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## Medical training and care under the rainbow umbrella

Surgical green joined the rainbow of colours at Toronto's 32nd Gay Pride Day, with 70 physicians joining the MD Pride March to promote better health care for lesbian, gay, bisexual transgender and questioning (LGBTQ) people and improved working conditions for nonheterosexual physicians.

"Many physicians who joined us said this should have been done 20 years ago," explained organizer Dr. David Knox, who terms himself a "queer-identified" family medicine resident completing his training at St. Michael's Hospital, in Toronto, Ontario. "The crowd showed huge appreciation for us."

Knox says there are already plans to expand physician involvement in future marches. The 2012 event drew tens of thousands of revellers and 158 groups onto the streets of downtown Toronto. "Many doctors watching from the sidelines say they'll be joining us next year."

But beyond celebrating gay pride, says Knox, physicians have some serious soul-searching to do with regard to the substantial cohort of LGBTQ patients who, despite progressive legislation and extensive efforts to combat societal homophobia, continue to experience negative interactions with the health care system.

Many nonheterosexual patients consistently report feelings of exclusion, isolation and fear as well as overt homophobia among Canadian health care practitioners, says Knox, citing findings from a recent study of youth and health (*J Child Adolesc Psychiatr Nurs* 2010;23:23-8).

Nonheterosexual physicians also have problematic experiences in the health care system, notes Dr. Nathan Stall, a resident at Mount Sinai Hospital in Toronto who helped organize the MD Pride March. "Physicians and medical trainees encounter extensive homophobic behaviour from colleagues. ... In some fields of medicine, a culture of male heterosexual machismo still prevails."

There is a lack of sensitivity about the "unique" medical needs of nonheterosexual people, Stall adds. "There's good evidence of increased risks of mental health disorders, substance abuse and certain types of cancers in this community. These are people who don't always get good primary health care."

To help sensitize physicians, Stall and Knox are calling for substantial reforms within medical education. "I haven't been taught what to look for, what language to use and what sensitivities to bring to my practice," Stall notes. "We've been taught that this is a population that has a higher risk for HIV, but beyond that we're really taught nothing with regard to caring for nonheterosexual patients."

Typical student grumbling?

Maybe so. But strong evidence suggests the problem is all too real.

According to a 2010 survey of deans of medical education (or equivalent) at 150 allopathic or osteopathic medical schools in Canada and the United States, the median reported time dedicated to teaching LGBT-related content in the entire curriculum was

five hours, and the quantity, content and perceived quality of instruction varied substantially (*JAMA* 2011;306:971-7).

Schools of public health have been found similarly deficient. According to a 2007 survey of 35 schools of public health in the US and Puerto Rico, fewer than 9% of the departments had offered a course covering lesbian, gay, bisexual or transgender health topics other than HIV and AIDS. “The unique and varied concerns of the lesbian, gay, bisexual, and transgender population may not be fully recognized within public health educational programs,” the authors concluded. “Lack of knowledge of the full range of lesbian, gay, bisexual, and transgender health needs can lead to suboptimal health services and programs for this population” (*Am J Public Health* 2007;97:1023-7)

Several Canadian medical educators urge change. “Medical schools do need to spend much more time on this,” says Dr. Mark MacLeod, who teaches surgery at the University of Western Ontario in London and recommends medical schools focus on communication skills and the mental health needs of nonheterosexual patients. “If patients aren’t comfortable they may be reluctant to communicate. This requires a specific focus and thoughtfulness.”

Not only are many physicians ill-equipped to meet the needs of nonheterosexual patients, they are insufficiently trained “to even ask the right sort of questions,” says Dr. Philip Berger, associate professor of medicine at the University of Toronto. As a consequence, physicians may miss the opportunity to address a patient’s increased risk of sexually-transmitted diseases, unique forms of cancer and in some cases, suicide, says Berger.

Physicians also need to be aware that some patients are in the process of discovering that they are actually nonheterosexual, Berger adds. “That’s an extraordinarily difficult situation for both patient and physician. It requires enormous sensitivity.”

Although Berger and Macleod want more pedagogical improvements in training physicians to be more sensitive about the needs of nonheterosexual patients and practitioners, they say progress has been made.

Dr. Christopher McIntosh, head of the Gender Identity Clinic at the Centre for Addiction and Mental Health in Toronto notes that the University of Toronto Faculty of Medicine has expanded some case-based learning courses to broaden the diversity of the examples used, including a case involving a lesbian patient during which students learn “not to make assumptions about marital status or the gender of life partners or sex partners.”

More comprehensive change is in the offing, adds McIntosh, a participant in a current review of curriculum used by the faculty. “The recognition of the importance of doctors being able to provide culturally competent care to a whole range of diverse populations is more generally accepted now.” — Paul Christopher Webster, Toronto, Ont.

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