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Dana Dudzinska-Przesmitzki
University of Connecticut

Matthew A. Eichler
Texas State University

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If Physicians “Don’t Ask” and LGBT Patients “Don’t Tell,” Then Who’s Talking?: Educational Strategies for Addressing Health Care Disparities Facing LGBT Patients

Dana Dudzinska-Przesmitzki, University of Connecticut, USA
Matthew A. Eichler, Texas State University, USA

Abstract: Numerous disparities exist in the provision of health services to LGBT people. The utilization of theoretical-grounded and empirically- tested adult educational strategies (e.g., deliberate practice and concept mapping) within medical education may improve the quality of health services offered to LGBT people.

Introduction

Recent advances in medical care enable physicians to provide today’s patients with unparalleled service not known to past generations. However, all segments of the U.S. population do not benefit equally from these gains (Dykes & White, 2009). Medical advocacy literature, for example, is ripe with instances of health care disparities encountered by ethnic and religious minorities, women, children, the elderly, the handicapped, the poor, and prison inmate populations (Dykes & White, 2009). Much less discussion though, has centered on the disparities encountered by lesbian, gay, bisexual, and transgender (LGBT) groups.

Of the LGBT research discussions that have occurred the focus is often limited to HIV/AIDS related issues (Arend, 2005). Although such research is valuable, it does not reflect the depth and breadth of health care and related disparity issues facing LGBT patient-groups. For example, lesbians are less at risk for contracting HIV and other STDs than heterosexual women (JAMA, 1996). However, few studies have noted that physicians tend to incorrectly assume that this decreased risk limits the possibility of developing other gynecological diseases (e.g., breast and ovarian cancer), leading physicians to erroneously omit certain routine exams and tests and to downplay to their need to their lesbian patients (JAMA, 1996). One study by the Gay and Lesbian Medical Association (GLMA), an organization of gay, lesbian, and bisexual U.S. physicians found that 45% of GLMA gynecologists had “observed substandard or denied care” given to homosexual patients (Schatz & O’Hanlan, 1994, p. 28). A doctor from the study commented that, “other OB/GYNs here don’t do Pap smears on a lot of their openly lesbian patients” (Schatz & O’Hanlan, 1994, p. 15). Other researchers have observed that on average lesbians have Pap tests at intervals nearly three times longer than heterosexual women (Robertson & Schachter, 1981). Sadly, the omission of such exams and tests, due to the assumed lack of need, leaves lesbians vulnerable to develop diseases that many physicians assumed they are unlikely to experience creating a healthcare disparity for this population (JAMA, 1996).

Issues of healthcare disparities are defined here as the, “differences in the quality of healthcare attributable to variability in the operation of healthcare systems or to discrimination at the patient-provider level” (Dykes & White, 2009, p. 2598). Scholars addressing LGBT healthcare disparities have argued that these issues exist, in part, due to deficits in LGBT content curricula (e.g., time spent of LGBT health issues and interacting with LGBT patients) in medical institutions (GLMA, 2001). Indeed, a survey of American medical schools revealed that a paltry total of 3 hours and 27 seconds was the average amount of time devoted to the study of

homosexuality for all 4 years of medical school (Wallick, Cambre, & Townsend, 1992). And, most of this instructional time was spent in lectures on human sexuality rather than dealing directly with LGBT patients (Wallick et al., 1992).

In 1995, the American Medical Association (AMA) took an initial step to address this dearth of education regarding LGBT patient populations. They issued a policy statement recognizing the critical need for medical students and physicians to receive more extensive LGBT instruction, and advocated for increased instructional time in educational settings (AMA, 1995). A study conducted 3 years after the AMA's statement, however, revealed that half of family practice departments in the U.S. devoted no time to LGBT health issues, while the other half spent roughly 2.5 hours on the topic (Tesar & Rovi, 1998). The outcome of such lackadaisical inclusion is the creation of culturally unaware physicians who are professionally and emotionally unprepared to handle the particular needs of LGBT patients (GLMA, 2001).

LGBT researchers and advocates have criticized medical institutions' seemingly lethargic adoption of LGBT curriculum (GLMA, 2001). They argue that such a lackluster approach is frustrating given psychology studies' repeated demonstration that little personal exposure to LGBT individuals is highly correlated with negative attitudes towards this group (Grack, & Richman, 1996; Walters, 1994). In response, medical educators have acknowledged the need to include educational methods that increase the direct contact medical students have with LGBT patients (Shidlo, 1994). Unfortunately though, since the AMA's policy statement encouraging the development of LGBT content, only a few studies on LGBT curricular innovations (see McGarry, Clarke, Cyr, & Landau, 2002; Sack, Drabant, & Perrin, 2002) have been published.

Of the studies that have been conducted the results are promising. Studies by McGarry et al. (2002) and Sack et al. (2002), for example, found that educational activities exposing medical students to LGBT patients increased students' comfort levels in dealing with LGBT populations, while decreasing homophobic attitudes. While these efforts should be applauded for their contributions to LGBT medical education, the absence of theoretically-grounded and empirically-tested instructional methods in these studies has not provided medical educators with insights on how to develop such learning opportunities.

In an effort to facilitate the adoption of LGBT subject matter into medical education curricula, this paper presents two theoretically-grounded and empirically-tested instructional strategies, medical educators can use in designing curriculum addressing LGBT patient care: deliberate practice and concept mapping. The use of deliberate practice and concept mapping can enable medical students to make more informed and empathic patient-care decisions. These strategies are particularly effective for students with limited exposure to LGBT populations.

Deliberate Practice

The term *deliberate practice* refers to repeated experiences in which individuals attend to the critical aspects of a learning experience and are able to incrementally improve their performance in response to knowledge of results and feedback provided by an external source (e.g., instructor, coach, etc.) (Ericsson, Krampe & Tesch-Romer, 1993). The goal of deliberate practice is not simple repetition. Instead, the goal is to engage with full concentration in authentic, structured, and novel activities of increasing complexity in order to improve learning and performance (Chio & Hannafin, 1995; Ericsson & Charness, 1994; Sonnentag & Kleine, 2000). In this way, deliberate practice is qualitatively different from both work and play; work being concerned with successful execution of previously learned methods, and play

encompassing activities that have no explicit goal (Ericsson et al., 1993). Hence, while neither work nor play activities are explicitly designed to improve learning and performance, deliberate practice activities target specific weaknesses, monitor improvements, and provide feedback and results to the learner in order to improve performance (Ericsson & Charness, 1994).

The development of LGBT curricula using deliberate practice activities would provide students and physicians with repeated, authentic encounters with LGBT patients, focusing on specific issues, under the guidance of instructors. Such activities could be integrated into any stage of the educational process. However, the hands-on learning focus of medical school's third year department rotation, the fourth year clerkship, and subsequent residency years, may be the most opportune time for implementation of deliberate practice activities with students. These medical training stages require students to interact daily with numerous patients under the guidance of faculty physicians. By tailoring learning activities to target student-specific weaknesses surrounding LGBT issues (e.g., knowledge of LGBT health care concerns, ability to conduct comprehensive history collections, skills in identifying common LGBT health risks, etc.), while monitoring improvements, and providing feedback, medical educators can help students develop complex mental representations of LGBT health issues leading to improvements in subsequent diagnosis and treatment (Chase & Simon, 1973; Ericsson et al., 1993). Furthermore, physicians could benefit from similarly designed deliberate practice activities targeting LGBT topics during continuing education classes.

While the of lack knowledge and experience with the unique health issues facing LGBT patients among students and physicians can hinder the quality of care these patients receive it is not the only factor leading to deficient care. Equally critical is the issue of physician-patient relationships. That is, the ability of physicians and students to develop empathic and trusting relationships with their LGBT patients. The use of concept mapping by medical institutions may be a way to address this deficiency.

Concept Mapping

Convention asserts that the practice of medicine is grounded in the ideals of patient sovereignty, professional ethics, and human compassion. Unfortunately, physicians do not always mirror these ideals in their interactions with LGBT patients (Dykes & White, 2009). Numerous studies, for example, have documented gay men's concerns regarding anti-homosexual feelings and discriminatory practices by physicians (Wadsworth & McCann, 1992), nurses (Getty & Stern, 1990) and health care providers in general (Hellman & Stanton, 1989; Paroski, 1987). Other studies have similarly found that lesbians and transgendered persons share these same concerns due to past experiences with physicians' ostracism, rough treatment, and derogatory comments (McCarthy, 2009; Stevens & Hall, 1990).

Negative experiences, like the ones described above, frequently lead LGBT patients to withhold information about their sexual orientation and behavior from their health care provider. In particular, scholars have found that patients will frequently withhold such information if they believe revealing themselves will affect the nature of their relationship with their physician, or the quality of the treatment they receive (Cochran & Mays, 1988; Johnson, Guenther, Laube & Keettel, 1981). However, withholding information inevitably hinders physicians' ability to correctly diagnose and treat patients, decreasing the quality of care patients receive, creating a lose-lose situation for both doctor and patient. To stop this cycle, students and physicians need to be able to foster empathic and trusting relationships, free from a "don't ask, don't tell" mentality,

with their LGBT patients. Concept mapping is one empirically-based instructional tool medical educators can use to help students and physicians examine their mental models of LGBT patients and reflect upon the impact their mental models have on the care their patients receive.

Concept mapping is a graphical elicitation method that can reveal learners' cognitive framework on a subject or domain, resulting in insights into the person's point of view—including biases and misconceptions (Gray, 2007). In concept mapping, learners are given a topic or a focus question and asked to express their response in the form of a map or drawings (Novak & Cañas, 2006). These maps use concepts linked by arrows that are labeled with explanatory phrases. The process emphasizes the “how” and “why” of links giving learners an “explicit point of focus for reflection” (Kinchin & Hay, 2000, p. 45). By engaging learners in such explicative discourses like concept mapping, educators facilitate learners' understanding of themselves and their relation to others in their environment, sparking transformative learning opportunities (Gray, 2007; Habermas, 1984).

The introduction of concept mapping activities could occur at any point of the medical education process. However, since the purpose of concept mapping is to help students and physicians identify both valid and invalid ideas held about LGBT patients (Novak & Cañas, 2006), the sooner it is applied the better it may be. The use of concept mapping during the first two years of preclinical study, for example—when most classes endeavor to develop an understanding of physician-patient relationship—may provide students with a firm self-reflective foundation early on in their medical education. Furthermore, even the most experienced physicians could gain valuable insights from actively reflecting on their notions of LGBT patients and patient relationships during LGBT-focused continuing education courses.

Concept maps could be used to address a variety of LGBT topics that would help students and physicians to develop healthy and empathic relationships with their LGBT patients. Topics and focus questions could ask participants, for instance, to reflect upon the particular trust and support needs of LGBT patients, how to best provide for those needs given the student's/physician's resources, how their own LGBT stereotypes impact the quality of care their patients receive; and how their lives personally and professionally are impacted by LGBT people. Additionally, maps could target known stereotypes in the field of medicine. For example, health advocacy researchers have found that in U.S. medical circles, bisexuals are frequently stereotyped as confused, hyper-sexual individuals, stuck in the coming-out process (GLMA, 2001). Physicians and students adhering to such stereotypes are more likely to subsequently perceive bisexual patients as psychologically damaged, developmentally immature, or as having a personality disorder (GLMA, 2001). Asking students and physicians to concept map how their (or a colleague's) adherence to this stereotype would alter the nature of the relationship between physician and patient, could help learners reflect on invalid assumptions, while considering more empathetic ways of interacting with LGBT patients.

Implementation of LGBT related concept mapping activities provides medical educators with a means to engage students in guided reflection of their mental models of LGBT patients. It is through such reflection (i.e., the checking of the validity of their interpreted experiences and thinking before acting) (Sheckley, Allen & Keeton, 1993) that students and physicians can become aware of known and unknown LGBT-related biases and beliefs that they harbor, and recognize their effects on patient relationships and care.

Conclusion

Medical educators play a crucial role in preparing students and physicians to be knowledgeable and empathic healthcare providers to LGBT patients. Yet if they are to be successful in this endeavor, medical educators need to possess effective instructional methods. We believe deliberate practice and concept mapping are two such methods that should be considered. The application of these methods will aid educators in sensitizing students to the unique health needs of LGBT patients, and improving students' ability to interact knowledgeably, confidently and respectfully with this population. Such interactions are essential because patients who believe their physicians are not only respectful towards their sexual orientation, but also knowledgeable about LGBT health issues, are more like to participate in routine healthcare and adhere to medical recommendations (Bonvicini & Perlin, 2003; O'Halan et al., 1997). Hence, through their curriculum, educators can instill in students and physicians that regardless of their own personal sexual orientation, political or religious affiliations that the highest standard of care is a right, and not a privilege, that must be extended to all patients. Only then can true gains in the elimination of LGBT health care disparities be made.

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