

Original Publication

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Introductory Learning of Inclusive Sexual History Taking: An E-Lecture, Standardized Patient Case, and Facilitated Debrief

Neha Bakhai*, Julia Ramos, Naomi Gorfinkle, Ryan Shields, MD, Errol Fields, MD, MPH, PhD, Emily Frosch, MD, Robert Shochet, MD, Renata Sanders, MD, MPH

*Corresponding author: nbakhai1@jhmi.edu

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Abstract

Introduction: This student-driven curriculum intervention, implemented with first-year medical students, was guided by the Association of American Medical Colleges' standards for medical education on health care for sexual and gender minorities. Its goals are to describe the spectrum of sexual orientation and gender identity and sensitively and effectively elicit relevant information from patients about their sexual orientation and gender identity through inclusive sexual history taking. **Methods:** Developed through student-faculty collaboration, this three-part module includes a 14-minute e-lecture on taking an inclusive sexual history, a 35-minute formative standardized patient encounter in which students take a sexual history and receive feedback, and a 20-minute facilitated group debrief on the standardized patient activity. **Results:** Students completed a postmodule evaluation anonymously; the majority of respondents (92%) agreed that they felt more prepared to take a sexual history inclusive of sexual and gender minority patients. Most were more comfortable discussing sexual orientation (91%) and gender identity (83%) with patients after the module. Content analysis revealed an improved confidence in creating a safe space for sexual and gender minority patients and an increased awareness of biases about sexual and gender minority patients. **Discussion:** This curriculum serves as an early foundation for students to understand sexual and gender minority identities and develop confidence in their inclusive sexual history taking skills before they provide care for patients. In addition, the student-driven curriculum development process used can serve as a template for students at other institutions hoping to collaborate with faculty to develop comprehensive sexual and gender minority curricula.

Keywords

Cultural Competency, Sexual History Taking, LGBT, Patient-Centered Care, Sexual and Gender Minorities, Sexual Minorities

Appendices

- A. Sexual History Taking Curriculum Guide Schedule .docx
- B. Inclusive Sexual History E-Lecture.mp4
- C. Character Sheet for J Patterson Male.docx
- D. Character Sheet for J Patterson Female.docx
- E. One-Page Guide to Taking an Inclusive Sexual History .docx
- F. SP Encounter Doorway Information.docx
- G. Structured Feedback Form .docx
- H. SP Debrief Session Facilitator Guide.docx
- I. SP Debrief Session Student Guide.docx
- J. Postactivity Evaluation.docx

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

Educational Objectives

By the end of this lecture, the learner will be able to:

1. Describe the spectrum of gender identity and sexual orientation.
2. Explain the rationale for taking an inclusive sexual history.
3. Acquire important information about the patient's sexual health by applying the principles of history taking (i.e., ask permission, make no assumptions, etc.) and the five Ps (partners, prevention of pregnancy/pregnancy desires, protection from STIs, practices, and past history of STIs).
4. Reflect on the standardized patient encounter and how it will impact the way the learner works with patients in the future.
5. Identify and discuss strengths and gaps in conducting an inclusive sexual history taking.

Introduction

There have been great legal and societal strides made nationally for sexual and gender minority (SGM) populations. Despite this, SGMs continue to experience disparities in access to quality health care and in health outcomes.¹⁻⁴ For instance, SGMs experience refusal of care and prejudicial attitudes by medical professionals; a study in 2010 showed that 56% of lesbian, gay, and bisexual individuals and 70% of gender-nonconforming respondents reported experiencing discrimination in the health care setting.⁵

It has been well documented that there is a low rate of disclosure about sexual orientation and gender identity (SOGI) from patients, in part due to the lack of provider training, comfort, and knowledge about SGM issues and sexual history taking.^{6,7} Despite this, many medical schools lack curricula teaching about SGM and inclusive sexual history taking.⁸ A survey of medical school deans showed that US and Canadian medical schools deliver a median of 5 hours of training dedicated to SGMs over the 4 years of undergraduate medical education.⁸ In summer 2014, we conducted a needs assessment at our institution with students from all 4 years of medical school ($N = 114$), which showed that 55% of students had poor or fair knowledge of SGM terminology and 41% reported little or no competence in sexual history taking with a lesbian, gay, or bisexual patient. That same year, the Association of American Medical Colleges (AAMC) released a report outlining professional competency objectives to be integrated into medical school curricula to improve health care for SGMs.⁹

At our institution, we formed the Student LGBTQ Curriculum Team, a student-led initiative to develop a 4-year comprehensive SGM curriculum. Our team recognized that there were many efforts underway to support SGM health in medical education and searched MedEdPORTAL, PubMed, and Google for instructional modules and standardized patients (SPs) related to sexual history taking and SGM health. Our MedEdPORTAL search found existing curricular topics on supporting SGM health running from sexual history taking to eliminating health worker bias.¹⁰⁻¹² However, there was no module that matched our goals and learning modalities, particularly one targeted towards early learners. Therefore, utilizing resources from MedEdPORTAL, the 2014 AAMC report, and the Fenway Institute, our team created a three-part module that was implemented with first-year medical students in September 2015 as an introduction to SGM terminology and inclusive sexual history taking.^{9-11,13} This module can be implemented any time in the medical school curriculum, but it was used in the first year of training at our institution to normalize the topic and create a foundation for future SGM health curricula.¹⁴ As repetitive reinforcement and reflection have been shown to improve learning, the module consisted of three parts: an e-lecture, an SP activity, and a facilitated debrief.

Methods

Three second-year medical student members of the Student LGBTQ Curriculum Team created the module, with support from two adolescent medicine faculty with expertise in SGM health. This team was dedicated to developing and implementing the module in the first-year clinical skills course, which introduces physician-patient communication and history taking techniques. The medical students partnered with the course directors to find space and time within the current curriculum to place the module. Resources such as the AAMC report, the Fenway Institute, and MedEdPORTAL served as content development guides.^{9-11,13} The drafted curriculum was presented to course directors and other experts in SGM health for feedback before its finalization. Members of the team attended the SP session and debrief in order to oversee its implementation and troubleshoot and identify areas for improvement. We have ensured the sustainability of the module by bringing new first-year medical students onto our team. By maintaining a body of students each year, the content and implementation of this module will be continuously reviewed and revised.

Target Audience

The target audience for the module includes learners with introductory-level training in communications and cultural sensitivity. No medical knowledge about sexual functioning or transmission of sexually transmitted infections (STIs) is necessary for participating in this module. This module can be shared with medical students, upper-level trainees, and practicing physicians of any specialty.

Logistics

The schedule includes a detailed breakdown of the timing of each component of the curriculum (see Appendix A). We used a multimodal approach for teaching inclusive sexual history taking; this resource includes a 14-minute e-lecture to be watched before class, an SP encounter, and a small-group debrief session. These components were designed to complement a preexisting sexual history taking small-group activity in which students review the content of the e-lecture and then role-play and discuss five cases. The SP and debrief could be a stand-alone 1-hour session, but our first-year students ($N = 120$) were split into four groups of 30 and did the activity on the day that each group learned how to perform the genitourinary exam.

Curriculum Components

Inclusive sexual history taking e-lecture (14 minutes): Students were asked to view this e-lecture (Appendix B) as the first part of the module. The e-lecture contains didactic slides defining key terminology and concepts related to SGM patients woven into a role-play of a physician taking an inclusive sexual history from a 23-year-old lesbian patient. The e-lecture uses graphics and cartoons to explain the spectrum of SOGI and highlights the importance of inclusive sexual history taking in supporting patients' sexual health. The e-lecture format was selected to standardize the way the content was delivered, as well as to support the varying levels of experience and comfort of students and physicians regarding SGM identities and sexual history taking.

SP encounter (35 minutes): Following the e-lecture, students practiced taking an inclusive sexual history from a middle-aged or elderly male or female widower. One week prior to the session, students were given a one-page document (Appendix E) reviewing key concepts from the e-lecture and providing sample questions for the learner to use while interviewing patients. Students were also given via email the doorway instructions for the SP encounter (Appendix F), which contain basic medical and social history for the patient and instructions for the encounter, prior to their assigned date. Students interviewed the SP for 15 minutes and received 10 minutes of feedback on communication and history taking skills from the SP (Appendix G). This format was selected for students to practice taking an inclusive sexual history in a controlled setting with a trained actor and for students to practice their skills in a safe space before they interview real patients. An SP activity was preferred to student role-plays because it eliminated the tendency for students to make assumptions about SGM identities and reinforce harmful stereotypes. To limit costs, we had students interview the SPs in groups of three but designed the module to have students interview the SP one-on-one. We worked with the simulation center staff to train five SP actors using a detailed character and clinical case description (Appendices C & D). These five SPs each participated in the activity twice per day on 4 different days.

Facilitated group debrief (20 minutes): Students participated in a facilitated group debrief directly following the SP encounter in groups of 15, with two facilitators per group. This modality was chosen to give students a chance to process what they had experienced and share any lessons learned or roadblocks encountered during the exercise. This activity also reinforced the notion of safe space learning, with students being invited to answer open-ended questions from a facilitator and welcomed to build off the reflections of their peers in a nonjudgmental atmosphere (see Appendices H & I). This, in turn, reflected the safe spaces that they were learning to create for their patients.

Analysis

After completing the module, a postsurvey of students' self-efficacy, knowledge, and satisfaction (Appendix J) was completed online. The survey was anonymous and voluntary. Students also answered open-ended questions about the module's impact on their learning of inclusive sexual history taking, and responses were analyzed using descriptive and content analyses.

Results

All first-year medical students ($N = 120$) watched the e-lecture and participated in the SP encounter and accompanying debrief. All clinical skills faculty advisors ($N = 24$) also watched the e-lecture. The completion rate of the student postsurvey was 65% ($n = 78$).

After watching the e-lecture, a majority of respondents strongly agreed or agreed that the e-lecture achieved its learning objectives (Table 1). Ninety-two percent ($n = 72$) of students strongly agreed or agreed that they felt more prepared to take an inclusive sexual history with patients who identify as lesbian, gay, or bisexual. A majority of students (85%, $n = 66$) also strongly agreed or agreed with the statement "I am more aware of the barriers to care that sexual and gender minority patients face" (Table 2). Ninety-seven percent of respondents ($n = 76$) correctly defined the term *transgender*.

Table 1. Student Satisfaction With E-Lecture Achievement of Learning Objectives on 5-Item Likert Scale ($N = 78$)

Learning Objective	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Understand the importance of taking an inclusive sexual history.	0 (0%)	0 (0%)	7 (8.9%)	27 (34.6%)	44 (56.4%)
Use of the principles of history taking (ask permission, make no assumptions) in the context of taking a sexual history.	0 (0%)	0 (0%)	4 (5.1%)	32 (41.0%)	42 (53.8%)
Learn strategies that I can use to create safe spaces for LGBT patients in the context of inclusive sexual history taking.	0 (0%)	0 (0%)	9 (11.5%)	35 (44.8%)	34 (43.5%)
Understand the spectrum of gender identity.	0 (0%)	2 (2.5%)	12 (15.3%)	34 (43.5%)	30 (38.4%)
Understand the spectrum of sexual orientation.	0 (0%)	2 (2.5%)	6 (7.6%)	40 (51.2%)	30 (38.4%)

Table 2. Student Self-Reported Comfort and Preparedness Following E-Lecture Viewing on 5-Item Likert Scale ($N = 68$)

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I feel more prepared to take an inclusive sexual history with patients who identify as LGBT.	0 (0%)	1 (1.4%)	10 (14.7%)	24 (35.2%)	33 (48.5%)
I feel more comfortable discussing topics related to sexual orientation with patients.	0 (0%)	1 (1.4%)	9 (13.2%)	24 (35.2%)	34 (50.0%)
I feel more comfortable discussing topics related to gender identity with patients.	0 (0%)	5 (7.3%)	13 (19.1%)	19 (27.9%)	31 (45.5%)
I am more aware of the barriers to care that sexual and gender minority patients face.	10 (14.7%)	23 (33.8%)	15 (22.0%)	11 (16.1%)	9 (13.2%)

After completing the SP encounter and debrief, a majority of respondents strongly agreed or agreed that the SP exercise achieved its learning objectives (Table 3). Eighty-five percent ($n = 58$) strongly agreed or agreed that they felt more comfortable discussing topics related to sexual orientation with their patients, and 74% ($n = 50$) felt similarly about discussing gender identity with their patients. Eighty-four percent ($n = 57$) strongly agreed or agreed that they felt more prepared to take an inclusive sexual history with patients who identify as lesbian, gay, or bisexual (Table 4).

Table 3. Student Satisfaction With SP Exercise Achievement of Learning Objectives on 5-Item Likert Scale ($N = 68$)

Learning Objective	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Practice using open-ended questions while taking an inclusive sexual history.	0 (0%)	1 (1.4%)	3 (4.4%)	26 (38.2%)	38 (55.8%)
Practice using the patient's terminology while taking an inclusive sexual history.	0 (0%)	1 (1.4%)	7 (10.2%)	25 (36.7%)	35 (51.4%)
Practice speaking to patients about their sexual orientation while taking an inclusive sexual history.	0 (0%)	1 (1.4%)	2 (2.9%)	28 (41.1%)	37 (54.4%)
Practice creating a safe space for the patient while taking an inclusive sexual history.	0 (0%)	1 (1.4%)	2 (2.9%)	23 (33.8%)	42 (61.7%)
Practice taking an inclusive sexual history using the five Ps.	0 (0%)	2 (2.9%)	18 (26.4%)	22 (32.3%)	26 (38.2%)

Table 4. Student Self-Reported Comfort and Preparedness Following SP Exercise on 5-Item Likert Scale (N = 68)

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I feel more prepared to take an inclusive sexual history with patients who identify as lesbian, gay, or bisexual.	0 (0%)	1 (1.4%)	10 (14.7%)	24 (35.2%)	33 (48.5%)
I feel more comfortable discussing topics related to sexual orientation with patients.	0 (0%)	1 (1.4%)	9 (13.2%)	24 (35.2%)	34 (50.0%)
I feel more comfortable discussing topics related to gender identity with patients.	0 (0%)	5 (7.3%)	13 (19.1%)	19 (27.9%)	31 (45.5%)
I am more aware of the barriers to care that sexual and gender minority patients face. ^a	0 (0%)	1 (1.2%)	11 (14.1%)	35 (44.8%)	31 (39.7%)

^aN = 78.

There were three key themes derived from a content analysis of the free responses. First, students had an increased awareness of assumptions made about SGM patients, with comments such as “Moving forward, I will be more aware of assumptions and biases, present a safe space for the patient, and allow the patient to use his or her own language,” and “I will certainly be more conscious about the importance of openness, and I will try to make sure to keep gender and sexual fluidity in the back of my mind when encountering patients.”

Second, students valued the SP experience. One student commented that

the SP’s feedback was very validating. . . . There was a greater measure of respect present when we interviewed an SP we didn’t know. In the [student-enacted] role-play interviews, sometimes members from my group broke character and made comments that totally wouldn’t have been okay to say to a real patient.

Finally, students felt an improved personal confidence in their ability to partner with patients. Student comments included “I really came to understand the importance of partnering and legitimizing the patient and their emotions,” “I will have the language and strategies I need to create a safe space for my patients to share with me an extremely important piece of their health,” and “It was very affirming to see that I could take the history in a way that made the patient feel comfortable. It made me more confident in my history taking.”

The free responses also revealed areas where students would like more support and time to develop their skills in inclusive sexual history taking. Students indicated they would like further training in sensitivity towards noncisgender or transgender patients, with comments such as “I feel comfortable talking with lesbian, gay, or bisexual people, but still wouldn’t feel comfortable in knowing how to talk to someone who is transitioning or is not cisgender.” Students also felt there could be further faculty development. One comment noted that

I think it’s so valuable that this is being included in our curriculum, and I think it’s necessary for faculty to also get a standardized training on this material so they are prepared to have conversations about it in class.

Lastly, students wanted more time dedicated to the topic. One student stated, “I wish I had more time to practice more of the sexual history taking skills; I am glad this experience made me realize that real patient experiences do not necessarily align with our question templates as physicians.”

Discussion

As a result of this student-led initiative, an inclusive sexual history taking three-part module was implemented in a first-year medical student course. After completing this module, students reported an increased confidence in their ability to conduct an SGM-inclusive sexual history, an increased comfort in discussing topics related to SOGI with patients, and an increased awareness of the barriers to care that SGM patients face. This module does not provide a comprehensive SGM-health education, but it has served as an effective introduction to SOGI terminology and practicing inclusive sexual history taking.

The main limitations for implementing such a curriculum are time and monetary resources. A Johns Hopkins University Diversity Innovation Grant covered the onetime production and editing costs of the e-lecture. The costs for hiring SPs for the case are incurred each year for this module and are therefore the largest standing expense for replicating it. We believe SPs who have experience portraying a particular clinical scenario and patient persona are an important expense for the quality and effectiveness of this module, and we therefore recommend utilization of OSCE resources available at your institution as the OSCE's intensive training and orientation to the SP case was an important contribution to its success. A third limitation regarding the evaluation of this module is the student postsurvey response rate, which at 65% represents a low majority and therefore limits the generalizability of our results. Nonresponders to the survey may differ significantly from responders regarding the exercise's delivery and content, which are both attitudinally sensitive and challenging.

Based on formal and informal participant feedback, we recommend the following adjustments to the SP module. While our module was implemented following a 4-hour session in which students were taught the genitourinary exam, we would recommend the SP case be placed on its own day so as to decrease learner fatigue. In addition, students found the group reflection session to be valuable, but when asked, they would have preferred individualized feedback from their faculty preceptors.

Moving outside the scope of the module, the electronic lecture can be utilized as a tool for students to revisit sexual history taking during their clerkships in the future. Although taking a sexual history is a skill for every clerkship, some of the clerkships to prioritize include adolescent medicine, obstetrics and gynecology, college health centers, and STI testing clinics. A simple way to do this is to include a link to the electronic lecture on the course syllabus as well as within the resources tab located on course websites such as Blackboard.

This module can serve as a foundation for teaching inclusive sexual history taking at other institutions. In addition, the approach to curriculum reform we utilized can function as a model for students hoping to effect needed change in their own medical curricula.

Neha Bakhai: Third-year Medical Student, Johns Hopkins University School of Medicine

Julia Ramos: Third-year Medical Student, Johns Hopkins University School of Medicine

Naomi Gorfinkle: Third-year Medical Student, Johns Hopkins University School of Medicine

Ryan Shields, MD: OB/GYN, Yale School of Medicine

Errol Fields, MD, MPH, PhD: Assistant Professor, Department of Pediatrics and Adolescent Medicine, Johns Hopkins University School of Medicine

Emily Frosch, MD: Associate Professor of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine

Robert Shochet, MD: Associate Professor of Medicine, Johns Hopkins University School of Medicine

Renata Sanders, MD, MPH: Assistant Professor, Department of Pediatrics and Adolescent Medicine, Johns Hopkins University School of Medicine

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Ethical Approval

This publication contains data obtained from human subjects and received ethical approval.

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