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INNOVATION HIGHLIGHT

Optimizing Psychological Safety: Using a Focus Group to Acquire Perspectives from Standardized Patients Who Identify as LGBTQ+

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Introduction: Gender and sexual minority (lesbian, gay, bisexual, transgender, questioning; LGBTQ+) patients report poor health care experiences, partly because health care providers are not trained to meet their needs. Simulation can help learners practice competencies related to diversity, equity, and inclusion, but there are psychological safety considerations when recruiting standardized patients (SPs). Our objective was to incorporate the expertise of members of the LGBTQ+ community in our SP pool as we developed related curriculum.

Methods: All SPs were invited to participate in a focus group if they identified as LGBTQ+ and wanted to contribute. Content experts developed a focus group guide and facilitated the meeting. Additional members of the research team took de-identified notes. After notes were reviewed for agreement, a thematic analysis was performed. An anonymous survey was sent to SP participants after the focus group meeting.

Results: Six SPs verbally participated in a 90-minute focus group, and 4 completed an anonymous follow-up survey. SPs acknowledged psychological safety risks but universally supported the developing curriculum. Most were willing to assume personal risk for the greater good. They emphasized the importance of lived experience to authentic portrayal, but they were open to eventual broader casting with coaching and proposed SP peer support and learner preparation as possible protective measures.

Discussion: SPs appreciated the recognition of content expertise and opportunity to influence curricular design. They shared concerns about LGBTQ+ SP self-portrayal in simulation and offered creative suggestions to promote psychological safety.

Conclusion: SPs with lived experience can share nuanced feedback and be a resource to co-create curriculum related to diversity, equity, and inclusion.

Keywords: sexual and gender minorities, patient simulation, psychological well-being, curriculum development

Gender and sexual minority (lesbian, gay, bisexual, transgender, questioning; LGBTQ+) patients report poor health care experiences,[1] in part because health care providers are not comfortable nor adequately trained to meet their needs.[2] With growing attention to health care topics related to diversity, equity, and inclusion (DEI), groups such as the American Association of Medical Colleges have issued recommendations to improve competency in LGBTQ+ health care. However, significant gaps remain in implementation and other levels of training, such as graduate medical education.[3] Some learners use elective experiences to fill those gaps, improving their personal comfort and knowledge. However, this approach can worsen the competency gap in

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LGBTQ+ health care between learners in similar programs.

Simulation is a training technique that amplifies real experiences with guided ones and has the potential to help learners practice DEI competencies in health care curricula.[4] Often, standardized patients (SPs) represent real patients, which support a learner's psychological safety. Within a simulation, a learner can speak up as needed without concerns of retribution or embarrassment as they make mistakes and get feedback in real time. Best practices in delivering DEI content are evolving, and there are a number of ethical and psychological safety concerns about recruiting SPs for DEI-related cases.[5] Having an SP with lived experience may provide a more authentic training for the learner. However, the risk of psychological harm for both the learner and SP is greater in this scenario. In other simulation cases, SPs are trained to portray medical conditions or social circumstances that they may not have personally experienced. With increasing recognition of implicit bias, DEI cases are considered somewhat differently. Microaggression, minority stress, stigma, and bias experiences in health care may be more difficult to recognize and respond to without personal experience. However, this call for authenticity must be balanced with the risk of re-traumatization that could occur to people from minority populations who have faced adverse experiences in health care.[5, 6]

We set out to develop a case aimed at improving inclusive care for LGBTQ+ patients through a non-elective curriculum. We determined that incorporating aspects of "co-creation," or consultation with representatives from gender and sexual minority populations, during case development was a best practice to minimize risk of harm to participants.[7] The objective of this study was to incorporate expertise from people within our own SP pool, who had lived experiences as LGBTQ+ people, to help inform curricular design.

METHODS

All members of our SP pool were invited by email to participate in a focus group if they identified as part of the LGBTQ+ community and wanted to contribute. Participation was voluntary. SPs were compensated at their normal pay rate.

A focus group guide (Appendix 1) was developed by content experts (BR, a simulation training specialist; CM, a SP educator from the Simulation Center; and BB, a licensed clinical social worker and faculty member from the Gender Clinic) on the study team. The guide was based on work from a previously published qualitative analysis.[6] The focus group was moderated by BR and BB. The meeting was not recorded due to the sensitivity of the subject. Three additional members of the research team (VH, LM, and CM) observed, selectively participated in an unstructured manner, and took handwritten notes that were de-identified. An 8-question, anonymous survey was designed by consensus among the research team and sent to SP participants after the focus group meeting.

The entire research team reviewed notes for validity and agreement immediately after the focus group meeting and then used a inductive thematic analysis to identify themes and subthemes from their notes.[8]

The MaineHealth Institutional Review Board issued a letter of determination for this project.

RESULTS

Sixty-seven members of our SP pool received emails. Among these members, 6 self-selected as members of the LGBTQ+ community who were interested in helping guide creation of simulated cases.

These 6 SPs attended an in-person focus group in August 2022 that was approximately 90-minutes long. All participants contributed verbally. Table 1 depicts themes, subthemes, and a participant input summary from the focus group.

Of the 6 participants, 4 also completed an anonymous survey after the focus group (Table 2). Survey responses indicated that all participants felt "heard", that "thoughts, feelings, ideas were respected." Three of 4 respondents felt that they could participate in a case related to sexual health, and 1 was unsure. One participant commented that they felt like one member of the focus group may have been "overlooked for comments and input."

Table 1. Themes and Subthemes from the Standardized Patient Focus Group (N = 6)

Themes	Subthemes	Participant input*
Case creation	Mission	"Should happen", "huge topic", "so important"
		Need to teach neutral language, pronoun use
		Feels hopeful—this can help avoid the trauma of health care for LGBTQ+ people
		Wrong name/pronoun use; assumptions; all make patients feel exhausted, demoralized, and angry
	Focused cases vs emphasis in *all* cases	Consider practicing asking for their pronoun in all cases (error less likely to cause harm to the SP)
		Need-focused cases, but also emphasize inclusivity in all cases
Role portrayal	Importance of lived experience (SP is LGBTQ+)	Reactions won't be automatic without that lived experience
		"Don't know what you don't know"
		Richer for the learner
		Interview vs physical exam: interview is just as stressful—misgender can create (bad) physical sensation
	Non-LGBTQ+ SP portrayal	Could a close family member (partner, parent) of an LGBTQ+ person authentically portray? Maybe
		May miss microaggressions
		Would need extra training (look for nuances, such as hesitations, stutters, and euphemisms)
	SP psychological safety	More vulnerable, danger of "self" portrayal—emotional support will be important
		Touch anywhere can be triggering
		Recruitment could be challenging (consider local organizations, other local simulation centers, offer that prospective new SPs could consult with current SPs to discuss safety)
		Reinforce purpose for learners and all their patients to come "suffer through personal discomfort to help"
		Ethical/comfort considerations—gain informed consent from SP, not too many cases in a day, in own clothes (vs hospital gown), virtual in own home (comfortable surroundings) could be helpful
	Role of an ally	Have an ally/observer and discuss after
		Have the SP with lived experience observe—avoids trauma to the SP—and be included in the debrief after
		Third party can engage immediately (person harmed may be emotional, dissociating, not able to react immediately; someone to stand up for you)
		SP with earpiece with directions given by the SP observer
		Observer changes dynamics (better behavior)

Abbreviations: LGBTQ, lesbian, gay, bisexual, transgender, questioning; SP, standardized patient.

* Interpretations of the research team with brief, illustrative quotes to clarify when appropriate.

Table 1. Themes and Subthemes from the Standardized Patient Focus Group (N = 6)

Continued

Themes	Subthemes	Participant input*
Role portrayal	Role of an ally	Emotional partner, “counselor”, “are you okay”, check-in at the end
		Someone else in the room?: depends on the intensity of case, the SP’s personal experience affects their needs
		Would feel more supported with another SP: same level, shared lived experience, shared experience with the SP
		An extra person in the room can be distracting—who to speak to
Learner psychological safety	Pre-education	Learners need pre-education (develop training program)
		SPs need to be clear on how much learners know ahead of time
	Emphasize formative (not summative) experience	Everyone should understand this is practice, not high stakes
		Reinforce educational component, group or 1:1 debrief, communicate what went wrong—that dialogue is key
		Time-outs—taking breaks, “stepping out” as you go along, for everyone including the learner; opens the door for more role-modeling, redo, and do it right (reinforcing); feels better to communicate and correct
	Intersectionality	Consider the genders of the SP and learner, being holistic in the interview but know where to improve focus (such as gender and any history of interpersonal violence)

Abbreviations: LGBTQ, lesbian, gay, bisexual, transgender, questioning; SP, standardized patient.

* Interpretations of the research team with brief, illustrative quotes to clarify when appropriate.

Table 2. Responses to the Post-Focus Group Survey (N = 4)

Questions	Yes	No	Unsure
Did you feel "heard" by everyone present?	4	0	0
Did you feel that your thoughts, feelings, and ideas were respected?	4	0	0
Did you feel that the staff were open-minded and able to take your suggestions in a positive, constructive manner?	4	0	0
Did you feel that this meeting was conducted in a manner that ensured you would have psychological safety and support?	4	0	0
Do you feel that the team you met with during the focus group (and other Simulation Center staff) are qualified enough to provide the right support for an event like this?	4	0	0
Do you feel that you could participate in a sexual health history session?	3	0	1
Do you feel that you could continue to work with a learner in the future if you saw that they struggled (showed resistance, disrespectful behavior, microaggressions, etc) during this encounter?	4	0	0
Did you have any other thoughts that you would like to share that came up after the meeting; things that you would like to add, change, or clarify?	3	0	1
Comments			
"There was a young…woman I was seated next to…, but her name escapes me. I was in a position to see that she was frequently overlooked for comments and input- it's definitely something to be aware of and consider."			
"LGBTQ casts a wide net, so doing a sexual history case is a great starting point because each person (SP) can bring their own personal orientation and perspective to the encounter."			
"This was, hands-down, the most productive and encouraging meeting I've ever been a part of! [T] hank you for asking for our input and truly hearing us."			

Abbreviation: LGBTQ, lesbian, gay, bisexual, transgender, questioning; SP, standardized patient.

DISCUSSION

We incorporated expertise from our SP pool to better understand perspectives and concerns of gender and sexual minorities before launching simulation-based education designed to improve inclusive communication. Our self-selected SP group was overwhelmingly supportive of the initiative and grateful for the opportunity to share their thoughts and perspectives during the curriculum development. They reiterated the risk of harm to the SP inherent in authentic portrayal, considering the very high incidence of adverse experiences in health care among sexual and gender minority populations.[6] However, most SPs were willing to risk personal harm for the greater good because they believed strongly in the mission. SPs gave specific suggestions to better ensure the psychological safety of SPs and learners, including careful consideration of case design and delivery (number and spacing of cases in one day and opportunity to debrief), expectation setting and pre-education ("the more the better"), and allyship or external support (third-person observer and/or video observation, debriefing opportunities with peers, and support from simulation staff). This feedback was used to revise our pilot scenario and format development phase, and was incorporated into future curricula.[7]

There are conflicting ethical values that need to be considered when recruiting SPs who represent a diverse identity.[5] The learner may experience a higher quality scenario with a realistic portrayal of an identity. However, the learner's experience with the SP can also reinforce stereotypes or biases that they hold about the target learning population. One person does not adequately represent a diverse community. Risks to the SP include the possible re-traumatization of SPs during their portrayal, as they may be exposed to learner biases, microaggressions, and possible discrimination. The scenarios could also mirror real-life experiences that they have faced in health care settings.[5, 6]

Noonan et al conducted focus groups with 10 gender minority SPs after delivering a similar case to medical students. They found that "personal connection" to the case was important, potentially very positive, as well as inherently risky. Interestingly, they identified a "dual benefit": student understanding of gender minority perspectives improved and the experience "humanized" the medical community for gender minority SP participants.[6] With our focus group "co-creation" phase of curriculum, before role portrayal, we also noted this dual benefit. Participants expressed gratitude that the educational team and the health care system were ready to tackle an issue of great importance to them.

Both our and Noonan et al's focus groups recognized the feasibility challenges inherent in strict authentic portrayal. Our participants considered whether a broader definition of lived experience, including family members of sexual or gender minorities, could promote authenticity, with or without consultation. Noonan et al's group saw possibility that an entire SP pool could be carefully trained to better portray minority perspectives.[6] Based on input from our focus group, we revised our pilot case (initially written as a transgender patient) to accommodate multiple sexual and gender minority identities.[7] This decision enables SP recruitment from a broader pool and also reinforces inclusivity, ensuring that the training principles were best practice for all patients.

There were numerous limitations to our study. Focus groups were not recorded or transcribed, which would enable analysis via more rigorous qualitative methodology. Although this approach may limit the validity of our findings, we chose this approach because we hoped to foster a safe environment for SPs to collaborate and freely share ideas. Also, we solicited input from a small, self-selecting population that does not reflect the perspective of all identities or individuals. This risk is illustrated by the post-survey comment that another member of the focus group may not have had an equal opportunity to offer input. However, all members of the group verbally contributed multiple times throughout the session. All our participants were existing SPs who likely reflect an implicit bias of believing in the value of contributing to medical education and may not represent views of the general population.

Next steps will include developing additional scenarios designed to improve the care of gender and sexual minority patients. These scenarios will include adopting best practices of inclusive communication across all simulation cases, expanding the diversity of the SP pool as a whole, and adhering to the practice of co-creation in designing curriculum aimed to improve health care for other minority populations.

CONCLUSIONS

Using a focus group of self-selected members of our SP pool who identify as LGBTQ+, we co-created curriculum focused on inclusion of gender and sexual minority patients. Insights gained from this group lead to key revisions in curriculum format and content. Our SPs were grateful to be recognized for their expertise and experience. Most, but not all, focus group participants were comfortable portraying a patient in the subsequent case. Those who were uncomfortable appreciated the opportunity to contribute to curriculum development.

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Conflict of interest: None

REFERENCES

1. Hswen Y, Sewalk KC, Alsentzer E, Tuli G, Brownstein JS, Hawkins JB. Investigating inequities in hospital care among lesbian, gay, bisexual, and transgender (LGBT) individuals using social media. *Soc Sci Med*. 2018;215:92-97. doi:10.1016/j.socscimed.2018.08.031
2. DeVita T, Bishop C, Plankey M. Queering medical education: systematically assessing LGBTQI health competency and implementing reform. *Med Educ Online*. 2018;23(1):1510703. doi:10.1080/10872981.2018.1510703
3. Pregnall AM, Churchwell AL, Ehrenfeld JM. A call for LGBTQ content in graduate medical education program requirements. *Acad Med*. 2021;96(6):828-835. doi:10.1097/ACM.0000000000003581
4. Daya S, Illangasekare T, Tahir P, et al. Using simulation to teach learners in health care behavioral skills related to diversity, equity, and inclusion: a scoping review. *Simul Healthc*. Published online September 26, 2022. doi:10.1097/SIH.0000000000000690
5. Picketts L, Warren MD, Bohnert C. Diversity and inclusion in simulation: addressing ethical and psychological safety concerns when working with simulated participants. *BMJ Simul Technol Enhanc Learn*. 2021;7(6):590-599. doi:10.1136/bmjstel-2020-000853
6. Noonan EJ, Weingartner LA, Combs RM, Bohnert C, Shaw MA, Sawning S. Perspectives of transgender and genderqueer standardized patients. *Teach Learn Med*. 2021;33(2):116-128. doi:10.1080/10401334.2020.1811096
7. Kupferman R, Gray B, Rocheleau B, et al. Improving inclusive communication: pilot results from a simulation-based learning opportunity to practice taking a sexual health history. *JMMC*. 2023;5(2):9. doi: 10.46804/2641-2225.1157
8. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101. doi:10.1191/1478088706qp063oa