for heterosexuals to state clearly their sexual orientation when making a comment that could be construed otherwise).

The sexuality survey was rated highly. The majority of learners who commented enjoyed the interactive nature of the workshop and, particularly, the visual comparison (by gender) of responses in real time. One student noted, “I liked . . . seeing how diverse our class was. It made me realize that I had made assumptions about a lot of my peers, and I want to prevent myself from making these assumptions in the future.” Another student reflected on specific items: “For example, I did not know that students have heard

homophobic remarks around campus or that so many feel asking these questions of medical students is inappropriate or intrusive.” Eleven out of 13 who commented once again remarked on the workshop’s interactive nature as a positive aspect. Of note, three students indicated that they felt the survey lacked adequate anonymity; all three reported that completing it in a lecture hall would allow students sitting near them to potentially see their individual responses. Finally, one student did not like the separation between men and women as it “endorse[d] binary.”

Students’ Evaluation of Paired Videos and Small-Group Discussion Exercise

The videos and discussion groups were also highly rated; however, there was more thematic diversity in the responses. Twenty out of the 30 participants who provided feedback commented on the unique and helpful nature of seeing both a poor provider-patient communication video with many pitfalls and a competent provider-patient communication video with several pearls. Ten students noted that the videos provided them with “better ways to ask [sensitive] questions,” while others said that the videos were “very helpful in preparing for real-life encounters.” Students also appreciated the small-group conversations, noting that they “fostered good conversation” and “provided an excellent space to ask honest questions that may have been difficult to ask in the huge lecture.” One student noted that this was the “most helpful” portion of the session. Other students felt that the poor provider-patient communication video was exaggerated in terms of the degree of poor clinical performance by the medical student interviewer. One student remarked, “Also it would be helpful to go over a video where the medical student isn’t blatantly being a poor medical student. It would be helpful to see mistakes a well-meaning student could unknowingly make.” Another suggested having “another video that is in between the bad and good with micro-aggressions.”

Students’ Evaluation of Genderbread Exercise

Students appreciated the specificity and thoroughness in defining terms. One student remarked that the session “brought up terminology that is often misused,” while another noted it “definitely exposed areas that I need to improve on in regards to the difference between gender identity and gender sexuality.” One student specifically commented that the Genderbread Person was “a great tool to learn terms.” Another student commented that “it would be great if more sexualities such as asexuals and pansexuals were introduced.”

Pre- and Postworkshop Evaluation of Self-Perceived Confidence in Addressing Learning Objectives

Participants were asked to rate their perceived confidence in addressing the objectives both prior to and after the session on a 5-point Likert scale (0 = *No confidence*, 4 = *Complete confidence*). Using the paired-sample *t* test, mean ratings for the first objective (define/compare terms) increased from 2.78 pre- to 3.59 postsession ($p < .001$). For the second objective (describe unique health issues/disparities), mean ratings increased from 2.34 pre- to 3.34 postsession ($p < .001$). For the third objective (develop better practices), mean ratings increased from 2.24 pre- to 3.42 postsession ($p < .001$).

Overall Evaluation Results

Using a 5-point Likert scale (0 = *poor*, 4 = *excellent*), participants’ mean rating of the lecture was 3.46; 87.3% rated it as very good or excellent. For the video portion, participants mean rating was 3.59, with 87.9% rating it as very good or excellent. Participants reported many strengths for the overall program. Nine students reported specifically enjoying the program’s interactive nature. Students felt the content was informative and filled both a knowledge and a skills gap. One student said, “It allows us to reveal inner unconscious assumptions that we make.” Another reported, “I thought I was well-informed but I was wrong. Now I feel more comfortable with the topic and feel more confident on the issue.” Two students specifically appreciated the use of video examples to delineate better practices when caring for patients who are women who have sex with women.

Discussion

Participants reacted favorably to the content and instructional methodology of this novel multimodal workshop consisting of PPT slides, an introspective and interactive sexuality survey, and video-based cases. Mean confidence in addressing the learning objectives increased substantially after the session, indicating that students had greater comprehension of terms related to sexuality, awareness of unique health issues, and knowledge of better practices when caring for LGBT-identified individuals.

A cornerstone of the development and implementation of this workshop was the involvement of LGBTA-identified medical students. Historically, the LGBT climate at medical schools has been suboptimal, with faculty members reticent to disclose their identity, let alone participate in and/or lead educational endeavors in this area. By integrating near-peers passionate about LGBT health, the module (a) was more relatable to the target audience and (b) created an opportunity for faculty members to support student efforts without feeling they were pushing an agenda. Such an approach could also mitigate a feeling of tokenism that can affect LGBT faculty leaders. Additionally, student engagement had a secondary benefit of creating diversity-related leadership opportunities for students early in their careers. Moreover, it has been suggested that providers who have a niche outside of their primary work experience greater satisfaction and may be resistant to burnout.²³

Early in first year, medical students typically receive instruction on medical ethics, professionalism, diversity and inclusion, and clinical skills but get little exposure to the clinical environment. With scant formal clinical space available, the best setting for students to start applying new LGBT-related knowledge and skills, we believe, is within their own medical school community. The use of the sexuality survey allows students to (a) better understand their own and their peers' dimensions of sexuality, (b) take inventory of their own comfort and preparedness for discussing these essential topics, and (c) unveil their own assumptions and biases about their peers (and future patients), all while maintaining anonymity. Most importantly, this exercise helps provide a foundation for lifelong habits of practicing inclusion and acceptance that lead to better team dynamics and provider-patient communication. One important barrier to the success of this exercise was a perceived lack of anonymity when filling out the surveys in the presence of peers. Several options exist to help mitigate this, including having surveys placed in folders before being collected for redistribution, having surveys completed online prior the session, or providing paper copies prior to the session to be handed in at the start of the session.

The video cases and accompanying small-group discussion serve as an invaluable interactive exercise. Integrating a small-group component allows students to ask questions and engage in discussion that would be somewhat harder in a large lecture hall. The use of the videos lets students engage their critical thinking skills in real time after having been exposed to didactic content. The use of a competent provider-patient video demonstrating best practices also presents a realistic model for an ideal patient encounter; such modeling fills a consistent gap in current medical education trends. Although some students commented that the poor provider-patient video seemed exaggerated, all the content was created using our combined experience from real-life encounters. We recommend stressing this fact to learners so they appreciate that what may seem exaggerated to them is in fact deeply rooted in reality.

Including questions on the sexuality survey regarding experiences with homophobia and transphobia in the medical school setting helps students and academic leaders learn early on about their educational climate. It affords learners the opportunity to critically evaluate their own experiences and those of their peers in real time and helps establish an accepting environment for patients and learners. Collecting data on the frequency and burden of phobias and isms in the nonclinical and clinical environments can aid institutional leaders in quickly investigating and addressing any reported incidents.

To allow for integration of the educational and clinical environments, participants were given an NJMS LGBT lapel pin to be worn on their white coats. Displaying the pin acknowledged a commitment to provide competent care to members of the LGBT community. It also allowed students to engage residents, faculty,

and other health care staff on the issue; anecdotally, several of our students shared stories of how the pin sparked lengthy discussions regarding diversity education and LGBT care. Finally, the use of palm-sized Genderbread cards provides a portable reminder about the dimensions of human sexuality that can be referenced in clinical environments or shared with patients and practitioners alike.

Limitations

Data were collected immediately after the sessions to assess the perceived effectiveness of the workshop in reaching our stated objectives. In our curriculum, this content is not formally examined or tested as it is felt that students should have an immersive experience without the associated fear of being tested. Given this, there is no direct way to evaluate performance on our objectives, though the material is covered in an OSCE during the clinical years. Different institutions may consider including a posttest or other form of assessment as a measure of the success of the program. We also recognize that our learning objectives address more than one item at a time; in subsequent iterations, we recommend that the educator modify the learning objective to include one learning term and one topic per objective. For example, for “Defining and comparing terms related to sex assigned at birth, sexual orientation, gender identity, and gender expression,” separate definition and comparison into two separate objectives. Similarly, for “Describing unique health issues and disparities for LGBT individuals,” separate unique health issues and disparities into two separate objectives. We have opted to use the term *better practices* rather than the typical *best practices* to recognize the lack of published evidence-based literature to date on culturally competent and affirming care for LGBT individuals.

In conclusion, LGBT education for medical students remains a challenge for medical schools and faculty alike. This novel multimodal workshop using didactic sessions, introspective and interactive surveys, and video cases with small-group discussion provides a strong approach that has been well received by students and can increase perceived confidence in outcome-based objectives regarding care for the LGBT community.

Samuel J. Gavzy, MS: Fourth-Year Medical Student, Rutgers New Jersey Medical School

Marc G. Berenson: Fourth-Year Medical Student, Rutgers New Jersey Medical School

Jilyan Decker, MD: Resident, Obstetrics and Gynecology Department, Rutgers New Jersey Medical School

Jason Domogauer, MD, PhD: Resident, Medicine Department, Rutgers New Jersey Medical School

Andreia Alexander, MD, PhD: Assistant Professor of Emergency Medicine, Indiana University School of Medicine

Matthew Pulaski: Fourth-Year Medical Student, Rutgers New Jersey Medical School

Maria Soto-Greene, MD, MS-HPEd: Executive Vice Dean, Rutgers New Jersey Medical School

Nelson Sánchez, MD: Associate Professor of Medicine, Weill-Cornell Medical College

John Paul Sánchez, MD, MPH: Associate Dean, Diversity and Inclusion, Rutgers New Jersey Medical School

Acknowledgments

The coauthors would like to thank Julia Kirchner, MD, for her contributions to the taping of the video.

Disclosures

None to report.

Funding/Support

None to report.

Informed Consent

All identifiable persons in this resource have granted their permission.

Ethical Approval

Rutgers University Health Sciences Institutional Review Board approved this study.

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Received: December 31, 2018 | Accepted: April 29, 2019 | Published: June 4, 2019